Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Healthier Together 2040

Strategic intentions to improve the wellbeing and health of working aged adults with multiple health needs in Bristol, North Somerset and South Gloucestershire

August 2025

Contents

5 Minute Read

Healthier Together 2040 started from a shared recognition that for people's health outcomes to improve, the health and care system needs to fundamentally change how it approaches delivering, measuring and paying for services. With significant expertise and resource available by working together we sought to reimagine health and care working with people and understanding all their needs, hopes, and what matters most to them.

We identified four groups of the population who are currently or at risk of experiencing the poorest outcomes, then started with a focus on working aged people living with multiple health challenges. Through extensive listening and gathering of insights, we have learned that meaningful change depends on moving beyond reactive, condition-focused services and creating support that is compassionate, preventative, and rooted in relationships.

While Healthier Together 2040 started before the NHS 10-year plan publication, many of the elements developed through the design process have aligned with the national policy. For example, the co-creation of personalised wellbeing plans, connecting people to wider support, and embedding specialists locally to reduce hospital reliance. Flexible access, strong employer partnerships, unified digital systems, and new payment models to enable joined-up, sustainable care, all underpinned by a relentless focus on outcomes that matter most to people.

Our Strategic Intentions: How we want to improve the wellbeing and health of working aged adults with multiple health needs

1. Healthy Neighbourhoods providing whole person care

We will develop a neighbourhood-based model of care for working-aged people living with multiple health challenges, combining consistent core features across all postcodes and enabling local tailoring to address community needs and reduce inequalities. Informed by personalised wellbeing and health plans, people will be supported by an integrated, multi-professional team that takes a trauma-informed, relationship-based approach, linking clinical care with wider wellbeing support such as housing, employment, and financial stability.

The places people go to access care and support will be flexible. This may be through community hubs, outreach, and optimising digital tools, with proactive support offered at key life moments to prevent crisis. Over time, this model aims to reduce the need for unplanned services, as people choose the holistic, preventative care options that are available in their local area. This will ease system pressures while enabling GPs and specialists to focus on those with the greatest need.

Our workforce will need support to make these transitions. We will require organisational development (OD) and training plans with a greater focus on relational skills, digital/ data capability, and care coordination, embedding a culture of person-centred, relationship-based care across the system. Ultimately, the model seeks to shift from fragmented, reactive provision to proactive, integrated neighbourhood care that improves outcomes and reduces inequalities, while remaining scalable and affordable.

System Architecture to Deliver the New Model of Care

To enable the neighbourhood-based, person-centred model of care, we will put in place a supporting system architecture that aligns incentives, harnesses data and insights, focuses on outcomes, embeds digital tools, rebuilds trust, supports healthy workplaces, and creates a culture of continuous learning. The digital tools and data that staff will need to make these new approaches real will be embedded. With professional staff being able to track outcomes for individuals and groups of people. Teams working in neighbourhoods will be able to use the dynamic population model as a view to understand which interventions are working for their population and those that need to be adjusted or improved.

2. **Aligning Incentives**

Funding will move towards outcomes-based models, beginning with Year of Care payments that consolidate primary, community, mental health, outpatient, and emergency care into a single annual budget per person. Personal health budgets will be explored to give individuals more control, while VCSE partners will be supported with stable, long-term contracting arrangements.

3. Data and Community Insights

A population health intelligence system will be developed to share data transparently across the system, combining clinical records with patient-reported outcomes and community insights. Interoperable systems, AI, and digital tools will enable proactive risk stratification and early intervention, ensuring action happens as close to home as possible.

4. Outcomes that Matter

The model will embed person-centred outcomes (e.g., activation, experience, functioning, health behaviours) alongside population-level measures (e.g., healthy life expectancy, years of life lost). Outcomes will directly inform personal wellbeing and health plans and be enriched by novel data sources such as wearables.

5. Digital Tools

A digital taskforce will co-design solutions with service users and partners, ensuring integration through unified records and human-centred design. To avoid digital exclusion, VCSE partners will support equitable access. Digital platforms will promote self-management, link to community resources, and connect people seamlessly with services.

6. Culture of Relationships and Trust

Neighbourhood models will prioritise trauma-informed, relationship-based practice, with trusted listener roles, peer coordinators, and co-design with communities. Staff will be trained, supported, and incentivised to build human-centred relationships, redistributing power and fostering trust across organisations, clinicians, and individuals.

7. Healthy Workplaces, Healthy Communities

All organisations in our partnership will actively support staff living with health needs, embedding wellbeing activities into workplace culture. Occupational health services may extend to carers and small employers, while procurement levers will strengthen local economies by favouring organisations with good employment practices and community benefit commitments.

8. Embedding a Learning Health System

An iterative, data-driven approach will underpin continuous improvement, informed by research, academic partnerships, and international collaboration. Mechanisms for real-time evaluation and system-wide knowledge sharing will ensure the model evolves responsively and spreads best practice across neighbourhoods.

Glossary of terms

AI - Artificial intelligence (AI) is the field of computer science focused on creating systems that can perform tasks normally requiring human intelligence, such as learning, reasoning, and problem-solving.

Behaviour change – the method in which professionals can help support individuals to change their behaviour.

BNSSG Healthier Together Outcomes Framework – a list of metrics used in BNSSG to measure health and wellbeing of the population.

BNSSG Integrated Care Board - NHS organisation responsible for planning, funding, and coordinating local health services to meet the needs of people in its area.

Care coordination – planning and communication between health and care providers, the public and care givers.

Community Hub – place or space outside of the traditional NHS estates where people will be able to connect for support.

Community Intelligence - information held in local communities about what matters to them.

Co-production – a way of working that involves people that use health and care services, carers and communities in equal partnership, often used in service design, development and evaluation.

Design phase – the period where the HT2040 project explored the activities that need to be achieved to improve the health and wellbeing of the working aged adult cohort.

Dynamic Population Model – statistical model that predicts the future health and care needs of a population.

FDP – the NHS Federated Data Platform (NHS FDP) is a digital platform that securely connects data from different organisations in the local system

Gain share arrangement – an agreement where the benefits, such as cost savings or efficiency improvements resulting from a project or service, are shared between the organisations involved. This encourages collaboration and ensures that all parties are rewarded for their contributions to positive outcomes.

Get the West of England Working Plan – WECA's strategy to support people to return to employment and other meaningful activities.

Good employment charter - a voluntary membership and accreditation scheme aimed to create an active network of employers within the West of England that are committed to supporting the basis of 'good work'.

Health and Growth Accelerator Models - joined up support from across work, health and skills systems to help people find and stay in work.

Health Coaching – support for professionals that help them change the way they practice supporting personalised care delivery (What matters to you).

Healthier Together 2040 – strategic project in BNSSG looking at improving the health and wellbeing of key population cohorts.

Integrated Care System (ICS) - partnership of NHS organisations, local authorities, and other partners that work together to plan and deliver joined-up health and care services for a defined population.

Integrated Health Organisations – organisation that will deliver a holistic set of services.

Integrated Prevention Team – similar to a multi-disciplinary team.

Intelligence centre – a digital platform that will combine and share data from different health and care organisations.

International Consortium for Health Outcomes Measurement (ICHOM) adult health framework - a patient-centred approach to measuring health outcomes in adults.

Life crossroad points - points of change in someone's life such as marriage, birth and changing employment status.

Locality Partnership - partnerships made up of local Government, NHS, VCSE sector, housing and increasingly communities, people and wider partners such as police. They work with each other to bring services together and plan how they are delivered to their local populations.

Model of care - the structure of how health and care professionals and organisations are organised to support people.

Multidisciplinary Neighbourhood Team – a diverse group of professionals in neighbourhoods that can support a range of needs.

National Neighbourhood Implementation Programme – a national programme that aims to deliver neighbourhood health schemes.

NHS 10 Year Plan – national plan for the NHS over the next 10 years.

NHS App – a nationally developed app that contains access to different functions related to health care provision.

NHS Green Plan – the plan that sets out how the NHS intends to meet its carbon reduction targets.

NIHR – National Institute of Health Research.

Neighbourhoods – although there is no single, universally agreed-upon definition, for the purpose of this document we are using the concept of an area defined by geographical boundaries, a sense of community and shared social interactions.

Outcome – the result or effect of an action, situation or event.

Outcomes based contracting – contracting that rewards the achievement of set outcomes

Patient Activation Measures - a tool that assesses a patient's knowledge, skills, and confidence in managing their own health and healthcare.

Personal health budgets - an allocated sum of NHS funding that individuals can use to plan and pay for their own agreed healthcare and wellbeing needs.

Population cohorts - groups of people with different conditions.

Population health management - an approach to improving the health outcomes of a defined group by using data to proactively plan and deliver targeted care and support.

Risk share - sharing of clinical risk across organisations.

SDE – the Secure Data Environment (SDE) is a secure data and research analysis platform

Shared investment fund – investment from different sources being combined.

Strategic Intentions – a road map of activities that will support the target cohort to improve their health and wellbeing for now and the future.

System wide intelligence sharing charter – a legal agreement that enables organisations to access and share information according for specific reasons.

Trusted listening function – people embedded within communities that have the trust of those around them, that can relay this information to statuary services.

User centred design - an approach to creating products, services, or systems that based on the needs, experiences, and perspectives of the people who use them.

User experience - is the overall impression and satisfaction a person has when interacting with a product, service, or system.

VCSE Alliance – the Voluntary, Community and Social Enterprise (VCSE) Alliance is a collaboration between the BNSSG health and care system and the VCSE sector. The network includes 250+ diverse VCSE organisations in BNSSG.

VCSE Brokerage – a new system-wide approach and route to market that enables a diverse range of VCSE organisations to deliver health and wellbeing improvements in local communities.

Well Aware – a website provides information on a wide range of organisations; support groups, community groups, events and activities that can help improve your health and wellbeing in Bristol and South Gloucestershire.

'Year of care' contract – defined by the total years' worth of average spend on health services for this cohort, this contract assigns a total value of this care to one organisation who will then deliver services to an individual. Should that individual use other health services, such as acute care, the value of this care is paid for solely by that host organisation out of the value assigned in this contract. At the end of the year, any remaining money on the contract is kept by that host organisation.

Years of Life Lost - a measure of premature mortality that calculates the difference between a person's age at death and their expected lifespan.

WECA – West of England Combined Authority.

Section One: One Year of Healthier Together 2040

Background

Healthier Together 2040 was established in 2024 to create a long-term strategic plan for the Bristol, North Somerset, and South Gloucestershire (BNSSG) Integrated Care System (ICS). Building on the system strategy published in 2023, it was designed to be more than a static blueprint for the future; it represents a local approach and an evolving process to shape health and care services, ensuring they adapt to current and future needs over time.

Why is Healthier Together 2040 needed?

Local goals now set within an aligned national policy direction

Healthier Together 2040 is aiming to create a sustainable, equitable future for the health system that is rooted in improving the overall health and wellbeing of the BNSSG population and reducing gaps in healthy life expectancy. The Healthier Together 2040 approach is centred around how we support people to stay healthy, prevent illness and /or deterioration. By designing for different groups of people in our communities and understanding the outcomes rather than the inputs of care we will drive the right changes that are most impactful for our population.

Our initial focus on redesigning services for people who are currently high users of services and those in at risk cohorts. Healthier Together 2040 aims to achieve medium-term improvements through more integrated services, stronger prevention, and proactive care—ensuring that future generations do not face the same health challenges over the longer term.

Healthier Together 2040 is setting how we can work as a partnership to organise services around population cohorts' needs, with a focus on preventing people living in poor health for extended periods of time. This approach will gradually inform decisions on where services, buildings, and infrastructure should be optimally located within the system. It will enable the system to focus on innovation aligned to the key strategic objectives for a long-term sustainable system.

In the initial phase of Healthier Together 2040, national and local trends were reviewed to shape what the BNSSG health and care system needs to address by 2040.

Key insights from the national and local modelling for the next 15 years

In the summer of 2024, Healthier Together 2040 started with a review of national and local population health need. The key insights are set out below.

People will be likely to live for longer in poor health, experiencing multiple health conditions from a younger age. Nationally, the number of people living with major illness is expected to increase by 37% in 2040 (Health Foundation, 2023[1]), which is corroborated by population modelling using local data.

Individuals in more deprived areas will face health challenges at a higher rate and at a younger age, driven by unresolved inequalities and a collision of health and social factors. 80% of the increase in the number of working-age people living with major illness will be from more deprived areas (Health Foundation, 2024[2]).

The working-age population is growing more slowly (4%) than the older population groups, presenting workforce and economic challenges (Health Foundation 2023).

Many existing buildings, particularly in primary care, are no longer fit for purpose. With 95,000 new houses projected to be built, the population increase will drive further demand, particularly in more deprived areas of South Bristol and Weston area (Healthier Together 2040 Analysis). Large scale population growth is also expected within South Gloucestershire.

Currently there is a concentration of health and care services in urban areas, however older people disproportionately live in more rural communities (CMO Report, 2023[3]).

A strong focus on general mental wellbeing is needed, especially for young people, working-age adults, and healthcare staff (Options 2040, 2024[4]).

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[1] https://www.health.org.uk/publications/health-in-2040

[2] https://www.health.org.uk/publications/health-inequalities-in-2040

[3] https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

[4] https://options2040.co.uk/health-and-social-care-the-ideas/

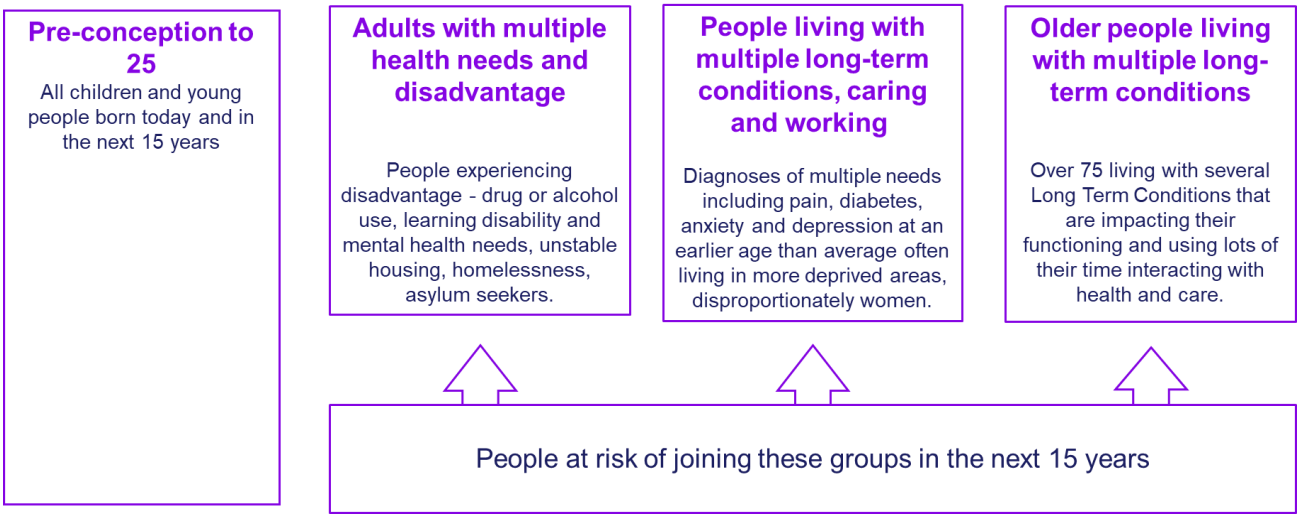
New technologies including AI, treatments and digital health solutions, along with climate change, political and economic instability and future pandemics present opportunities and threats. All require the health and care system to be more resilient, efficient, connected and innovating locally (Options 2040, 2024). The move towards joined up and effective data driven decision making requires information sharing processes to continue to be safe whilst continuing to be modernised and streamlined. The Darzi report recognised the “as is” state that the NHS is operating in. Day to day, staff are working under extreme pressure with unrelenting demand being seen across the spectrum, leading to burnout, dissatisfaction and retention challenges. These operational concerns are reflected in data and putting ever increasing demand on already stretched financial resources. In the current ways of working, there is not enough trained staff in the right roles across the system, both clinically and managerially. Inevitably, there are cracks developing that need addressing. Ultimately, it leads to a skills mix deficit to effectively support the population.

This analysis makes clear that the current health and care system must change to meet both current and future needs. A central design principle adopted by Healthier Together 2040 is that solutions to these interconnected issues revolve around people, their communities, the choices they make, and how the health and care system can best operate at the local level.

Population Cohorts Analysis

The initial analysis phase sought to identify cohorts of the population who are currently experiencing poor outcomes, high users of multiple types of services, where there is an opportunity to prevent further deterioration of health and understand the risk factors to prevent future waves of people entering that cohort.

The Health Foundation reports [3,4] demonstrate that for adults, an ageing population with increased multimorbidity or multiple conditions along with deprivation and social complexity is a critical health and social issue looking to 2040. Of all the evidence reviewed this was the clearest indication of impact on the sustainability of the health and care system. When analysing the local linked data for people living with multiple health needs, experiencing poor outcomes, three key adult groups of the population emerged clearly, these are set out below. The fourth cohort focuses on Children and Young People currently in the broadest possible definition, as it is logical to include them in any long-term planning. These population cohorts are defined in the data at a moment in time and are mutually exclusive to enable planning and the creation of boundaries, however people can and will move between cohorts.


Pre-conception to 25
All children and young people born today and in the next 15 years
Adults with multiple health needs and disadvantage
People experiencing disadvantage - drug or alcohol use, learning disability and mental health needs, unstable housing, homelessness, asylum seekers.
People living with multiple long-term conditions, caring and working
Diagnoses of multiple needs including pain, diabetes, anxiety and depression at an earlier age than average often living in more deprived areas, disproportionately women.
Older people living with multiple long-term conditions
Over 75 living with several Long Term Conditions that are impacting their functioning and using lots of their time interacting with health and care.
People at risk of joining these groups in the next 15 years

Section Two: Strategic intentions to improve the wellbeing and health of working aged adults with multiple health needs in Bristol, North Somerset and South Gloucestershire

Context

The initial cohort of focus was agreed to be the Working Age adults living with multiple long-term conditions, and an Evidence Review was completed in early 2025 to inform the design phase. The *Evidence Review - Understanding working-age adults affected by multiple long-term conditions and those at future risk* was published in April 2025 and it sets out the design principles used to inform the development of the Strategic Intentions. The Design Phase approach and outputs are available in Section Three.

These **Strategic Intentions** have been shaped to provide strategic direction for the system through a co-design process with partners, professionals and the public, and grounded in the design principles set out in the Evidence Review. These intentions have been formed through wide participation in events, focus groups, and stakeholder discussions.

The word **intention** is purposeful. It is expected that all intentions will be tested, but not necessarily realised, yet all will provide a clearer shared vision for the future. The intentions set out here **are our Big Bets to address the health needs identified and are signposts pointing towards a better future.** They will inform commissioning and strategic planning going forward from 2026/27, providing a direction of travel for the health and care system over the coming years.

These intentions all require the next cycle of detailed design, and this section includes the first next steps that have been agreed so far. The next section outlines how these will be taken forward in the coming months and years, based on current thinking about how the health and care system will be operating.

We extend our sincere thanks to everyone who participated in questionnaires, focus groups, interviews, and design events throughout this process. Your input and feedback during drafting have been vital in shaping this shared vision for the future.

People living with multiple health needs, caring, and/or working

The needs of this population have been outlined in detail within the Evidence Review and summarised below.

In 2024, there are about **5,300 people aged 20 to 64** living in the Bristol, North Somerset and South Gloucestershire area who have three or more long-term conditions from a short list of hypertension, diabetes, anxiety, depression, and chronic pain. Our Future Health – the Health Needs assessment undertaken for our health system and published in 2022 highlighted that people in the most deprived areas have the **same level of ill-health in their early 50's as people in the least deprived areas in their late 60's.** This group is projected to grow by 50% in the next 15 years, under the assumptions of our local Dynamic Population Model. Most people in this group live in deprived areas and their ability to manage their health is significantly impacted by their living and working conditions. In addition to this cohort, there are **38,000 people in wider at-risk groups** where there is a prevention opportunity to delay or prevent further deterioration in health.

This cohort is the **third highest in terms of emergency hospital visits and long-term care needs** which is an indicator that our current healthcare system is unable to adequately support this cohort's health and wellbeing. Furthermore, local modelling suggests that about a half of this cohort are expected to be living and in an increasingly frail condition in 15 years' time.

People told us….

Quite often when you've got multiple things wrong with you, you see one person who's focused on 'that's my area'. Then you go down the corridor and you speak to somebody else, and that's their area. And the two never seem to overlap. It's quite clear one side effects the other, but never the twain shall meet, but they do meet because one affects the other."

"It's like reinventing yourself because of things that you can no longer do."

"Some days you're fine, then other days you hit rock bottom."

"I've put my own health on the back burner a lot for everything else that goes on… I will sacrifice my mental health to make sure that my family's ok, and my partner's ok, and I will kind of push through feelings of, you know, tiredness and exhaustion."

"[It's] one problem at a time [at the GPs], but you're thinking… "it's all related"."

Design Principles from Evidence Review

Bringing together the evidence and insights led to a set of ten design principles developed to ensure that ideas generated through the design phase are based on evidence and informed insights:

1. **Recognise the Causes of the Causes:** Solutions must address individuals' life contexts holistically, considering the wider determinants of health to prevent exacerbating health inequalities
2. **Mental Wellbeing First:** Enhancing mental health should be central to any care, as it plays a critical role in people's overall wellbeing
3. **Physical Activity and Nutrition**: Systematically focusing on physical activity and healthy dietary practices address key risk factors for this population cohort
4. **Community-Based Proactive Clinical Models:** Develop community-based clinical models that integrate specialist support and are rooted in peoples' holistic needs
5. **A Core Value of Whole-Person Wellbeing:** A shift to redesigning services to enable professional interactions rooted in building trusted relationships and addressing the causes of the causes
6. **Supporting busy people, caring and working:** Care models should recognise and respond to unique needs of this population, including many multi-generational caregivers
7. **Addressing Self-Worth and Feelings of Guilt:** Approaches to condition management should actively address guilt, shame, self-worth and the impacts trauma has on positive health behaviours
8. **Making VCSE Involvement Essential:** Effective solutions should actively involve communities and Voluntary, Community, and Social Enterprise (VCSE) organisations as essential partners
9. **Sustainable Funding for Community Initiatives:** Funding arrangements for community-based organisations addressing broader health determinants should prioritise long-term investment and incorporate outcome monitoring
10. **Workplaces vital in health and keeping people in work:** Workplaces can prevent poor physical and mental health, and some can be part of solutions

Vision: A new approach to supporting people with multiple health needs who are of working age

We are reimagining care for people with multiple health challenges — grounding it in **compassion**, **connection**, and **empowerment**.

This vision marks a shift away from reactive, medication-first models. Instead, we focus on **prevention**, support for **behavioural change**, and **holistic wellbeing**. Our approach is anchored in evidence-based foundations such as **movement, regular physical activity,** and **access to green spaces and nature**. This is strengthened by **trauma-informed, relationship-centred behavioural change, proactive coaching, group consultations**, and tailored **wellbeing and health plans** that start with the question: "*What matters to you*?"

Care is **person-centred, coordinated, and easy,** delivered in line with people's jobs and other commitments. This may be in the workplace, in Neighbourhood Hubs or in pop-up style surgeries in the evenings. At its core is a team of people, based in neighbourhoods, focused **on building relationships and trust**, reviewing people's health remotely and connecting them into what they need, if that's about their **employment, housing, wellbeing** or **benefits**. At the heart of this model is the principle **"Let's get you sorted"** with personal wellbeing and health plans agreed between people and the team addressing health and wider determinants of health.

That means meeting people exactly where they are — and working together to tackle the root causes of poor health, not just the symptoms. Some of the solutions sit with better working relationships with employers and this vision includes testing **employment support partnerships** between small employers including carers, and large anchor organisations.

Specialists in **diabetes, cardiovascular disease**, and **chronic pain** are fully embedded in this approach — not in isolated clinics, but as part of localised **multidisciplinary neighbourhood teams**. This allows for a significant reduction in hospital outpatient appointments and disease specific reviews for more joined-up, localised support.

This vision is underpinned by a purposeful movement towards a **unified digital system** that offers a complete, real-time view of people's needs and interactions — breaking down silos across services. At the same time, we will test **new payment models** that align financial incentives with better health outcomes and more sustainable, relationship-based care.

To deliver this model:

- We commit to a **relentless focus on outcomes** that matter most to people, without losing the human touch required to make it happen
- We will **align system incentives** to support those outcomes
- And we will **co-design** the delivery — including teams, roles, and tools — through deep collaboration across all partner organisations and with the wider health and care workforce

Increasing value through a relentless focus on outcomes and experience

Outcome measures serve as a golden thread between people's health status and the demonstration of progress over time, playing a crucial role in aligning the delivery of a shared vision within a complex system. Throughout the design process, we have aimed to identify outcomes that are attainable only through integrated working and relentless attention to listening to people's needs.

With a national recommitment in the 10 Year Plan to halving the healthy life expectancy gap between the poorest and richest regions, the overarching goal of Healthier Together 2040 is to increase the number of years that a person can expect to live in full health.

By focusing on outcomes and the needs of this population, we can better target resources to where they make the greatest difference to people's health and wellbeing. This shift in emphasis enables us to invest more in prevention, early intervention, and neighbourhood-based support, reducing reliance on hospital care for conditions that could be managed effectively in the community. Over time, this approach will allow resources to flow out of hospitals and into local services, creating a more sustainable system that improves health, reduces inequalities and delivers care closer to home.

Health and Healthcare Outcomes for working aged people with multiple health challenges

The outcome set below has been developed over the course of the design process, using several sources.

Firstly, several reflect the existing BNSSG Healthier Together Outcomes Framework for the Integrated Care System, anchoring Healthier Together 2040 in our local approach to improving population health and reducing inequalities.

Others reflect outputs from the design phase of this work and closely linked to the needs of this population cohort with further details on the methodologies used available later in this document.

We have also drawn on internationally recognised tools, particularly the International Consortium for Health Outcomes Measurement (ICHOM) adult health framework[5], which provides a balanced and validated set of measures. This ensures that the approach is evidence-based and benchmarked against global best practice.

Finally, we have included established Person Reported Outcome Measures already used by partner organisations such as Sirona Care and Health and Avon and Wiltshire Partnership Trust as these approaches have been tested in practice and can be scaled up more efficiently.

We have structured the outcomes across three levels:

Whole population - reflecting the overarching, long-term ambitions for population health and wellbeing in BNSSG. These outcomes will also recognise the need to support people to lead happy, fulfilled lives that are productive – reducing disability, and wherever appropriate, return to work.

Aggregated - cohort-level outcomes relate to working-age adults with three or more long-term conditions and describe the specific changes we expect to see for this population.

Individual - Person-reported and clinical outcomes capture how individuals feel, their quality of life, and clinical indicators of wellbeing—what people can tell us about their own lives. The intention is that some of these will also be aggregated at cohort or place level.

Further development of these outcomes

The outcomes outlined here are intended to signal the direction of travel in improving healthy life expectancy for this population. Developing these outcomes will be a priority and they will form the foundation for any outcomes-based commissioning going forward. Getting the right outcomes, and the measures that sit beneath them, is critical for aligning organisations and supporting strategic commissioning, which is why one of the Strategic Intentions will focus specifically on this area.

The next steps will involve testing and further co-design with both the public and the workforce to ensure the framework is meaningful and achievable. While some outcomes can already be measured through existing reporting processes, others will require the development of new data collection methods and baseline measurements to track progress over time. Working alongside professional experts, we will establish target trajectories for improvement. This local approach is reinforced by national ambitions set out in the NHS 10 Year Plan, with some outcomes expected to be supported through national implementation.

[5] International Consortium for Health Outcomes Measurement. (2022). A standard set of value-based patient-centred outcomes and measures of overall health in adults. Available at: https://www.ichom.org/ [Accessed July 2025].

Level	Domain	Outcome Indicator	Possible Tool or Data Source	Measure Type
Whole Population Level	Overall Health	1. Healthy life expectancy and reduced gap between different population groups	Fingertips – Public Health England	Population Health
		2. Early deaths from preventable causes	Fingertips – Public Health England	Population Health
		3. Years of Life Lost	Trial System Dataset local measure	Population Health
Aggregated Cohort Level	Multiple Conditions	4. Number of people living with 3+ preventable long-term conditions (e.g. type 2 diabetes, hypertension, anxiety, depression, chronic pain)	System Dataset	Population Health
		5. Age of onset of 2nd long term condition	System Dataset	Population Health
		6. Number of people in Risk Group One: Aged 20–64 with two of the long-term conditions of interest	System Dataset	Population Health
		7. Number of people in Risk Group Two: Aged 40–64, high BMI (over 30), and one long-term condition of interest	System Dataset	Population Health
Individual Level	Functioning and Goals	8. Functional ability	Activities of Daily Living	Clinical Reported Outcome Measure
		9. People employed within partner organisations who are in the cohort or at-risk cohorts	To be developed	Population Health
		10. Quality of Life and Treatment Satisfaction	DIALOG+	Person Reported Experience Measure
		11. Improvement against goals set in Health and Wellbeing Plans	NHS App	Person Reported Outcome Measure
	Mental Wellbeing	12. Self-reported wellbeing	ONS 4 Wellbeing Questions	Person Reported Outcome Measure

		13. Motivation to take action on health	Patient Activation Measure	Person Reported Outcome Measure
		14. Health Related Quality of Life	EQ-5D-5L	Person Reported Outcome Measure
	Social Wellbeing	15. Time spent in nature	To be developed	Person Reported Outcome Measure
		16. Living in safe and secure housing	To be developed	Person Reported Outcome Measure
	Physical Wellbeing	17. Body Mass Index	System Dataset	Clinical Reported Outcome Measure
		18. Smoking rate	System Dataset	Clinical Reported Outcome Measure
		19. Physical Activity	GPPAQ	Person Reported Outcome Measure
		20. Alcohol consumption	System Dataset	Clinical Reported Outcome Measure
		21. Substance Use	System Dataset	Clinical Reported Outcome Measure
		22. Pain	British Pain Society pain rating scale	Person Reported Outcome Measure
	Disease Control	23. Diabetes Control	System Dataset	Clinical Reported Outcome Measure
		24. Blood Pressure	System Dataset	Clinical Reported Outcome Measure
		25. Depression and/or Anxiety severity	To be defined	Clinical Reported Outcome Measure
		26. Use of opioids for more than 12 months	System Dataset	Clinical Reported Outcome Measure
	Health Services Utilisation	27. Non-elective attendances at hospital	System Dataset	Clinical Reported Outcome Measure
		. Non-elective admissions to hospital	System Dataset	Clinical Reported Outcome Measure
		29. Use of long-term social care	Adult Social Care Dataset	
		30. Time spent interacting with health services for urgent needs per month	System Dataset	Clinical Reported Outcome Measure
		31. Experience of Shared Decision Making – CollaboRATE tool	CollaboRATE	Person Reported Experience Measure

Experience Measures

The Institute for Healthcare Improvement (IHI) developed the well-known **Triple Aim framework**, which emphasises that health systems should simultaneously pursue three interdependent goals to improve value:

1. **Improving the health of populations (outcomes)**
2. **Improving the individual experience of care (experience)**
3. **Reducing the per capita cost of health care (cost)**

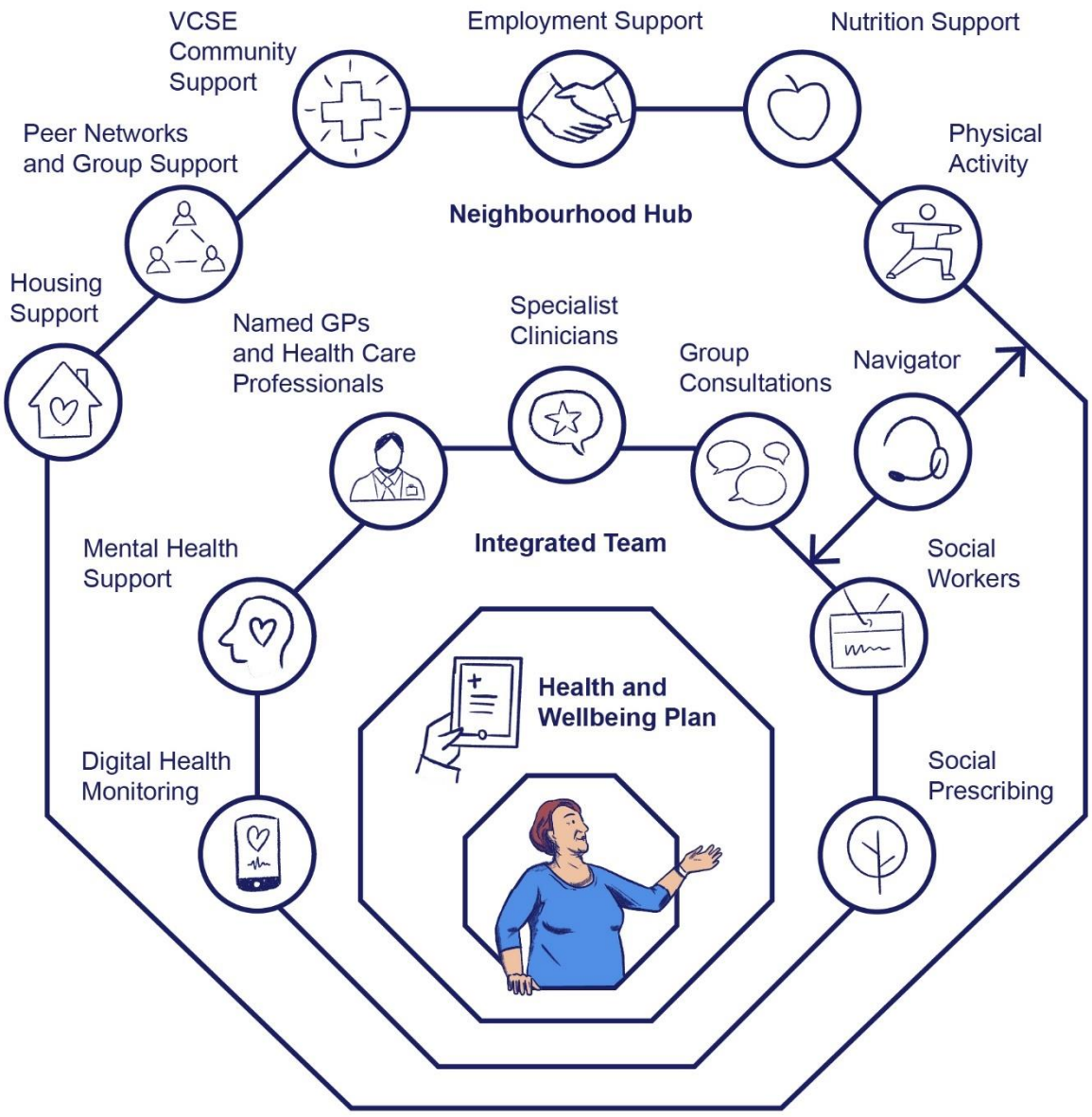
Many established Person Reported Experience Measures (PREMs) focus upon single disease pathways or episodes of care. In mental health care the **DIALOG+** tool helps structure communication between mental health patients and providers, guiding discussion via patient-led feedback across life domains. This has been included as it is currently used in our health care system and is aligned to some of the goals. The **CollaborRATE** measure has also been included as this is a short tool that captures the person's perspective on how well professionals involved them in decisions about their care.

Additional measures of experience will be included as the model is developed as well as national developments are made in this area.

Section 2: Strategic Intentions

1 – Healthy Neighbourhoods providing whole person care

Overall model



This intention brings together multiple component parts of a neighbourhood-based model of care, focusing firstly on people who are working aged and living with multiple health conditions.

It describes a neighbourhood-based model with **consistent core features** available to people across all postcodes, whilst also supporting **local tailoring** to meet the requirements of communities and neighbourhoods. All the component features will be focused on delivering the outcomes set out. The intention is that this balance will address inequalities in access and outcomes, whilst also enabling services to be delivered across a system at a scale which is affordable.

The model centres on an integrated team collaborating with the target group to create wellbeing and health plans, outlining specific actions to support them in overcoming their health challenges. At a population level it is expected that this will slow rising levels of need and **reduce inappropriate, persistent, and frequent use across multiple services**. These individuals are currently underserved by the system and will benefit **from holistic support**, easing system pressure in the **short to medium term**.

There would also be a focus on the rising risk cohort, providing increased digital support and some access through a neighbourhood hub. Over time there would be more proactive intervention for this cohort to offer preventative support before crisis occurs. Therefore, over the medium to long term, the need for reactive care would reduce for both the target and rising risk cohorts as proactive interventions increase.

All services will be designed to ensure that people who are caring or working have access that suits them, considering time, location, transport, and mode of delivery.

To note – while these components may inform a model for care for other people living with complex health challenges over time, this model has initially been developed with the working age cohort in mind.

Consistent Features:

Personal Wellbeing and Health Plan: Everyone within this cohort will have an individualised Personal Wellbeing and Health Plan. Goals will be defined in partnership with a member of the integrated team coordinator to address the challenges they face and act as a starting point that is appropriate for a focus on their wellbeing and health. This plan will be their key to accessing a bundle of support opportunities, focusing on their whole person, not just specific conditions. The plan may cover mental wellbeing, physical activity, and nutrition along with wider influences on people's health. Staff will be trained in coaching and motivational interviewing to support shared decision making based on the persons strengths needs and preferences.

Dedicated Integrated Team: People will be supported in pursuit of their wellbeing and health plan by a neighbourhood based integrated-team that takes a case management and relationship-based approach to care coordination. This multi-professional team will hold connections with a defined number of people or families, proactively supporting people to achieve their plan objectives and navigate the system. This is critical in the shift from a fragmented, condition-focused system to a trauma informed neighbourhood-based model built around people, their families, and communities. Staff will be trained and recruited to provide consistent, trauma informed, supportive and trusted relationships. It is expected that this team will encompass specialist nursing, mental health support, named GPs, in-reach from specialised allied health professionals, and a community navigator with a case management and relationship-based approach to support people with their plans – focusing on mind, body and social needs. Furthermore, access to VCSE proactive support through **social prescribing** and **health and wellbeing coaching** will be supported for all, with direct links to support for wider wellbeing challenges such as employment, financial stability, housing, access to nature and caring needs.

Community Hubs and Flexible, inclusive access: People will have **access to this team in a real face-to-face setting from a community hub**, with outreach or virtual support available if needed. This could be a physical space, a dynamic service like a bus, or pop-up settings – designed around whatever is deemed locally appropriate. Access will be equitable and co-designed with place and non place-based communities.

Proactive outreach at life-crossroads points: Taking a trauma-informed approach, this team will proactively identify and offer support to people:

- To focus on the areas that they've identified as important
- If any data submitted indicates that their health is worsening

- At life-crossroads points for example family milestones or interventions, menopause, diagnosis of a condition, a bereavement or loss of a job where evidence indicates that it is a good opportunity to make a behavioural change.

Tech-Enabled Support: Supporting people to monitor their own health, share information and supported self-management will be integrated to the integrated team to proactively identify and support people who are struggling. This will also enable increased understanding of what is going on for people so that they can connect with the right professionals at the right time.

Secondary Care and Community Specialists joining neighbourhoods: Where clinically appropriate, specialists like cardiologists and endocrinologists and chronic pain specialists will support people and other professionals in community through **multi-disciplinary teams (MDTs).** Instead of traditional outpatient appointments and disease-specific reviews, unless there is a clinical need, they will review people's health remotely and work in partnership with GPs to support secondary prevention as well as treatment. Community based specialists such as nurses and Allied Health Professionals will move away from focusing on single condition pathways and towards becoming part of these multi-disciplinary teams

Enabling General Practice and Primary Care to focus on people who need them most: The Integrated Team will provide more support for peoples' ongoing monitoring and social conditions enabling GPs to focus on the most complex and those with new or escalating needs. We will also trial appointments for people in this cohort to automatically be longer reflecting the interconnecting nature of their health and social needs.

Mobilising a Workforce Movement for Change: We intend to mobilise a workforce movement that places relationship-based care at the heart of how staff are recruited, trained, and incentivised across health and care. This requires a comprehensive shift in workforce development, focusing on digital capability, relational skills, and care coordination competencies such as system navigation.

A system-wide workforce development plan will be created to identify what is needed at neighbourhood, organisational, and system levels. This plan will emphasise knowledge growth, skills development, and behaviour change across the collective workforce to enable the delivery of integrated, person-centred care.

Recognising that many people within the identified population cohort already work within the health and care sector, we will prioritise engaging staff from partner organisations in accessing and benefiting from the new models of care, supporting them as both providers and participants in the transformation.

System architecture to support this new model

2 - Aligning Incentives

It is recognised in the national 10 Year Plan that the current funding flows do not support a neighbourhood based, proactive and holistic model of care. Therefore, a strategic commissioning priority will be to explore new financial and contracting arrangements towards an outcomes-based payment models that will incentivise alignment, integration, and a focus on wellbeing for this population group across multiple partners.

The approach will first be trialled through a nationally recommended Year of Care payments; these are budgets per person, per year to encompass all care needed to keep people healthy and well. The Year of Care payment could include all primary care, community health services, mental health, specialist outpatient care, emergency department attendances and admissions consolidated into a single payment. This will require integrator organisations at neighbourhood or place level to hold local contracting arrangements and design and deliver services to achieve the outcomes set. Stability for VCSE partners is essential with flexible with long-term contracting arrangements included.

The use of personal health budgets as part of a move towards Year of Care payments will also be explored to give people maximum opportunity to direct resource to meet their wellbeing and health goals.

3 - Data and Community insights for Intelligence and Action

We intend to create a population health intelligence system that enables genuine insight, transparency, and action across the whole system. Intelligence currently held within the ICB will be more effectively shared, allowing us to monitor population needs, trends, and changes, and to use this information to drive improvement and strengthen public accountability.

Our focus will extend beyond understanding what conditions people have, to include their health behaviours, how they interact with services, and their motivation and ability to make changes that improve their health. By progressing interoperability of data systems, underpinned by robust system-wide data-sharing agreements, we will lay the foundation for more integrated working.

This intention aligns with and supports national and local initiatives such as the FDP, the Intelligence Centre, and the SDE. But our ambition goes further: to redefine what data is valuable, moving beyond simply relocating existing datasets, towards using data as a tool for shaping future health and care. The aspirations set out in the NHS 10 Year Plan, including the NHS App, integration with wearables, and the single patient record, give us the opportunity to shape national programmes so that they capture the right measures of progress and support individuals to improve their health. We will also explore how personalised insights can be shared back with patients through digital tools.

We recognise that administrative data alone cannot deliver the insights communities need. We will combine it with community intelligence, patient-owned goals, and patient-reported outcomes to build a richer picture that informs decisions and supports neighbourhood-level development. Looking forward, we will harness AI tools to strengthen population health monitoring, enable active risk stratification, and identify early signs of new or worsening issues, ensuring support is offered as close to home as possible.

4 – Outcomes that matter

We intend to embed direct links between person-centred outcome measures and aggregated population-level outcomes to track whether people's health and wellbeing are improving over time, with visible changes at the neighbourhood level.

The outcomes set out earlier in this document will form the basis of this approach. They include person-level more immediately impactable outcomes that signal progress for example, Patient Activation Measures, experience measure, and indicators of functioning including as physical activity and pain. These will sit alongside measures of health behaviours such as medication adherence and increased physical activity. These are in pursuit of the ultimate goals of improving healthy life expectancy and reducing years of life lost.

An outcomes-focus will be central to the creation of personal wellbeing and health plans. These will be grounded in best practice, co-designed with communities, and developed to support local adoption and use. We will also utilise novel data collection techniques, such as wearable technology and link these into the personal plans to enrich the insight available and enhance personalised support.

5 - Digital Tools

Establishing a digital taskforce involving service users, system partners including experts within the system and industry to explore, test and recommend the digital solutions to be embedded in the model including the roll out of any national advances. Applying human centric design principles to ensure optimised user experiences. Key to success will be the roll out of digital solutions that join up services with unified clinical records to help facilitate service integration.

To reduce the risk of digital exclusion, working with VCSE partners to ensure equitable access and maximal public uptake to digital solutions developed for the model.

Promotion of information sources that support self-management and referrals to community platforms like Elemental or the successor to Well Aware currently being reprocured by Bristol City Council.

6 - Culture of Relationships and Trust

To address decades of eroded trust with key communities we will co-design a shift towards more relationship-based, trauma-informed, and holistic practice. This will include establishing a trusted listener function within neighbourhoods to enable continuous co-design and shared learning, working closely with local VCSE networks to ensure change is shaped and owned by communities themselves.

We will invest in the training, development, and incentivisation of staff to build and sustain human-centred relationships, redistributing power between organisations, clinicians, and individuals. Trauma-informed and needs-based approaches will be embedded into commissioning to ensure services consistently respond to what matters most to people.

To support this, services will be designed and incentivised to create the time and space required to build trust and hold meaningful conversations. We will also develop peer care coordinator roles and create a clear career pipeline into and out of community-based holistic models of care, with targeted recruitment from at-risk groups to strengthen the capability and cultural relevance of neighbourhood care.

7 - Healthy Workplaces, Healthy Communities

We intend to provide targeted support for people employed by partner organisations who are living with multiple health needs, prioritising their active involvement in the new model of care. Across all partner organisations, we will commit to enabling staff to participate fully in health and wellbeing activities as part of a shared culture of care.

We will trial extending occupational health services to small organisations and carers, supported through the *Get the West of England Working Plan*, and embed national initiatives such as **WorkWell** and regional health and work programmes within the neighbourhood model.

Using procurement levers, we will ensure our approach also strengthens local economies, prioritising suppliers and partners with good employment standards, such as those belonging to WECA's Good Employment Charter, and those committed to supporting local supply chains and community benefit.

8 – Embedding a Learning Health System

We intend to embed a systematic approach to iterative, data-driven improvement across both the commissioning and development of models of care, drawing on the Health Foundation's principles of a Learning Health System. This will ensure that improvement is continuous, evidence-based, and responsive as the model of care evolves.

Working in partnership with local universities and wider academic partners, we will integrate research on behaviour change, culture, and prevention into the implementation of the model, and leverage academic expertise to support rapid evaluation and real-time learning as the model is rolled out. We will also foster international partnerships to accelerate learning and bring coaching on change approaches from leading systems worldwide.

At the same time, we will establish systematic mechanisms for sharing learning across the system and between neighbourhoods, ensuring that insights are spread, adopted, and scaled so that improvement benefits all communities.

Strategic intentions aims, outcomes and next steps

	Strategic Intention	First Next Steps	Organisations involved/going first
1	Redesigning Care Around People and Places	a. Next cycle of design and user testing - mapping alignment of current elements of the model at neighbourhood level and modelling scope and scale of what it would take to deliver this	Pier Health GPs in the Deep End Other places to be confirmed
		b. Setting out a phased approach to moving specialists into community for cardiology, endocrinology/diabetes, pain (AHPs, consultants, nursing)	Bristol Hospital Group Sirona
		c. Development and testing of a Target Operating Model for Neighbourhood Health for submission in line with national planning timelines	ICB, Locality Partnerships and VCSE Alliance
		d. Establish a Shared Investment in Community Wellbeing Fund (including Social Prescribing) and develop VCSE Brokerage approach to channel available VCSE funding into neighbourhoods	System Shared Investment Steering Group / VCSE Alliance
		e. Implementation of the Trauma informed Pledge for Partners	ICB
		f. Create a system-wide workforce development plan to identify what is needed to facilitate knowledge growth, skills development, and behaviour change across the collective workforce at neighbourhood, organisational, and system levels	ICB, VCSE, Bristol Hospital Group, Sirona, Social Care
2	Aligning Incentives	a. Involvement in national working group to be one of the first systems to implement new financial flows and contracting arrangements.	ICB
		b. Establishment of a working group to bring together current funding streams related to care coordination, social prescribing and disease specific developments to make progress towards a Year of Care contracting approach	ICB
3		Development of improved data infrastructure to facilitate easier linking and sharing of data to support the neighbourhood model development for this cohort	ICB to lead on Intelligence centre and data sharing agreements

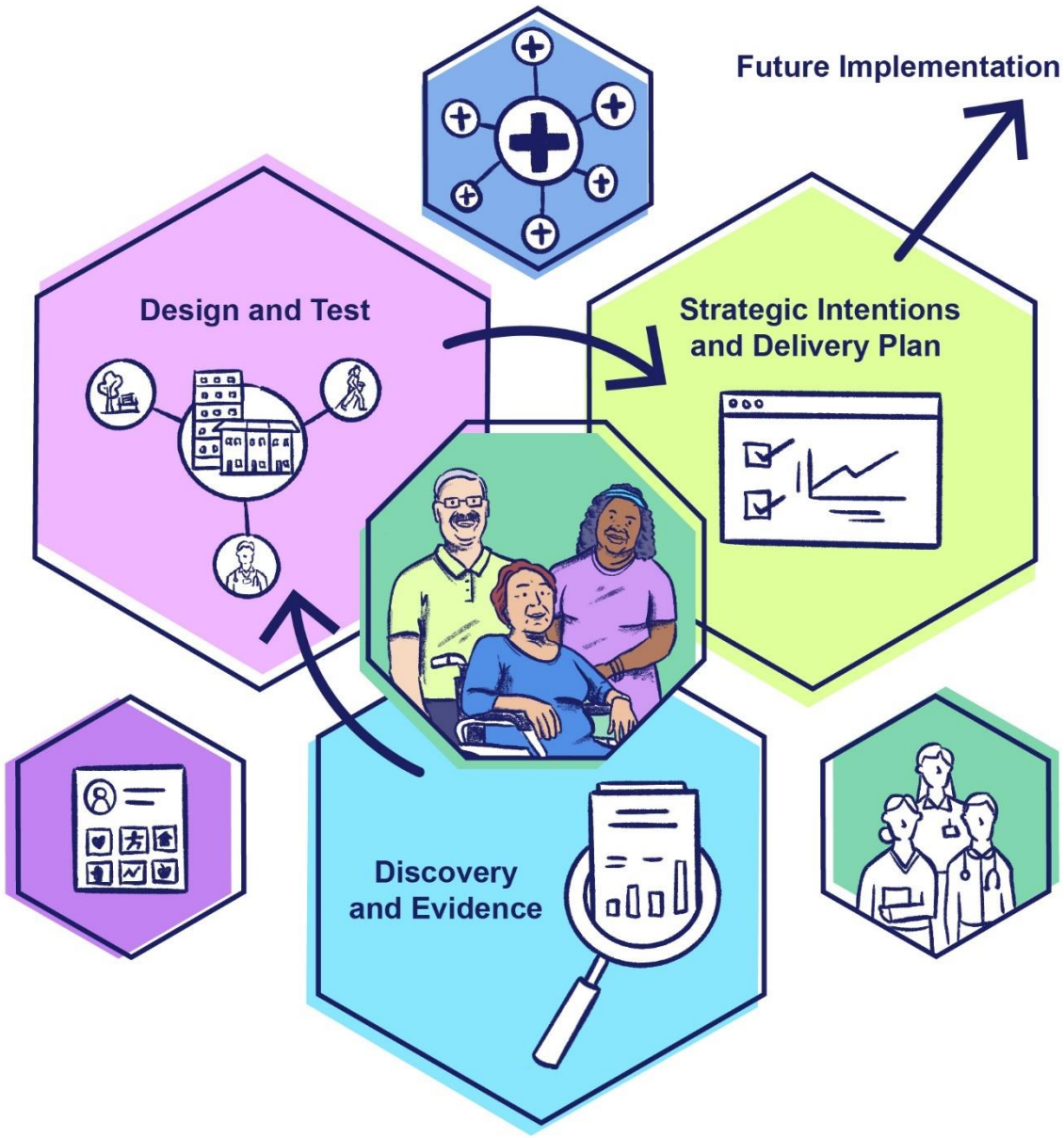
	Unlocking Data for Intelligence and Action	Develop a plan on how to collect, store and share the data required for outcome and progress measures and ensure alignment with local and national technology programmes.	ICB
		Implement system wide intelligence charter	ICB
4	**Outcomes that matter**	Test outcomes list with focus group	ICB via Locality Partnerships and VCSE Alliance, Research Engagement Network
		Establish Data Specification for each outcome	ICB
		Working with the national NHS App development to connect into outcomes collection	National NHS App – measurement of PAM
5	**Digital Tools**	Establish local taskforce including people, Digital leads, Industry to advise on products required to address the needs for this population	ICB Digital / Pier Health
		Identify a work program to mitigate the risks associated with digital exclusion	ICB, VCSE Alliance
6	**Culture of Relationships and Trust**	Co-design behavioural standards/expectations of a trauma informed relationship-based approach through the development of the personal wellbeing and health plan – via action 1a	See 1a
		Embedding a trusted listener function into neighbourhoods to enable co-design and evaluation.	VCSE Alliance
		Work with local and regional academic organisations to address through training programmes	To be confirmed
		Health coaching provision to support staff skills to deliver the standards expected for personalised conversations - based on golden thread of what matters to you - personalised care approach	To be confirmed

7	**Healthy Workplaces, Healthy Communities**	Align work and health strategic framework with the combined authority including testing how large health and care organisations can provide occupational health support to smaller organisations	Get West of England Working Plan (WECA)
		Align WorkWell initiatives to reduce fit notes	Work Well Plan through Bristol City Council, VCSE & ICB partnership
		Work with procurement departments (NHS, system partner, organisations within existing local networks) to embed good practice into new and existing suppliers	Embed through Green Plan delivery
8	**Embedding a Learning Health System**	Submit a research bid for funding from NIHR into 'Mid-life interventions to support healthy ageing', using the strategic intentions and Neighbourhoods model providing the framework to underpin this	University of Bath/ICB joint bid to submit bid
		Co-design with diverse communities then embed behaviour change methodology into model of care	Research Engagement Network
		Test and learn through rapid evaluation of model of care pilots	ICB Research Capability
		Ongoing capture of stories and evidence of impact around trust, empowerment and how people feel their being treated; at a sufficient scale to enable analysis by inequalities – academic partnership and research	VCSE Alliance

Section Three: HT2040 Approach and Learning

This section sets out the approach undertaken to develop these strategic intentions and learning from the process set out.

Overall Approach



A three-phase approach was used to develop the intentions:

- **Discovery Phase** - undertake an evidence-based approach to understanding the needs, motivations and pain points of the population (for now and into the future) using literature and insights review

- **Design Phase -** through professional insight and utilising design methodology generate the solutions to tackle the problems generated through the population approach

- **Test and Agree Strategic Intentions** - translate the generated solutions into a plan, with aligned outcomes, which can in turn be strategically commissioned. Formalise and agree this at system level

Design Phase

The Design phase used the Design Principles (Section One) and the aims of Healthier Together 2040 set out below to bring key stakeholders together to explore the problem and identify a vision and ambition.

Aims of Healthier Together 2040:

1. Addressing the **critical issues for long term system sustainability** (3 – 15 years)
2. **Creating the conditions** for large scale coordinated change for whole system
3. Test use of **population cohorts** (people, their lives, their health) to organise how we work
4. Embed approach of **prevention at every level**
5. Outcomes focused strategic intentions - golden thread to **improving healthy life expectancy delivered through local innovation**
6. Creating sense of **hope, alignment and clearer future** through shared missions

The design phase included a series of stakeholder events running in parallel with focus groups were conducted with individuals from various organisations and with members of the public who have lived experience of multiple long-term conditions across the system. This approach facilitated genuine co-production, ensuring that all feedback was integrated into the final products.

The three events build upon each other and have directly led to the strategic intentions set out in this document.

Design Event One using the Three Horizons Framework, we articulated a desired future and the features of the current system to develop and to shed for the future. Finally, there was development of the innovations that will enable the system to progress to that future state. This generated ideas for innovative interventions which centred around themes of community-based wellbeing, models of care, technology, workforce training and working with employers.

Design Event Two built used these ideas and a set of Design Thinking Techniques to develop strategic improvement ideas that emphasised holistic, community-based approaches and proactive prevention and were based around four key themes

- 'Culture shift toward whole-person approaches'
- 'Addressing risk factors for at-risk groups'
- 'Work and health'
- 'Radical redesign for community-based care'

Ideas were generated under each theme which were then further explored by assessing feasibility vs impact. These ideas were developed into 'Concepts' which provided a brief proposal of what the future could look like. A summary of these concepts is set out below:

Focus Groups

These eight ‘concepts’ went on to be tested with members of the public through multiple Focus Groups. A mixture of one-to-one and small focus groups were held across BNSSG hosted by members of the ICB and by VCSE partners, recruiting participants via three routes:

- **VCSE organisations** held and facilitated groups with their networks. These were: Southern Brooks Community Partnerships, Voscur/Wellspring Settlement, Nutriri, For All Healthy Living Company “The Rattlers” group, Knowle West Health Park and CVS South Gloucestershire.

- **Primary Care**, using EMIS coding to identify registered patients with multiple long-term conditions at East Trees Practice and online

- **Existing participants who participated in the Phase 1 interviews** as part of the evidence review

A total of 74 participants contributed to the focus groups from a wide range of cultures, ages and ethnicities; all had years of lived experience managing multiple long-term conditions and spoke openly about their challenges of the healthcare system.

Participants commonly reported living with conditions such as diabetes, anxiety, depression, obesity, arthritis, chronic pain, fibromyalgia, and cardiovascular diseases. The conversations were structured to review each of the ideas in each theme, to understand which elements people liked, any elements that concerned them and considerations for future implementation.

After all eight concepts were discussed, participants were invited to identify those they believed would most effectively support the management of their long-term conditions. However, some groups found it challenging to prioritise their responses, noting that each concept contained aspects likely to have a substantial impact on their lives. Consequently, participants highlighted that these concepts should not be considered in isolation; rather, there is considerable overlap among them. **For a truly comprehensive model of care, it is necessary to incorporate elements from all eight ideas**.

The key messages from the focus groups highlighted the need for integrated, human-centred healthcare models that utilise **existing community resources** to collaborate with the NHS in providing localised, accessible care that the community trusts. While there was some interest in increased digitalisation, including the use of AI, there was also significant caution about potential exclusion and the loss of a human touch, which is highly valued in helping individuals feel heard and supported in managing their health and wellbeing. Furthermore, in some communities that have areas of deprivation in them, a lack of trust in the use of digital solutions was evident indicating a significant barrier to uptake.

Design Event Three brought together feedback from the eight concepts and focused on creating the conditions required to achieve this future state. To do this, stakeholders used a framework for tackling complex problems named Systemcraft developed by Wasafiri. Each of the eight concepts developed in event two and tested in the focus group were analysed using the domains set out in the framework.

The key themes identified:

- **Collaboration**: Emphasis on involving communities, improving funding access, fostering cross-organisational sharing, and creating systems for seamless service delivery.
- **Goals**: Focus on shared outcome measures, personalised care plans, reducing administrative burdens, and prioritising prevention and early intervention.
- **Data**: Importance of collecting meaningful data, sharing it across systems, and using it for continuous improvement rather than performance monitoring.
- **Stories**: Valuing diverse client stories to inform decision-making, fostering trust, and ensuring feedback impacts system changes.
- **Incentives**: Aligning funding and incentives with long-term goals, prevention, and wider determinants of health, while recognising contributions from VCSE partners.

The tables below outline the Systemcraft domains in further detail, including the actions that were noted in the groups. Please note that as the setting of actions was the final activity of the session, there is a variety in depth of completion of this task due to time constraints on the day.

Systemcraft approach to describe what the future will look like in pursuit of these strategic intentions (Wasafiri consulting model)				
Organise for Collaboration	**Set the direction**	**Harness collective intelligence**	**Make it matter**	**Change the incentives**
How will people & organisations be collaborating? **What connections and structures will be enabling this?**	**What goals and measures of success will we have set?** **What difference are these making?**	**What data are we now gathering?** **How is this being gathered and shared?** **Who has access to it?**	**What new stories are we telling about this issue in our system?** **Who is telling these stories?** **What impact is this having?**	**What different incentives will be in place?** **What behaviours are they driving? How were they agreed?**
Collaboration is standard across system Communities actively shape our services Staff roles support cross-working People experience joined-up care Specialists work within communities Referrals made early and preventatively Funding follows the individual's journey	System uses shared PROMs, PREMs Long-term system-wide outcome measures spanning all organisations Care standards clearly communicated system-wide Outcomes reflect wider life goals such as happiness, employment, wellbeing, connections	Trained staff routinely collect meaningful data as part of their roles Lived experience, especially from the VCSE, is valued as core intelligence Data is used to support improvement, not to monitor performance Information is shared across NHS, social care, benefits, and other partners	Need to use both system and individual level stories Use of stories, coming from a respected source, can help clients make informed choices 'You said, we did' stories are liked Communicating a vision leads both top down and bottom-up leadership There is a fear that clinicians are opting out of sharing data/stories from deprived areas Clinicians want to be able to tell people that when they enter care that they will be cared about and	Shared investment funds prioritise prevention Easy access to local service information Data sharing is enabled and supported Incentives aligned with social value goals Shift funding toward prevention, not volume Positive patient stories drive motivation Collaboration rewarded with training and time

Shared digital records enable coordination Clear, inclusive language is used System acts as one entity	Clinicians prioritise meaningful conditions freely Staff experience measured and empowered Personalised care plans co-owned Admin burden on staff and people reduced Wider determinants built into care Fewer people reach target cohort	A shared data platform enables a single version of the truth Insights are drawn by triangulating data across services and organisations Patient happiness and wellbeing are routinely measured and used Long-term trends are tracked to guide sustainable change	they can access the support they need	Incentives based on wellbeing, not biomarkers Money follows the patient's care choice VCSE and lived experience reimbursed fairly Commissioning enables holistic staff action Long-term value justifies higher-cost interventions Wellbeing incentives improve business outcomes Volunteering recognised as return-to-work route Funding decisions reflect health inequalities Move away from tenders and competition Lower barriers for VCSE partnerships Reciprocal support across organisations (e.g. supervision and training) Long-term funding replaces in-year pressures

First next steps using the Systemcraft framework					
	Organise for Collaboration	**Set the direction**	**Harness collective intelligence**	**Make it matter**	**Change the incentives**
Target and at risk population	1.To gain deep understanding of what people think, 2.Transparency, 3.Designing with communities/the pop, 4. Able to commission for outcomes, as we don't currently have that data - we need data to bridge the gap. 5.Sharing the data we find with the 'at risk' pops - to inform the 'make it matter' - to make it real and to tell a story that can be understood				
Digital	Establish a digital taskforce - Patients, Digital ICS leads, Industry. Invest in digital leadership at all levels - continuous development. Digital and human leadership.		NHS staff = our population. They have good digital literacy and confidence. Can help test wearables etc		
Multiple disease management	Design holistic hubs across primary and secondary care from the beginning Understanding data linking multiple health conditions that often co-exist Understand local preferences and current offers - why isn't this working?		Utilise local and system demographic data to better understand populations		Real culture change for integrated system working is incentivised

	MDT approach having the correct staff and knowledge of when to escalate - resulting in smoother treatment pathways and less disjointed care. These MDTs to be virtual and easily accessible. Medium to long term funding with focus on sustainability and for LTCs with better evaluating data				
Social prescribing	A single version of the truth is needed to allow services to know where to refer people. There is a window of opportunity to use the Well Aware recommission to join up statutory and non-stat services, including building it into the Neighbourhood team development.	There is a window of opportunity with the ICS lead on personalised care including social prescribing to renew and expand their role as current funding runs out in November		Shared use of data to demonstrate impact	For all new contracts relevant to social prescribing, it can be a requirement to use Well Aware and commit to keeping organisation details up to date on there, Creation of a shared investment fund to pool finances from different sources for social prescribing, Embedding a culture where social prescribing is used as a preventative tool across all levels of acuity

Section Four: What's next for Healthier Together 2040

Context

This design phase for Healthier Together 2040 has taken place alongside the delivery of the national 10 Year Plan and the Integrated Care Board (ICB) blueprint. While this work remains relevant, the context has shifted. The following assumptions should therefore be made when reading this document:

1. **Alignment with the National Neighbourhood Health Focus:** The national neighbourhood health implementation programme, also beginning with the Working Age population, sets the direction of travel. The work undertaken here is therefore assumed to provide a relevant foundation for local implementation against the national strategy. The neighbourhood model of care for this population is expected to be developed based on the strategic intentions captured in this document.

2. **Value of the Healthier Together 2040 Approach:** The approach taken over the last year to develop a long-term vision rooted in current and future health needs (rather than short-term demand management such as urgent care pressures) is starting to demonstrate that it is the right approach to bring together multiple partners. National interest and positive feedback confirm that this way of working has shifted mindsets in line with the NHS 10 Year Plan. It is therefore assumed that this approach is valuable and will continue to be applied in the development of future strategic intentions and delivery arrangements.

3. **Evolving Role of the ICB:** As the ICB transitions from a system convener to a strategic commissioner, delivery of these Strategic Intentions will require different governance and decision making. It is assumed that the ICB will adopt outcomes-based contracting approaches for neighbourhood health, drawing on model components developed through this work. Then the ICB will work in partnership across the system to develop a plan for delivery according to natural thinking around system governance.

4. **Current lack of clear System Governance and Architecture:** No defined governance or system architecture currently exists to oversee delivery across BNSSG organisations. It is therefore assumed that future work will need to address this gap to ensure delivery is coordinated and accountable.

5. **Changing Geography:** This work was developed collaboratively across BNSSG with partners and communities in the three council areas. It cannot be assumed that the models and intentions set out here are directly transferable to Gloucestershire without further work as BNSSG and Gloucestershire move towards a cluster ICB arrangement.

6. **Population Cohorts Beyond Working Age:** The Healthier Together 2040 work began with the Working Age population both to test the approach and to meet a pressing health need. The original ambition to systematically progress through all four population cohorts now appears unfeasible. It is therefore assumed that while elements of these strategic intentions may be relevant for other cohorts, this cannot yet be confirmed. However, as these intentions move into delivery, through both strategic commissioning and neighbourhood planning, they may begin to inform wider approaches for people with complex lives and contribute to building an outcomes-based commissioning architecture.

Delivery plan given this context

Set out below is an initial delivery plan given the current and rapidly changing context. ICBs, as strategic commissioners are responsible for building new neighbourhood health services, which improve population health and tackle inequalities and service providers are responsible for shifting care delivery into neighbourhood health services. Neighbourhood health plans will be agreed by Local Authorities, the NHS and partners under the leadership of Health and Wellbeing Boards (HWBs), HWBs are expected to provide oversight and hold neighbourhood health plans to account.

The ICB is therefore planning to prioritise progression of the following elements over the coming months:

1. Working Age – contracting and incentives
2. Working Age – data and outcomes
3. Desktop review of other population cohorts with Gloucestershire
4. All age (informed by Working Age) – development of Neighbourhood Target Operating Model bringing together Integrated Care @Home, model of care from Healthier Together 2040 and Locality Partnership models as they develop