Bedfordshire, Luton and Milton Keynes
Health and Care Partnership

Transformation of Community and Mental Health* Services

* Inclusive of Learning Disabilities, Autism and Neurodivergence

Case for Change
September 2025

Foreword

Adult community services and all-age mental health services are the backbone of a compassionate, effective health and care system. In Bedfordshire, Luton and Milton Keynes (BLMK), these services support thousands of people every day - helping them stay well at home, avoid unnecessary hospital admissions, live with dignity, and feel supported. They are vital to improving health outcomes, tackling health inequalities, and ensuring people get the right care, in the right place, at the right time.

We are proud of what we have achieved together in BLMK. Across our towns, neighbourhoods and communities, dedicated teams are making a real difference, often in challenging circumstances. Their work is valued, and there is much to celebrate. At the same time, demands on the NHS are changing and we must evolve to meet these. Our population is growing rapidly (21% by 2043), and with ambitious new housing and infrastructure developments alongside an aging population (53% increase in those aged 65+ by 2043), demand for care will continue to rise.

The NHS 10 Year Plan (July 2025) sets a clear direction of travel, identifying three fundamental left shifts that we fully embrace: a shift from sickness to prevention; and a shift from hospital to community and a shift from analogue to digital. In BLMK, we will deliver these shifts with a strong focus on strengthening neighbourhood-based care, ensuring services are rooted where people live and tailored to the unique needs of local areas. These shifts are essential if we are to meet the needs of the future, both for individuals and for our communities.

BLMK is a great place to be. We are a vibrant, diverse and growing region, home to innovation, ambition and a skilled and dedicated workforce. But we must continue to adapt. We must support our people to live longer, healthier lives. We must work across organisational boundaries to deliver truly joined-up care. And we must ensure that every pound we spend delivers maximum impact for our population, our workforce, and our local economy.

This case for change is a critical milestone. It provides a robust, evidence-based account of current experiences, outcomes and system performance. It lays bare both the strengths and the challenges across adult community and all-age mental health services in BLMK. And it gives us a solid foundation to make strategic, informed commissioning decisions that will shape services for years to come.

Our ambition is bold, but essential: to deliver outstanding care, closer to home, that empowers individuals, strengthens neighbourhood connections and communities and enables people to thrive. Together, we can make this a reality.

Robin Porter
Chair of Bedfordshire, Luton and Milton Keynes Integrated Care Board

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The document is split into six key chapters with accompanying appendices that provide evidence to support the case for change. The document begins by setting the context before breaking into specific chapters which focus on Population Needs, Community Services, Mental Health Services (inclusive of Learning Disabilities, Autism and Neurodivergence) and Enablers & Shared Opportunities. The final chapter of the document outlines the priorities which provide a framework for the next stage of this transformation programme.

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The Case for Change is supported by two critical appendices: 1) Data Pack and 2) Engagement Report

Executive Summary

The Case for Change sets out why adult community and all-age mental health services need to be redesigned in BLMK. It is rooted in delivering the 'three shifts' and evidence from population health data, system performance, finance analysis and wide-ranging engagement with residents, service users, carers, our workforce and partners.

Current services are commissioned and delivered through a complex landscape shaped by legacy CCG footprints, resulting in variation in access, models and outcomes for our population. Provision is delivered by a diverse mix of NHS community trusts, foundation trusts, acute hospitals, general practice, independent providers and the VCSE sector. While this diversity brings strength, it also creates challenges in co-ordination, consistency and equity of care, as reported through engagement.

A rapidly growing and ageing population has been projected over the next decade, driven by existing population demographics and extensive house building in BLMK. The cost of continuing to deliver services 'as is' will significantly increase in the next decade which is unsustainable in a system that is already under significant financial and capacity stress.

The case for change considers local and national priorities including the Community Mental Health Framework principles and the NHS 10-Year Plan's "three left shifts": sickness to prevention, hospital to community, analogue to digital, and developing neighbourhood working.

Embedding a data driven approach is a priority and will ensure commissioning decisions are made with the backing of sound evidence. We will continue to develop our Population Health Management approach and make better use of patient segmentation and risk stratification to plan and personalise services for residents in the neighbourhoods they call home.

The BLMK community and mental health workforce is skilled and diverse, but faces significant challenges in succession planning, retention, and data quality. Addressing these issues through improved recruitment, training, and data standardisation, while embedding carers and peer support, will be essential to meet future demand and sustain high-quality care. Strategic workforce planning aligned to the NHS 10-Year Plan and local demographic trends is critical to future sustainability.

What are the key findings from the case for change?

1. **Variation in service models and access** – Historic commissioning arrangements have created different service offers across BLMK, resulting in inequitable access, inconsistent pathways and variation in outcomes.
2. **Limited focus on prevention and population health** – Services are predominantly reactive and medicalised, with insufficient emphasis on upstream prevention, early intervention and addressing the wider determinants of health.
3. **Challenges in care co-ordination and service navigation** – Residents, as reported through engagement, describe difficulty navigating a complex system, with long waits, multiple referrals and repeated storytelling between services.
4. **Provider accountability and cultural shift** – The diverse provider landscape, while a strength, requires clearer local leadership and accountability and a cultural shift towards collaborative, outcomes-based models based on BLMK population needs and place context, in line with the ICB's evolving role as a strategic commissioner.

How do these inform our transformation priorities?

In response to the key findings, six transformation priorities have been developed and tested through engagement. The transformation priorities set out the areas where change will have the greatest impact in addressing the challenges identified in the Case for Change:

- **Priority 1: Develop Neighbourhood Working** – Responds to the finding of variation in service models and access by embedding consistent, place-based multidisciplinary approaches across BLMK.
- **Priority 2: Embed Population Health Management** – Addresses the limited focus on prevention and population health by using data and insight to proactively target need, reduce inequalities and anticipate demand.
- **Priority 3: Expand Innovative Models of Care** – Builds on evidence of rising demand and unmet need by focussing on new approaches to manage complexity more effectively.
- **Priority 4: Deliver Personalised and Coordinated Care** – Directly tackles challenges in care co-ordination and navigation by ensuring care is wrapped around individuals and families, reducing duplication and improving experience.
- **Priority 5: Shift Services Closer to Home** – Responds to pressures on acute capacity and the system's reliance on inpatient care by redesigning pathways so that more care is delivered in community and primary care settings.
- **Priority 6: Strengthen Coordinated Community Urgent Care** – Addresses findings of preventable admissions and high-cost crisis use by creating more responsive urgent and crisis alternatives to A&E and out-of-area placements.

What next?

The Case for Change will now support the programme to move into Phase 2 – Transformational Planning, shifting the focus from why change is needed to what and how it should happen.

This stage will include developing outcomes and service specifications aligned to the transformation priorities; and development of a business case, setting out the preferred options, financial requirements and implementation plan.

Introduction

Community and Mental Health services are central to the health and wellbeing of people across Bedfordshire, Luton and Milton Keynes (BLMK). They support people to live well in their homes and communities, manage long-term conditions, recover from illness, access timely mental health support across all life stages and ultimately positively contribute to society.

The BLMK Integrated Care Board (ICB) invests significantly in these services, spending approximately **£203 million per year on all community services** and a further **£235 million annually on all-age mental health services**. This reflects their critical role in enabling people to stay well, avoid unnecessary hospital admissions, and access holistic, person-centred care.

These services are commissioned and delivered through a **complex landscape of provision shaped by legacy CCG footprints**, which has led to variation in models, providers, and access across the geography. While the ICB is moving towards more strategic and consistent commissioning, historic arrangements still influence how services operate today impacting access to services and the outcomes delivered.

Community health services and Mental Health services in BLMK are **delivered by a diverse mix of providers**, including NHS community trusts, foundation trusts, acute hospitals, general practice, independent sector organisations and the voluntary, community and social enterprise (VCSE) sector. This diversity offers strength but multiple providers with differential service offers also presents challenges in co-ordinated care, consistency and equity.

Crucially, these services do not operate in isolation—they are **a vital part of the whole care pathway**, supporting people and their carers as they receive health and care input at home, from primary care, in community, hospital, and social care. Whether it's district nursing, crisis mental health care, rehabilitation, or talking therapies, these services often provide the bridge between prevention, planned and urgent care.

At their best, community and mental health services sit at the **very heart of integrated care alongside primary care**, bringing together multidisciplinary teams around individuals, carers and families, and wider communities. They are key, along with primary care, statutory and non-statutory organisations, to delivering the NHS's ambition to move care closer to home, reduce pressure on hospitals, and provide more proactive, preventative and personalised support.

As we look to the future, these services will be critical to the success of the BLMK system, in meeting rising demand, delivering financial sustainability and achieving better outcomes for our growing and changing population.

In April 2026, Central East ICB will be established which will be responsible for commissioning services for the 3.2 million population of BLMK, Cambridgeshire & Peterborough and Hertfordshire. In the lead up to 1st April 2026, the current ICBs are working in partnership with a single executive team and that team will take on responsibility for this transformation programme from 1 October 2025, however this does not impact the need for a BLMK case for change.

Why do we need a case for change?

As a health and care system, it is essential that any case for change for transforming services is based on a clear understanding of our population's current and future needs. The case for change will consider the national and local context, including national frameworks, current issues and the three left shifts to prevention, community and digital.

To further understand the challenges and benefits of our local health and care system, the case for change will draw upon a range of quantitative and qualitative evidence to explore:

- Population need, generally and specifically for adult Community and all age Mental Health
- Mapping of existing services – exploring service variation, service gaps and existing areas of collaboration
- Performance – waiting times, patient feedback, CQC reports, quality indicators and demand
- Insights from patients, residents, carers, community and mental health workforce and wider stakeholders
- Exploring link between future neighbourhood needs and Community and Mental Health Services
- Synergies between both adult Community and all age Mental Health Services

The case for change will then set out the transformation priorities which are core to key decision making for current and future Community and Mental Health Services.

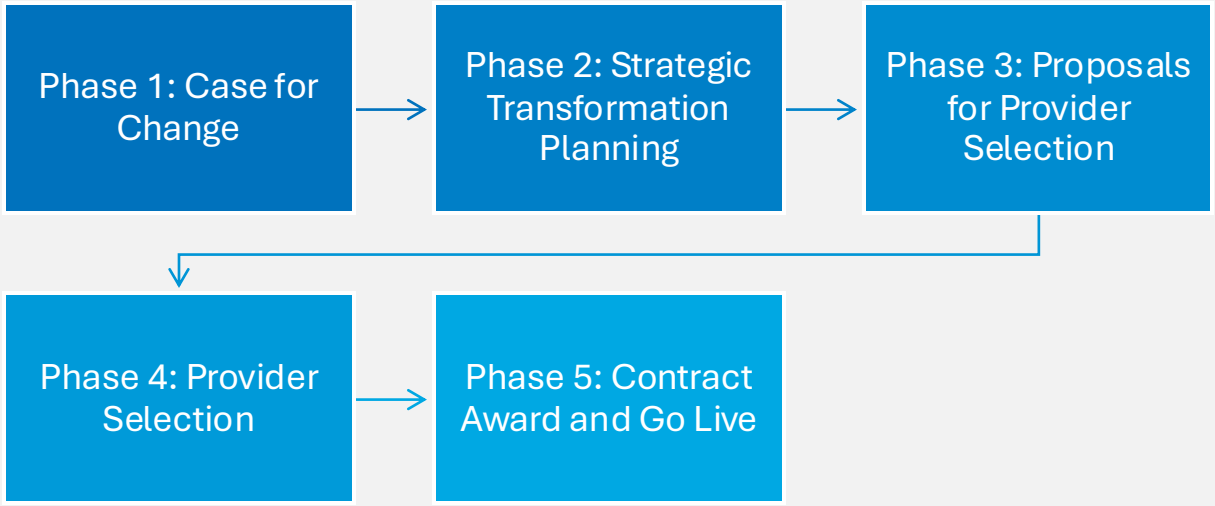
Purpose and Scope

What is the purpose of the case for change?

The case for change explores *why* the current community and mental health provision need to change based on a comprehensive understanding of strategic context, population need, current service delivery, performance and system pressures. It brings together quantitative data and qualitative insight to form a shared understanding of what is working, what could be improved and why.

The case for change sets out the evidence and findings, setting the stage for the transformation priorities which supports the Integrated Care Board (ICB) and Local Authority partners (as a joint approach) to make informed strategic decisions about how to prioritise resources, design care models, and support sustainable services that improve outcomes for our population.

The case for change does not describe the *what* or the *how*. This is developed with providers as part of: Phase 3 Proposals for Provider Selection.



What is in scope of the case for change?

The case for change covers the following services across Bedfordshire, Luton and Milton Keynes:

A. **Community Services for adults**

B. **Community and Inpatient Mental Health Services** (including Learning Disability, Autism and Neurodivergence) **for adults, children and young people**

A definition and more detailed scope for each of these two areas can be found in the relevant chapters: Part B Community Services and Part C Mental Health Services.

Physical and mental health are deeply inter-connected and long-term physical conditions are managed more effectively when mental health needs are recognised and supported — and vice versa. These services are being considered together in a single case for change to understand the synergies or opportunities that a combined case generates. However, no decisions have been made on the future commissioning arrangements for these services, including whether these services will be commissioned together or separately. It is important to note that this case for change does not set out the scope for any future commissioning process.

Community Services for children and young people are out of scope of the case for change as contracts have recently been awarded for all areas except Milton Keynes.

Community and Mental Health Services are commissioned by both the NHS and Local Authorities, often jointly and therefore the scope also extends to include these arrangements.

Vision and Strategic Context: NHS 10 Year Plan (July 2025)

Hospital > Community | **Analogue > Digital** | **Sickness > Prevention**

Integrated, Neighbourhood Based Care
Design services that are neighbourhood-based, multi-disciplinary, and integrated across health, social care, and VCSE to meet local population needs.

Timely Access + Early Intervention
Ensure people of all ages can access mental health support quickly and early, including through self-referral, enhanced primary care pathways, crisis response and mental health teams in schools/

All-Age + Seamless Care
Build age-inclusive services that support smooth transitions, lifelong mental health needs, and trauma-informed approaches for children, young people, adults, and older people.

Narrow Health Inequalities
Design services that are equipped to narrow health inequalities, providing targeted and co-ordinated care based on a deep understanding of population need

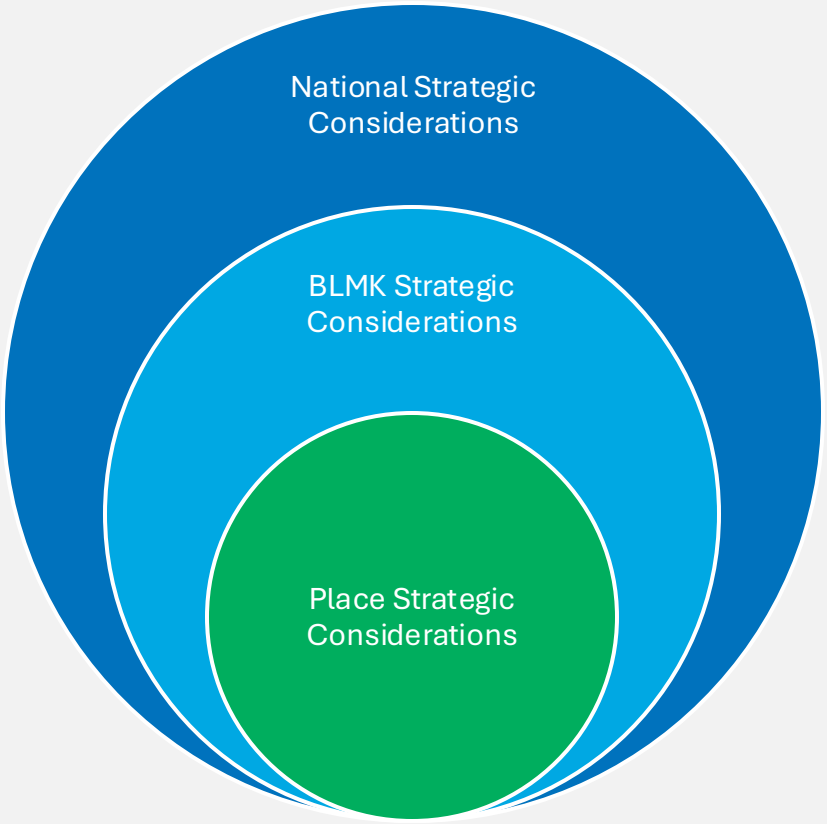
Workforce + Lived Experience
Invest in a sustainable and skilled workforce, including peer support roles, and co-produce services with people who have lived experience.

Achieving continuous improvement
Use digital innovation, advanced data analytics, and outcome-focused commissioning to drive continuous improvement and deliver value for money.

Vision and Strategic Context – National Strategic Considerations

Our **vision** in BLMK is for everyone in our towns, villages and communities to live a longer, healthier life. To **increase** the number of years people spend in good health; and **reduce** the gap between the healthiest and least healthy in our community.

The design of adult community and all-age mental health services aligns strategically with both **national priorities** and the **local ambitions of the BLMK Integrated Care System and priorities at Place**, ensuring care is **more personalised, proactive, preventative, and place-based**.



National Strategic Considerations

The design of adult community and all-age mental health services should consider key national policy and strategy:

- Integrated Care Boards (ICBs) should increasingly adopt the role of **strategic commissioners**, focusing on setting system priorities, driving integration, and aligning resources to deliver improved population health outcomes.
- Services should support the national shift towards **24/7, neighbourhood-based mental health services** to reduce pressure on hospitals. These should work closely with dedicated **mental health emergency departments** to ensure timely, appropriate crisis care and reduce avoidable hospital admissions.
- **Neighbourhood Working,** which could also include **Neighbourhood Health Centres,** should continue to be developed across primary care, social care, mental health and VCSE partners to deliver joined-up, place-based care.
- **Digital** tools, including the NHS App, should be embedded to improve access, enable self-referral, and support care navigation, supported by the ambition to have full digital interoperability across services.
- **Preventative and early intervention** approaches must be prioritised to reduce long-term demand on services. National coverage of mental health support teams in schools and colleges by 2029/30
- **Workforce** models with the right capacity and capabilities should enable integrated, multidisciplinary teams with peer support roles and VCSE collaboration.
- Commissioning approaches should be aligned to **outcomes-based models**, with a focus on delivering measurable impact.
- NHS 10 Year Plan describes new 'Integrated Health Organisations (IHOs)' as playing more of a future role in holding the full health budget for a local population with a responsibility for improving population health
- The service model must actively address national priorities around tackling **inequalities** in access, experience, and outcomes.
- Services should support the **Specialised Commissioning** strategic ambitions to integrate pathways, bringing care closer to home and through collaboration enable more people to be identified as needing support earlier, and following specialist care to be supported sooner in the local system.

Vision and Strategic Context – BLMK and Place Strategic Considerations

The design of adult community and all-age mental health services aligns strategically with both **national priorities** and the **local ambitions of the BLMK Integrated Care System and priorities at Place**, ensuring care is **more personalised, proactive, preventative, and place-based**.

BLMK Strategic Considerations

The design of adult community and all-age mental health services should consider BLMK ICB priorities and local strategy:

- Services must address known **health inequalities** across BLMK's diverse populations as described in the Denny Review, including areas of deprivation and marginalised communities.
- Services should directly contribute to BLMK's three **system transformation priorities** by enabling better support for complex care needs, embedding co-ordinated community and mental health in end-of-life pathways, and improving admission and discharge processes.
- The model should move away from a deficit and medicalised model of care to deliver care and support at the earliest opportunity and reduce the **frequency and severity of crisis** presentations, pressure on emergency and inpatient services.
- Service delivery should be structured around patients, families and carers utilising **neighbourhood** and place-based teams to ensure care is integrated and locally responsive.
- The design must enable the roles of carers and the **VCSE sector** and integrate peer support between NHS and VCSE workforce to enhance reach and community resilience.
- Services should contribute to **financial sustainability** by shifting resources upstream and providing a real alternative to high-cost acute care.
- BLMK is also undertaking an independent **Hospitals Opportunity Assessment** to determine opportunities for services to left shift from hospital into community and/or primary care. The recommendations from this programme will be explored in future phases of this work.

Place Strategic Considerations

Each of the four localities within BLMK has strategic priorities that depend on community and mental health services for successful delivery.

Bedford	Luton	Central Bedfordshire	Milton Keynes
• **Starting Well:** Reduce childhood obesity, boost activity, improve oral health, increase antenatal/childhood immunisations. • **Living Well:** Focus on adults—prevent/manage cardiovascular disease, raise cervical/breast screening uptake, prevent suicide. • **Ageing Well:** Support over-65s to stay independent and healthy in winter. • **Health Estate:** Ensure facilities meet Bedford Borough's needs.	**Vision 2040:** A healthy, fair, sustainable town where no one lives in poverty. Priorities: • Strong, empowered community with fairness and local pride. • Inclusive economy with jobs, business growth, and incomes. • Better wellbeing, tackling inequalities, improving quality of life. • Child-friendly town—safe, healthy, with opportunities to thrive. • Tackle climate emergency; become net zero with sustainable growth.	**Vision:** Improve health/wellbeing, reduce inequalities now and for future. Priorities (2024–29): • Give children best start with focus on education. • Tackle social isolation and loneliness. • Make Central Bedfordshire smoke-free. • Improve integrated health and care outcomes (Place Plan).	MK Deal priorities: • **System Flow:** Improve urgent/emergency care for elderly/complex patients; support safe discharge. • **Obesity:** Reduce rates via referrals, weight services, environmental innovation. • **Children & Young People's Mental Health:** Improve outcomes, reduce inequalities. • **Bletchley Pathfinder:** Trial integrated neighbourhood working for wider use if successful.

Financial Context: National

NHS Revenue/Capital Budgets (DP 11.1)

The NHS in England has a budget of nearly £196 billion this year, but despite a significant allocation its budgets are under severe pressure due to rising demands for services together with increasing costs of delivery. In order to try and balance spending the NHS is required to make efficiency savings each year – in 2025/26 this equates to £11 billion (7% of budget) Although healthcare spending in the UK is about average compared to other countries, the government faces limited capacity to increase NHS funding further because taxes and borrowing are already at an 80 year high. Over the years, NHS funding has usually increased by about 3.7% a year, but future increases will be smaller than that, especially compared to the sizable budget increases the Service received in the 2000s. In addition to this position for revenue, it is generally accepted that over the last 20 years the NHS has under invested in capital resulting in a build up of backlog maintenance and limited investment to fund changes and new technologies. The financial outlook is therefore extremely challenging - the NHS is already having to make significant savings each year simply to maintain current service levels and yet it still needs to accommodate future rises in costs due to an aging population, changes in technology and workforce shortages.

NHS 10 year plan

To address the challenges faced by the NHS, including financial shortfalls, a 10-year plan has been published focused on delivery. Over time, less will be spent on hospitals and more on local services, with new ways of paying that reward better health outcomes rather than just one-off treatments. In the longer term, there is expected to be a move to a new NHS financial model where money will increasingly follow patients through their lifetime. Providers will be rewarded based on how well they improve outcomes for individuals, not solely on whether they provide episodic instances of care on demand.

Whilst the NHS 10 Year Plan is seen as a good blueprint to address these challenges there are no further monies available to deliver the transformation outlined in the plan - this will need to be delivered within existing resources. Organisations must reserve at least 3% of their annual spend for one-off investments in service transformation. Difficult decisions will be needed, and allocation of funding will need to take account of outcomes and a drive towards value-based decision making

Revenue Funding / Allocations from NHS England (DP-11.2)

To meet the population's health needs NHS England allocates the majority of the funding it receives to ICBs. NHSE have a target formula (based on Needs Index), which produces a target allocation or 'fair share' for each ICB.

This is worked out using a formula that includes population factors such as age, illness levels, and local deprivation. Areas with more health needs as calculated by the formula get a greater share of the national funding. Whiles BLMK does have an aging population, it remains relatively younger than other parts of the country. In addition, although there are pockets of significant deprivation in the patch, this is balanced by areas of lower deprivation. As a result, the national capitation formula indicates that BLMK's population, relative to the national average, has less demand for core services, including Community and Mental Health Services, which results in lower than average funding for community and MH services in the ICB allocation under the NHSE capitation model.

In addition to being allocated less money than the national average because of the calculation of relatively less health need, historically, BLMK has in addition received less funding than its calculated target allocation.

In 2025/26:

- The overall system allocation (including Specialist Commissioning) is 3.9% below target, equating to a shortfall of approximately £93 million.
- The ICB Core allocation, used for commissioning secondary care, mental health, and community services, is 1.7% below target, or around £31 million lower than it should be.

NHS England permits a variation of +/- 2.5% from target allocations, which means the ICB may not receive funding that fully aligns with its calculated fair share, particularly as it takes a long time for allocations to catch up. The proposed new clustered ICB will have a combined Needs Index that reflects its larger population. Based upon current information, the proposed new ICB will be over its target fair share of funding. Should the allocation however be adjusted before it is offset by the changes to ICB configurations, BLMK ICB are clear that any additional monies will be targeted against priority areas including investment in community and mental health services

Key Considerations

- The finances for the NHS are extremely challenging currently, with significant efficiencies being required to balance the books
- Further pressure will be put on budgets in coming years through a number of factors including an aging population
- This national picture is further compounded for BLMK due to the national formula that calculates the ICB has relatively less health need therefore receives lower than the national average in funding. Furthermore, the ICB does not currently receive its target fair share of national NHS funding.
- As a result, any changes to improve outcomes from services will need to be financed within existing constrained resources, both capital and revenue. Innovative solutions will be required to address these constraints

Financial Context: Local

ICS Revenue Financial Plans 2025/26

BLMK ICS submitted a balanced revenue financial plan for 2025/26 as did the three constituent NHS organisations; BLMK ICB, Bedfordshire and Milton Keynes Hospital NHS Foundation Trusts (community and Mental Health Trust providers are hosted by systems other than BLMK)

The ICB plan is balanced to its annual allocation from NHSE of c£2.6bn. To meet this target, it will be necessary to deliver c£32m of efficiencies, of which at the point of plan submission c£7m were deemed high risk.

ICB Structural Deficits and Underlying Financial Imbalance

Historical cost growth, particularly in acute, continuing healthcare and prescribing budgets, has outpaced funding uplifts and in previous years our financial plans have relied on non-recurrent (one off) savings to achieve in-year breakeven, masking the scale of underlying pressures. BLMK ICB is currently operating with a material underlying structural deficit, estimated at 1% of allocation – this reflects a mismatch between recurrent funding allocation and actual costs of commissioned services.

ICB Capital Plans for 2025/26

The system receives a system-level capital allocation (System CDEL) from NHSE to cover day-to-day operational capital requirements investments. In 2025/26 this provides £74m of system operating capital; of which c£70m is with local acute providers and £3.7m is for primary care. In addition, the system has bid for other national funding schemes amounting to £74m. This provides a total potential system and national capital allocation of £148m (subject to NHSE approval of business cases). Although this would appear to be a large amount of resources it is not significant in relation to the system's backlog maintenance which is estimated to be over £300m in our two acute Trusts. Importantly, the capital allocation for NHS community and mental providers who provide services in BLMK, but are hosted in other systems (ELFT, CNWL & CCS) is managed within other NHS systems and BLMK has no control as to how this capital is deployed.

Medium Term Financial Modelling

Our medium-term financial modelling shows that without action the financial position of the system will deteriorate over the coming years, potentially leading to the need to deliver ever more challenging efficiency programmes and / or reduced services

In Autumn 2024, the system assessed that without action the gap between available funding and expenditure would grow to c£182m by 2028/29.

We continue to review the best way of delivering services including the financial outlook over the medium to longer term - this work will be supported and tested through the Hospitals Opportunities Assessment during Autumn 2025.

Financial Position of our Local Partners

Our Local Authorities are associate commissioners to a small number of ICB Contracts with NHS community and mental health providers. Councils within the BLMK are operating within a highly constrained financial environment similar to the NHS. As part of the 2025/26 budget-setting process, local authorities have faced difficult funding decisions resulting in careful prioritisation and, in some cases, reductions in non-essential service areas. Key financial pressures includes increased demand for core services, particularly: children's and adults' social care, special educational needs and disabilities (SEND) transport, supported living arrangements and homelessness prevention and support.

BLMK's services providers are facing similar levels of financial challenges. NHS Mental Health providers operating within BLMK (ELFT and CNWL) are currently facing a variety of cost pressures. These include the financial impact of implementing safer staffing levels, managing higher patient acuity, and increased reliance on private sector specialist placements. Similarly, NHS Community Services providers in BLMK (ELFT, CNWL and CCS) are experiencing cost challenges driven by rising demand and inflationary increases in supplies and services.

Key Considerations

- The current financial position for BLMK mirrors that of the NHS as a whole. The system can only achieve a breakeven plan by delivering significant efficiencies
- Despite planning to achieve breakeven for 2025/26, the ICB has an underlying deficit of £26m and if it does nothing to change the position over the next 3 years this will rise to £182m
- System partners also have similar financial pressures and action must be taken to design services in order to, not only achieve better outcomes but also to address future significant financial shortfalls

Financial Context: Financial Considerations for Community and Mental Health Services

ICB Spending on Community & Mental Health Services

The table below shows the amount spent by BLMK ICB over the last 3 years

	2022/23	2023/24	2024/25
	£m	£m	£m
Community	181.4	190.4	203.0
Mental Health	194.9	217.6	235.5

Since 2022/23, expenditure on community services has grown by 12% which is below the level of ICB core allocation growth (14%).

There is currently no nationally reported benchmarking of community services expenditure by ICB, however for the 2023/24 financial year Community Service expenditure was published in response to a Parliamentary question. In absolute terms BLMK spent £177 per head of population on Community Services. However, once adjusted for the community needs based population, BLMK spent £222 per head of population, more than the England average community needs weighted £207 per head of population. BLMK ranked 11 out of 42 ICBs in England for needs based spend per head.

For Mental Health services, expenditure on services has grown by 20.8% since 2022/23 and includes additional investment included as part of the NHS Long Term Plan. The Mental Health Investment Standard (MHIS) was introduced by NHSE to redress historic underfunding in mental health and expand access to services. ICBs are required to increase their spending on mental health services by at least the same percentage as their overall budget increases. BLMK ICB and its predecessor organisations have met the MHIS, which has been subject to independent auditor verification.

The NHS England Mental Health Dashboard shows the proportion of core allocation that ICBs spend on Mental Health services. BLMK spend more than the national average (15.2% in BLMK vs. 14.6% nationally) in spite of assessed Mental Health Need in BLMK (as defined in the weighted capitation formula) being less than the all-England average.

The availability of financial information for community and mental health services is limited. It is often complex and fragmented across service areas, making it challenging to assess overall cost effectiveness. Transparency around how spending translates into outcomes has been challenging, particularly where benefits are typically long-term and harder to measure. As a result, the ICB has faced challenges in using financial data to inform decision-making and in demonstrating the for the level of resources deployed deliver best possible value and outcomes.

In addition to understanding the financial aspects of community and mental health services in their own right, it is also important to consider the impact of these services on other parts of the patient pathway, in particular on acute services

- **Unnecessary acute admissions** represent a significant financial burden to the system. For example, research suggests that potentially 1 in 6 hospital admissions for ambulatory sensitive conditions could potentially be avoided. Despite our efforts to manage demand, such as virtual wards, remote monitoring, and community urgent response services - many patients with ambulatory care sensitive conditions are still being treated in acute hospitals, the most expensive care setting. In BLMK in 2024/25 the costs of avoidable adult admissions is estimated at £31m.
- **Delayed discharges from hospital** are adding millions in avoidable expenditure. NHS Model Health System data shows that the proportion of patients who are clinically ready for discharge but are inhibited by other contributing factors, is higher in BLMK than our ICB peer group. (DP 11.3)
- **ASD / ADHD referrals –** BLMK, much like other systems nationally, has seen a sharp rise in referrals to private sector providers for diagnosis due to the introduction of right to choose pathways - this driving a significant overspend.

Where patients do not receive adequate support in community settings, their conditions often worsen, resulting in crisis interventions that require emergency or inpatient care. Acute care, whether in secondary care or mental health is more often considerably more costly than early intervention, prevention, or ongoing community-based support.

Continued reliance on Acute Trusts to manage growing demand will divert funds away from upstream investments in community and Mental Health Services. This perpetuates a cycle that that keeps unwarranted pressure on the acute sector and leads to escalating acute care costs.

Key considerations

- Despite receiving less than the national average for community and mental health services in its allocation, it would appear that BLMK spends more than the national average on these services
- Complex and fragmented financial data in relation to existing contracts means it is difficult for the ICB to demonstrate that it is achieving value for money and the best outcomes for the resources deployed currently
- Due to the impact of community and mental health services on other aspects of a person's care, continuation of the existing model will result in more and more pressure on the acute sector, which is already at capacity.

Approach to Stakeholder Engagement

In BLMK, we are committed to ensuring that the voice of our residents shapes the future of health and care. Building on the insights gathered from over 3,500 people from engagement and co-design initiatives in BLMK, including The Denny Review, Big Conversation, the Joint Forward Plan, and Community MSK, we have identified consistent, cross-cutting themes:

Cultural Competency	Communication	Access	Representation	Care Co-ordination

These themes have not only guided our current work but have become central pillars of our continued engagement efforts, particularly in the areas of Community and Mental Health.

We have intentionally created new spaces for dialogue, reflection, and collaboration with a wide range of stakeholders - residents, health and care professionals, VCSE (Voluntary, Community and Social Enterprise) organisations, and democratically elected councillors. From the outset and throughout the life of this programme, their voices and lived experiences are informing every stage of our thinking and planning.

Our engagement approach is explicitly designed to reflect the principles of the BLMK Working with People and Communities Strategy: it has been inclusive, ongoing and co-designed, ensuring that voices directly shaping the priorities and evidence base for the case for change.

This is not a one-time conversation. It is an ongoing commitment to listen, learn, and act. Themes from both past and recent engagement will be reflected throughout the core sections of this Case for Change with a more detailed account in **Appendix 2 – Engagement Report**. Our approach has included:

- The **Systems Insight Network** on 6th May 2025 with over 200 public and partners. (ER – 3.1)
- **Appreciative Enquiry Interviews** with 9 residents/service users (ER – 3.2)
- **Resident and Workforce Surveys**. (ER – 3.5)
- **Clinical Senate** on 3rd June 2025 considered the draft transformation priorities with follow-up survey until 26th June 2025.
- **Briefing sessions** with Primary Care, local Councillors (JHOSC) and Board members.
- We have established a multi-professional **Clinical Reference Group** to provide clinical input through key stages of the programme. Membership from ICB, Providers, primary care. First meeting held on 14th August 2025.

- Four **Market Engagement Events** in July-Oct, giving providers the opportunity to feed into the case for change and shape the transformation priorities, outcomes and benefits. Between 39-45 provider representatives from broad range of sectors include VCSE attended the first three events, which were advertised via PIN notice. (ER – 3.3)
- **Communications and Engagement Group** established to guide engagement of this programme, including representatives from Community, Mental Health, Acute providers and VCSE.
- Fortnightly meetings with **lead strategy directors** from our Community, Mental Health and Acute providers.
- Incumbent provider-led **workforce engagement** (over 200 members of staff) and learning from **provider case studies and reports**. (ER – 3.5)
- Engagement with the **BLMK VCSE Strategy Group** and **VCSE Mental Health Alliances** in BLMK. (ER – 3.4.5)
- **Resident feedback groups** on the case for change throughout August and September. Working with **Access Bedford** to help engagement with the deaf community and **Autism Bedfordshire** to run a bespoke focus group. in person in were offered in each place and online to increase accessibility. (ER – 3.4.1)

System Insight Network, 6 May 2025

Market Engagement Event on 10 July 2025

Further supporting evidence available in **Appendix 2 - Engagement Report (ER)**

Part A: Population Needs

This section looks at the key findings from the population needs analysis, including:

- Population growth, ageing and diversity
- Future projections
- Health inequalities and deprivation
- Prevalence and trends for specific conditions
- Needs along the life course

All evidence relating to key statements and findings in this section can be found in **Appendix 1 – Data Pack (DP)**

Part A: Population Needs (1/5)

As a health and care system, it is essential that any case for change for transforming services is based on a clear understanding of our population's current and future needs. This ensures that any design is targeted where it will deliver the greatest impact, address the most pressing inequalities, and anticipate future pressures on services.

The population and needs analysis in **Appendix 1 - Data Pack (DP)** provides a robust evidence base, highlighting the demographic trends, health outcomes, and projected demand that will shape the way our communities use services over the coming decades. By considering these population needs, we can design adult community and all-age mental health services that are responsive to population growth, ageing, and changing health profiles, while prioritising those with the greatest unmet needs. This approach enables us to allocate resources effectively, reduce avoidable health inequalities, and build models of care that are sustainable, equitable, and resilient for the future.

Who makes up our BLMK population and how is it changing?

BLMK ICB serves **1.139 million GP-registered patients** (March 2025).

Deprivation: 34% live in the 40% most deprived areas nationally (DP 1.2)

Overall health: Life expectancy and healthy life expectancy vary widely across BLMK. (DP 2.4)

Locally, healthy life expectancy is getting worse. (DP 2.5)

Mortality has not returned to the 2019 pre-COVID baseline.(DP2.4)

Ethnic diversity: 64% White ethnicity (vs. 82% nationally); higher proportions of Asian, Black, and mixed heritage communities. (DP 1.2)

Ageing population with significant increases expected in older age groups – currently **15% aged 65+** (vs. 18% nationally) but this age group is projected to grow by **53% by 2043.** (DP 2.2)

Population growth: +6.1% since 2019/20, forecast to reach **1.382m by 2043** (+21%)[3]. The **80+ age group will nearly double.** (DP 2.2)

Projections may under-estimate future local growth given recent plans to accelerate housebuilding

Demographic shifts, partly driven by planned housing growth, will increase both the volume and complexity of need.

Disease prevalence rates and numbers of patients with LTCs will increase (DP 3.1) as will multimorbidity.

Where are the biggest gaps in health and who is most affected?

Life expectancy gap: Deprivation has a substantial impact on life expectancy.

The slope index (a measure of socioeconomic inequality in life expectancy) shows the widest gap in Bedford, with inequalities worsening for women across BLMK (DP 4.1)

Ethnic disparities: Higher diabetes and obesity prevalence in Luton and Bedford (DP 5.9, 5,14), which have larger minority ethnic populations.

There are disparities by ethnicity in emergency admission rates and in detentions under the Mental Health Act.

Mental health, LD and Dementia inequality: People with serious mental illness (SMI) have a **3–4.5x higher risk** of premature mortality (DP 4.2).

People with LD or SMI have higher rates of many common physical and mental health conditions. (DP 3.7)

Part A: Population Needs (2/5): Mental health, neurodivergence and learning disabilities

SMI and suicide:

- National evidence suggests that adults with SMI die15-20 years earlier on average. Locally, there are much higher mortality rates in people known to mental health services. (DP 4.2)
- Sadly, the rate of deaths from suicide in BLMK is climbing. (DP 3.2)
- Serious mental illness(SMI) prevalence is increasing gradually, but new diagnoses of depression are more stable in the post-pandemic data. (DP 3.3, 3.5)

Wider mental health:

- National survey estimates suggest that about 1 in 5 children aged 8-16 had a probable mental health disorder in 2023.[4] Half of all adult mental health disorders begin by age 18.[5]
- Between 20-31% of adults in BLMK have a high anxiety score on a survey measure (rates vary by Place).[1]
- The numbers of people with dementia are projected to increase by 71% by 2043.

Neurodivergence:

- The proportion of BLMK children with a diagnosis of ADHD or autism spectrum disorder is rising across BLMK, and there are long waits for these services. (DP 3.9)
- Demand for adult diagnosis is likely to continue to increase.

Learning disability:

- In BLMK, around 0.5% of our population is on the GP LD register (DP 5.13)
- This proportion is slowly rising and population growth and improved life expectancy will also contribute to the numbers of people with LD.[2]
- Rates of physical and mental health conditions are higher in people with a learning disability. (DP 3.7)

Referrals:

- Referrals to both CAMHS and adult mental health services are increasing in terms of both numbers and rates.[3]
- Referrals to memory clinic services are projected to increase by more than 80% by 2043 (DP 4.9)

Key implications for service change:

- Our services need to be flexible enough to manage different levels of need and vulnerability, in order to reduce the mortality risk associated with SMI and learning disability and to ensure equality of opportunity to benefit.
- Early identification of poor mental health in childhood may reduce the impact in later life.
- Managing ongoing demand for neurodivergence diagnosis and services will be important.
- The ageing population will create more demand for age-related MH services but also means that all MH services need to be able to care well for additional older adults.

Further supporting evidence available in **Appendix 1 - Data Pack (DP)**

Part A: Population Needs (2/5): Physical health

Overall health:

- Life expect-ancy and healthy life expectancy vary widely across BLMK. (DP 2.4)
- Healthy life expectancy is getting worse. (DP 2.5)
- Mortality has not returned to the 2019 pre-COVID baseline. (DP 2.4)
- Deprivation-related inequalities in life expectancy are getting worse. (DP 4.1)
- MSK problems and mental health conditions contribute the most to 'years lived with disability'. (DP 2.6)

Disease prevalence:

- BLMK's population is relatively young, and this is reflected in lower overall prevalence of many conditions, including hypertension, CKD, cancer and AF. (DP 3.10)
- Despite this, BLMK has a higher prevalence of non-diabetic hyperglycaemia and diabetes.
- Disease prevalence rates will increase as our population ages (DP 3.1)

Multi-morbidity:

- Multi-morbidity increases with age, and the ageing population means this challenge to our system will increase.
- Increasing numbers of patients with a dementia co-morbidity will impact many services. (DP 3.1)
- People with depression, serious mental illness, or learning disability, are much more likely to have physical health comorbidities. (DP 3.7)

Towards end of life:

- The number of deaths is predicted to increase by 19% by 2034/25 and by 38% by 2042/43. (DP 4.5)
- Deaths / proximity to death are a good predictor of demand as on average a person will consume 1/3 of their lifetime care costs in the last two years of life.

Referrals:

- Referrals to services associated with older age are projected to see very large increases in the next 20 years (to 2043) (DP 4.8, 4.10)
- For example, a 77% increase in referrals to Crisis Response Intermediate Care, and to Home-Based Intermediate Care community services, and a 69% increase in referrals to District Nursing.

Key implications for service change:

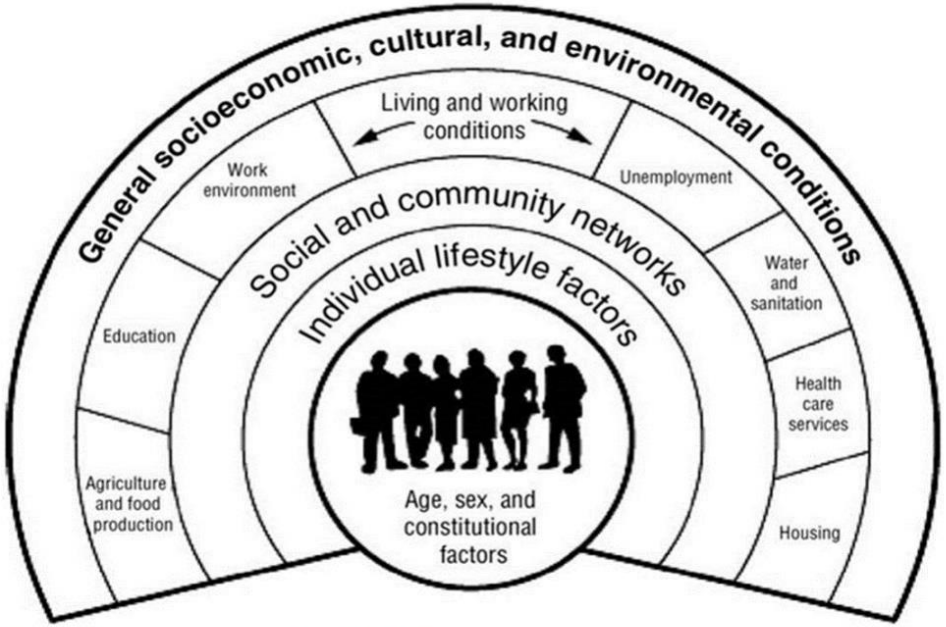
- Our population's overall health varies considerably by Place, but high-level indicators are worsening.
- Services will need to be able to support increasing numbers of older patients with increasing multimorbidity and/or dementia
- Prevention and good management of early disease is key to delaying disease onset for individuals and the population as a whole, but prevention will not completely mitigate the impact of growth and ageing.[1]

Further supporting evidence available in **Appendix 1 Supporting Data Pack (DP)**

Part A: Population Needs (4/5): Drivers of need for healthcare in BLMK

Health outcomes are influenced not only by the quality of medical care, but also by the conditions in which people live, learn, work, and age. This includes a huge range of factors, as illustrated by the classic diagram below from Dahlgren and Whitehead. Most notable are poverty and the consequences of poverty, which can have lasting impacts on children, but environmental and cultural factors also have considerable impact.

The wider determinants of health indicate the need for a shift towards a more preventative, integrated, and holistic approach. When we design services, we must recognise the social and environmental factors shaping health, and how they may affect residents' ability to access and benefit from clinical care. We should enable our services to tackle these factors where possible, alongside partners.



Source: Dahlgren and Whitehead (1991)

What are the biggest drivers of future growth and demand?

- Population growth (which may be even higher than estimated if New Towns are built)
- Population ageing (both numbers and proportion of older people)
- Increased pressure on MH services from higher diagnosis of mental health / ND conditions
- Increasing numbers of people with learning disability, mental health conditions, and dementia
- Increasing prevalence and complexity of multimorbidity
- Future changes to socioeconomic factors, most importantly poverty, likely to drive need for community and mental health services

Part A Population Needs: Key Considerations (5/5)

The following considerations will help to ensure that transformation efforts respond directly to the most pressing needs and inequalities. These findings are a summary of Part A: Population Needs with further supporting evidence available in **Appendix 1 - Data Pack (DP).**

A1 | Population growth and demographic change

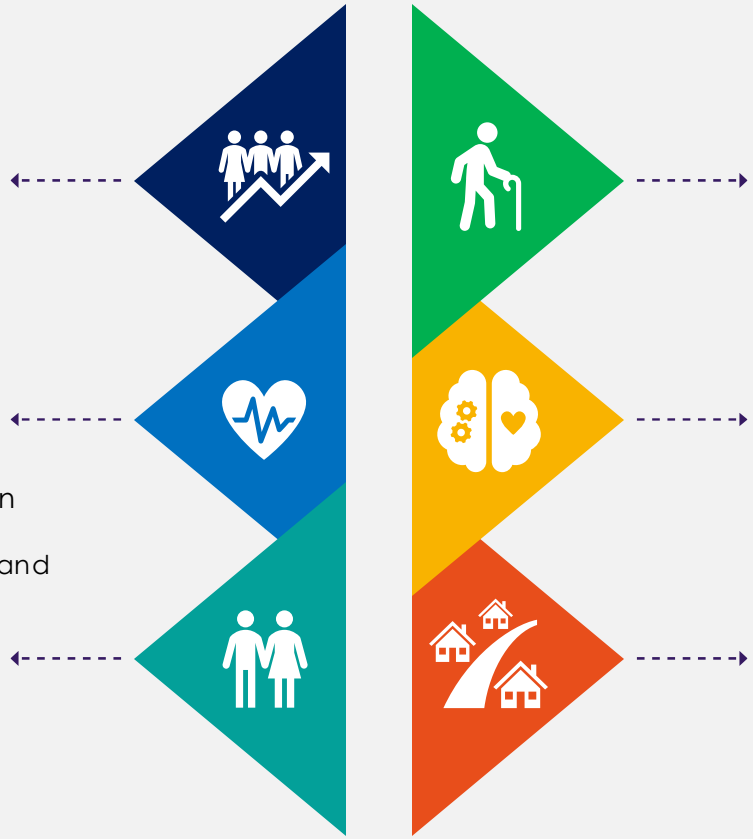
- An ageing population and rising demand will place greater pressure on services particularly on elderly care, chronic disease management, and age-related health services (DP - 3.1).
- Changing health profiles require adaptable, joined-up community care models.
- Planning to account for increasing demand, including potentially faster growth than projected (DP - 4.4).
- Prevention matters but on its own, it won't be enough to offset the impact of population growth and ageing (2024 Director of Public Health reports)

A2 | Health needs across the life course: children

- Childhood poverty and unstable housing affect lifelong wellbeing, and half of adult mental health conditions start before age 18). Early identification of poor mental health in childhood may reduce the impact in later life. [1]
- Services need to meet growing demand for timely diagnosis and lifelong support for neurodivergent individuals (DP – 3.9).

A3 | Working-age health challenges

- 11% of adults in BLMK have depression and between 20-31% of adults in BLMK have a high anxiety score (DP – 3.4).
- Poor housing, insecure work, and low income worsen health risks. [2]
- MSK and mental health conditions together underly around 40% of the all-age disability burden (DP – 2.6).



A4 | Growing needs in older adults

- Referrals to services associated with older age are projected to see very large increases in the next 20 years (to 2043) eds (DP – 4).
- Ageing and multi-morbidity will increase demand on community services (Page 18)
- Increasing numbers of patients with a dementia co-morbidity will impact many services (Page 17/18)

A5 | Link between LTCs and mental health / LD

- People with depression, serious mental illness, or learning disability, are much more likely to have physical health comorbidities (DP – 3.11).
- People with severe mental illness or learning disability have a higher risk of premature mortality (DP – 4.2).

A6 | Wider determinants of health

- Housing, employment, education, environment and income shape health outcomes as well as health services. [2]
- Adverse socioeconomic conditions increase need and reliance on community-based care.
- Services need to be able to identify and tackle inequalities in access and outcomes.
- Increasing ethnic diversity in our area (DP – 1.2) also means our services need to be flexible in approach to ensure all our residents can access and benefit from care.

1. Slide 27, and Fingertips online tool from OHID, DHSC https://fingertips.phe.org.uk/search/mental%20health#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/90812/age/173/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1
2. Fair Society, Healthy Live (The Marmot Review) (2010) https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Part B: Community Services

This section looks at the key findings specifically for adult community services, including:

- Current services overview
- Provider mapping
- Performance, Quality and Improvement
- Stakeholder feedback
- Financial analysis

All evidence relating to key statements and findings in this section can be found in **Appendix 1 – Data Pack (DP) and Appendix 2 – Engagement Report (ER)**

Part B Community: Current Services Overview (1/6)

Community health services refer to a range of healthcare and support services provided in local settings, such as patients' homes, clinics, neighbourhoods or community health centres, rather than in hospitals. Services include:

Planned Care

- Episodic / specialist care
- Management of long-term conditions
- Prevention of deterioration of long-term conditions
- Community rehabilitation
- Palliative care and end of life care
- Intermediate care

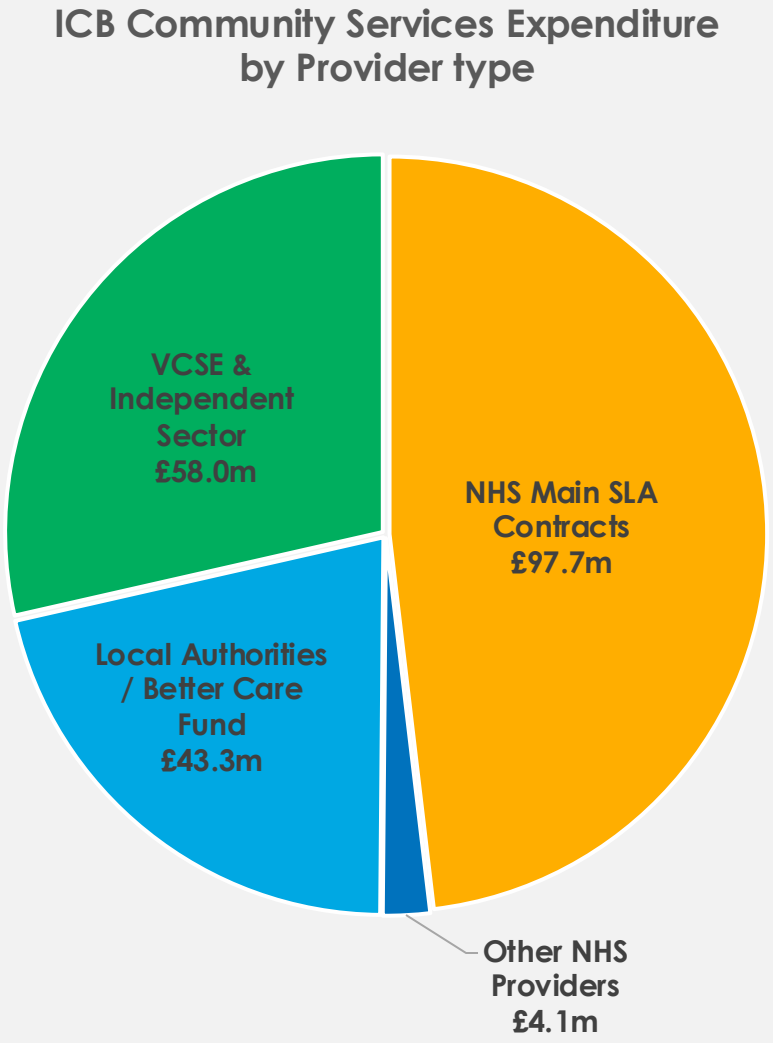
Reactive Care

- Urgent Care
- Palliative care and end of life care

In 2024/25 BLMK ICB expenditure on all community health services was circa £203m and represented circa 8% of total ICB expenditure.

Community services are provided by a range of providers, but they are predominantly provided by CCS/ELFT/CNWL representing 48% of total community service expenditure.

The total value of £203m includes a range of other services provided by a number of NHS and non-NHS providers including but not limited to: Palliative and end of life services provided by Hospices, IVF services, wheelchair services, community equipment, Any Qualified Provider (AQP) Services, intermediate care, acquired brain injury, and services commissioned within the Better Care Fund.



Part B Community: Strategic Alignment and Current Position (2/6)

National Context and Strategic Alignment

The Neighbourhood Health Guidelines published in 2025/26 and the Standardisation of Community Services framework set a clear national expectation for the delivery model of community services to provide integrated Neighbourhood Multi-Disciplinary Teams, Integrated Intermediate Care with a 'Home First' approach, and Coordinated Urgent Care in the Community.

The NHS 10 Year Plan (July 2025) reinforces this ambition for a neighbourhood health model of care to deliver the three 'left-shift' priorities: 1) sickness to prevention, 2) hospital to community and 3) analogue to digital.

In BLMK, we are working to develop and embed at place an asset-based approach across 19 geographical neighbourhoods, with many current good examples of collaboration and integrated working. We know that clinical health services only account for 20% of health outcomes while social and economic factors and physical environment together make up 50% - that's why understanding and mobilising all of the assets in neighbourhoods is so important to improving outcomes for residents.

The BLMK Population Health Intelligence Unit is leading the development of how the system utilises population health intelligence data.

Primary Care Networks are in the process of implementing the John Hopkins ACG Risk Stratification Tool. This is an internationally recognised tool which combines primary and secondary care data to classify patients into one of 11 patient need groups (PNGs) and also looks at the risk of hospitalisation. There will be an initial focus on the four highest PNGs, where patients have a dominant mental health condition or multiple other high-needs long-term conditions. Using best practice examples from early adopters like Frimley ICB, we are looking at how alternative primary care pathways can be developed to meet the needs of these patients.

Building on the foundations of current progress the future model of community services should be delivered consistently using an embedded population health management approach with high levels of integration between primary care and community services in each neighbourhood supported by the expertise of all system partners, such as secondary care specialists support neighbourhood multi disciplinary teams.

Current Position (informed by analysis of contracts)

Spend & Provision

- £203m annual spend (2024/25) on all community services (c8% of ICB total expenditure) (page 12)
- Services delivered by multiple providers – largest providers are CCS, ELFT, CNWL – with variation in service offer driven by historic commissioning models
- No single service specification or consistently applied model of care across BLMK

Avoidable Admissions & Demand Pressures

- 9% of hospital admissions in 2024/25 were for Ambulatory Care Sensitive (ACS) conditions – which could be preventable with effective community-based care. Top ACS causes: cardiovascular, respiratory, and neurological conditions. (DP – 8.4)
- Over-reliance on intermediate/step-down beds in Bedfordshire and Luton, under utilisation of Commissioned pathway two beds and over use of spot purchase (DP - 8.16)
- Dementia is a major factor behind delayed discharges from acute hospitals, due to insufficient community or social care capacity. Delayed discharges costing £350–£400 per bed day, resulting in avoidable spend. with up to 8 days delay between Discharge Ready Date and Date of Discharge. These delays often result in deconditioning for the patient and additional cost impact for social care (DP – 8.13)
- There are avoidable hospital admissions and readmissions for palliative and end of life patients due to fragmented support in managing symptoms closer to home. Shifting care from acute to community settings and enhancing pathway co-ordination will enable more patients to be cared for in the right place, by the right clinician, at the right time. (DP – 8.4, 8.5, 8.6, 8.8, 8.9)
- There is increasing demand and constrained capacity for district nursing and community matron services which requires consideration across BLMK (DP – 1.1, 4.7)

Quality & Safety

- All providers rated Good or Outstanding by CQC (DP – 10.2)
- Shared improvement priorities include preventing pressure ulcers, improving referral pathways, and strengthening communication

Partnership Working (gathered from

- Some progress with Integrated Neighbourhood Working, Care Coordination and Multi-Disciplinary Teams; good practice examples include how community services are working with primary care, co-located teams delivering virtual wards and unscheduled care hubs.
- There is growing collaboration between ELFT, CCS, CNWL and other partners to address rising District Nursing demand through training and new approaches.
- Existing joint work with ambulance services and acutes for Unscheduled Care Coordination.
- Partnerships in step-down/intermediate care provision across Bedfordshire and Luton.

Further supporting evidence available in ***Appendix 1 - Data Pack (DP)***

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- Partnerships in step-down/intermediate care provision across Bedfordshire and Luton.

Further supporting evidence available in ***Appendix 1 - Data Pack (DP)***

Part B Community: Provider Mapping (3/6)

An in-depth mapping of community services has confirmed a variation in commissioning arrangements, delivery and care settings. Many of these services were commissioned and specified by the three previous Clinical Commissioning Groups prior to the current developing BLMK neighbourhood approach. Historic commissioning means that there are different requirements of providers within specifications which cover the same service area.

While provider diversity can bring innovation and local responsiveness, a multiple provider landscape with different service specifications does present challenges and variability in access, and challenges in system co-ordination and integration. This variation from legacy commissioning and provision has led to duplication, inequity of access and an impact on outcomes, which affects resident experience and brings a strain on the workforce. These are key themes emerging from the service variation assessment (next slide) and qualitative stakeholder feedback.

Provision by service line, Local Authority place and provider is summarised below:

Service Descriptions	Bedford	Central Bedfordshire	Luton	Milton Keynes
Planned Care - Episodic / specialist care *(podiatry, audiology, and phlebotomy)*	ELFT, Circle, BHFT, Independent Sector, Primary Care	ELFT, Circle, BHFT, Independent Sector, Primary Care	ELFT, CCS, BHFT, Independent Sector, Primary Care	CNWL, Primary Care
Planned Care - Management of long-term conditions *(continence, bladder and bowel, respiratory, diabetes, tissue viability and wound care, lymphoedema, heart failure, and cardiology)*	ELFT, BHFT, Sue Ryder	ELFT, BHFT, Sue Ryder	ELFT, CCS, BHFT	CNWL, MKUH, Whaddon, Willen Hospice
Planned Care - Prevention of deterioration of long-term conditions *(occupational therapy, nutrition and dietetics, residential and nursing home in-reach, speech and language therapy, physiotherapy, falls and fracture prevention, and community nursing)*	ELFT, BBC	ELFT, CBC	BHFT, HCRG, CCS	CNWL, MKUH, Newport Pagnell
Planned Care - Community rehabilitation *(neurology, pulmonary rehab, stroke, cardiac rehab (longer-term pathways), inpatient ward rehabilitation and falls and fracture prevention)*	ELFT, CCS, BBC, BHFT	ELFT, CCS, CBC	ELFT, CCS, HCRG	CNWL
Planned Care - Palliative care and end of life care	ELFT, Sue Ryder	ELFT, Sue Ryder	CCS, Keech Hospice	Willen Hospice (only)
Planned Care - Intermediate care *(home and community based, discharge facilitation and discharge home to assess)*	ELFT	ELFT	HCRG, CCS	CNWL
Reactive Care – Urgent Care *(urgent community response / rapid response and virtual wards (also known as 'hospital at home')*	ELFT, BHFT	ELFT, BHFT	CCS, BHFT	CNWL, MKUH
Reactive Care – Palliative care and end of life care *(including 24/7 access to advice for professionals)*	ELFT, Sue Ryder	ELFT, Sue Ryder	CCS, Keech Hospice	Willen Hospice (only)

Key: Community | Acute | Independent Sector | VCSE | Primary Care | Local Authority

Part B Community: Service Variation and Opportunities (4/6)

Service Descriptions	Service Variation and Gaps	Opportunities
Planned Care - Episodic / specialist care	• Inequitable funding and commissioning leading to different provider models and capacity for some service lines and differing wait times across BLMK. • Phlebotomy is provided by a range of providers across a range of settings and there is inconsistencies in delivery and capacity challenges in peaks.	• Review existing models and service lines of commissioning and delivery and work towards equity of service access and provision across BLMK. • Review efficient and effective phlebotomy delivery, including Point of Care Testing, to maximise access for the population.
Planned Care - Management of long-term conditions	• Sustainable commissioning of some of these services is inconsistent, with some non-recurrent arrangements in place in some parts of the patch to address known challenges and gaps. • Some services lines are commissioned and delivered differently across the patch – some have a caseload, and others provide only advice and guidance only to general practice teams who also have capacity and capability challenges.	• Develop a clear, standardised commissioning approach and specification for a consistent delivery model. • Review effective models of care and explore patient experience for the different services to commission the correct pathways for patients.
Planned Care - Prevention of deterioration of long-term conditions	• Long Term Conditions services are mostly condition-specific despite increasing multimorbidity and there is a lack of single care co-ordination. There are different models of delivery between providers and different ways of working with primary care. • Some localised service models face capacity pressures and don't have benefits of scale to support resilience. • National specialist workforce shortages with competition for recruitment against acute roles which may be perceived as more attractive • Prevention services are highly variable in funding, provision, and response models.	• Explore more consistent, resident-centred LTC pathways, including single care co-ordination across multi-disciplinary team, embedded in neighbourhoods; utilise digital technology to support resident self management where appropriate. • Leverage whole system collaboration in delivery of prevention of long-term conditions to meet forecast demand growth. • Reconcile distribution of resources across planned and reactive delivery to ensure appropriate balance of urgent response and 'long-term' caseload needs. • Review prevention services and ensure recurrent funding.
Planned Care - Community rehabilitation	• Limited specialist step-down/rehab capacity for neurological conditions; stroke has early supported discharge but similar conditions excluded.	• Explore where early supported discharge models could be extended beyond stroke to other neurological conditions.
Planned Care - Palliative care and end of life care	• Variation in commissioning/funding for Specialist Palliative & End of Life Care; inconsistent community / hospice arrangements.	• Continue with the partnership working to develop a single community model across BLMK which supports community provision and reduces unnecessary hospital admissions.
Planned Care - Intermediate care	• Heavy reliance on intermediate/step-down beds in Bedfordshire and Luton; higher delayed transfers of care.	• Develop a clearer, standardised commissioning approach for step-down services.
Reactive Care – Urgent Care	• Avoidable hospital admissions linked to conditions manageable in primary and community settings achieved through integrated muti-disciplinary working. • Virtual ward activity and application is varied across BLMK. • Unscheduled Care Co-ordination Hub in Bedfordshire supports admission avoidance and taking patients from EEAST ambulance stack not replicated in MK	• Build on current reactive and urgent delivery towards a consistent and comprehensive 'home first' model of care. • Review suitability of virtual ward models for more patient cohorts. • Increase support provided through UCCH including EOLC and provide same service in MK (systems are a constraint here and some mitigations in place/developing)
Reactive Care – Palliative care and end of life care	• There is variation in service such as night sits across the patch.	• Develop a clearer, standardised commissioning approach for palliative and end of life care

Part B Community: Engagement Themes (5/6)

In developing this Case for Change and as described on page 13 (Engagement Approach), we have brought together insights from a wide range of engagement activities with residents, carers, service users, our workforce, providers, and system partners. Through surveys, interviews, focus groups, market engagement events and community-led discussions, we have captured what people feel is working well and where improvement is needed.

This process has highlighted consistent themes across different groups – including the importance of communication, access, integration, cultural sensitivity, and personalised care – while also surfacing specific challenges for seldom-heard communities and the workforce. By consolidating these perspectives into common themes, we have been able to identify both the strengths to build upon and the areas of greatest concern, ensuring that the priorities for transformation are firmly rooted in lived experience and professional insight.

What works well

- **Personalised and compassionate care:** Many case studies highlight the difference made when staff demonstrate empathy and build trusting relationships (ER - 4.4), such as community matrons providing both practical and emotional support to families (ER – 4.1.1).
- **Specialist community services:** Pulmonary rehabilitation, neuro-rehabilitation, and tissue viability nursing were praised for equipping people with knowledge, tools, and confidence to manage their health (ER – 4.1.1).
- **Innovation and adaptability:** Use of assistive technology (e.g. voice-controlled devices for people with physical disabilities) was valued for enabling independence (ER – 4.1.1).
- **Co-production:** Providers described meaningful collaboration with local communities, for example developing self-help tools for lung conditions and tailoring resources for bereaved families (ER – 4.1.2).
- **Neighbourhood clinics and local venues**: Services delivered in community settings (e.g. local clinics, neighbourhoods) were valued for making care more accessible and trusted (Resident Focus Groups)
- **Community resilience and peer groups:** Activities such as wellbeing groups and peer-led initiatives ("knit and natter", exercise groups) help reduce loneliness and improve prevention (Resident Focus Groups)
- **Recovery College and interpersonal support**: Relational, trust-based support from community psychiatric nurses, wellbeing workers and recovery programmes seen as effective complements to medical care. (Resident Focus Groups)
- **VCSE contributions**: Local VCSE partners provide practical support and engagement that reduces demand on NHS services e.g. social prescribing, condition-specific support (Resident Focus Groups)

Areas for improvement

- **Variation in access and equity:** Service models and referral processes differ across BLMK, and people report postcode-based differences in waiting times and support (ER – 3.1 and 4.4.15).
- **Navigation and information gaps:** Patients and carers often feel unclear about available services, particularly around discharge planning, falls prevention, and community support (ER – 4.1).
- **Prevention not prioritised:** Case studies show how missed opportunities for early intervention led to avoidable hospital admissions, especially among older people (ER – 4.1.1).
- **Workforce pressures:** Providers and service users noted inconsistent capacity in services such as district nursing, speech and language therapy, and falls response.
- **Digital exclusion**: Older adults and those without digital access are at risk of exclusion when services are digital-first (Resident Focus Groups and Workforce feedback)
- **Prevention gaps:** Prevention often overlooked, with over-reliance on medication and limited health promotion for older adults (Resident Focus Groups)
- **Workforce sustainability:** Staff raised risks that neighbourhood hubs could dilute expertise if not resourced properly; retention and training remain major challenges (Workforce feedback)
- **Integration with social care:** Limited joint working with local authorities and inconsistent referral pathways undermine seamless care (Workforce feedback)
- **Transitions and discharge:** Patients described rushed hospital discharges and poor follow-up; carers reported stress and confusion without clear information (Resident Focus Groups)

Part B Community: Key Considerations (6/6)

The following considerations will help to ensure that transformation efforts respond directly to the most pressing needs and inequalities. These findings are a summary of Part B: Community Health Service and supporting evidence available in **Appendix 1 - Data Pack (DP)** and **Appendix 2 - Engagement Report (ER).**

B1 | Service + Care Pathway Alignment

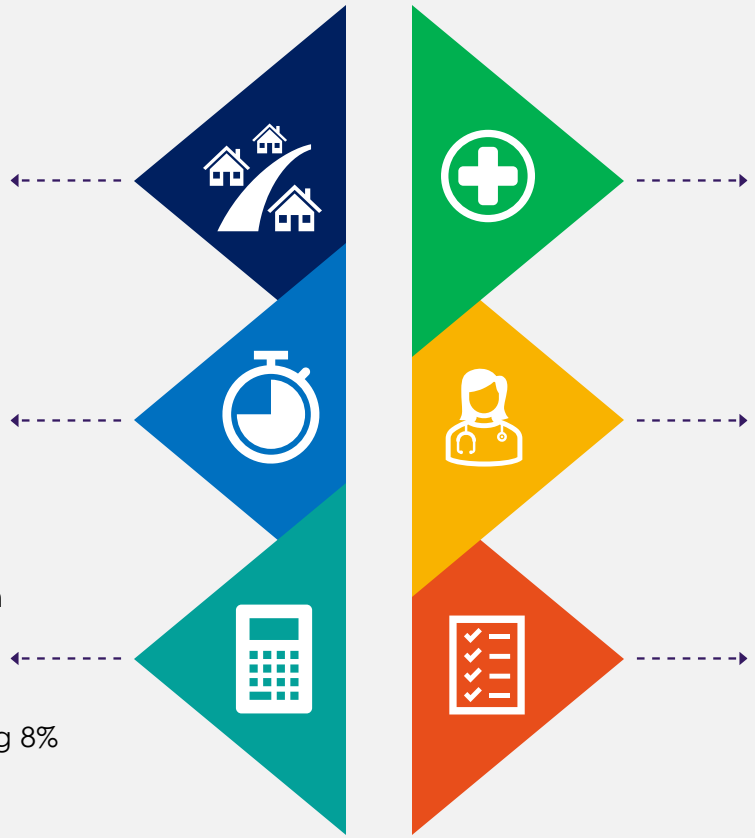
- Multiple providers shaped by legacy commissioning leads to variation in models, experience and access, and outcomes (Page 23).
- Whilst there are some positive examples of integration, overall levels of provider integration are limited (DP - 9.1, 9.3, 12.3) and there is no consistent alignment to primary care and neighbourhood footprints; furthermore, primary care networks are not geographical, and neighbourhoods. (DP 7.9)

B2 | Timely Access + Demand Pressures

- Significant variation in waiting times across services, with Podiatry, Adults Speech & Language Therapy Adults Nutrition and Dietetics Service, Specialist Memory Service, continence and CAMHS – ADHD service among longest waits for some providers [note data quality caveats] (DP – 7.7 – 7.8)
- High demand for district nursing and reliance on step-down beds contribute to system bottlenecks. (Page 22/24)

B3 | Financial Sustainability Pressures

- £203m annual spend on all community services representing 8% of ICB expenditure in 2024/25. (Page 21).
- Delayed discharges cost £350–£400 per bed day and benchmark above peer ICBs (Page 22).



B4 | Avoidable Acute Admissions + Bed Occupancy

- 9% of admissions are for Ambulatory Care Sensitive Conditions, adding avoidable cost and bed days (DP – 1.1).
- Differences in step-down and discharge pathways between localities affect consistency of patient experience and acute flow (Page 22/24).
- Fragmented support in managing symptoms closer to home for palliative and End of Life patients could improve avoidable hospital admissions and readmissions (Page 22/24).

B5 | Workforce + Capacity Constraints

- Growing demand and complexity place sustained pressure on community teams (Page 23).
- Workforce shortages and retention issues impact service capacity across the system and in particular services such as district nursing, speech and language therapy, and falls response (Page 23).

B6 | System-Wide Standards + Measurement

- No consistent benchmark for waits, access, or outcomes across providers.
- Limits ability to assess equity and track performance at system level.

Part C: Mental Health Services

This section looks at the key findings specifically for all age mental health services, including:

- Current services overview
- Provider mapping
- Performance, Quality and Improvement
- Stakeholder feedback
- Financial analysis

All evidence relating to key statements and findings in this section can be found in **Appendix 1 – Data Pack (DP) and Appendix 2 – Engagement Report (ER)**

Part C Mental Health: Current Services Overview (1/6)

Mental Health Services (inclusive of Dementia, Learning Disabilities, Autism and Neurodivergence) refer to a range of healthcare and support services provided in acute inpatient, specialist hospital beds and the subsequent Section 117 of the MHA aftercare provision. Care and support is also delivered in community settings, such as patients' homes, Primary Care and other community health settings.

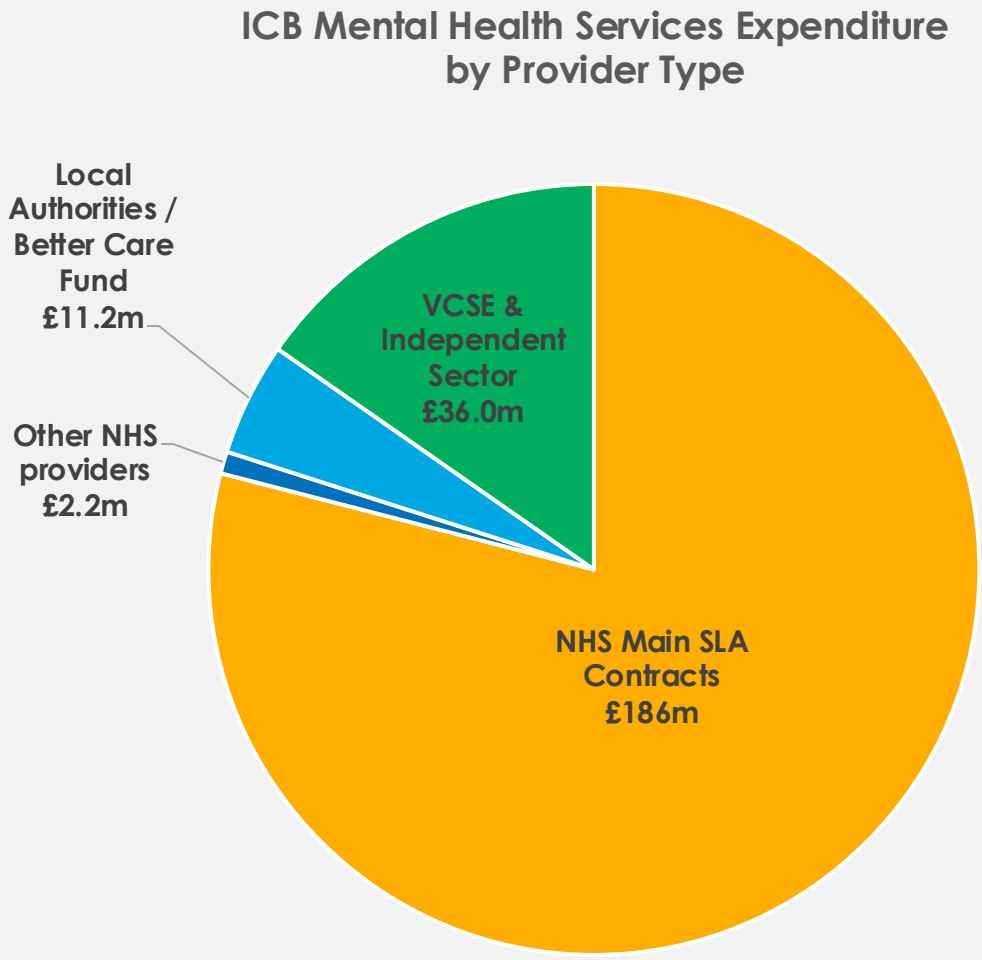
There are a wide range of services including (but not limited to):

- Community Mental Health (Adults and C&YP)
- NHS Talking Therapies, for anxiety and depression (Over 16 or 18 yrs)
- Crisis and Acute Mental Health (Adults and C&YP)
- Autism (Adults and C&YP)
- ADHD (Adults and C&YP)
- Specialist Learning Disability community and crisis (Adults and C&YP)
- Mental Health Support Teams and Early Intervention (C&YP)
- Specialist provision e.g. perinatal, early intervention in psychosis, individual placement support

These services are provided by several NHS Mental Health Trusts and national and local VCSE providers, but they are predominantly provided by East London Foundation Trust in Bedfordshire and Luton, and Central & North West London Foundation Trust in Milton Keynes.

In BLMK, for 2024/25 ICB expenditure on all-age mental health services of £235m*.
In addition, four specialist services are commissioned by an NHS Specialised Mental Health Provider Collaborative across East of England through a contract with NHS England (and excluded from this value).

ELFT, CNWL and the ICB have formed an MHLDA Collaborative Committee for BLMK which is supported by a matrix team from across all three organisations that plan and deliver improvements in health outcomes for the BLMK population. ELFT, CNWL and CCS represent the bulk (79%) of all mental health expenditure in BLMK.



** There are other costs associated with mental health services that are included in the MHIS but excluded from this total, this includes prescribing of mental health drugs in primary care and Mental health / LD CHC costs.*

Part C Mental Health: Strategic Alignment and Current Position (2/6)

National Context and Strategic Alignment

The government's 10-Year Health Plan ("Fit for the Future", July 2025) reorients the NHS around three defining shifts - hospital to community, analogue to digital, and sickness to prevention and the development of modern service frameworks - providing the strategic backdrop for redesigning neurodivergent-inclusive mental health services. Key focus areas include:

- **Community-based care:** Services for people with learning disabilities, autism and mental health needs should be delivered via local neighbourhood hubs and service outreach (not hospitals), making access easier and less stressful.
- **Digital inclusion and autonomy:** Digital tools, including enhancements to the NHS App and virtual consultation options - should include neuro-inclusive features (such as easy-read formats and digital "reasonable adjustment" flags), improving accessibility and user control.
- **Preventive health and early intervention:** Embed routine physical and mental health checks and anticipatory interventions in community settings, including schools, drives the shift from reactive care to prevention, helping to reduce premature mortality and improve long-term wellbeing.
- **Mental health inpatient reduction:** Plans should deliver a minimum 10 percent reduction in reliance on inpatient mental health admissions for people with learning disabilities and autism - endorsed by 2025/26 operational planning guidance.
- By 2030 all school-aged children should have access to **Mental Health Support Teams.**
- **Crisis Services Reform** should provide 24/7 access and alternatives to admission
- Dedicated **Mental Health Emergency Departments**

Strategic alignment should consider that services for neurodivergent and LD communities are not only integrated into strategic NHS reforms, but also designed to be more accessible, equitable, and proactive, supporting local systems to meet both national mandates and community needs.

Current Position (informed by analysis of contracts)

Spend & Provision

- £235m annual spend (2024/25) on mental health services. (page 12)
- Services delivered by 15 core providers across BLMK with variation driven by historic commissioning models, these include a range of VCSE providers
- Service offer, pathways, and waiting times vary between Bedfordshire, Luton, and Milton Keynes (DP – 1.1, 6.8, 7.7, 7.8, 8.12)

Access & Waiting Times

- Talking Therapies – delivering above the national ambition across BLMK (DP – 7.7, 7.8)
- Dementia diagnosis rates of 69.3% which is 2.61% higher than the national average and expected to grow due to ageing population placing increased demand on services and carers (DP – 5.8)
- SMI health checks at 65% which is 5% higher than the Q4 target and working toward the national ambition of 75%
- Community MH - access to routine CMHT services may still be subject to long waits, especially for specialist pathways (e.g. autism, eating disorders) (DP – 7.7, 7.8)
- Long waits of up to 5 years for ADHD assessments with a growing number of being seen under Right to Choose. (DP – 7.8)

Quality and Safety

- Majority of providers rated *Good* or *Outstanding* by CQC. (DP - 10.2)
- PSIRF implementation has identified common safety themes: medication administration errors, safeguarding concerns.
- Reduction in inpatient length of stay and out-of-area placements in Bedfordshire through targeted quality improvement. There are no out of area placements for Milton Keynes residents. (DP - 6.8, 8.14, 8.15)

Demand and Pressure

- Memory Services and Crisis Response services show the sharpest increases in demand (DP – 4.7, 4.9, 7.8)
- Child and Adolescent Mental Health Services (CAMHS) – referrals are rising, particularly in Milton Keynes with have seen a 200% increase in CAHMS referrals since 2018/19. (DP – 8.2, 8.3)
- BLMK currently (August 2025) has 15 patients in adult acute mental health out-of-area beds. This is against our plan of zero due to sustained demand and capacity pressures in Bedfordshire and Luton. (DP – 7.5)
- Mental Health Housing – whilst housing is commissioned directly by Local Authorities, Limited capacity is leading to delayed discharges from Mental Health beds and step-down provision. (DP – 8.13, 8.16)

Further supporting evidence available in **Appendix 1 - Data Pack (DP)**

Part C Mental Health: Provider Mapping (3/6)

An in-depth mapping of local Mental Health services has confirmed a variation in commissioning arrangements, delivery and care settings. Many of these services were commissioned and specified by the three previous Clinical Commissioning Groups. Historic commissioning means that there are different requirements of providers within specifications which cover the same service area.

While provider diversity can bring innovation and local responsiveness, a multiple provider landscape with different service specifications does present challenges and variability in access, and challenges in system co-ordination and integration. This variation from legacy commissioning and provision has led to duplication, inequity of access and an impact on outcomes, which affects resident experience and brings a strain on the workforce. These are key themes emerging from the service variation assessment (next slide) and qualitative stakeholder feedback.

Provision by service line, Local Authority place and provider is summarised below:

Service Descriptions	Bedford	Central Bedfordshire	Luton	Milton Keynes
Adult Mental Health (Community)	ELFT, BLMK MIND	ELFT, BLMK MIND	ELFT, BLMK MIND	CNWL, BLMK MIND
Adult Mental Health (Inpatient)	ELFT	ELFT	ELFT	CNWL
Children & Young People (Community)	ELFT	ELFT	ELFT, TOKKO	CNWL, CHUMS
Learning Disabilities	ELFT, BCC	ELFT, CBC	ELFT, LBC	MKCC
Older Adults (Memory Services, Dementia Post diagnostic support, Dementia Intensive Support Service-DISS)	ELFT, Carers in Beds, Tibbs, DISS	ELFT, Carers in Beds, Tibbs DISS	ELFT, DISS	CNWL
Autism (Adults) Autism (CYP)	ELFT/Autism Beds, CCS(<12yrs), ELFT (>12yrs)	ELFT, Autism Beds, CCS(<12yrs), ELFT (>12yrs)	ELFT, Autism Beds, CCS(<12yrs), ELFT (>12yrs)	CNWL, Autism Beds
ADHD (Adults) ADHD (CYP)	ELFT, CCS	ELFT, CCS	ELFT, CCS	Psychiatry UK, CNWL, CAMHS
Eating Disorder	ELFT, Caraline	ELFT, Caraline	ELFT, Caraline	CNWL
Talking Therapies	ELFT	ELFT	Turning Point	CNWL

Key: Community | Acute | Independent Sector | VCSE | Primary Care | Local Authority

Part C Mental Health: Service Variation and Opportunities (4/6)

Partnership Working

- In BLMK, an All-Age Mental Health, Learning Disability and Autism (MHLDA) Collaborative across the ICB, ELFT and CNWL has been established to create a one team approach to plan and drive system-wide improvement and consistency of offer across the age range.
- The Collaborative has already begun to deliver a pan-BLMK approach to some areas of delivery such as:
  - Perinatal Mental Health service has demonstrated strong collaborative working, ensuring consistency of provision.
  - The Care (Education) and Treatment Reviews (C(E)TRs) Hub, delivered by ELFT on behalf of BLMK, transforming services for people of all ages with a learning disability and autistic people under the Transforming Care Programme.
  - Adult autism service delivered by ELFT across the BLMK footprint.
  - Development of a BLMK recovery programme
- Supported existing VCSE partnerships, using the mental health alliances as the vehicle. Currently we have a Luton, Bedfordshire and Milton Keynes MH Alliance.
- Co-production is a key component and is embedded in all transformation programme workstreams with service users playing a key role.

Service Variation / Gaps – Children & Young People

- Variation in early intervention (DP – 13.10), neurodevelopmental provision, crisis/home treatment, and Single Point of Access (SPOA), often due to historic funding arrangements (DP – 11.6)
- Increased access to mental health services that provides appropriate support to more children and young people needed and in line with the access target and the long-term ambition (DP – 11.6)
- Mental Health Support Teams vary in delivery and productivity ; there is a need for focus on direct support and group delivery to ensure consistency in delivery and sustainable provision. The national requirement to incrementally increase to full coverage by 2030 will add a significant system workforce and cost pressure. (DP – 11.6 , 11.7, 11.8, 12.1, 12.3, 12.7)

Service Variation / Gaps – Adults

- Talking Therapies differ in model and unit cost.
- Community MH teams face increased demand (DP – 1.1, 2.3, 2.6, 3.2),and pressure along with workforce shortages (DP – 12.1, 12.2, 12.3), impacting continuity of care, relapse prevention, crisis escalation and outcomes
- Co-occurring MH and substance misuse services are commissioned separately between health and public health, creating access barriers and delays to care. (DP – 3.8, 7.7, 7.8)
- Gap in provision for people with Complex Emotional Needs (also known as Emotionally Unstable Personality Disorder –EUPD) who often do not meet the Community MH Team threshold but too complex for talking therapies.
- Quality oversight of and spend on Section 117 packages of care and specialist hospital placements differ between MK (provider contract) and Bedfordshire/Luton (IMHLDA Collaborative Complex Care team).

Service Variation / Gaps – Older Adults

- Variation in post-diagnostic dementia support (health contribution only in Bedford & Central Beds).
- Variation in dementia diagnosis rates and provision; uneven access to Dementia Intensive Support Service (DISS) across BLMK. (DP – 5.8)

Service Variation / Gaps – All Age

- Learning Disability provision: Variation in delivery across BLMK and between adults and CYP, including differences in the Community LD nurse function (integrated in some areas, absent in others) and absence of a Specialist LD team in MK.
- Eating Disorder service: 47% increase in CYP cases post-pandemic,(DP – 4.9) with variation in capacity (DP – 7.1), service models, and absence of an Avoidant Restrictive Food Intake Disorder (ARFID) pathway for CYP. No commissioned service to support primary care with medical monitoring and shared care.
- ADHD: Long waits for assessment (DP – 7.7), especially in Beds and Luton. CYP services delivered via CAMHS in MK and Community Paediatrics in Beds/Luton, causing variation in access
- Forensic provision: No community forensic pathway for MH or LD, making BLMK an outlier regionally.

Opportunities

- Single and standardised MHLDA offer across BLMK
- A preventative approach, working closely with VCSE and trusted communities, to assist in tackling mental health stigma and raising awareness and improving understanding of MH and LDA in the general population.
- Community mental health offer that is well resourced with a range of clinical and non-clinical staff to deliver proactive, early support for people experiencing a decline in mental health, in the community to prevent crisis escalation.
- Consider exploring the development of a consistent, all-age Learning Disability & Neurodevelopmental offer across BLMK to address variation in current provision.
- Potential to assess the feasibility of extending crisis alternatives, such as the crisis house model, to ensure more equitable access across BLMK.
- Scope to examine the current gap in complex trauma intervention for CYP and identify potential approaches to address it.
- Review and assess alternative models for CYP crisis presentation in acute settings, drawing on learning from other areas (e.g., Birmingham model) to inform future planning.
- Opportunity to explore more integrated approaches for people with co-occurring mental health and substance misuse needs, given current commissioning separation.
- Consider ways to strengthen the role of carers as active and informed participants in care planning and decision-making processes.
- To explore better transitions between C&YP and Adults services. To encompass a review of thresholds, expectations and handover pathways.
- To design an integrated / person centred approach where physical and mental health needs are treated together, as close to home for residents, using the neighbourhood model.
- A total bed management approach to NHS and independent ad specialist hospital provision.
- Systemwide approach to oversight (clinical/ quality/ financial) of people funded for s117 aftercare as well as managing the independent provider market.

Further supporting evidence available in **Appendix 1 - Data Pack (DP)**

Part C Mental Health: Engagement Themes (5/6)

In developing this Case for Change and as described on page 13 (Engagement Approach), we have brought together insights from a wide range of engagement activities with residents, carers, service users, our workforce, providers, and system partners. Through surveys, interviews, focus groups, market engagement events and community-led discussions, we have captured what people feel is working well and where improvement is needed.

This process has highlighted consistent themes across different groups – including the importance of communication, access, integration, cultural sensitivity, and personalised care – while also surfacing specific challenges for seldom-heard communities and the workforce. By consolidating these perspectives into common themes, we have been able to identify both the strengths to build upon and the areas of greatest concern, ensuring that the priorities for transformation are firmly rooted in lived experience and professional insight.

What works well:

- **Peer and community support:** Recovery Colleges were repeatedly described as empowering, safe spaces that reduce isolation and help people re-engage with education, work and daily life (ER - 4.2.2).
- **Co-production and lived experience:** ELFT's "People Participation" model and VCSE-led groups show how service users and carers contribute meaningfully to design, training and quality improvement (ER - 4.2.2 and 4.4).
- **Therapeutic environments and crisis alternatives:** Crisis cafés (ER – 3.1), early intervention in psychosis services (ER - 4.2.2), and perinatal mental health support (including the Milton Keynes trauma and loss service) were highlighted as positive experiences (ER - 4.2.2).
- **Family-centred approaches:** Carers valued being involved in care planning and recognised as partners in supporting recovery (ER - 4.2.2).
- **Peer support and lived experience roles**: Emotional and practical support from peers was highly valued, especially for people with severe and enduring mental illness (Resident Focus Groups)
- **Culturally tailored VCSE services**: Organisations like BLMK Mind (Asian women's groups) and Autism Bedfordshire cited as examples of trusted, culturally competent support (Resident Focus Groups)
- **Community crisis teams**: Where available, these were effective in avoiding hospital admission and providing local alternatives (Workforce feedback)

Areas for improvement

- **Access and waiting times:** Long waits for diagnosis, treatment, and crisis care remain a consistent concern, particularly for neurodivergent people (ER - 4.4), children and young people (ER - 4.3), and those in peri-mental health services (ER - 4.2.2).
- **Varied care and transitions:** Service users reported repeating their story to multiple professionals, experiencing gaps when moving between services (e.g. CAMHS to adult), and lack of continuity (ER - 4.2).
- **Cultural sensitivity and equity:** People from ethnically diverse backgrounds, those with limited English, and seldom-heard groups reported services often felt inaccessible or not culturally appropriate (ER - 4.2.2 and 4.3).
- **Crisis responsiveness:** Difficulties accessing timely, appropriate crisis care – including lack of community-based alternatives to A&E – were a strong theme across engagement (ER – 3.1, 3.2 and 4.4).
- **Workforce understanding:** Calls for better awareness and training in autism, trauma, and addiction to reduce stigma and ensure appropriate responses (ER – 3.1, 4.2.2, 4.3 and 4.4).
- **Neurodiversity and reasonable adjustments:** Services often fail to meet autistic and ADHD needs, with patients repeatedly having to explain themselves. A "reasonable adjustment flag" was suggested (Resident Focus Groups)
- **Crisis support gaps:** Lack of timely, out-of-hours provision leaves people reliant on A&E or police. Follow-up care after crisis is inconsistent, and phone-based assessments were criticised as unsafe (Resident Focus Groups and Workforce feedback)
- **Carer involvement:** Carers feel excluded from care planning and crisis response, with little recognition of their role or need for support (Resident Focus Groups)
- **Over-medicalisation:** Medication often used as the default response, with limited therapeutic options beyond CBT/IAPT; some groups reported better outcomes with alternative therapies (Resident Focus Groups)
- **Inequalities and cultural competency:** Patients called for more culturally sensitive services, better awareness of diversity, and improved outreach to marginalised communities (Resident Focus Groups and Workforce feedback)
- **Service navigation:** Both patients and staff reported unclear referral routes, inconsistent signposting, and difficulties moving between children's and adult services (Resident Focus Groups and Workforce feedback)

Further supporting evidence available in **Appendix 2 - Engagement Report (ER)**

Part C Mental Health: Key Considerations (6/6)

The following considerations will help to ensure that transformation efforts respond directly to the most pressing needs and inequalities. These findings are a summary of Part B: Community Health Service and supporting evidence available in **Appendix 1 - Data Pack (DP)** and **Appendix 2 - Engagement Report (ER).**

C1 | Variation in offer

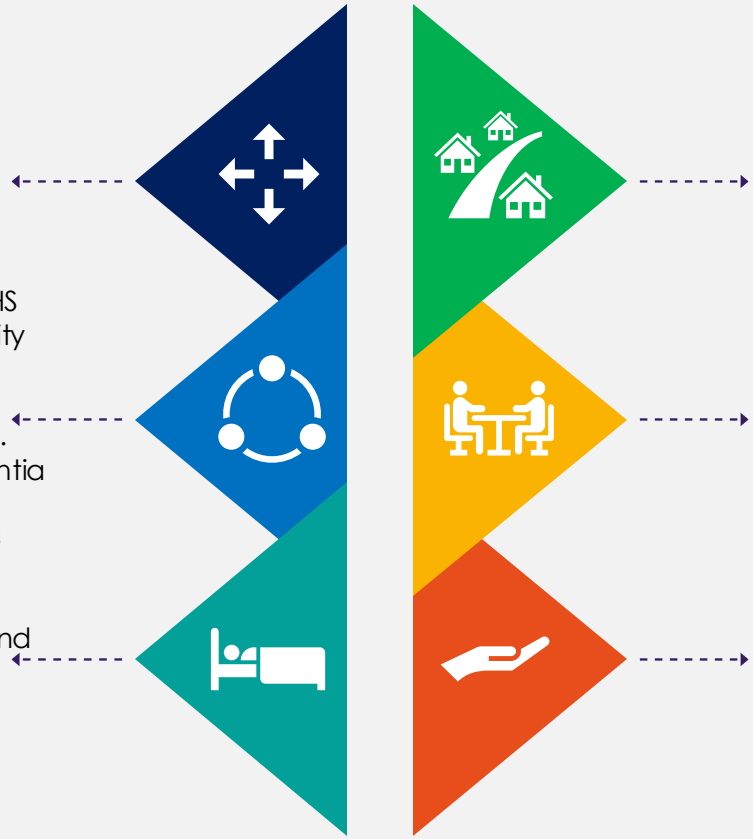
- Differences in provision in LD, ADHD, eating disorder, and dementia pathways create unequal access across BLMK (Page 31/33).
- Workforce shortages and separate commissioning for co-occurring needs impact continuity and outcomes (Page 32).

C2 | Capacity, Flow & Diagnosis

- Rising referral volumes, including a 200% increase in CAMHS demand since 2018/19, are increasing pressure on capacity (Page 30).
- Limited housing and step-down provision cause discharge delays and reliance on out-of-area placements (Page 35).
- BLMK exceeds national targets in Talking Therapies, dementia diagnosis, and SMI health checks, but faces long waits for community mental health services and ADHD assessments (Page 30).
- Crisis care remains a critical challenge, especially for neurodivergent individuals, children and young people, and those in peri-mental health services (Page 32).

C3 | Financial + Out-of-Area Impact

- £235m annual spend on all-age mental health, learning disability, autism, and dementia services (9% of ICB expenditure in 2024/25)(Page 12).
- Above-average per capita spend, with significant costs linked to out-of-area inpatient placements, crisis presentations and Right to Choose activity (Page 12).



C4 | Strategic direction and service alignment

- Develop an integrated, well-resourced, and preventative mental health and learning disability system across BLMK that works closely with communities, improves access and equity, strengthens transitions and carer involvement, and combines physical and mental health care locally (Page 8).
- Neuro-inclusive digital tools, proactive health checks, and early interventions should be embedded in service design (Page 30).
- Service models should be designed to fit evolving NHS priorities and local population needs (Page 8).

C5 | Partnership Working

- The All-Age MHLDA Collaborative is driving consistent approaches across the system (Page 32).
- Successful models, such as the pan-BLMK Perinatal Mental Health service, demonstrate the value of joint working (Page 32).

C6 | Case Complexity + Workforce Training

- Increased prevalence of long-term conditions, frailty, and mental health co-morbidities is driving more complex case management needs (Page 15).
- Higher acuity levels create sustained pressure on service capacity and specialist provision (Page 11)
- Clear need for improved awareness and training in autism, trauma, and addiction to reduce stigma and enable more appropriate, compassionate responses (page 32).

Part D: Enablers and Shared Opportunities

This section explores :

- Workforce
- Digital and Data
- Shared opportunities between Community and Mental Health Services

All evidence relating to key statements and findings in this section can be found in **Appendix 1 – Data Pack (DP) and Appendix 2 - Engagement Report (ER)**

Part D: Workforce (1/6)

Current BLMK Position [ESR data submitted by providers to AGEM CSU]

- The **BLMK workforce is the systems' biggest asset** and work to attract, retain and develop it to best meet the future needs of BLMK residents is imperative.
- The current BLMK mental health and community workforce totals **4,701 staff** across ELFT, CNWL, and CCS **(14% of all NHS staff locally)** (DP 12.3).
- 20% are aged 55+ with only 14% under 30 indicating that **stronger attraction work** and **succession planning** will be needed in the coming years (DP 12.5).
- **Turnover rates:** The turnover rate has been falling for the last two years and in June 2025 was 9.4% (NHSE data - DP 12.3)
- Incomplete local **vacancy rate** reporting limiting the ICB's ability to accurately model. (DP 12.3)
- **Variance in vacancy rates** across different service settings (this data is not available for community nursing services):

Data taken from NHSE Workforce Census Reports 2024		
Sector	National Vacancy Rate	BLMK Vacancy Rate
Adults & Older People's MH services	11%	16%
Talking Therapies and anxiety & depression	6%	2%
Psychology professions (adults)	8%	0%
Specialist perinatal MH	12%	9%

- 38% of workforce is from **ethnic minority backgrounds**, exceeding the local population average, but does reflect some of our place demographics (DP 12.6).

National Context

Released in July 2025, the NHS 10-Year Health Plan calls for:

1. Expanding workforce capacity to meet growing demand.
2. **Shifting care from hospital to community settings.**
3. Strengthening career pathways and retention.
4. Increasing diversity, inclusion, and local recruitment.

Opportunities for change

- **Increase local clinical placements in community physical and mental health services** to support future movement of activity from hospital to community setting; this work has already commenced
- **Standardise workforce data submissions** across all providers for better planning; greater granularity and frequency of reporting required
- Development of skills to support **multi-disciplinary and cross organisational working**
- **Develop early-career recruitment and structured progression** to senior roles, education and training placements' growth.
- **Learning from MH services with lower vacancy rates** to support services with higher than national average rates
- **Strengthen retention strategies** in high-turnover areas.
- Consider role and offer from **VCSE workforce**
- Work with training providers and employers regarding training for staff in reasonable adjustments and when to offer and accommodate these

Positive Developments

- **Supported employment pathways** work with those furthest from employment helps create a workforce more reflective of the population it serves (beyond just ethnicity).
- Oliver McGowan training provides **paid employment for experts by experience** with LD & Autism; how could this model of recruitment and pastoral support be scaled up?
- **Peer support worker roles** in ELFT & CNWL MH services support those with lived experience of mental health challenges to support others
- Work underway to expand numbers of **student nursing placements in out of hospital settings**
- ELFT, CCS and CWNL used **apprenticeships** to support recruitment to hard to fill AHP roles.
- The BLMK ICS has developed a **workforce strategy** including support for health and social care staff, encompassing carers and volunteers. Carers play a vital role in supporting NHS workforce sustainability. Many staff balance professional roles with caring responsibilities, and providing flexible working, targeted wellbeing support, and recognition of carers' skills can improve retention and reduce burnout.

Challenges

- **Low levels of workforce growth** permitted in most recent round of operational planning
- Ability to provide employment for all **newly qualified nurses and midwives** (being addressed nationally)
- **Cultural change** needed to support movement of workforce from hospital to community settings
- Gaps in **workforce data** reporting

Further supporting evidence available in **Appendix 1 - Data Pack (DP)**

Part D: Digital and Data (2/6)

Context

Across Bedfordshire, Luton, and Milton Keynes (BLMK), there are strong opportunities to use digital, technology, and AI to improve care coordination, access, and outcomes. While progress has been made, the current mix of separate IT systems, variable digital adoption, and occasional reliance on paper processes limits seamless information sharing. This reflects the priorities in the **national NHS strategy to transition from analogue to digital**, which calls for:

- Full interoperability between systems
- Real-time access to patient information
- Phasing out paper records
- Expanding digital-first pathways

Opportunities for improvement

- Broaden data sharing and interoperability between GPs, out-of-hours services, and rapid response teams, ensuring all opportunities for digitisation and automation of processes are implemented including laboratory results reporting directly into records, implementation of AI to release efficiencies in handling results of interest and reduce delays caused by manual processes through system integration.
- Expand shared dashboards and analytics for population health management
- Adopt AI-enabled decision support tools to enhance diagnosis, triage, and personalised care planning
- Address data quality and completeness issues with Community Services Data Set (CSDS) and Mental Health Services Data Set (MHSDS) - (DP 9.1 - 9.3)

Positive developments already in place

- Performance dashboards for severe mental illness (SMI) and learning disability (LD) checks
- Digital initiatives supporting higher dementia diagnosis rates
- Streamlining of test requesting and results reporting, iRefer which is appropriate diagnostic tests are requested.

Potential for AI and advanced digital tools

- AI and advanced digital tools offer transformative potential for BLMK, enabling a shift from reactive, hospital-based care to proactive, personalised, and community-focused services. By enhancing data use, empowering patients, and improving system efficiency, these technologies support BLMK's ambition for integrated care and better population health outcomes.
- AI enables predictive modelling to identify individuals at risk of illness before symptoms emerge. This supports earlier, community-based interventions and reduces reliance on acute services.
- AI and analytics optimise how resources are deployed—whether staff, beds, or services—based on real-time demand and predictive trends. This ensures care is delivered efficiently and equitably, supporting system resilience and enabling more responsive, community-based care.
- AI enables real-time analysis of health data, allowing BLMK systems to learn and adapt continuously. This supports targeted interventions, identifies emerging risks, and helps reduce health inequalities. By embedding learning into everyday operations, BLMK can evolve services dynamically and improve outcomes across integrated care systems.

Expanding remote monitoring and predictive analytics for long-term conditions

- Digital tools allow seamless sharing of patient data across primary, secondary, and social care. This enables joined-up care that follows the patient, improving continuity and reducing duplication. Clinicians can make better-informed decisions, and patients benefit from more personalised, coordinated support across the entire care pathway.
- AI-powered platforms help individuals manage long-term conditions at home, offering tailored guidance, symptom tracking, and medication support. This promotes independence and reduces unnecessary hospital visits.
- Natural language processing to streamline clinical documentation
- AI-powered patient navigation tools to match people with appropriate services faster
- With coordinated investment and alignment to the national digital strategy, BLMK could accelerate its transition to a fully connected, data-driven, and AI-enabled health system that improves both patient experience and clinical efficiency.

Data Quality

There are challenges for the ICB in analysing data from providers due to variation in IT systems creating variation in data entry and extraction. The standardised national data sets (CSDS and MHSDS) also have issues with the quality and completeness (DP 9.1 -9.3).

Poor data quality undermines the NHS's ambition to deliver integrated, preventative care

- Inaccurate, incomplete, or siloed data hinders clinical decision-making, disrupts continuity across care settings, and limits the effectiveness of AI and digital tools.
- It impedes population health management, delays early interventions, and reduces trust in digital systems.
- For BLMK and other ICSs, high-quality data is essential to enable seamless care coordination, empower patients, and support the shift from hospital-based to community-led services.

Supporting evidence available in **Appendix 1 - Data Pack (DP)**

Part D: Infrastructure (3/6)

BLMK ICB has developed an **Infrastructure Strategy** (2025) supported by a detailed **Infrastructure Assessment**. These documents set out the condition, capacity and investment needs across the system, including community and mental health services. The assessment highlights that while much community care is delivered in people's homes, services still rely on suitable bases, clinical space, and inpatient facilities. It also identifies a consistent pattern of underinvestment in community and mental health estate compared with acute hospitals, with major pipeline schemes unfunded and capital allocations constrained.

Infrastructure Challenges

- **Estate condition and capacity:** While some community services (such as district nursing, therapies and crisis response) are primarily delivered in people's homes, these teams still require suitable bases, clinical space for assessments, and training facilities. Demand for these services is projected to rise by 60–75% by 2043, yet over half of primary and community sites are already rated as "very or severely constrained." Without new investment, estates will not be able to absorb this additional activity or support the workforce to deliver at scale. Many of the current buildings occupied by community and mental health services are in poor condition and have growing backlog maintenance challenges.
- **Mental health beds and facilities:** Unlike home-based community care, mental health services rely heavily on estate. A lack of investment has left inpatient capacity insufficient, with schemes such as Bedford Health Village (>£80m), Luton Crisis House (£2m) and Evergreen CAMHS expansion (£5m) all unfunded, sustaining reliance on out-of-area placements.
- **Limited capital investment:** Annual system capital is £74m, with <£4m for primary care and no dedicated funding for community or mental health. The capital allocation for current providers sits with external systems, and it can be challenging for investment to be prioritised towards BLMK assets – especially when most of the properties occupied are leased and not owned by the current providers.
- **Growth and demographics:** The population is projected to grow by 21% by 2043, with over-65s rising by 50%. Major housing and infrastructure schemes will add further pressure on already constrained facilities.
- **Health inequalities:** 47% of residents live in the most deprived 40% of areas, and ethnic diversity is above the national average. In areas like Luton and Bedford, constrained estate compounds inequalities in access. For serious mental illness, people face a 3–4x higher risk of premature death, with estate models still separating physical and mental health care.

Infrastructure Opportunities

- **Home-based care supported by infrastructure:** Expanding digital capability, mobile equipment, and modern bases would strengthen home-based services such as district nursing and crisis response, enabling them to meet rising demand.
- **Reducing avoidable admissions:** 9% of admissions are for conditions manageable in the community. Strengthening local estate (for diagnostics, therapy, step-down care) could avoid the need for 300 extra acute beds by 2037, saving £100m capital and £60m annual revenue.
- **Integrated hubs:** Co-locating community, primary, mental health and VCSE services would improve navigation, tackle inequalities and support workforce training.
- **Neighbourhood teams:** Developing neighbourhood teams with modern shared bases supports the 10-Year Plan vision for integrated, place-based care. Estate investment in neighbourhood facilities provides space for multidisciplinary working, anchors home-based teams, and improves access in high-growth and high-need areas.
- **Mental health capacity:** Investing in inpatient and crisis facilities would reduce reliance on out-of-area beds and improve patient outcomes.
- **Digital and sustainability:** Estate investment should enable shared records, care coordination, and support Net Zero ambitions.
- **Capital investment:** Explore longer-term contracts and alternative mechanisms to bring capital investment into local assets within BLMK.

Part D: Sustainability and Social Value (4/6)

Context:

- "Climate change is the single biggest health threat facing humanity" (WHO, 2023). Healthcare services generate emissions and pollution, which drives climate change and environmental degradation. This impacts on our health and disrupts services, leading to greater healthcare use.
- The BLMK ICS Green Plan 2025 outlines how ICS Partners will work towards the national goal of a Net Zero NHS by 2045. The Vision has 3 themes:
  - People: Improve Health & wellbeing, Reduce Health Inequalities
  - Places: Reduce Pollution, Support nature Regeneration
  - Planet: Reduce emissions, Save Lives
- **The Environmental & Social Impact Assessment (EaSIA)** helps commissioners evaluate how proposed projects affect key health determinants—environmental and social factors—during initial planning.
- The completed assessment shows the expected changes to the Community & Mental Health services will have a very positive effect on Environmental Sustainability and Social Value as shown in the Dashboard wheel opposite.

Environmental Opportunities:

- Prevention - Risk to health from poor housing, Patient/staff/resident physical activity levels, excess weight, inequalities in socio-economic situation, service access and/or health outcomes
- Medicines - Reducing use/overuse, stockpiling and/or waste of medicines
- Reducing use of items – Consumables, single use consumables particularly plastic, increasing reusable items reprocessing/remanufacturing equipment schemes
- Reducing travel and Transport – delivery miles, care miles, patient and staff travel modal shift to active transport, location of services close to other public services
- Food – increasing low carbon menus, using food and nutrition as part of treatment pathway

Social Value Opportunities:

- Local economy - Supporting economic development and tackling economic inequality, health & care procurement in the local area, utilising unused public estate for community benefit
- Training and development - opportunities for residents, outreach to local FE Colleges and HEIs, working with education providers to develop workforce for the future, supporting those in education to reach their potential
- Research and innovation - Opportunities for novel research between local organisations and HEIs, making it easier to test and implement innovations

Key		Colour	Impact	Action
++	Very positive impacts	Very Positive	Significant and/or long-term positive impact identified.	No changes needed.
+	Somewhat positive impacts	Somewhat positive	Slight or short-term positive impact identified.	No changes needed but could be reviewed to improve.
+/-	Neutral Impacts	Neutral	No net change or not applicable.	No changes needed but could be reviewed to improve.
-	Somehwat negative impacts	Somewhat negative	Slight or short-term negative impact identified.	Review to identify possible improvements.
--	Very negative impacts	Very Negative	Significant and/or long-term negative impact identified.	Changes needed before proceeding. If changes are not possible, justification is required.
O	Incomplete response		Responses incomplete.	Please return to assessment and answer all questions in this section.
n/a	Not currently assessed		Equality Impact is not currently assessed using this tool - please complete the separate EqIA / HEAT process	

Part D: Shared Opportunities (5/6)

This slide brings together the key synergies between community and mental health services identified through the case for change, Appendix 1 – Data Pack and Appendix 2 – Engagement Report. It highlights where joint working can deliver the greatest impact – from neighbourhood-based care and prevention, through to workforce, digital, financial sustainability, and reducing inequalities. These shared opportunities reflect consistent themes across residents, carers, and professionals, and provide a foundation for transformation across BLMK which is explored through the transformation priorities (page 45).

- **Neighbourhood working as a shared foundation** – Both community and mental health services can be rooted in neighbourhoods, creating consistent, place-based multidisciplinary teams. This model allows physical and mental health needs to be addressed together, alongside social care and VCSE partners, reducing fragmentation and improving continuity of care (page 7-11, 24 and 31)
- **Joint focus on prevention and population health** – Community and mental health services share the opportunity to move upstream, supporting earlier intervention, tackling wider determinants, and addressing risk factors that contribute to both physical and mental ill health. This integrated approach can reduce avoidable admissions, delay long-term conditions, and ease pressure on acute care (page 5-6, 24-25 and 31-32)
- **Aligned personalised and coordinated care** – Both services are central to wrapping care around individuals and families. Integration offers opportunities to streamline navigation, reduce duplication, and smooth transitions between physical and mental health pathways, particularly for people with long-term conditions, neurodivergence, or serious mental illness (page 24-25 and 31-32)
- **Shared workforce development and culture** – Community and mental health services face similar workforce challenges. Joint planning can build flexible, multidisciplinary teams, embed peer support, and strengthen links with VCSE partners. This helps foster a culture of collaboration, empathy, and resilience across both sectors (page 24, 32 and 37)
- **Digital and data as a cross-cutting enabler** – Integrated care records and shared digital tools can improve continuity between physical and mental health services. This includes enabling joint assessments, supporting residents to self-manage, and providing professionals with a single version of the truth (page 36)
- **Financial sustainability through integrated investment** – By working together, community and mental health services can reduce reliance on acute hospitals and high-cost crisis interventions, shifting resources into earlier and more cost-effective community-based care. The opportunity lies in aligning commissioning and investment to maximise impact across both sectors (page 10-12 and 38)
- **Stronger co-production and partnerships** – Both services have heard consistent calls from residents and carers for more involvement, dignity, and respect in how care is designed and delivered. Bringing together community and mental health perspectives through co-production strengthens trust and ensures services are culturally competent and equitable (page 25 and 33)
- **Reducing inequalities across systems** – Both sectors face stark inequities, from higher premature mortality in people with SMI to poorer physical health outcomes for deprived or ethnically diverse groups. Tackling these together provides an opportunity to narrow gaps in access, experience, and outcomes across the whole BLMK population (page 16-20)

Part D Enablers and Shared Opportunities: Key Considerations (6/6)

Accounting for the following findings ensures that transformation efforts respond directly to the most pressing needs and inequalities. These findings are a summary of Part D: Enablers and Shared Opportunities with further supporting evidence available in **Appendix 1 - Data Pack (DP).**

D1 | Skilled workforce (page 35)

- 4,701 staff in community and mental health (14% of NHS workforce).
- Ageing profile: 20% 55+; only 14% under 30.
- Shared planning needed for recruitment, retention, and new peer/VCSE roles.

D2 | Connected Digital Systems (page 36)

- Multiple IT platforms limit integration.
- Shared care records and NHS App can improve access and navigation.
- Better data quality (CSDS, MHSDS) supports planning and commissioning.

D3 | Fit-for-Purpose Estate (page 37)

- Over half of sites "very or severely constrained."
- Limited capital compared with acute hospitals.
- Opportunity for neighbourhood hubs co-locating services.

D4 | Sustainable Resources (page 38)

- Modernising estate supports Net Zero ambitions and greener models of care.
- Embedding social value in service design can improve local employment, volunteering, and community resilience.
- Research and innovation partnerships strengthen long-term sustainability.

D5 | Stronger Partnerships (page 39)

- Residents, carers, and staff call for greater involvement and respect.
- Co-production and VCSE collaboration build trust and cultural competence.
- MHLDA Collaborative provides integrated planning framework.

D6 | Shared Opportunities (page 39)

- Community and mental health are interdependent, facing common pressures.
- Integration enables joined-up pathways, neighbourhood teams, and single access points.
- Coordinated action reduces duplication, avoids admissions, and tackles inequalities.

Case for Change Conclusion

This section brings together the findings of the case for change and reviews:

- Conclusion summary
- Transformation Priorities
- Next Steps

Conclusion: Summary (1/4)

Taking into consideration the case for change analysis and the voices of residents, carers, staff and partners, four cross-cutting themes consistently emerge from the insights and findings:

1. Variation in service models and access

Services across BLMK are delivered by a range of providers, which brings strengths such as innovation and tailoring to local community needs. However, this has also led to variation in access, waiting times and care pathways. Residents and staff report that experiences can differ depending on where people live, creating concerns about equity and consistency. The NHS 10-Year Plan highlights that "every single person, no matter who they are or where they come from, deserves the same quality treatment", and this underlines the need for a consistent core offer of community and mental health care across BLMK, with flexibility to respond to differing levels of need. Variation is also influenced by differences in workforce capacity and models of delivery, meaning people's access to services can depend on the staffing and resources available in their area.

2. Limited focus on prevention and population health

While there are excellent examples of proactive care including virtual wards, rehabilitation programmes and Recovery Colleges, most activity remains focused on responding to illness or crisis. Evidence and feedback highlight a strong need for more emphasis on helping people to stay well and for services that are informed and planned based on population health data and local needs. The NHS 10-Year Plan calls for a "shift from sickness to prevention", strengthening the case for a greater focus on early intervention and personalised support in BLMK. Shifting towards prevention and early intervention will also require new ways of working, with staff supported to adopt population health approaches and to work differently across organisational boundaries. Without this shift and transformation of how services are delivered, the cost of providing these services will increase by 50% by 2037 which is unsustainable.

3. Challenges in care co-ordination and service navigation

People value the care and support they receive but often describe services as complex to navigate, with differences in information, systems and handovers between providers. Engagement shows many experience duplication, disruption at transition points, and limited clarity on where to go for support, despite positive examples of collaboration. The NHS 10-Year Plan emphasises care "delivered as locally as it can be, digitally by default, and in a hospital only when necessary". This reinforces the importance of embedding care in neighbourhoods, improving coordination and information sharing across services in BLMK, so care feels more joined-up and easier to navigate.

4: Provider accountability and cultural shift

With the ICB moving towards a strategic commissioning role, including the expectation to set out three-year commissioning intentions, provider organisations will need to take a leading and coordinating role in service design and innovation. The workforce analysis tells us that we have gaps in our workforce based on our current delivery model. which supports the drive for greater collaboration and transformation of how the services are delivered. The diverse provider landscape, while a strength, requires clearer local leadership and accountability and a cultural shift towards collaborative, outcomes-based models based on BLMK population needs and place context, in line with the ICB's evolving role as a strategic commissioner. As the NHS 10-Year Plan states, "success will be measured not just by activity delivered, but by the outcomes achieved for people and communities."

Conclusion: Transformation Priorities (2/4)

Building on the findings, engagement and conclusions of the case for change, the transformation priorities will guide future commissioning intentions, help to shape measurable outcomes, and provide a clear framework to deliver the BLMK system vision.

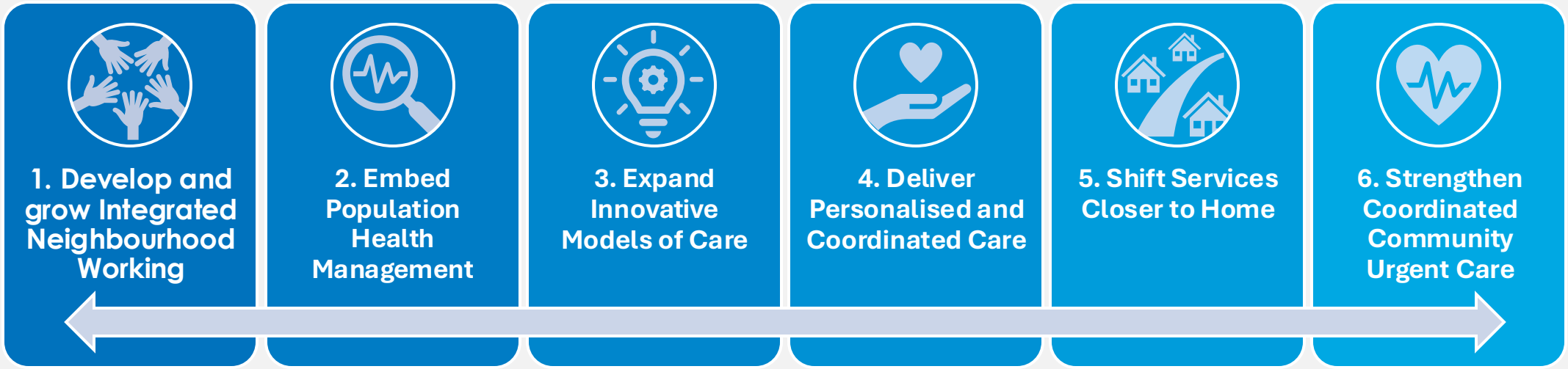
What is our system vision?

Our **vision** in BLMK is for everyone in our towns, villages and communities to live a longer, healthier life. To **increase** the number of years people spend in good health; and **reduce** the gap between the healthiest and least healthy in our community.

What are the key focus areas that help to deliver this vision?

Healthier Communities → Personalised care → Joined up local teams → Local specialist services → Centres of excellence

What are the priorities for transformation of Community and Mental Health Services?



Conclusion: Transformation Priorities (3/4)

The Transformation Priorities have been developed from analysis, insights and discussed in key engagement forums, including recent market engagement events. The resident "I want" statements and paired workforce developments signal the importance that transformation is not only about new models of care but also about the people and behaviours that are required to make them succeed.

Transformation Priorities	Description	Resident Perspective	Workforce Development Priorities
1. Develop Neighbourhood Working	Bring together primary care, community, mental health, and VCSE partners through collaborative neighbourhood working to deliver joined-up support tailored to local needs.	"I want local services to work together to avoid handoffs and understand my personal needs, so I don't have to repeat my story."	Work collaboratively across organisations, share information, and develop the skills needed to coordinate care around individuals and communities.
2. Embed Population Health Management	Use shared data and analytics to target resources at those most at risk, reducing inequalities and preventing avoidable hospital use.	"I want services to understand my needs and risks early, so I can get help before things get worse."	Use data and insights in daily practice, adopt proactive approaches, and feel confident working with communities to address health inequalities.
3. Expand Innovative Models of Care	Grow approaches such as virtual wards, multi-agency crisis prevention and AI-enabled care planning to reduce acute demand.	"I want care that uses modern tools and ideas to keep me safe at home and avoid unnecessary hospital stays."	Adopt new technologies confidently, adapt to new service models, and be supported with training and change management.
4. Deliver Personalised and Coordinated Care	Deliver services around individual needs with single care plans and seamless handovers.	"I want my care to be personalised to me, joined-up and co-ordinated, so I get the right help at the right time and I can take more accountability for my health and wellbeing."	Enhance personalised care approaches, work with shared care plans, and involve patients and carers in planning and decision-making.
5. Shift Services Closer to Home	Provide more services in community and home settings, improving access, independence and recovery.	"I want to be treated as close to home as possible, so I can stay independent and connected to my community."	Deliver care in home and community settings, work flexibly across neighbourhoods, and collaborate with local partners.
6. Strengthen Coordinated Community Urgent Care	Enhance rapid response and crisis services in the community to reduce reliance on A&E and inpatient care.	"I want urgent help when I need it, without always having to go to hospital."	Provide timely crisis and urgent response, work as part of 24/7 neighbourhood networks, and develop skills for community-based urgent care.

Conclusion: Next Steps (4/4)

The **Case for Change** is a critical foundation for transforming adult community and all-age mental health services in Bedfordshire, Luton and Milton Keynes. It sets out a clear, evidence-based rationale for why the current way of working will not be fit for the future - bringing together population needs analysis, service mapping, performance data, financial pressures, and stakeholder insights into a single, shared view of the challenges and opportunities ahead.

By articulating the drivers for change and identifying areas of synergy between community and mental health services, the Case for Change sets out priorities for action and where partners need to align to act together. This shared understanding now enables the programme to move confidently into **Phase 2 – Strategic Transformation Planning**, where the focus will shift from *why* change is needed to *what* and *how* that change will happen. In this next phase, the ICB will:

- Develop measurable outcomes based on the findings of the case for change
- Explore commissioning and contracting options to support integration and sustainability.
- Quantify the impact of proposed changes on outcomes, inequalities, capacity, and cost.
- Produce a business case that sets out the preferred model, financial requirements, and implementation plan.

Through this phased approach, the Case for Change becomes more than a diagnostic - it is the strategic launchpad for delivering a future-ready, integrated, and financially sustainable model of care across BLMK.

In April 2026, Central East ICB will be established which will be responsible for commissioning services for the 3.2 million population of BLMK, Cambridgeshire & Peterborough and Hertfordshire. In the lead up to 1st April 2026, the current ICBs are working in partnership to deliver on the key commitments of the three current ICBs from 1st October 2025.