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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Population Health and Strategic Commissioning Plan for 2026 – 2031

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board (ICB) developed in parallel with NHS Gloucestershire ICB

VERSION 1.2

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If you require this document in an alternative format, please contact bnssg.strategy-planning@nhs.net.

Contents

SECTION ONE – VISION AND STRATEGIC AMBITIONS 4
1.1 Introduction from ICB Chief Executive Officer and ICB Chair 5
1.2. Context for the Population Health and Strategic Commissioning Plan 6
1.3. Our vision and shared ambitions 8
1.3.1 Vision 8
1.3.2 Three Strategic Ambitions across BNSSG and Gloucestershire to guide Strategic Commissioning Approach 9
1.3.3 Strategic Ambition 1: Healthy Lives - People live healthier lives for longer, by reducing the risk of avoidable illness and decline 10
1.3.4 Strategic Ambition 2 - Health Equity - Health outcomes, experience and access are fairer across all communities 11
1.3.5 Strategic Ambition 3 - Best Value - Care and support are redesigned so that value is defined by people's experiences and outcomes within a sustainable system 13
SECTION TWO – POPULATION HEALTH NEEDS FOR BNSSG 14
2.1. Understanding Population Health Needs in BNSSG 15
2.2 People's experience of healthcare and care in BNSSG: why redesign is now essential 18
2.3 Population segmentation and populations of strategic importance 21
SECTION THREE – COMMISSIONING INTENTIONS FOR BNSSG 24
3.1 Redesigning for the future 27
3.1.1 Healthy neighbourhoods providing whole person care 27
3.1.2 Improving children and young people's health - recommissioning of children's health services 30
3.2 Creating the conditions for success 31
3.2.1 Market development and management 31
3.2.2 Financial incentives 33
3.2.3 Digital 34
3.2.4 Healthy workforce and workforce of the future 35
3.2.5 Strategic estates plans 39
3.2.6 Strategic procurement plans 40
3.2.7 A systematic approach to addressing health inequity 41
3.2.8 Supporting sustainability of health and care services 43
3.2.9 Adopting trauma-informed practice 45
3.2.10 Research and innovation 45
3.3 Areas requiring focus 46
3.3.1 Support for neurodivergent children and adults 46
3.3.2 Urgent and emergency care 46

3.3.3 All Age Continuing Care 47
3.4 Core business 50
3.4.1 Prevention and risk factors 50
Drugs and alcohol 50
Reducing smoking prevalence 51
Tackling obesity 51
3.4.2 Primary care 53
3.4.3 Maternity services 58
3.4.4 Mental health services 61
3.4.5 People with learning disabilities and autistic people 64
3.4.6 Children's services 67
3.4.7 Elective care, diagnostics and cancer services 71
3.4.8 Medicines optimisation 76
SECTION FOUR – HOW WE WILL DEVELOP A STRATEGIC COMMISSIONING APPROACH 79

Note – Artificial Intelligence has been used to triangulate information and support the formatting and editing of this document.

SECTION ONE – VISION AND STRATEGIC AMBITIONS

1.1 Introduction from ICB Chief Executive Officer and ICB Chair

As Chief Executive Officer and Chair of NHS Gloucestershire Integrated Care Board (ICB) and the NHS Bristol, North Somerset and South Gloucestershire (BNSSG) ICB Cluster, we are pleased to introduce our Strategic Commissioning Plan for BNSSG, a plan underpinned by our collective ambition to improve population health and wellbeing for all communities.

In developing this Plan, we have worked at pace to bring together a broad range of evidence, insights and established strategies into a single framework. This framework is focused on delivering outcomes, promoting prevention, and strengthening neighbourhood-based approaches to care.

Our Plan has also been shaped in close alignment with NHS Gloucestershire ICB, reflecting our shared ambition that, from 2027 onwards, there will be a single, integrated strategy and operating model across the wider footprint as the new, merged Integrated Care Board takes shape. By building on trusted relationships and established practice, we are laying the foundations for a more consistent, integrated and sustainable approach to improving population health for the long term.

We are driven by a clear and unwavering commitment to improving the health and wellbeing of the entire population, with a relentless focus on equity. Over the next five years, we are determined to close the unacceptable gaps in health outcomes that persist between communities, ensuring that where people live, work and grow no longer determines the quality or length of their lives.

Our efforts will be guided by evidence, strengthened by partnership, and shaped by the voices of the communities we work with. We will measure what matters, adapt continuously, and remain motivated not only by the scale of the challenge, but by the progress we achieve together. Through this sustained endeavour, we will deliver tangible improvements in life expectancy, healthy life years and lived experience for those who need it most.

In pursuit of that, we have three Strategic Ambitions to unite us over the coming years – **Healthy Lives, Health Equity and Best Value.**

As the two Integrated Care Boards move towards merger, this Plan provides the emerging shared framework that supports our alignment of vision and purpose. We look forward to working with our partners, stakeholders and communities as we deliver this ambitious vision—building a healthier future for everyone across Gloucestershire, Bristol, North Somerset and South Gloucestershire.

Shane Devlin and Jeff Farrar – Chief Executive Officer and Chair

NHS Gloucestershire ICB and NHS Bristol, North Somerset and South Gloucestershire ICB Cluster

1.2. Context for the Population Health and Strategic Commissioning Plan

Approach and purpose

This Plan has been developed by bringing together existing published strategies, evidence and engagement insights, rather than creating a new standalone narrative. This ensures continuity, coherence and pace, while building on agreed priorities and established directions of travel across the system.

Through the NHS 10 Year Plan (2025), NHS Strategic Commissioning Framework (2025) and related guidance, the overarching direction for the system is set out, including establishing neighbourhoods as the focal point for change. In BNSSG our progress over 2024 and 2025 towards a strategic population health approach, Healthier Together 2040, has helped to provide the beginning of a framework for our first Strategic Commissioning Plan.

In addition, this Plan draws on a wide range of supporting materials from across BNSSG, including Our Future Health (2022), the BNSSG Integrated Care System (ICS) Strategy (2023), the Dynamic Population Model, and insights derived from relevant engagement. Collectively, these sources provide a sufficient evidence base, reflect the views and experiences of local people, and set out a clear consensus on the changes needed to improve population health and reduce inequalities.

In developing this Plan, we have aimed to align these materials into a framework that focuses on outcomes, prevention, and is rooted in neighbourhood-based approaches to care. We will review and update this Plan annually, taking account of what has been delivered and the future work that will need to be undertaken.

This Plan has therefore been developed using the principles of the four-stage approach to strategic commissioning:

1) Understanding the local context: The Plan is formed on an understanding of local population needs, drawing on whole population segmentation, intelligence in the form of community insights, public feedback on health and variations in access, quality and productivity. In the future this will be informed by Integrated Needs Assessments.

2) Developing long-term population health priorities: Drawing on our understanding of local needs, the Plan sets out our strategic ambitions as well as commissioning intentions that respond to these local needs. These intentions and plans have been informed by feedback from partners. In the future we will link our commissioning intentions even more closely to an understanding of local population health.

3) Delivery through payor function and resource allocation: We will allocate resourcing to meet the commissioning intentions and priorities set out within this Plan and, through relationships, relational commissioning and contracting will ensure that outcomes are being delivered. In this Plan we describe our commitment to shift the proportion of spend away from the acute sector as part of our commitment to prevention.

4) Embedding an approach to evaluation: We will ensure that we assess and evaluate the impact of the commissioning intentions set out within this plan. We describe in this Plan the key outcomes and metrics that we will monitor impact against. In the future we will develop our formal evaluation framework to more robustly track service quality, access, cost and outcomes.

The Plan has also been shaped to align with Gloucestershire Integrated Care Board's, with a shared ambition that from 2027 onwards there will be a single, integrated strategy and operating approach across the wider system as the merged Integrated Care Board forms. This alignment supports greater consistency, reduces duplication whilst building on established practices and relationships to create the foundations for a more integrated and sustainable approach to improving population health over the longer term.

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1.3. Our vision and shared ambitions

1.3.1 Vision

In 2023, we declared our mission as '**Healthier together by working together.**' We explored the opportunities to promote good health, with our vision being that for people to enjoy healthy, productive lives. People are supported by a fully integrated health and care system that offers personalised support close to home for everyone who needs it.

We aim to improve healthy life expectancy across BNSSG and reduce disparities among different population groups driving inequalities. This goal has guided Healthier Together 2040 (a cohort based strategic project), which serves as our main approach to addressing overall population health needs.

As strategic commissioners in the NHS, we face a dilemma: while our resources and expertise are directed at healthcare improvement, major gains in population health depend on broader social, economic, and environmental factors over which the NHS has limited control. This means that, though the NHS must boost its own quality and efficiency, clinical excellence alone cannot achieve the necessary health outcomes.

This challenge arises as the NHS grapples with unprecedented pressures, including financial constraints, increasing demand due to an ageing, multi-morbid population, and widening health inequalities linked to deprivation. Staff shortages, sickness, and burnout further strain service delivery.

To resolve these issues, our commissioning strategy must both enhance healthcare performance and act as a system leader—building partnerships across local government, communities, voluntary groups, and other sectors to support prevention efforts beyond healthcare. Our modelling highlights the need to improve both productivity and risk reduction to ensure sustainability as shown in Figure 1.

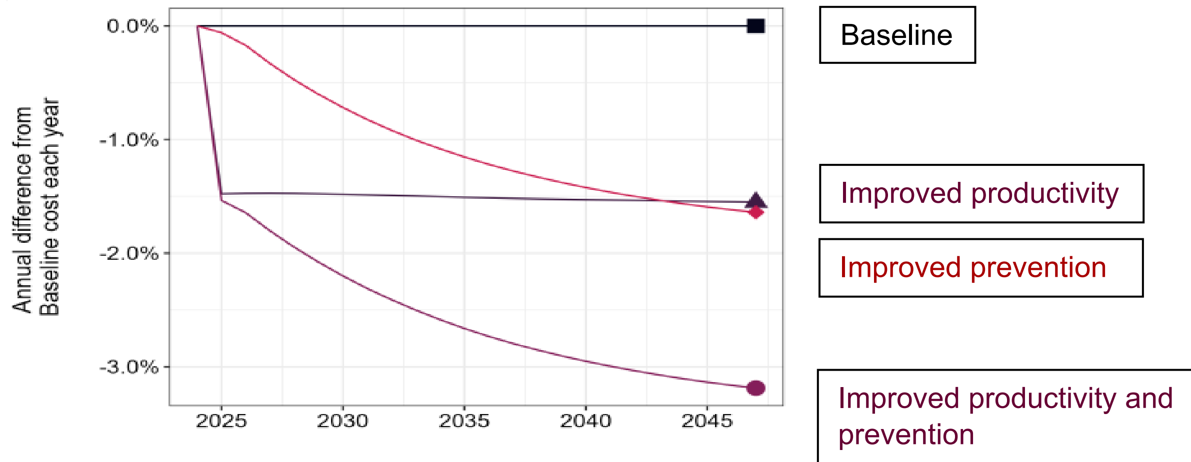


Figure 1: Annual difference to baseline costs with improved productivity and prevention according to the Dynamic Population Model v2.

1.3.2 Three Strategic Ambitions across BNSSG and Gloucestershire to guide Strategic Commissioning Approach

BNSSG and Gloucestershire have agreed to pursue the same three strategic ambitions to guide commissioning plans enabling an alignment on a direction of travel, whilst maintaining local approaches and priorities to achieve those ambitions.

Building on this foundation, these shared Strategic Ambitions not only reflect our evolving understanding of the challenges facing our population but also provide a cohesive framework for collaborative action across the region. By embedding these goals at the heart of our commissioning approach, we are better positioned to deliver measurable improvements in both health outcomes and system sustainability. This ensures that our efforts remain aligned with the broad national perspective including the three shifts described in the 10 Year Health Plan and local needs identified in Our Future Health (2022) and vision articulated in the Healthier Together 2040 strategic approach. In doing so, we reinforce our commitment to a unified direction of travel, one which balances local priorities with system-wide objectives while harnessing the collective strengths of BNSSG and Gloucestershire to drive meaningful change for our communities.

With population segmentation and linked data, it will be possible to measure the progress towards these aims where we haven't been able to achieve this previously. The system outcomes framework is a set of metrics that is used to currently monitor success at a strategic level, which is aligned to these aims as shown in Figure 2 below.

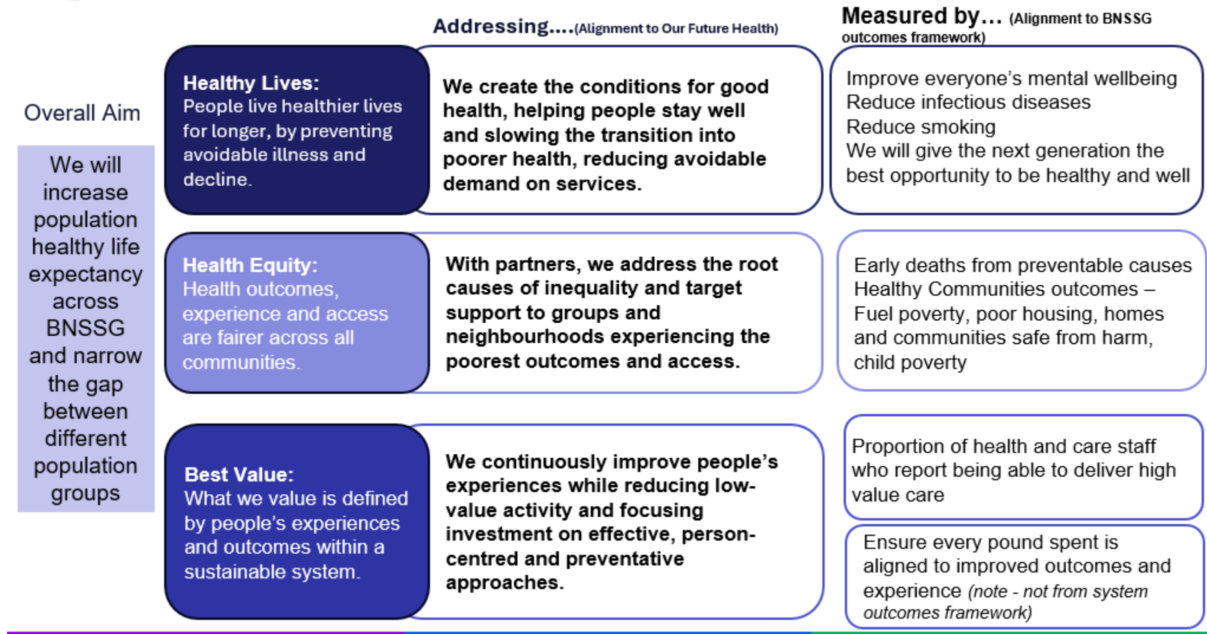


Figure 2: Shared BNSSG and Gloucestershire ambitions, mapped against Our Future Health and BNSSG outcomes framework

1.3.3 Strategic Ambition 1: Healthy Lives - People live healthier lives for longer, by reducing the risk of avoidable illness and decline

We know that increases in life expectancy and healthy life expectancy in our population have slowed or flattened out as shown in Figure 3.

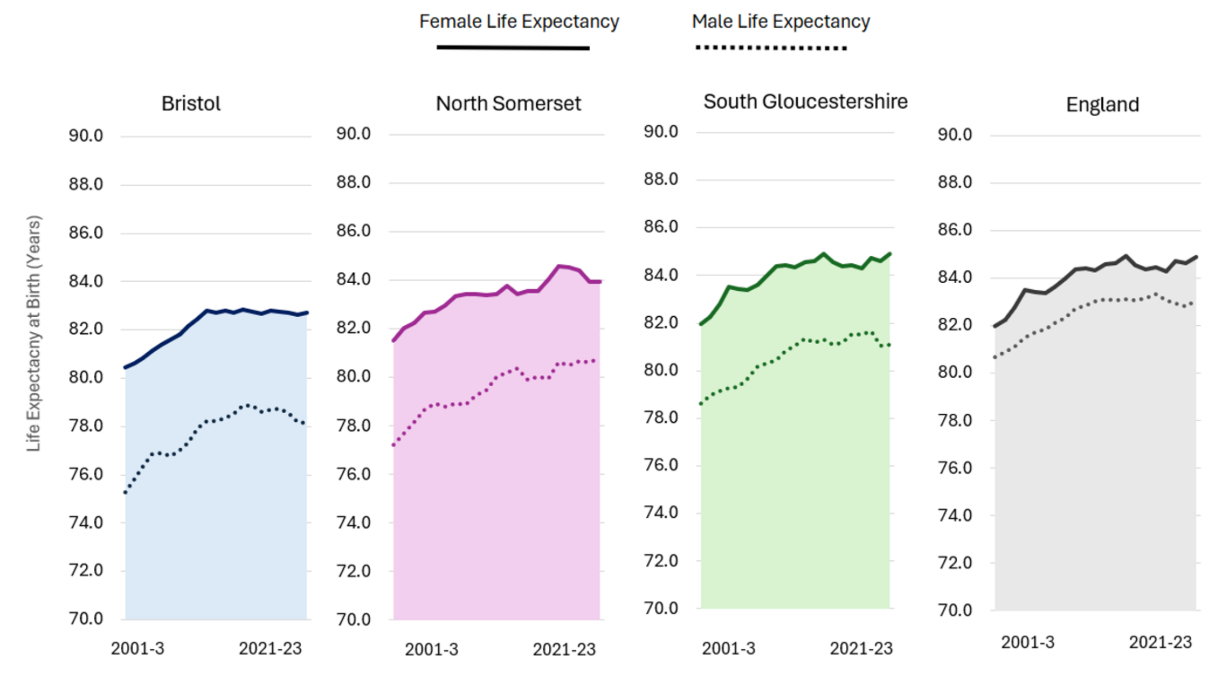


Figure 3: gains in life expectancy and healthy life expectancy in BNSSG over the last 20 years

We will create the conditions for good health, helping people stay well and slowing the transition into poorer health, reducing avoidable demand on services.

Our local modelling indicates that, to achieve financial sustainability by 2047, we must reduce the rate at which people transition between health segments (see more in section two Population Health Needs for BNSSG) in some cases by up to 20%. Addressing this rate is crucial for ensuring that our resources are used efficiently and that we can continue to deliver high-quality care over the long term.

To meet this aim, our strategy will focus on specific population groups who are experiencing higher rates of health deterioration. By concentrating our efforts on these groups, we can more effectively slow the progression of avoidable illness and decline, supporting both improved health outcomes and a sustainable financial future for our system.

There are two key actions:

1. **Slow the movement of people with rising health needs ('moderate need') into poorer health ('high need'):** We will prioritise population groups where we know that population needs are expected to change significantly (particularly those population cohorts identified through HT2040) by targeting the development of our Neighbourhood Health models of care at these cohorts first.

2. **Slow the movement of people currently living in good health ('low need') into moderate health:** Wider prevention activities, targeted at the communities with known health and social risk factors will enable us to direct our resources to have the highest impact. The NHS can only do this in our role as strategic commissioner with organisations such as the three local authority partners, community services, primary care and voluntary, community and social enterprise (VCSE) sector to enable this. As such we will pursue this objective through joint commissioning and the market development of the VCSE sector.

1.3.4 Strategic Ambition 2 - Health Equity - Health outcomes, experience and access are fairer across all communities

Currently, as shown in Figure 4, people living in the most deprived areas have the same level of ill health in their early 50s as people in the least deprived areas in their late 60s. Over the

next five years, we aim to reduce health disparities between these communities so that location no longer dictates health or lifespan.

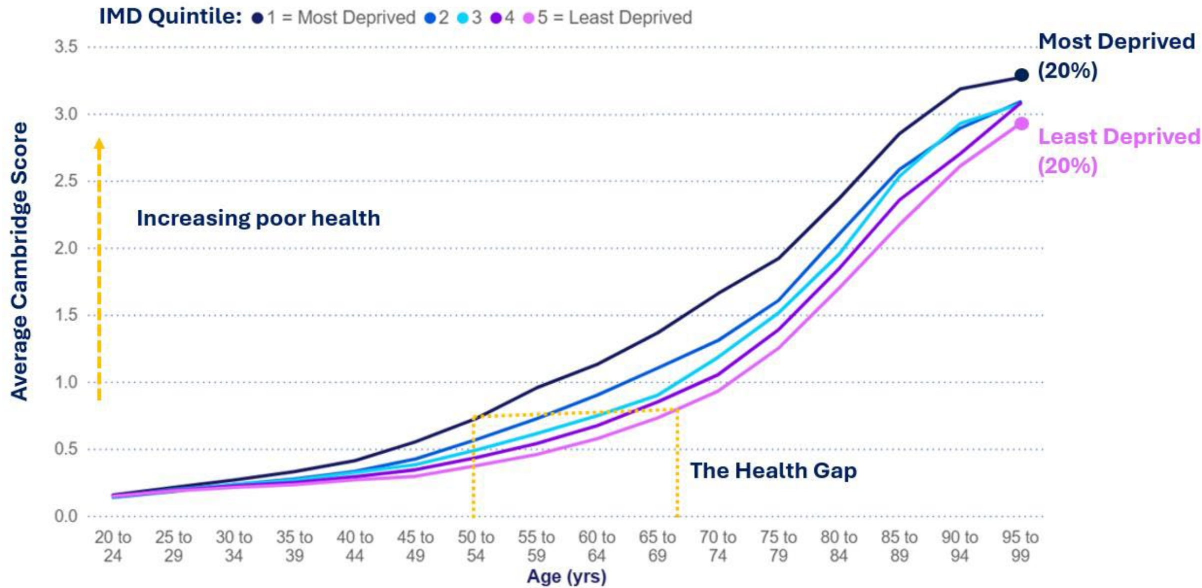


Figure 4. The life course health gap in BNSSG by deprivation

As we stated in our Strategy in 2023, our organisations have historically made decisions about services that have inadvertently favoured some groups over others due to biases involving ethnicity, gender, disability, sexual orientation, age, income, immigration status, housing, criminal justice history, language, and other factors. As a result, inequalities persist and human potential is wasted, weakening society (Professor Camara Phyllis Jones, 2022). We acknowledge this inaction and are committed to change.

A neighbourhood-based care model is central to delivering population health goals and addressing these inequalities. By combining data, professional expertise, and community insights, we will better understand local needs and tailor interventions for urban, coastal, and rural areas. Commissioning will actively support daily living conditions, including housing, income, employment, safety, and early years, helping neighbourhoods become platforms for better health.

We remain focused on providing safe, high-quality, and equitable services for everyone through a financially sustainable system, applying proportionate universalism – maintaining broad access while directing resources according to need. Neighbourhood initiatives will align with broader pathway redesign to reduce variation, shift from acute to preventative care, and improve outcomes and experiences, while also reducing avoidable demand and supporting financial and workforce sustainability.

1.3.5 Strategic Ambition 3 - Best Value - Care and support are redesigned so that value is defined by people's experiences and outcomes within a sustainable system

Our third strategic ambition is to maximise the value of care delivered, regardless of individuals' health needs, by making every £1 spent as effective as possible. Our modelling shows in Figure 5 that costs are not growing evenly across services, meaning that we need to use our resources effectively to improve outcomes. We aim to optimise care within each population segment, seeking opportunities to reduce costs without sacrificing quality or outcomes, including clinical effectiveness, patient experience, and safety.

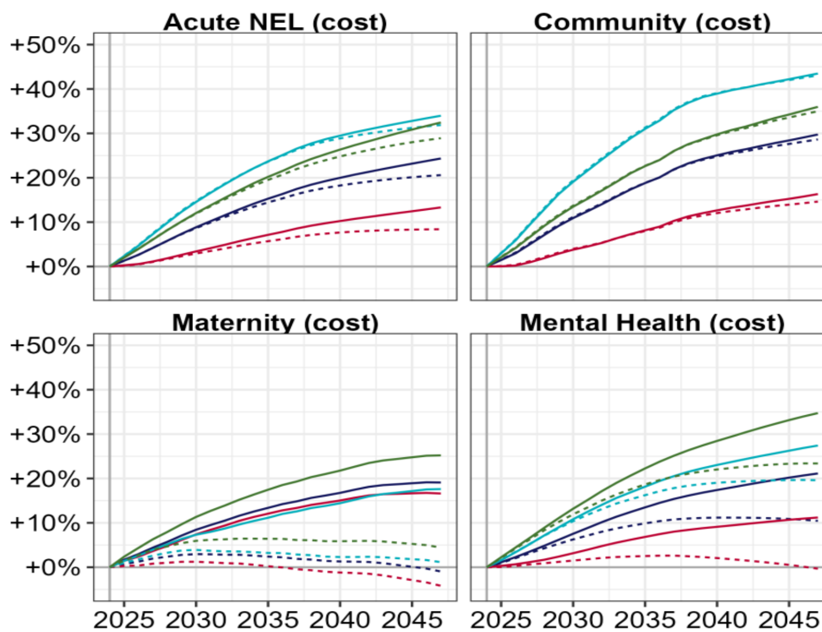


Figure 5. Projection of costs by service area and broken down by local authority by the Dynamic Population Model (v2)

Focusing on improving experiences strengthens outcomes and decreases avoidable costs. When care prioritises clear communication, continuity, dignity, and shared decision-making, people are more likely to trust services, follow treatment plans, and seek timely help – improving results and reducing duplication, complaints, and unnecessary acute care. System-wide, analysing experience reveals inefficiencies, allowing redesigns that eliminate waste and improve flow. This supports the Triple Aim Framework (Institute for Healthcare Improvement, 2008) demonstrating that patient experience is integral to value.

We will also leverage technology to improve productivity, while ensuring digital inclusion, and seek ways to remove barriers to efficient care and support.

SECTION TWO – POPULATION HEALTH NEEDS FOR BNSSG

2.1. Understanding Population Health Needs in BNSSG

This section draws together insights from some key sources that have been published in recent years such as Our Future Health (2022), the Joint Strategic Needs Assessments (JSNAs) for Bristol, North Somerset and South Gloucestershire local authorities (n.d.), and the Healthier Together 2040 report to provide an overview of the themes for the population health needs in the area and inform the strategic agenda. Through triangulating these key sources, we have identified six central themes that characterise the health challenges and priorities facing our local communities now and looking to the future.

A full Integrated Needs Assessment will be conducted by the clustered BNSSG and Gloucestershire systems in 2026/27.

The Defining Pattern of Need: Inequality, Early Multimorbidity and Escalating Demand

Across Bristol, North Somerset, and South Gloucestershire, population health needs are shaped by deprivation, early onset of multiple long-term conditions (multimorbidity), and increasing demand for health services, as highlighted by the BNSSG Our Future Health analysis and each area's JSNA. In Bristol, deprived neighbourhoods face lower healthy life expectancy, higher risk behaviours, and earlier long-term conditions. North Somerset reveals hidden deprivation, especially in coastal and rural communities, leading to poor service access, social isolation, and rising chronic illness. South Gloucestershire shows generally better health, but growing inequalities and an ageing population. A growing population in all areas will compound these trends, with modelling in Figure 6 showing that the largest growth is expected in South Gloucestershire.

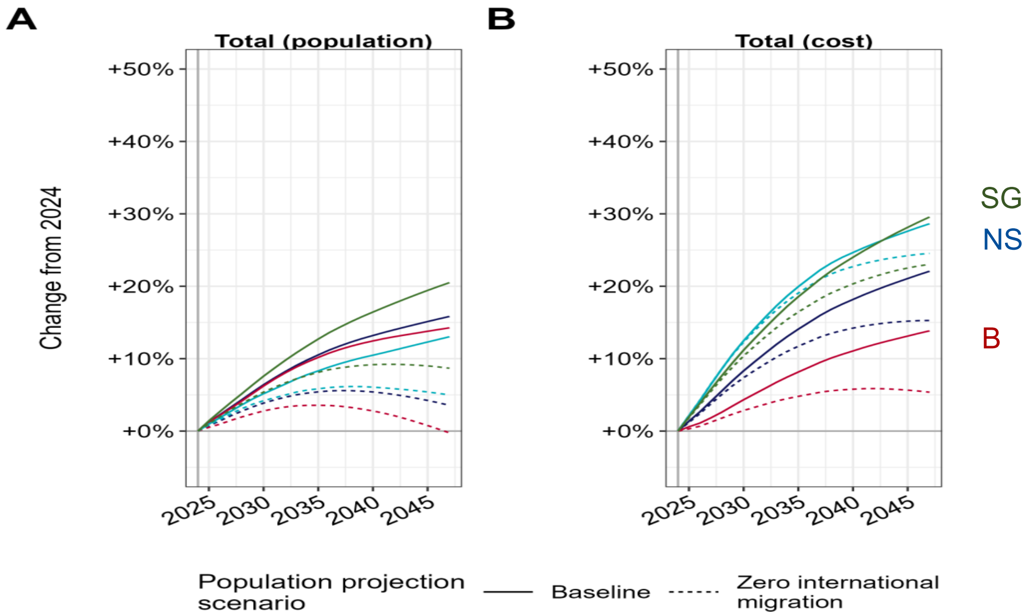


Figure 6: Population growth and total cost expected by Local Authority in BNSSG as predicted by the Dynamic Population Model (v2)

System-wide, Our Future Health estimates annual inequality-related hospital costs above £100m in BNSSG, emphasizing the impact of ill-health linked to social factors. Healthier Together 2040 predicts that mid-life multimorbidity will rise significantly without prevention efforts, making it a common issue beyond just older age in deprived areas. Collectively, the evidence shows multimorbidity is becoming central to population health needs, spanning childhood neurodevelopmental issues, working-age conditions, and frailty in later life.

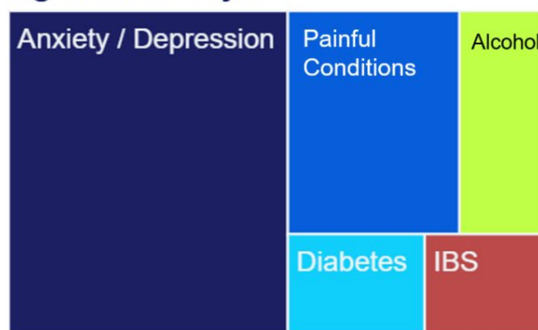
Emerging principle: **Need to design around the challenge of complex multiple needs**

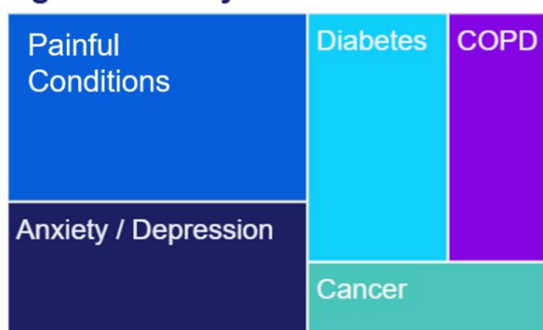
Preventable Ill-Health and Life-Course Patterns: The Main Drivers of Morbidity, Mortality and Health Inequality in BNSSG

Preventable or modifiable factors are the main causes of early death and chronic illness in BNSSG, impacting health from childhood to old age. Local data shows that about half of cancers, most type 2 diabetes cases, and most Chronic obstructive pulmonary diseases (COPD) can be prevented, with risk factors like smoking, poor diet, inactivity, alcohol misuse, and poor mental health being highest in deprived groups.

Healthier Together 2040 highlights that these conditions often co-exist, especially where poverty and social challenges are present. Multimorbidity - experiencing multiple long-term conditions, including both mental and physical health problems - is more common than single diseases, leading to increased complexity, higher social care needs, and greater emergency service use.

This pattern appears throughout life. Children face overlapping social and developmental challenges. Working-age adults manage combinations of physical and mental health issues affecting employment and wellbeing. Older adults experience frailty and multiple conditions, often alongside isolation. Clinically, conditions that cause the biggest impact to the population, across the ages, are shown in Figure 6 below.





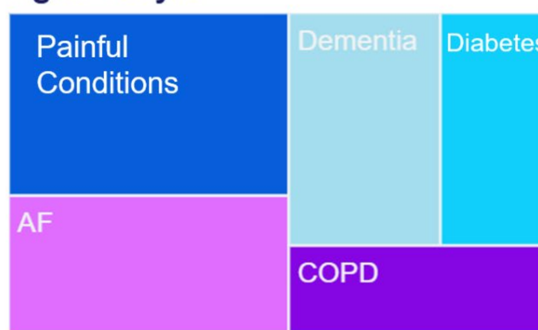


Figure 6: The impacts on health through the life-course in BNSSG

Inequality begins early and widens over time, with disadvantaged children facing poorer health outcomes that lead to riskier behaviours, lower achievement, and earlier chronic illness. An ageing population will further increase demand on services. Present models focused on single diseases are not fit for current needs. Early prevention and integrated, person-centred care across all life stages are vital to reduce health inequality and future healthcare demand.

Emerging principle: **Organise by population cohorts to address how health inequality accumulates and build in a prevention approach throughout.**

Wider Determinants as the Structural Drivers of Poor Health

The main structural factors affecting health outcomes include poor housing, fuel poverty, low income, insecure jobs, limited education, lack of green space, loneliness, social isolation, discrimination, homelessness, and experience of trauma. NHS must collaborate with wider systems to address these issues and improve health overall. Local reports highlight the significant impact of homelessness, rural isolation, limited service access, transport barriers, worklessness, housing costs, and loneliness on health. Healthier Together 2040 identifies these as system risks, emphasising that neglecting them will result in more preventable illnesses and greater future healthcare needs.

The NHS must continue to operate as a partner in addressing these issues through Health and Wellbeing Boards. By collaborating in this way, the NHS can work alongside other sectors to address the broader determinants of health.

Emerging principle: **Wider determinants must be addressed in partnership.**

Geography, Place and Future Pressure

The JSNAs and Healthier Together 2040 also demonstrate that population health need is highly place-based. Urban deprivation in Bristol, coastal and rural deprivation in North Somerset, and locality-level inequality in South Gloucestershire each generate distinct service pressures.

Healthier Together 2040 provides longer-term insights by projecting population growth in certain areas, identifying shifting patterns in the prevalence of long-term conditions, and assessing the current state of the health estate and its capacity to deliver community-based care at scale.

This reinforces that future demand will not be evenly distributed and that place will remain a critical dimension of population health need over the coming decades.

Emerging principle: **Place must be central to strategy.**

Health System as part of the problem

The health system in BNSSG is increasingly unsustainable, and in its current form is unintentionally contributing to poor health outcomes, widening inequalities and rising inefficiency. Local evidence shows persistently high and growing demand for urgent and emergency care, with emergency admissions and A&E attendances disproportionately concentrated in more deprived communities and among people experiencing multiple long-term conditions. BNSSG data also demonstrates that a small proportion of the population accounts for a large share of acute activity, reflecting unmet need, fragmented pathways and limited preventative impact. At the same time, despite sustained increases in activity and spend, improvements in life expectancy, healthy life years and patient experience have stalled, indicating diminishing returns from an illness-focused, hospital-centred model of care.

Emerging principle: **A full redesign focused on better experiences and outcomes for those with the greatest needs will begin to tackle problems caused by the health system itself.**

2.2 People's experience of healthcare and care in BNSSG: why redesign is now essential

People's experience with the NHS shows growing frustration with long waits and access issues, rather than dissatisfaction with staff or values. National surveys reveal that delays are

now routine, and improvements to individual services alone won't address overall system challenges, especially in high-demand areas like BNSSG.

Access inequalities persist, particularly for deprived groups, disabled individuals, and some ethnic minorities, due to a care model reliant on outpatient appointments and complex pathways. Evidence suggests people desire timely, continuous care rooted in relationships and communities, not more appointments.

BNSSG's partnership with Alaska's Nuka System of Care reinforces this approach. The Nuka model, which prioritises relationship-based, community-owned care, has informed Healthier Together 2040, aiming to redesign services for equity, continuity, and proactive support.

What local people tell us matters

In BNSSG, insight has been gathered through the Have Your Say survey (November 2022), NHS 10-Year Plan engagement (April 2025), *The State of Health and Social Care* (November 2023), and targeted engagement linked to Healthier Together 2040. Additional insight has come from work with people experiencing multiple long-term conditions, children and young people, procurement activity, and intelligence from Healthwatch and local authorities.

Across these sources, around 60% of people report that the factors affecting their health and wellbeing feel outside their direct control. At the same time, people consistently express aspirations to be more physically active, eat better, improve mental health and spend more time outdoors. Affordability is frequently identified as a barrier.

Social connection is highly valued. People want to spend more time with friends and family, avoid loneliness, and contribute to their communities.

Achieving a better work–life balance is commonly described as both a personal and systemic challenge, reflecting the interaction between individual behaviour and wider social and economic conditions.

Where people identify factors beyond their control, distinctions are clear. Timely access to good-quality care is seen as the responsibility of the NHS, while issues such as deprivation, transport and community infrastructure are recognised as requiring wider system action.

Public recommendations consistently focus on six themes: investment in community-based care; inclusive use of technology; prevention and risk reduction; fairness and inclusion; coordination around people; and ongoing public engagement. There is strong support for well-funded, local services and for education that enables people to take greater ownership of their health.

Insights from people facing multiple health challenges

Engagement with working-age adults experiencing multiple long-term conditions highlights how current system design amplifies daily challenges. The interaction between physical and mental health is a recurring theme, alongside frustration with fragmented services and repeated storytelling.

> **"Managing your health is challenging enough, but when I have to chase things… sometimes when I'm depressed, I lack the capacity to do that." (Female, aged 18–30, South Bristol locality)**

Critical life transitions, such as parenthood, bereavement, job loss and relationship changes are identified as key moments for intervention. While these periods may increase openness to support, they are also marked by high stress, reinforcing the need for personalised, proactive approaches.

Children, young people and marginalised communities

Rising demand across mental health, special educational needs and wellbeing is limiting timely access to coordinated support for children and young people. Vulnerable groups include young carers, neurodivergent children, asylum seekers, Gypsy, Roma and Traveller communities, those without stable housing, and young people not in education, employment or training.

Engagement with deprived and marginalised communities shows that many people disengage after repeated barriers to access, reducing opportunities for early diagnosis and intervention. Healthwatch evidence highlights systemic obstacles and a failure to accommodate individual access needs (Healthwatch). Trust is a particular issue for some ethnic minority communities, shaped by experiences of discrimination and the quality of relationships with professionals (Inequalities Programme).

Learning from professionals and the case for neighbourhoods

Neighbourhood discovery with professionals across BNSSG identified four consistent challenges: siloed working leading to poor experience; persistent health inequalities; over-reliance on acute and reactive care; and a system organised around conditions rather than whole people.

While these ambitions are not new, progress has been constrained by the absence of a shared vision for neighbourhood services, fragmented commissioning, short-term funding, system incentives that prioritise organisational performance, and limited change management capacity. At the same time, staff emphasise that BNSSG has strong

foundations on which to build, including established partnerships and learning from earlier integration efforts.

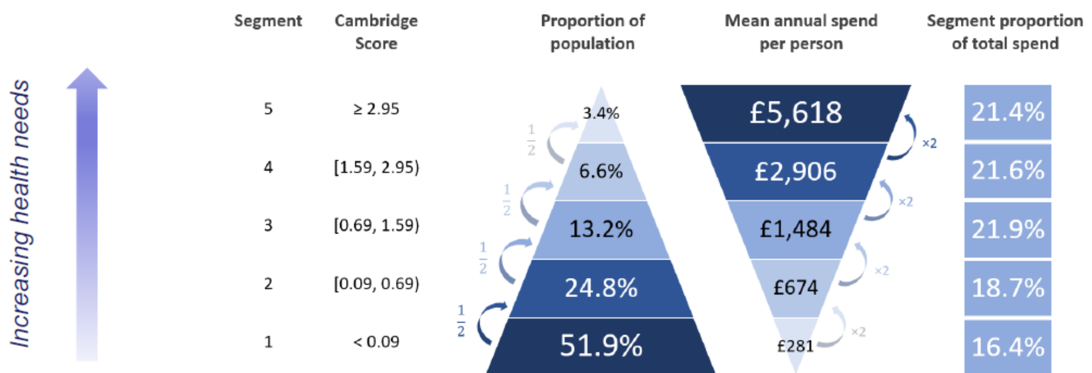
Why action is needed now

Modelling indicates that more people will spend longer periods in poor health, with major illness expected to rise 37% by 2040, most notably in deprived communities (Health Foundation, 2023 & 2024). Drivers such as population growth, housing development, an ageing population, workforce shortages, and outdated infrastructure will intensify demand, especially in areas like South Bristol and Weston (HT2040 Analysis). Additionally, increasing mental health needs, technology changes, climate effects, and system shocks highlight the urgency for a more resilient, preventative, and community-focused healthcare model (Options 2040, 2024). Therefore, redesigning care around neighbourhoods and relationships is essential to address rising needs and inequalities by 2040.

2.3 Population segmentation and populations of strategic importance

Segmentation

BNSSG ICB's Dynamic Population Model (DPM) uses a **clear, risk-based population segmentation** that groups residents into five Core Segments using the **Cambridge Multimorbidity Score** as an indicator of overall health need and likely service use. The segments are designed so that, as health needs increase, groups become smaller but average costs rise, helping to make the link between population health and resource use easy to understand. The model tracks how people move between segments as they age, using observed transition patterns alongside Office for National Statistics population projections. It then applies segment- and age-specific activity and cost assumptions across care settings to estimate future demand and spending, and to explore the potential impact of prevention and productivity improvements.



Wood, R. M., Budiman, T. A., Hassey, N., Onen Dumlu, Z., Vasilakis, C., Budd, F. J., ... & Kenward, C. (2024). Development and practical use of a risk-sensitive population segmentation model for healthcare service planning: Application in England. International Journal of Healthcare Management, 17(4), 715-724.

Figure 7 – CMMS segments mapped against the population size, mean annual spend per person and by segment proportion of the total spend

Through Healthier Together 2040, we identified the population cohorts of strategic importance to understand further the clusters of people 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.

This analysis made clear that the current health and care system must change radically 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.

Health Foundation reports (2023 and 2024) demonstrate that for adults, an ageing population experiencing increased multimorbidity or multiple conditions along with deprivation and social complexity is a critical health and social issue looking to 2040. Locally, the BNSSG Dynamic Population model corroborated with the Health Foundation findings of the growth and key underlying drivers when exploring the “do nothing” scenario. When analysing the local linked data for people facing 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.

Cohort name	Description	Population Numbers	Proportion of total population
Adults facing multiple disadvantage	People experiencing disadvantage drug or alcohol use, learning disability and mental health needs, unstable housing, homelessness, asylum seekers.	3,100	0.3%
Older people experiencing multiple conditions	Over 75s living with several conditions that are impacting their functioning and using lots or their time interacting with health and care.	35,000	3.3%

Table 1 – description of the population cohorts of strategic importance in BNSSG

SECTION THREE – COMMISSIONING INTENTIONS FOR BNSSG

How we are structuring Commissioning Intentions

We have structured and stratified our commissioning intentions to create a clear line of sight between today's pressures and tomorrow's opportunities. This approach allows us to surface a small number of deliberate "big bets" where transformational investment and redesign energy will be required, while also highlighting specific areas for improvement where targeted action can deliver measurable gains. At the same time, it recognises our responsibility as strategic commissioners to protect and sustain core requirements, ensuring continuity, quality, and equity of essential services.

To do this, we have identified four overarching themes to organise our commissioning intentions for the forthcoming year. This approach reflects our commitment to delivering the ambitions of the 10 Year Health Plan, despite operating with reduced capacity and a growing emphasis on our evolving role as a strategic commissioner. These themes are designed to guide and shape the direction of travel for the Integrated Care Board (ICB) as it navigates a significant period of transition over the next twelve months.

The themes are:

1. **Redesigning for the Future:** Setting out the models and ways of working to address complex challenges – these are the big bets for the future
2. **Creating the conditions for success**: Addressing building and sustaining the infrastructure needed for quality care, now and in the future
3. **Areas requiring improvement:** Health and care areas needing improved quality, effectiveness, or safety to meet standards and reduce risks.
4. **Core Business:** Improving and/or maintaining quality in Core Requirement. Delivering safe, high-quality, and accessible health care is a core responsibility. This requires upholding standards, meeting feedback and regulation, and ensuring resilience in essential services.

Achieving progress in all these areas should guide us towards the three strategic ambitions:

- Healthy Lives – people live healthier lives for longer by preventing avoidable illness and decline
- Health Equity – Health outcomes, experience and access are fairer across all communities
- Best Value – What we value is defined by people's experiences and outcomes within a sustainable system

Noting the nationally mandated timescales requiring NHS Provider Trusts to develop 5-year Integrated Business Plans in parallel with the ICB's development of 5-year strategic commissioning plans, there is a risk that provider plans may not be fully aligned with system priorities or sufficiently reflect interdependencies, capacity constraints, and potential unintended consequences across the ICS. This could result in conflicting service models, sub-optimal use of resources, displacement of financial and workforce pressures between organisations, and reduced ability for the system to deliver agreed population health and recovery objectives.

To mitigate this, the system will mature its system-wide planning framework, iterative engagement and co-production, system governance and oversight, and develop agreed mechanisms for the annual refresh of system and provider plans to reflect final commissioning intentions, updated national guidance, and evolving system priorities.

Summary of all Commissioning Intentions

3.1 Redesigning for the future	3.1.1Healthy Neighbourhoods providing whole person care 3.1.2 Improving Children and Young People's health
3.2 Creating the conditions for success	3.2.1 Market Development and Management 3.2.2 Financial incentives 3.2.3 Digital 3.2.4 Healthy Workforce and Workforce of the Future 3.2.5 Strategic Estates Plans 3.2.6 Strategic Procurement Plans 3.2.7 A systematic approach to addressing health inequity 3.2.8 Supporting Sustainability in Health and Care Services 3.2.9 Adopting Trauma Informed Practice
3.3 Areas requiring focus	3.3.1 Support for Neurodiverse Children and Adults 3.3.2 Urgent and Emergency Care 3.3.3 All Age Continuing Care
3.4 Core business	3.4.1 Prevention and Risk Factors 3.4.2 Primary Care 3.4.3 Maternity Services 3.4.4 Mental Health Services 3.4.5 People with Learning Difficulties and Autistic People 3.4.6 Children's Services 3.4.7 Elective Care, Diagnostics and Cancer Services 3.4.8 Medicines Optimisation

3.1 Redesigning for the future

At the core of our strategic commissioning intentions is a commitment to fundamentally transform the health care system by focusing on population cohorts of strategic importance, through the lens of neighbourhoods, but ultimately spanning all services required by each population. This will not be at the expense of delivering services which support delivery of the system flow targets, including admission avoidance and facilitating timely discharge from hospital.

This large-scale redesign is not only essential for delivering our strategic ambitions, but also for ensuring that care becomes more personalised, proactive, and responsive to local needs. By organising services around distinct community groups, we can better target interventions, harness local assets, and foster stronger partnerships leading to improved outcomes, greater equity, and a more sustainable system. This approach positions neighbourhoods as the foundation for innovation and integrated care, enabling us to tackle complex challenges such as multi-morbidity and health inequalities in a way that is both compassionate and effective.

3.1.1 Healthy neighbourhoods providing whole person care

Ambitions

We have set out five ambitions for Neighbourhood Health to be achieved by 2030:

1. Integrated care models are implemented throughout BNSSG, ensuring seamless, coordinated support for individuals across the system.
2. A culture of continuous learning is embedded, with teams collaborating towards shared objectives and driving collective improvement.
3. Incentives are purposefully aligned to prioritise outcomes that matter most to people and communities.
4. A mature provider landscape is nurtured, underpinned by robust partnerships delivering high-quality, joined-up services.
5. Outcomes are improved for all, with a steadfast focus on advancing equity and reducing disparities across our population.

Population cohort focused model for neighbourhood health

Through the Healthier Together 2040 approach run through 2025, we established the development of a commissioning model focused on working-age adults facing multiple long-term conditions. In the coming year term, the model will be developed further through phased testing and iteration, with learning used to inform scale-up and extension to other population groups.

We are using this starting point to inform a strategic commissioning approach, so that by 2027 we intend to have the commissioning architecture in place so that the neighbourhood model can begin to be commissioned in a structured scalable way to achieve these ambitions.

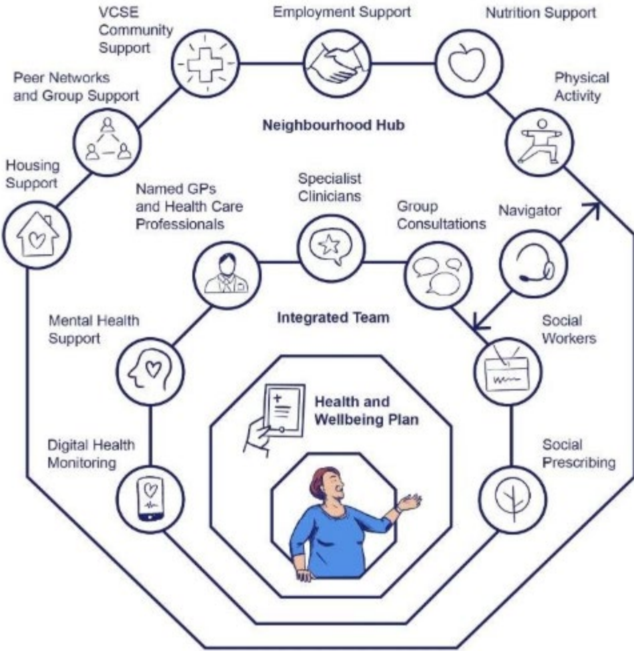


Figure 8 - Model for Working Age Population with Multiple Long-Term Conditions developed through Healthier Together 2040

The neighbourhood model shifts care away from reactive, institution-led provision towards a community-based biopsychosocial approach. It prioritises prevention, behavioural change, and holistic wellbeing, underpinned by trauma-informed, relationship-centred practice. Care planning is personalised and outcomes-focused, shaped around “What matters to you?” and supported through coaching, group consultations, and coordinated multidisciplinary input. 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.

Furthermore, we will use local data to measure progress and impact through a series of key indicators, reflecting both service user and staff experience, system effectiveness, and equity of access. These indicators include:

1. Trust & Relationships: Track trust levels and relationship quality to measure progress in collaboration and person-centred care.
2. Non-Elective Admissions: Fewer hospital admissions signal effective prevention and better chronic condition management in the community.
3. Equity – GP Access Variation: Monitor access differences across communities to ensure fairness and target support where needed.
4. Experience & Activation: Use PROMs, PREMs, and PAM to assess user experience and self-management confidence, focusing on key groups.
5. Staff Satisfaction: Regularly measure staff satisfaction to maintain wellbeing and improve service delivery.
6. Segment Progression: Review changes in population segments moving from moderate to high need as an indicator of intervention success.

Building on existing foundations and national support

Commissioning will build on existing BNSSG initiatives supporting people with complex needs, including locality-based programmes, Frailty Assessment and Coordination of Urgent and Emergency Care (F-ACE) , MINT teams, One Weston Integrated Care Home Hub . Procurement will continue as required with dementia services coming soon, with all the best practice identified and applied in the commissioning processes as they emerge. The National Neighbourhood Health Implementation Programme currently in two neighbourhoods (South Bristol and Woodspring, North Somerset) will support acceleration, alignment, and shared learning as neighbourhood models are tested, refined, and commissioned at scale.

Neighbourhood Development Fund – driving system change through strategic investment

Building on insight from Healthier Together 2040, and our emerging neighbourhood model, we recognise that shifting to this new way of working requires dedicated space, resource and structured support for innovation.

The Neighbourhood Development Fund provides the resource to develop, test and scale neighbourhood models, with VCSE partners, local authorities, primary care and providers contributing as equal partners. The ICB will work with the system through a three-phase process to agree what we progress and how we do it locally.

Phase 1: Identify priorities

We will collate a long list of essential component parts of the neighbourhood health model to determine where to start our efforts and energy at scale testing these with partners to understand impact, feasibility and alignment, these might be care plans, Integrated Teams, or digital tools. Through workshops, we will agree the 3–5 areas most likely to improve outcomes and reduce inequalities.

Phase 2: Develop proposals

Partners and people with lived experience will take part in focused design sprints to examine these in depth exploring what is needed, barriers, workforce and digital requirements, interdependencies, and where each proposal is best led (provider, place or locality). This phase will produce 3–5 detailed, practical development proposals.

Phase 3: Allocate and govern the fund

Working with Health and Wellbeing Boards, we will identify the most appropriate host providers/integrators for each priority, and confirm the resource required to progress proposals. This phase establishes the process for investment, monitoring and shared learning, with final funding decisions made through ICB governance.

The fund is a key enabler of our transition to strategic commissioning for neighbourhoods by 2027/28. It will help us demonstrate impact on prevention, inequalities and integrated experience; strengthen provider partnerships; support digitally enabled access; and align incentives and resources around outcomes as part of a mature neighbourhood commissioning approach.

3.1.2 Improving children and young people's health - recommissioning of children's health services

As a starting point to address the needs of the priority cohort of children and young people we will use the opportunity of the need to recommission children's health services to test a strategic commissioning approach for a segment of the population.

A key priority for the ICB, particularly in 2026/27 is a large scale, multi-agency commissioning programme designed to secure safe, high quality, equitable, and financially sustainable children's community health services across BNSSG from 2028 onwards. Already commenced in 2025, it is evidence driven, collaborative, and anchored in extensive engagement with children, families, and the workforce. The programme has been established to set out the vision, outcomes and approach to improve outcomes and reduce inequalities through the strategic commissioning of integrated children's community health services.

The result will be a single contract that covers children's health services, due to start in 2027.

3.2 Creating the conditions for success

3.2.1 Market development and management

We will take an active, long-term approach to developing the neighbourhood health services market, aligning our resource allocation, contracting and commissioning decisions with population need and agreed neighbourhood outcomes. This will include shaping the provider landscape so that services are delivered at the most appropriate scale, supporting collaboration across NHS, local authority, voluntary, community and independent partners, and using flexible contracting and procurement approaches to enable stability, innovation and integration. Rather than episodic procurement, we will focus on sustained relationships, clear outcomes, and proportionate contractual management that supports providers to adapt, grow capability and work as part of neighbourhood-based teams, ensuring access, quality and financial sustainability over time.

Market Management & Development for Neighbourhoods

The Neighbourhood Development Fund creates a clearer and more intentional approach to market development by signalling the 3–5 priority areas where the system most needs new capability, partnership and innovation. By drawing on system insight and partner engagement to agree these priorities, providers across VCSE, primary care, community and specialist services gain early visibility of future demand and the types of neighbourhood functions the system intends to grow. This helps the market plan investment and align offers to the outcomes and models of care required locally.

The structured development process sharpens market management by rapidly defining what good looks like and where capability needs to grow. Through focused design sprints, partners and people with lived experience stress-test each priority, exposing barriers, capability gaps and the best locus for delivery provider, place or locality. This clarity helps providers understand the roles they can play and the capabilities they need to build.

This approach supports the growth of a more agile and integrated neighbourhood market, ready to deliver the models of care needed for strategic commissioning from 2027/28.

VCSE market development

Our approach prioritises equitable inclusion of diverse VCSE organisations, especially those led by people from excluded communities. By intentionally involving micro/small, equalities-led, and hyper-local VCSEs, we aim to foster neighbourhood-level inclusion and provision.

This will enhance community wellbeing, improve health outcomes, and generate valuable insights into effective support for diverse groups, particularly regarding prevention and reducing health inequalities.

The BNSSG VCSE Vision & Framework for Action describes the intention for VCSE integration in our system and the goals and actions that will serve to achieve the vision.

Our vision is a system where health creation and equity emerge from trusted, inclusive partnerships, where VCSE organisations are valued as co-creators of a healthier, fairer future and are at the heart of everything we do – from culture, planning and decision-making to delivery, learning, innovation and improvement.

Goal 1: A system **culture** rooted in mutual respect, that values people, relationships and learning alongside outcomes.

Goal 2: System **planning** supported by strong, sustainable, inclusive VCSE collaborations that strengthen wellbeing and health in the system.

Goal 3: Governance and **decision-making** that values communities of place, practice and identity, reflects diversity and shares power to improve outcomes for all.

Goal 4: Equitable investment and input in design and **delivery** of support and services through co-production and VCSE organisations embedded in every stage of the commissioning cycle.

Goal 5: Data, insight and **learning** from VCSE organisations drives **innovation** and continuous **improvement** in the system. .

To support VCSE involvement in delivering this plan we will commission these VCSE structural developments in 2026/27:

VCSE Structure & Strategy – VCSE as equal partner in ICS	• VCSE structure / interface with the system – focus on culture, planning, decision-making, new models and innovation / improvement. • Support co-design and implementation of strategic commissioning and strategic developments
VCSE Support & Deliver – enable a mature VCSE market	• Development of VCSE collaborations in neighbourhoods/communities. • Market shaping / support for priority VCSE organisations of and serving priority communities.

	• Enable innovative VCSE proposals for delivery (VCSE Brokerage).

3.2.2 Financial incentives

The existing financial system does not effectively link financial rewards to the goals of better health and wellbeing, nor does it discourage the use of non-elective and A&E services, which often indicate that the system has not managed to support people's health needs proactively by services close to home. As a result, these financial arrangements are making health inequalities worse. If we are to transform how care is delivered, we must also reform how it is funded.

To address this, we plan to test new payment approaches by 2030 that will ensure funding supports joined-up, community-focused care and incentivises progress towards our three main ambitions. This will also involve developing suitable payment structures to support a range of organisations, including those in the voluntary, community, and social enterprise sector. This new system needs to ensure that partners, places, people, and communities have a "fair share" that promotes equity not just equality.

For 2026/27, we will participate developing a shadow form with a national group of systems, steadily shifting our measurement and reporting towards Year of Care-type funding approaches tailored to defined population segments. This transition is underpinned by a set of key priority actions:

- High quality data capture and processing
- Establishing outcomes for population cohorts and tracking and monitoring
- Establishing what we are spending on current care and opportunities to improve value
- Market maturity development, with a particular focus on the local VCSE sector as a priority market
- Testing and exploring different contractual mechanisms to determine the best fit for our system

By focusing on these priorities, we will lay the groundwork for a more outcomes-oriented funding model, identify areas for value improvement, and develop a mature local market capable of delivering integrated care. Evaluating various contractual approaches will help ensure that any future system is both effective and sustainable.

3.2.3 Digital

A key aim of system digital work is to drive digital transformation across BNSSG by supporting the delivery of the neighbourhood programme through a discovery, design, and test phase, ensuring technology underpins integrated and patient-centred care. Human centric design principles will be used to implement and maintain key digital enablers such as shared care records, shared care plans, electronic referrals, and electronic prescribing to improve coordination and efficiency. System partners are advancing digital diagnostics and exploring innovative technologies such as ambient voice solutions and artificial intelligence in wound care to enhance clinical practice. Strengthening system intelligence through the development of an Intelligence Centre, ensuring robust cybersecurity, and maintaining resilient networks and electronic patient records are core priorities. Additionally, the system partners aim to improve patient engagement and accessibility through platforms such as the NHS App, NHS Notify, and patient engagement portals, while embedding digital solutions that support prevention, early intervention, and improved health outcomes across the system. To reduce the risk of digital exclusion, the ICB will work with VCSE partners to ensure equitable access and maximal public uptake to digital solutions developed for the model.

Our system partners in primary care and acute care are at different stages of piloting voice activation technology to record notes, care records and observations. This key development has already increased service efficiency, and very importantly the quality and detail of records, also releasing time to care for patients. In our mental health trust, a current pilot enables individuals to review and agree what is written in their plans, before it is confirmed. This digital intervention supports an ethos for our system of personalised care and shared decision making that needs to spread. GP Practices have embedded successful voice technology pilots to create time saved and are testing further products in digital labs at the University of the West of England (UWE) to prepare more innovative solutions in 2026. Access to the labs is widening in 2026 beyond One Care to all system partners to work together on approaches and testing, to create a learning community, and potentially partner on contracting with suppliers for best value.

BNSSG has experienced the highest increase nationally in NHS app uptake through concentrated communication and training efforts during 2025. These efforts will extend during 2026 to further increase its uptake and benefit for our population. The app itself releases time for GP Practices by streamlining patient access to medical records, test results and ordering repeat prescriptions, automates the process for reducing SMS templates and provides practices within BNSSG with the resource to do so, enabling efficient use of SMS messaging, and promotes digital inclusion by engaging patients in one-to-one support

sessions to encourage the use of the NHS App through supporting with language barriers and providing access to devices and connectivity.

BNSSG will continue to support digital maturity in social care, by working actively with care homes and social care providers to train, share knowledge and usage of digital systems.

Bristol NHS Group will soon utilise one form of digital medical rostering for a single system, with better use of the workforce across the hospital group.

Work to improve the Electronic Patient Record (EPR) remains a heavily resourced priority over the next few years. In particular, the Bristol NHS Group will deliver a large programme of work to level up UHBW clinical systems and estates, and the digital teams will be merged to one by the end of December 2025, to work on joint solutions. The levelling up will mitigate current risks associated with poor user experience by clinicians of the current system. The current Group EPR contract ends in 2029 and the transition and improvements will be planned and carried out in anticipation of this. The ICB and general practice will also move from legacy systems to a 'modern office', again focussing on enhancing collaboration and productivity through better and more reliable technology.

Shared care records will be commissioned by the ICB from the Bristol NHS Group as the lead organisation in developing a system wide product for patients. In addition, our current local care records will be connected to a national record locator. This key development will enable patient records and care plans to be shared nationally, wherever in the country a person presents for their care.

The Intelligence Centre Programme is the ICB's digital and strategic intelligence flagship innovation. This advanced programme is developing an accessible portal for system data with strategic governance and commissioning products to support decision making and data sharing across all partners. Delivering one source of truth for all areas of care and partnerships, and an informed and dynamic environment for strategic commissioning.

Lastly, the ICB is commissioning the implementation of an agreed ICS-wide cyber security strategy. This will involve establishing a Cybersecurity Operations Centre to monitor threats and coordinate action to defend as one across the whole of BNSSG.

3.2.4 Healthy workforce and workforce of the future

Over the next five years, we will drive a workforce movement for change across BNSSG health and social care, uniting over 64,000 staff as One Workforce. Our goal is to move from fragmented approaches to a cohesive system, aligning with Healthier Together 2040, national NHS strategies, and workforce ambitions. We'll focus on developing relational,

digital, and care-coordination skills to deliver person-centred, neighbourhood-based care, while promoting continuous learning, inclusion, and wellbeing.

We aim to grow our workforce and make good employment decisions central to improving population health. By expanding apprenticeships, work experience, T-levels, and inclusive recruitment, we will improve access and career progression for local communities – especially young people, care leavers, veterans, and underserved groups. Clear pathways across NHS, social care, VCSE, primary care, and education will support career mobility and development.

Workforce planning and development will become a core function, using labour market intelligence and strategic forecasting to address future needs. Leadership models will help put strategy into action, strengthening staff experience, retention, and patient outcomes. By year five, BNSSG will be recognised for aligning workforce development, employment, and population health.

What is our overarching aim?

Our workforce intentions will be driven by our population health needs alongside national policies including the NHS 10-Year plan, Get Britain Working, the Educator Workforce Strategy, the People Promise and the Safe Learning Environment charter. Delivery of our intentions will mature over coming years through changes of skills, knowledge and behaviour in individuals, partner organisations and across the system. This will ensure the future workforce meets the population health needs.

Our strategic approach intends to cultivate a culture of continuous learning throughout a career lifecycle, prioritising the wellbeing and inclusion of our staff. The link between 'good' employment and good health is well evidenced and documented, and as anchor institutions at the heart of our communities we play an essential role in integrating work and health. This link demonstrates that positive workforce actions can prevent ill-health, reduce inequalities and improve economic outcomes.

Our approach has two main themes:

One Workforce

One Workforce is a system-wide approach to strategic workforce planning. It will dissolve traditional boundaries between sectors with fragmented siloed workforce models to create a unified workforce that is inclusive and agile to deliver person-centred care. It will be a skills-based approach unlocking new opportunities and career development.

This approach will be realised through system commissioning and strategic workforce planning that facilitates the growth of a workforce capable of responding effectively to future demands while delivering high-quality care. By engaging in collaborative planning, utilising data-driven decision-making, and fostering inclusive partnerships, we will ensure that staff are adequately prepared, supported, and equipped to meet evolving population needs and advance sustainable health and wellbeing outcomes for communities.

Good Employment

We are committed to building a resilient, inclusive, and future-ready workforce by investing in the attraction and development of local talent. Our educators and learners will be at the centre. The link between 'good' employment and good health is well evidenced and documented, and as anchor institutions at the heart of our communities we play an essential role in integrating work and health. We will realise the full potential of an ICB to improve the wider determinants of health through economic growth. This will be achieved in two ways. Firstly, through our commitment to the work and health agenda, collaborating with local stakeholders to further small-scale interventions such as Youth Guarantee, WorkWell and Skills Connect. Secondly, through our commissioning practices, ensuring positive outcomes in access and attainment in education, and improved employment levels and opportunities in our disadvantaged and at-risk communities.

Our commitments and approach:

Commitment	Approach	Action	HT2040 Strategic Intention
We are committed to growing our own workforce, that comes from and is reflective and representative of the population that we serve.	One Workforce	We will strengthen our partnerships with our education and training providers, co-developing curricula that reflects the real-world health and care needs of our population.	Outcomes that matter A learning health system Culture of relationships and trust
		We will centralise and scale programmes such as work experience, apprenticeships and T-levels, recruiting from our communities.	Outcomes that matter Data and community driven insights to drive constant improvement
	Good Employment	We will align our objectives to the principles of Get Britain Working, contributing to this national strategy by integrating	Outcomes that matter

		health, skills and employment systems, ensuring that local delivery plans reflect the needs of our communities. Harnessing the power of place-based partnerships, we will develop specific approaches to include care leavers, veterans and underserved communities working across boundaries to ensure consistency and equity of access.	A learning health system Healthy Workplaces Healthy Communities
		We will provide safe learning environments for our learners, embedding the Safe Learning Environment Charter (SLEC) into our commissioning and placement practices. Our learners will feel valued, supported and empowered to speak up, with regular reviews and self-assessments guiding continuous improvement.	Outcomes that matter A learning health system Healthy Workplaces Healthy Communities

Commitment	Approach	Action	HT2040 Strategic Intention
We are committed to offering inclusive and lifelong employment opportunities through the principles of “No Wrong Door”.	One Workforce	We will ensure that any individual recruited to any role is able to access career progression and pathways across our system. We will strengthen and establish new clear and accessible career routes across VCSE, primary care, social care, NHS Trusts and education, enabling transition across our system and services at all stages of a career.	Outcomes that matter A learning health system Culture of relationships and trust
	Good Employment	We will promote good employment practices, inclusive recruitment and comprehensive preceptorships and mentorship models to support retention and progression, particularly for newly qualified professionals.	Outcomes that matter A learning health system Healthy Workplaces Healthy Communities

We are committed to embedding learning and education as a golden thread.	One Workforce	We will be informed by robust labour market intelligence, equality, diversity and inclusion (EDI) data and strategic forecasting to ensure that training offers match current and future sector demands. Aligning our strategic planning to our training, we will ensure a sustainable and skilled workforce with development informed by clinical and professional voice.	Outcomes that matter A learning health system Data and community driven insights to drive constant improvement
	Good Employment	We will learn from staff experience to foster a positive, supportive culture across all roles and providers to deliver continuous improvement in experience and employee relations.	Outcomes that matter A learning health system Healthy Workplaces Healthy Communities

3.2.5 Strategic estates plans

The ICB plays a strategic role in convening and coordinating system-wide capital planning to ensure that investment is aligned with shared priorities, addresses the highest risks, and supports sustainable service delivery across BNSSG for the current and future population. As system commissioner, the ICB provides leadership in bringing partners together, supporting the development and application of jointly agreed principles, and ensuring transparency and consistency in how capital funding decisions are made across the system.

A joint ICS Capital Board has been established, supported by a unified Capital Policy that applies to all NHS capital expenditure within the BNSSG system. This governance framework ensures:

- Consistency and accountability in capital planning.
- Alignment with the ICS's overarching strategic goals and transformation programmes.
- Effective prioritisation of limited capital resources to maximise system benefit.

Focus of priorities

The BNSSG Infrastructure Strategy (2024) sets out three priority streams for capital investment:

1. **Stream 1 – Critical / high-risk infrastructure**
   Addresses property, plant, equipment, and digital assets essential for safe, compliant, and sustainable service delivery.

2. **Stream 2 – Strategic projects**
   Supports transformation programmes and long-term system objectives.
3. **Stream 3 – Net Zero**
   Funding ringfenced to deliver environmental sustainability commitments.

Priority is given to Stream 1 requirements before Stream 2 strategic projects are considered. Stream 3 funding remains protected to ensure continued progress towards Net Zero by 2030.

Key principles

- Transparency: All organisational capital plans are shared with the ICS Capital Board to identify opportunities for joint benefits, efficiencies, and system learning. Progress and in-year changes are reported for system-wide visibility.
- Standardisation: Capital planning processes are matched across organisations, with decisions recorded and shared for assurance. Learning and best practice are embedded to drive continuous improvement.
- System Collaboration: Partners work collectively to ensure investment decisions support the ICS Infrastructure Strategy and wider system priorities. Opportunities for shared solutions, joint procurement, and co-location are actively pursued.
- Joint Decision-Making: All significant schemes (including those with unfunded revenue consequences, asset transactions, lease changes, or multi-organisational impacts) require endorsement by the relevant ICB sub-groups and approval by the ICS Capital Board.

This coordinated system approach ensures that capital resources are directed where they deliver the greatest value, mitigate critical risks, and enable strategic transformation. By embedding transparency, collaboration, and sustainability into capital decision-making, the system maximises the benefit of limited allocations and strengthens long-term infrastructure resilience.

In addition, the ICS Capital Board undertakes annual capital prioritisation to determine how system capital is allocated each year and is developing a rolling five-year capital plan to provide greater strategic certainty and enable long-term investment planning.

3.2.6 Strategic procurement plans

As the ICB makes decisions regarding the procurement of the goods and healthcare services it commissions, all procurements that the ICB undertakes seeks to positively influence and support the ICB's strategy, transformation and transition plans utilising agreed principles in its procurement policy. The ICB in relation to the procurement of healthcare services acts with a view to:

- Securing the needs of the people who use the services.
- Improving the quality of the services.
- Improving efficiency of the services.
- Ensuring that services provided are accessible.
- Ensuring its procurement activities are undertaken transparently, fairly, proportionately, and where appropriate through integrated service delivery.

And in relation to the procurement of all goods and healthcare services that the ICB complies with the law, regulations and published guidance and its own standing orders.

In the period to March 2031, we intend to procure/secure services in the following key areas, including but not limited to:

Primary care, community care and children's care

- Alternative provider medical services (APMS) contract for Graham Road Surgery and Horizon Health Centre
- Non-emergency patient transport services
- Adult community services including community learning disability and autism
- Community children's services and child and adolescent mental health services (CAMHS)
- Clinical waste (primary care)
- Community rehabilitation beds
- Integrated community equipment services
- Locality neighbourhood procurements and mobilisation.

Acute care, independent sector care and mental health and learning disability care

- Mental health VCSE service
- Dementia service
- NHS provider care and independent sector care.

Goods and services

- Federated data platform plus
- VCSE brokerage service
- Digital electronic referral system
- Dynamic support register.

3.2.7 A systematic approach to addressing health inequity

The BNSSG ICS strategy acknowledges the opportunity to tackle systemic inequalities. It makes the following commitments that the ICB will use to direct how it commissions to meet population health need and address inequity:

- **Decision-making as a way of valuing all individuals and populations equally:** The ICB will continue to work with communities to continuously review and improve decision-making processes and groups to ensure that people who experience health inequalities influence the decision.
- **Valuing all individuals and populations equally:** The ICB will routinely review quantitative and qualitative data that shows what patterns of fairness and unfairness exist and actively plan to close the gap for those experiencing poorer outcomes. We will consistently challenge ourselves to correct our course when patterns of injustice are clear.
- **Recognising and rectifying historical injustices:** As the ICB reviews and develops new approaches to commissioning, we will check how they can improve health equity and that they won't make things worse.
- **Providing resources according to need:** The ICB will change how it spends money to provide funding in a way that supports people who experience health inequalities to get what they need so that they can achieve what matters to them. We will target resources to those most in need and who will benefit the most.

The ICB also has its own equality objectives (in line with its legal duties). We will use our commissioning responsibilities to help achieve them:

- To increase the administration of optimally timed antenatal steroids and magnesium sulphate in our population racialised as Black at risk of pre-term birth within BNSSG by March 2026
- Increase the completeness of ethnicity recording in the patient administration systems of University Hospitals Bristol and Weston NHS Foundation Trust, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust to 80% for BNSSG patients by 2027
- As cardiovascular disease (CVD) is one of the largest contributors to health inequalities, the ICB aims to improve the treatment of high blood pressure in our Black African and Caribbean populations so that 80% reach treatment targets by 2029. We will also reduce the gap between our Black African and Caribbean populations and our white population to less than 3%.
- Supporting the Local Authority Future of Prevention programme to accelerate targeted, proactive prevention in adult social care.

Examples of supporting work underway or planned include:

The Trauma-Informed programme promotes an intersectional approach to understanding trauma and adversity. It emphasises the importance of recognising and addressing the

trauma and adversity caused by structural inequalities and discrimination. This work will improve access, engagement, experience and outcomes for services, creating opportunities for recovery and reducing the risk of individuals, families, communities and the workforce experiencing trauma and adversity.

NHS Health Checks have been rolled out to target under-represented and harder to reach population groups, such as the older population, men, people who live in more deprived areas, Black and minority ethnic groups, people who smoke, and those with poor mental health.

The Healthy Weight work is driven by the evidence of disparities regarding access, experience and outcomes from healthcare services, as well as other prevention areas of work such as drugs, alcohol and smoking cessation. A race equity lens will be used to distinguish the need, and how that is best met, between the different groups that are racialised as Black and Brown in our population.

Substance use frequently intersects with other factors such as poverty, poor housing, poor mental health and domestic abuse to create multiple disadvantage. The Drugs and Alcohol programme works with GPs to address the physical health needs of those using substances, which is a key part of our work to tackle health inequalities.

A successful NHS Trust project in Cardiology in 2024/25 focused on understanding and addressing missed appointments for global majority and IMD1 groups. Training, based on the learning from the Cardiology project, is being rolled out across specialities and aims to replicate the successes in Cardiology in decreasing missed appointments for those in IMD1 and global majority groups.

3.2.8 Supporting sustainability of health and care services

Our system Green Plan aligns with the ICS strategic aim to be a national leader in sustainable healthcare, underpinned by three central outcomes:

1. **Improve the environment**: Improve environmental impact, reduce air pollution and restore biodiversity.
2. **Achieve net zero carbon**: Reach net zero for directly controlled emissions by 2030.
3. **Drive a wider sustainability movement**: Inspire change across local communities and partners.

In the next five years we will deliver Low Carbon Care; for the emissions we control directly (the NHS Carbon Footprint) we will decarbonise by 2030. We plan to power our activities without fossil fuels, only using renewable electricity. For the emissions we can influence (our

NHS Carbon Footprint Plus), we will reach a 50% reduction by 2030, 80% by 2036 and fully decarbonise by 2045.

In addition, we will deliver Clinical Transformation; environmental sustainability leveraged as a tool to improve public health outcomes, reduce health inequalities, and promote active lifestyles, healthy diets, and clean air. We will embed sustainable practices into healthcare delivery, focusing on prevention and shifting from high carbon hospital-based treatment to community-based treatment to achieve our net zero target.

Moving resources to a strong focus on prevention and early intervention will help people stay well at home, reducing reliance on high-carbon acute care and easing demand on the health system while delivering environmental benefits.

We will have:

1. Achieved a 50% reduction in supply chain emissions
2. Ensured our procurement activity delivers social value that supports local health priorities, including employment by expanding offset fund approach to include wider partners such as local authorities
3. Switched highest carbon impact medicines to low carbon alternatives where clinically appropriate
4. Reduced waste generation through reviewing the use of medicines, medical devices, and equipment greater use of structured medication reviews
5. Achieved net zero carbon emissions from our buildings.

The impact will be seen in our Carbon Emissions, financial savings, and in the percentage of our staff and patients' travel that is healthier and lower carbon.

Examples of supporting work underway or planned include:

All Age Continuing Care teams are embedding NHS Green Plan principles by reducing travel through virtual assessments and digital case management systems, cutting carbon emissions from paper and in-person processes.

A medicines waste campaign was launched in July 2025 to encourage patients and public to 'only order what you need' and encourage medication reviews and use of the NHS app, to help reduce medicines waste and improve adherence.

NHS Trusts are switching their search engine to Ecosia on all Trust devices. Ecosia is a not-for profit search engine that dedicates 100% of its advertising profits to climate action, primarily through tree planting projects all over the globe.

VITA Health has partnered with Windmill Hill City Farms for green social prescribing and Hartcliffe City Farm to offer staff volunteering opportunities in a green community space.

The General Practice Collaborative Group (GPCB) supports a sustainability group for interested General Practitioners.

3.2.9 Adopting trauma-informed practice

Examples of supporting work underway or planned include:

Trauma-Informed Champions are being established throughout AWP to support teams in embedding Trauma-Informed Care (TIC) principles, with several already identified and mentored in BNSSG. Additionally, TIC principles are being woven into AWP practices, exemplified by the highly trauma-informed approach of ‘Your Team, Your Care, Your Plan’.

Both North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust have made their Trauma-Informed Pledge detailing the actions they are committed to over the next 12 months and naming their trauma-informed leads.

There has been embedding of trauma-informed principles throughout the Drugs and Alcohol programme commissioning process. Examples of specific pieces of work include North Star, which provides mental health support for those using drugs and alcohol in a specially designed trauma-informed environment.

The Why Weight? Pledge recognises the negative health impacts of weight stigma. The pledge is actively seeking to raise awareness of stigma and reduce the impact of this on our population, particularly for those with lived experience of unhealthy weight, ensuring this does not pose a barrier to accessing health and care within our system.

3.2.10 Research and innovation

To deliver the priorities in the 10 Year Plan and local strategy, it is acknowledged that the challenges associated with these are complex and require new solutions. Research is best placed to provide evidence to potential solutions to these, as new approaches are required.

To address this, there is an active research and innovation community in BNSSG, with relationships across the academic community. Bristol Health Partners and the ICB are among others working in partnership to facilitate access to research in the local populations, with the ICB releasing a three-year strategy that has five pillars that drive ICB research support:

1. Targeting the greatest needs.
2. Radically diversifying research.

3. Academic partnerships at every level of the ICS.

4. Accelerating research into practice.

5. Generating resources for the ICS.

Networks like GPs in the Deep End and the Research Engagement Network are key routes of dissemination of opportunities and connections for research.

3.3 Areas requiring focus

3.3.1 Support for neurodivergent children and adults

We are developing an integrated needs-led model which should improve support for neurodivergent children, young people and adults, including people with autism and ADHD.

Currently the BNSSG system operates a diagnostic model for identifying and supporting our neurodivergent children and young people, with more and more families waiting for a diagnostic assessment before accessing support for their child. Due to the significant increase in referrals for an autism and ADHD diagnostic assessment, this model is no longer viable and is leading to unmet needs and poorer outcomes for our children and young people. There is also a lack of support post-diagnosis for the autism population with no commissioned health support and uncoordinated health support for schools in supporting their pupils.

The proposed needs-led model focuses on early identification of needs and providing support, removing the diagnostic 'barrier' to accessing support. It brings together system partners to work together and support children with neurodivergent needs throughout their childhood through understanding their strengths and challenges.

A business case for investment to expand and redesign the model, was approved in February 2026 with the aim that no child will be waiting for more than 52 weeks for an assessment by 2029 and that people's quality and experience of services will be improved.

3.3.2 Urgent and emergency care

We intend to commission services and activity to deliver on our System Urgent and Emergency Care (UEC) Strategic Plan and support our NHS Constitutional Commitments. We have identified seven priorities to improve UEC over the next three years. These priorities provide the direction and focus for our UEC provision, ensuring we target resources effectively and focus on the things people tell us matter the most. These priorities have not been developed in isolation and will be embedded into the Healthier Together 2040 strategic commissioning approach, with primary care and integrated neighbourhood health as key delivery vehicles for this. At their core, these priorities reinforce the importance

of coordinated urgent care with a focus on care closer to home. Our priorities address four themes:

Theme 1: UEC closer to home

We intend to unlock resources and provide urgent and emergency care closer to home and in the community, aligned with neighbourhood health and supported by:

1. Integrated Care Coordination Hub
2. Co-located Urgent Treatment Centres and Minor Injury Unit upgrade
3. 'Right place, first time' project

Theme 2: Integrated and coordinated care

We intend to ensure our urgent and emergency care system is integrated, and care is coordinated for people experiencing mental health crisis, children and young people. This will include:

4. Children's Emergency Department enhancements, plus a package of interventions to shift activity out of hospital
5. Co-located mental health crisis capacity

Theme 3: Support for high impact users

We intend to ensure our high intensity users are supported to access the right care, preventing escalation:

6. Targeted high intensity user initiative

Reduction in health inequalities

We intend to reduce health inequalities in access, experience and outcomes:

7. Targeted health inequalities intervention projects

3.3.3 All Age Continuing Care

1. What is our overarching aim?

Our overarching aim is to deliver a high-quality, timely and person-centred All Age Continuing Care (AACC) service for adults, children and young people, with consistent decision-making and responsive commissioning, enabled by strong clinical leadership, integrated digital case management and joint working with local partners.

AACC is the umbrella term encompassing NHS Continuing Healthcare (CHC), Joint Funding, Funded Nursing Care (FNC), and Children and Young People's Continuing Care (CYPCC).

The ICB will:

- Uphold statutory compliance and defensible decision-making by retaining nondelegable eligibility decisions for CHC and FNC.
- Maintain clear executive leadership, clinically-led SOPs, and formal governance for accountability, risk and oversight across BNSSG.
- Use data and digital to drive quality, equity and value; draw insights from AACC Patient-Level Dataset (PLDS); integrate interoperable case management tools; and implement automated workflows to improve timeliness and reduce administrative burden.
- Strengthen workforce capability and sustainability by optimising skill mix, exploring regional AACC workforce opportunities and trusted assessor models.
- Shape the care market with partners, building on existing brokerage functions, and pursuing joint commissioning arrangements to support capacity, price stability and integrated pathways.

2. What will care and support look like in five years?

Over the next five years, AACC in BNSSG will be digitally enabled, clinically assured and outcomes focused, with:

- More individuals supported at home or in community settings with tailored plans, with regular reviews that safely step down intensive support where appropriate.
- Adults' CHC and CYPCC eligibility decisions consistently meet national timeliness standards, with Fast Track capacity commissioned proactively and aligned to an integrated 24/7 palliative/urgent community response.
- A fully interoperable electronic case management system, including a patient/carer portal for real-time updates, two-way messaging, digital consent, and shared care documentation, reducing delays and improving transparency.
- An established skill mix across assessment, commissioning and review with brokerage operating at scale and planned market engagement to stabilise capacity and costs.
- Embedded multi-agency governance with Local Authorities and providers, pooled arrangements where beneficial, and data-driven assurance of quality, equity, and value.

3. What will we do and when?

2026/27

- Codesign a single, clinically led AACC operating model across BNSSG / Gloucestershire, engaging assessment, review, commissioning, brokerage and finance to define common SOPs, CHC/FNC eligibility decision pathways (including Fast Track), governance and escalation, digital case management standards, and the role of place-based/neighbourhood delivery. Complete definition and agreement during 2026/27.
- Produce a digital roadmap for a single, interoperable electronic case management solution (referrals, MDT scheduling, commissioning, payments) with automated scheduling/clerical workflows and a patient/carer portal specification.
- Strengthen programme of caseload review cycles (e.g., 6/12weekly for high intensity packages) to safely step-down enhanced care hours and improve value.
- Resolve the Funded Nursing Care practice variation in North Somerset, ensuring that the ICB is the decision-maker in all FNC eligibility cases.
- Develop a cross-footprint AACC workforce plan (skill mix, training, trusted assessor models) and initiate agency reduction actions (towards the Model ICB 25/26 cost reduction expectations), exploring a regional AACC workforce bank.
- Complete an up-to-date CHAT (Continuing Healthcare Assurance Tool) self-assessment and improvement plan for AACC.

2027/28

- Implement one clinically led AACC operating model across BNSSG / Gloucestershire addressing CHC/FNC eligibility decision pathways (incl. Fast Track), governance/escalation, digital standards and place-based arrangements, through a phased rollout, retaining local panels and escalation at place where appropriate.
- Go live with the shared electronic case management platform and patient/carer portal; embed real-time tracking and automated notifications for assessments and reviews.
- Test regional/multi-ICB brokerage hubs and purchasing methods to improve capacity and price consistency across the wider market.
- Embed joint commissioning with LAs to converge pricing and reduce competition between NHS/LA markets; further integrate CYPCC panels with EHCP processes.

2028/29

- Mature outcomes-based contracting for complex homecare; expand provider development support to reduce avoidable admissions from FNC settings.

- Enhance analytics and forecasting (activity, acuity, costs) to inform market/capacity planning and continuous improvement.

2029/30–2030/31

- Explore AI decision support to improve consistency and efficiency in assessment/ back-office operations, subject to clinical governance.
- Maintain digital, workforce and market capabilities with annual case management process reviews and benchmarking against high performing systems.

4. How will we measure impact?

A range of illustrative measures we will track to evidence impact are:

- Percent of CHC/CYPCC decisions within national timelines
- Percent of Fast Track packages operational ≤48h from decision
- Percent of AACC caseload supported at home (vs. institutional settings)
- Personal Health Budget (PHB) uptake and outcomes
- Average 1:1 hours per complex case and proportion stepped down
- Financial variance to plan and delivery against savings schemes.

3.4 Core business

3.4.1 Prevention and risk factors

Drugs and alcohol

Outcome: Improve health and wellbeing for vulnerable populations by addressing drug and alcohol needs together with mental health and wider health determinants.

Intentions: To achieve this outcome we will:

- Work across the system to tackle drug and alcohol issues alongside mental health.
- Explore a real-time data dashboard to inform decisions.
- Secure joint commitment to integrated service design and expand dual diagnosis support.
- Partner with housing, homelessness, and disadvantage services to reduce demand from high-impact users and prevent repeated service use.
- Drive clinical guideline adoption in acute settings.
- Ensure pathways between acute and community substance use care.

- Strengthen early intervention in primary and community care.
- Ensure all partners recognise the link between health determinants and wellbeing.

Reducing smoking prevalence

Outcome:

To achieve a significant reduction in smoking prevalence and associated health inequalities across the BNSSG population by embedding a comprehensive, system-wide approach to tobacco dependency and prevention.

Intentions:

- Leverage data and insights to inform targeted smoking cessation interventions.
- Deliver the NHS Treating Tobacco Dependency Service within acute inpatient, maternity, and mental health settings.
- Implement campaigns and communications to encourage quitting and prevent smoking uptake.
- Provide tailored support and resources for the workforce to strengthen smokefree initiatives.
- Identify and utilise funding opportunities to expand smokefree programmes.
- Foster a social movement to drive cultural change around tobacco use.
- Deliver transformation programmes and innovative interventions within smokefree services.
- Embed evidence-based practice and facilitate research and evaluation in BNSSG.
- Ensure the link between health determinants and wellbeing is recognised and addressed across partner organisations and the wider system.

Tackling obesity

Outcome:

The overarching outcome is to foster a healthier BNSSG community by implementing the Why Weight? pledge, promoting equitable access to care, reducing weight stigma, and improving the prevention and management of obesity for individuals of all ages. This will be achieved through collaboration, shared learning, and evidence-based interventions across the BNSSG ICS.

Year 1 progress (2025–2026)

- Implemented targeted actions within BNSSG ICS organisations that have committed to the Why Weight? pledge, focusing on creating healthier environments and aligning joint system priorities.

- Established a Community of Practice to support ongoing delivery of pledge commitments and foster shared learning across the system.
- Agreed Terms of Reference and set up the meeting structure for the Community of Practice before the financial year begins.
- Activated a weight stigma subgroup and commissioned insights research to understand lived experiences of weight stigma and its impact on health and care access. Began co-production of a workforce development product to address weight stigma.
- Launched a new programme aimed at improving advice, support, and access to obesity treatment for all ages, including providing access to weight loss medications and enhancing specialist services.

Year 2 intentions (2026–2027)

- Sustain and further develop the whole-system Community of Practice to continue implementing actions aligned to the Why Weight? pledge and promote healthier places across BNSSG.
- Collaborate with the NIHR Three Schools Prevention Programme to deliver a focused evaluation of the initial 18-month implementation period (September 2025–March 2027), identifying opportunities for improvement and enhancing the effectiveness of the programme.

3.4.2 Primary care

Outcome and purpose

The ambition is to deliver preventative and proactive care as close to home as possible, shifting the focus from treating illness to actively managing health and wellbeing. Primary care will act as the main, easy-to-access first point of contact for most health needs, coordinating care across providers to ensure seamless, person-centred support tailored to individual circumstances.

This approach will improve population health and equity by reducing unwarranted variation and inequalities in outcomes, while also improving sustainability and value by reducing unnecessary hospital admissions and avoidable demand on secondary care. Communities and patients will be empowered to play an active role in their own care, with a strong emphasis on self-management, community-based support, and appropriate use of digital tools to improve access and efficiency.

The approach will develop plans as part of transition and clustering for spreading good practice and shared approaches to supporting Primary Care.

What care and support will look like in five years

General practice

In five years' time, general practice will sit at the heart of neighbourhood health. Access and patient experience will be significantly improved, with continuity of care and trusted personal relationships delivering measurable benefits for patients. Population health management will be embedded into daily practice, enabling clinicians to proactively identify risk, personalise care, and address health inequalities more effectively.

Care will be delivered by highly skilled, multi-disciplinary teams working in strong partnership with other providers, supported by resilient and sustainable practices. General practice will benefit from at-scale infrastructure and delivery models that allow patients to be seen close to home while enabling non-patient-facing services to achieve economies of scale. Clinicians will be supported to manage workload effectively and work in environments where they are proud to practise and able to deliver the care they aspired to provide when training.

Digital innovation will be routinely used to support workload and improve access, including increased uptake and full use of the NHS App. Relationships with secondary care will be strong and mature, with improved understanding of the general practice offer, effective Advice and Guidance, and streamlined access to specialist advice and diagnostics.

Community pharmacy

Community pharmacy will be a core and fully embedded part of neighbourhood care. Pharmacy First will be an established cornerstone of the system, enabling people with minor illness or common conditions to receive timely treatment from their local pharmacist without needing to see a GP.

Prescribing-based services in community pharmacies will be expanded, supported by the growth of independent prescribing and continued development of locally enhanced PGDs. Strong working relationships between general practice and community pharmacy will support access and continuity, while services such as emergency contraception, HPV vaccination, and the Discharge Medicines Service will help reduce medicines harm and avoidable readmissions.

Digital integration will be routine, with patients able to manage and track prescriptions through the NHS App and receive communications via NHS Notify. Community pharmacies will be financially viable and well supported, enabling them to continue playing an expanded clinical role within primary care.

Eye care

Optometry practices, located conveniently across the system, will be fully utilised to reduce unnecessary pressure on both general practice and secondary care. The ambition is to enable direct referrals from primary care optometry sites, supported by a uniform IT system that reduces administrative burden and supports service development.

Community eye care services will be expanded and enhanced, including minor and urgent eye care, glaucoma referral refinement, cataract pre-operative assessment, and system-wide post-operative cataract services. Integrated pathways will support children, young people, and people with learning disabilities, ensuring timely, appropriate care closer to home and fewer avoidable hospital referrals.

Dental services

Dental services will be transformed through implementation of contract reforms and delivery of a comprehensive oral health and dental strategy. Access to urgent and routine dental care will improve, with a particular focus on reducing inequalities and addressing unmet need in deprived communities.

Targeted approaches will ensure vulnerable groups—including children in care, care home residents, people experiencing homelessness, asylum seekers, and people with learning disabilities—receive tailored support that meets their specific needs. Stabilisation services will be expanded to help secure patients' oral health and reduce reliance on urgent care,

while Tier 2 and sedation services will increasingly be delivered in community settings, reducing the need for general anaesthetic and secondary care.

Oral health promotion will be strengthened, particularly for children, building on programmes such as supervised toothbrushing. Digital innovation will support more efficient pathways, beginning with electronic referrals from primary care dentists to hospital-based services. The dental workforce will be supported through improved training, career development, and workplace wellbeing, helping to recruit, retain, and sustain skilled professionals for the long term.

Training Hub

The Training Hub will support consistent, quality education, training and development for all Primary Care staff to attract pipeline workforce, retain existing workforce and maximise quality patient outcomes.

The Training Hub will act as a link between the system, ICB and Primary Care supporting strategic workforce planning and strategic commissioning in the development and implementation of Neighbourhood Health.

Primary care delivery, timeline and impact (2026–2031)

Theme / service area	What we will do	When (indicative)	How we will measure impact
System-wide primary care	Enhance and integrate primary care services across neighbourhoods and localities. Continue delegated primary care commissioning, including contractual oversight and support for compliance. Build on partnerships with councils, neighbourhoods and voluntary organisations to ensure services reflect local need and preferences. Prioritise prevention, early intervention and proactive care.	**Year 1 (2026/27):** Strengthened contract oversight, monthly monitoring, action plan for unwarranted variation. **Years 2–3 (2027–29):** Scaled PHM, strengthened neighbourhood models. **Years 4–5 (2029–31):** Consolidated integrated neighbourhood teams; strategy refreshed.	Improved access and patient experience. Demonstrable reduction in inequalities. System sustainability and reduced avoidable secondary care demand.
General practice	Support robust, resilient and sustainable practices. Embed population health management using risk stratification and proactive care models. Enable practices to deliver improved care within an integrated system. Expand Advice and Guidance and direct access to diagnostics. Increase uptake and full utilisation of the NHS App.	**Year 1:** Contractual oversight strengthened; initial digital tools implemented. **Years 2–3:** PHM and proactive care scaled; PCN and neighbourhood models strengthened. **Years 4–5:** Digital-first primary care at full maturity.	Number of appointments delivered. Improvements in access, continuity of care, proactive care and patient experience.
Community pharmacy	Continue to implement and embed Pharmacy First so people with minor illness or common conditions can be treated by their local pharmacist. Expand clinical and prescribing-based services, including independent prescribing. Strengthen GP–pharmacy relationships. Enable full digital integration through NHS App and NHS Notify. Support financial viability.	**Year 1:** Pharmacy First embedded. **Years 2–3:** Enhanced pharmacy services rolled out. **Years 4–5:** Pharmacy fully embedded as a core neighbourhood clinical service.	Pharmacy First referrals. Clinical service uptake. Prescribing capability and utilisation.

Theme / service area	What we will do	When (indicative)	How we will measure impact
Ophthalmology / community eye care	Review community eye care services and pathways. Implement direct referral pathways from community optometry to ophthalmology using a uniform IT system. Expand minor and urgent eye care, glaucoma referral refinement, cataract pre-operative assessment and post-operative cataract services. Integrate services for children, young people and people with learning disabilities.	**Years 2–3:** Community eye care review implemented and pathways established. **Years 4–5:** Consolidated system-wide delivery.	Macular pathway referrals. Secondary care referrals avoided. Uptake of community urgent and minor eye care services.
Dental services	Implement dental contract reforms. Deliver the Oral Health and Dental Strategy to improve access, reduce inequalities, increase recruitment and retain the workforce. Increase urgent dental capacity and stabilisation services. Target access for vulnerable groups. Expand community Tier 2 and sedation services. Introduce digital referrals to hospital dental services.	**Year 1:** Contract reforms commenced; urgent access maintained. **Years 2–3:** Enhanced access, stabilisation and targeted services expanded. **Years 4–5:** Mature community-based services and strengthened workforce model.	UDAs delivered. UDC activity. Percentage of adults and children seen. Increased stabilisation and Tier 2 activity. Improved access in underserved communities.
Workforce (all services)	Attract, support and develop the primary care workforce. Improve recruitment, retention, training, career progression and workplace wellbeing across general practice, pharmacy, optometry and dentistry.	Ongoing across all years.	Workforce stability, service resilience and ability to deliver expanded and integrated care.

3.4.3 Maternity services

The three-year delivery plan for maternity and neonatal services was launched in 2023 and sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. Our work locally helps to support the delivery of this national plan.

Bristol, North Somerset and South Gloucestershire Local Maternity & Neonatal System (LMNS) is focused on making further improvements in the quality and experience of care in our maternity and neonatal services. We know that we still have underserved communities within our population, so improving outcomes and reducing inequity is the primary focus over the next 5 years.

What will care and support look like in 5 years?

- Women and families consistently listened to, and feedback acted on in real time.
- Anti-racism accepted as a core principle with training embedded in all perinatal areas.
- Accurate and robust meaningful local data available, segmented by ethnicity, to clearly direct where inequalities are evident so strategic commissioning can ensure inequity is reduced and services are targeted at our populations most in need.
- Joined up system working and strengthened collaboration with all system partners e.g. Primary Care, local authorities etc.
- Digital Maternity record integration into NHS App.

What will we do and when?

Year 1

- Review and work towards the next NHSE Perinatal strategy (due in Spring 2026), which will be based on the ongoing National Maternity Review commissioned by Secretary of State.
- Commence mobilisation of new host organisation for Maternity and Neonatal Voice Partnership (MNVP), ensuring the lead team remains diverse and reflects the population we serve. Keeping the focus on making sure the voices of our most underserved communities are heard and contribute towards shaping future perinatal services.
- Review and work towards the New Ockenden report (due in Spring 2026).
- Review and work towards the Thirlwall Inquiry (due in Spring 2026).
- Support implementation of the new Maternal Care Bundle.
- Continued collaboration with the Race and Health Observatory (RHO), focusing on disparities associated with pre-term births in our population racialised as Black.

- Continued commissioning and support of Black Maternity Matters Anti-Racism training.
- Commission a repeat Health Needs Analysis (last completed in 2021) to ensure there is an understanding of our population needs and where disparities exist, so support and commissioning is targeted.
- Continue to act on and embed the priorities within the Bristol, North Somerset and South Gloucestershire LMNS Equity & Equality Action Plan.
- Improve visibility and accessibility of feedback and complaints pathways and strengthen use of insight to drive service improvement.
- Improve personalised care planning, shared decision-making and communication across maternity pathways
- Develop and deliver targeted GP education covering maternity red flags, perinatal mental health risks and escalation pathways.

Years 2-3

- Develop new Equity & Equality plan based on Health Needs Assessment.
- Develop targeted improvement actions co-produced with communities to reduce disparities for Black and Asian Women.
- Move towards community hubs and continuity models as staffing improves.
- Integration of maternity with public health and early years, Family Hubs model rolled out more widely.
- Launch equity dashboards to track outcomes by ethnicity.
- Stronger links with community and VCSE partners to support co-production of targeted improvement programmes.
- Ensure consistent domestic abuse screening, documentation and coding across acute trusts and primary care.
- Improve access to interpreting services, accessible materials and inclusive communication across maternity pathways.
- Implement equality, diversity and inclusion (EDI) focused workforce action plans across the LMNS to improve staff wellbeing, retention and psychological safety. This includes mentorship and leadership development by minoritised staff, with oversight through existing workforce and governance arrangements.
- Embed trauma informed principles across maternity services, including staff training and co-produced guidance
- Improve discharge summaries, communication and referral pathways between primary care and maternity teams. Embed in digital maternity records and primary

care communications. Train staff to complete and review summaries consistently and audit compliance.

Years 4-5

- Align digital systems and referral processes across maternity, neonatal, primary care and public health to enable seamless information flow.
- Strengthen data entry processes, improve ethnicity completeness, and introduce routine data quality checks across trusts and Maternity Services Data Set submissions. Evidence to include targeted improvements.
- Embed equity-focused risk assessment tools throughout pregnancy continuum and strengthen pathways for women with complex social or medical factors.
- Strengthen perinatal mental health pathways through consistent risk assessment, co-led care planning, improved joint working between Perinatal Mental Health Teams, maternity and primary care, streamlined referral routes and enhanced data sharing with monitoring of local uptake.
- Continue to identify and address inequalities affecting priority groups via data insights, outreach and targeted improvement programmes.
- Strengthen co-production with MNVP and VCSE partners and expand outreach and accessible community engagement activities to ensure service user voices shape how maternity services are designed. Ensure feedback loops, for example 'You said - we did'.

How will we measure impact?

Several different outcome measures will be used to measure impact during the period. Firstly, a regular review of the Perinatal Quality Oversight Metrics (PQOM) covering all safety metrics will be conducted.

Equity dashboards will be developed and referenced to monitor the impact of programmes, and this will be used alongside patient experience measures from feedback generated by the MNVP.

We will monitor progress towards addressing National Recommendations, together with outputs and insights from ‘Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK’ and feedback from staff.

3.4.4 Mental health services

Our overarching aim is to deliver a high-quality, sustainable and integrated mental health system that aligns with local and national strategies.

If all the Medium-Term Plan priorities for mental health are achieved, mental health care in five years will be more accessible, personalised, community-based, digitally enabled, and focused on prevention and recovery. People will experience joined-up support that helps them stay well, recover faster, and live healthier, more independent lives.

Year 1 (2026/27): Laying foundations and early delivery

- Expanding access to NHS Talking Therapies and community-based mental health support.
- Developing Mental Health Emergency Department (MHED) and 24/7 Neighbourhood Mental Health Centres (NMHC) and crisis response services.
- Embedding outcome measurement.
- Rolling out new training, recruitment, and retention initiatives for workforce development.
- Implementing digitised care pathways and digital front doors.
- Addressing health inequalities with targeted interventions for high-need groups.
- Performance tracking: regular review of progress against national and local metrics, with adjustments as needed.

Years 2-3 (2027/28 and 2028/29): Scaling and integration

Quarterly milestones: focus shifts to quarterly delivery.

- Further expansion of community-based and integrated care models, including assertive outreach, community rehab and proactive support for High Impact Users (HIUs).
- Full implementation of digital-by-default care and capacity management systems.
- Continued reduction in out-of-area placements and inpatient admissions.
- Strengthening partnerships with VCSE.
- Ongoing workforce transformation, including new roles and flexible working options.
- Embedding trauma-informed and personalised approaches.
- System integration: Greater alignment between mental health, physical health, neurodiversity, and social care, with shared care protocols and data systems.

Years 4-5 (2029/30- 2030/31): Consolidation and impact

Annual milestones: focus on consolidating gains and demonstrating impact.

- Achieving and sustaining national performance standards.
- Reviewing and refreshing the strategy to reflect new evidence, policy and population needs.
- Demonstrating measurable reductions in health inequalities and improved outcomes for all groups.
- Ensuring economic and environmental sustainability of services.
- Ongoing innovation, with new models piloted and scaled as appropriate.
- System review: annual review and adjustment of plans to ensure continued alignment with the 10 Year Health Plan and local priorities.

We will measure our success in the following ways

a) Achievement of national and local performance metrics

Success measures and targets are set for each year and include:

- number of people completing a course of NHS Talking Therapies treatment and achieving reliable recovery and improvement
- elimination of inappropriate out of area placements
- reduction in average length of stay in adult mental health beds
- increased access to perinatal mental health services
- number of people accessing Individual Placement and Support

b) Robust outcome measurement

All commissioned services will report on service outcomes, including outcomes measured by patients. This ensures care is effective and person-centred, and that progress is tracked.

c) Progress against strategic deliverables

Success is also measured by progress on key deliverables, such as:

- expansion of community-based care models
- implementation of digital-by-default pathways
- development of 24/7 Neighbourhood Mental Health Centres
- reduction in health inequalities and improved access for priority cohorts

d) Continuous monitoring and forecasting

Performance is tracked regularly and used to monitor progress against targets and to forecast future performance. This allows for timely adjustments and ensures accountability.

e) Stakeholder feedback and experience:

Feedback from service users, carers, and system partners is sought to ensure strategies are delivering the intended impact and meeting real needs.

In summary, success will be measured through:

- achievement of national and local targets
- robust outcome measurement
- progress on strategic deliverables
- continuous performance monitoring
- stakeholder feedback

These metrics ensure that strategies are effective, sustainable, and delivering real improvements in mental health care.

3.4.5 People with learning disabilities and autistic people

Our vision is for people with a learning disability and autistic people in Bristol, North Somerset and South Gloucestershire to have the same opportunities as anyone else to live healthy, satisfying and valued lives. We will work alongside experts with lived experience to reshape health and care services, ensuring that support meets people's needs and reflects their aspirations. This includes enabling people to have greater choice, control and independence, and ensuring that everyone is treated with dignity and respect. Our approach is grounded in rights, citizenship and belonging.

Health and social care partners are committed to working together to ensure the voices of people with learning disabilities and autistic people inform, drive, develop and deliver our strategy.

Our priority areas

To achieve this vision, we have four priority areas and the following priorities:

Supporting people to move into their communities and thrive.

- Support people to play a meaningful role in their local communities, secure their own accommodation and in the longer term, benefit from education and achieve meaningful employment.
- Increase personalisation within care packages to reduce gaps between standard and specialist support.
- Reduce reliance on inpatient care while improving the quality of inpatient provision.
- Support national service models in collaboration with the NHS Lead Provider Collaborative.
- Enable people to remain living locally.
- Expand community crisis support and intervention.
- Develop strategies to reduce detention under the Mental Health Act (MHA) and improve Section 117 aftercare.
- Strengthen processes for clinical supervision to support safe and timely discharge.

Best start in life for children and young people

- Continue learning and best practice from the Partnerships for Inclusion of Neurodiversity in Schools (PINS) programme into planning for the reform of Special Educational Needs and Disabilities (SEND) provision.
- Deliver the Neurodiversity Transformation Project.

Improving healthcare for the learning disability and autism (LD&A) population

- Increase uptake of Annual Health Checks (AHCs) and associated Health Action Plans (HAPs).
- Continue to use Learning from Lives and Deaths reviews (LeDeR), to improve care and reduce health inequalities.
- Improve the adult ADHD assessment pathway and expand primary care support.
- Identify and reduce inequalities across all pathways.

Improving engagement and co-production

- Strengthen and embed co-productive approaches.
- Continue to collaborate closely with Voluntary, Community and Social Enterprise (VCSE) partners.

What we will do and when: our timelines for delivery

Year 1 (2026/27)

- Reduce the number of people with a learning disability and/or autism receiving care in an inpatient bed, aiming for at least a 10% reduction year-on-year.
- Develop and implement an all-age digital Dynamic Support Register (DSR).
- Support pupil profiling to improve early identification of need and continue development of autism and ADHD pathways.
- Embed the Kingfisher Unit, a new specialist mental health facility and outreach service for people with learning disabilities and autistic people, into our care pathways.
- Learn from and apply improvements following LeDeR reviews.

Years 2–3 (2027–2029)

- Phased implementation of an all-age digital DSR.
- Continue developing pathways for neurodiversity support and assessment.
- Achieve further reductions in inpatient numbers.

Years 4–5 (2029–2031)

- Deliver a fully operational, all-age digital DSR.
- Continue to reduce inpatient admissions and enhance community-based support.

How we will measure impact

Success measures and annual targets include:

- Number of adults with a learning disability or who are autistic in an inpatient mental health bed.
- Number of children and young people with a learning disability or who are autistic in an inpatient mental health bed.
- Percentage of children and adults with a learning disability or who are autistic with long lengths of stay.
- Admission rates for adults with a learning disability or who are autistic.
- Admission rates for children and young people with a learning disability or who are autistic.
- Percentage of people aged 14+ who have received an AHC and a HAP.

Success is also measured by achieving our local priorities, we will have increased admission avoidance through earlier identification of people requiring support. There will be increased availability of specialist mental health support and greater focus on supporting people who have experienced long lengths of stay to leave hospital.

Feedback from service users, carers and system partners will ensure strategies deliver intended outcomes and reflect real needs.

These measures will be tracked over time to demonstrate reduced inequalities, improved access, strengthened community support and progress towards our vision for high-quality, rights-based learning disability and autism services.

3.4.6 Children's services

What is our overarching aim?

The overarching aim of the children's plan is to commission and deliver high-quality, trauma-informed, integrated health services for children and young people across BNSSG. Our ambition is rooted in a deep understanding of need, evidence-informed practice and meaningful collaboration with children, families and system partners. Through this, we will reduce health inequalities, strengthen early intervention, particularly for neurodiversity, mental health and learning disabilities, and ensure smoother, more consistent transitions into adulthood.

The plan also prioritises expanding access to physical and mental health support, improving our local area partnerships for Special Educational Needs and Disabilities (SEND) and fostering inclusion in schools. By embedding prevention, wellbeing, safeguarding practice and personalised support into innovative care models, and by investing in workforce capability across sectors, we aim to deliver better outcomes for all children and young people.

The recommissioning of children's community health services will enhance neighbourhood-based care models, making support for children and young people with SEND more coordinated, responsive and inclusive through collaboration with local authorities.

What will care and support look like in 5 years?

The recommissioning of children's community health services will be a major enabler over the next five years, creating the platform for modern, outcomes-driven, integrated models of care that align to our ambitions for prevention, early support, reduced waits and stronger inclusion across the whole system. Alongside this, the transfer of specialised commissioning into the ICB footprint will further strengthen this approach by allowing paediatric acute, community and specialist pathways to be planned and commissioned together, improving continuity, reducing fragmentation and ensuring children and young people experience seamless, end-to-end care.

The BNSSG system will provide a community-first, digitally-enabled, needs-led system that delivers timely, inclusive support close to home through:

Community-based, integrated models of care:

- Expanding neighbourhood health and care models, including Best Start in Life hubs, Families First and paediatric hubs and locality-based integrated teams.

- Increasing access to mental, physical and wellbeing support within community settings.
- Targeted place-based work to reduce inequalities, especially in areas of highest deprivation.

Prevention, early identification and early intervention:

- A strong focus on maternity and early years with enhanced early childhood development checks and family support.
- Tackling inequalities through integrated approaches with public health and local authorities (e.g. Families First, Best Start).
- A needs-led neurodiversity approach with early identification, personalised support and reduced reliance on diagnosis.
- BNSSG will sustain and expand Complications from Excess Weight (CEW) clinics in line with the national expectations, ensuring early identification and coordinated specialist support to reduce pressure on secondary care.

Mental health transformation:

- Expanding Mental Health Support Teams in Schools (MHSTs) to full coverage by 2030.
- Improving access and reducing waits, ensuring timely, equitable mental health support (online and face-to-face).
- Improving experience and outcomes for children and young people with eating disorders.
- Re-procurement and transformation of mental health inpatient services to modernise effectively to meet the needs of children and young people.
- A deep dive across services to understand and reduce rising mental-health-related hospital admissions, followed by a system-wide improvement plan.

Tackling waiting times, productivity and modernisation:

- Reducing community, mental health and acute waits, aiming to bring longest waits back to 52 weeks, with the most urgent children seen within 18 weeks.
- Embedding annual 2% productivity improvements through new care models, digital tools and innovation.
- Supporting services to manage demand more effectively and sustainably.

Personalised, inclusive and digitally-enabled support:

- A system-wide transformation of SEND and neurodiversity, supported by a digital, multi-agency Dynamic Support Register.
- Embedding co-production — children, young people and families shape and review services.

- Developing a compassionate, trauma-informed, skilled workforce through joint training and professional development.
- Delivering digital-first pathways: population health analytics, digital therapies (e.g. online Cognitive Behavioural Therapy), NHS App personal health records ("My Children") and secure system-wide data sharing.
- Strengthening partnerships across health, education, social care and Voluntary, Community and Social Enterprise (VCSE) organisations to deliver wrap-around support.

What will we do and when?

Year 1: 2026/27

- Develop a shared, co-produced vision and ambition for future Children's Community Health Services (CCHS).
- Begin the mobilisation of the co-produced needs-led model for neurodiversity, including a waiting list reduction plan.
- Evaluation of the impact of young people's mental health transition services.
- Identify mental health pathway issues and gaps in provision across BNSSG with feedback through to the CCHS future vision.
- Continue to build upon our system improvement plans to improve access and long waits for community, mental health and acute services.
- Continue to monitor performance through monthly monitoring meetings of both local and national metrics.
- Develop and begin implementation of local area partnership SEND reform plans to strengthen a cohesive, needs-led SEND system.
- Scope commissioning opportunities for evidence-based short breaks, reviewing and improving the quality and suitability of alternative educational provision.
- Implement a new residential therapeutic home that delivers high-quality, needs-led support.
- Roll out of Mental Health Support Teams to increase coverage across BNSSG.
- Support the development of neighbourhood health and care, including further development of paediatric hubs.
- We will work with local authority partners and Barnardo's to tackle learning loss in children and young people and develop a theory of change based on the identified root causes.
- Continue to deliver the national Complications with Excess Weight (CEW) service and ICB round table in April to share the learning from the pilot.

Year 2 & 3: 2027/28 - 2028/29

- Implementation of the new Children’s Community Health Services contract (2028/29).
- Quarterly monitoring of system improvement plans to ensure sustained improvements of national and local metrics.
- Review, develop and implement evidence-based short breaks and health input to support alternative education provision and a BNSSG residential therapeutic home.
- Continue to deliver local area partnership SEND reform plans.
- Review of specialised commissioning services and pathway integration with community services.
- Continued roll-out of Mental Health Support Teams.
- Decision making regarding future commissioning of CEW service.

Year 4 & 5: 2029/30 and 2030/2031

- Achieve 100% coverage of Mental Health Support Teams and produce project closure report.
- Review of new BNSSG Children’s Community Health Service provision.
- Achieving and sustaining national and local performance standards.
- Reviewing and refreshing the strategy to reflect new evidence, policy and population needs.
- Demonstrating measurable reductions in health inequalities and improved outcomes for all groups.
- Ensuring economic and environmental sustainability of services.
- Ongoing innovation, with new models piloted and scaled as appropriate.

3.4.7 Elective care, diagnostics and cancer services

Our overarching aim across elective care, diagnostics and cancer care in BNSSG is to drive quality service delivery and high performance, ensuring the system upholds patients' rights around choice and access.

Our priority is a return to constitution standards across elective, cancer and diagnostic pathways. By the end of March 2029, Referral to Treatment (RTT) achievement will ensure 92% of patients receive treatment within 18 weeks of their referral; Diagnostics achievement will mean no more than 1% of patients will be waiting longer than 6 weeks for their test; and for Cancer 85% of patients will begin their treatment within 62 days of referral onto an urgent suspected cancer pathway. Standards will be achieved sooner for other cancer standards, whereby by the end of March 2027, 80% of patients will receive their diagnosis or confirmation of not-cancer within 28 days of their referral; and by the end of March 2028, 96% of people will begin their cancer treatment within 31 days of a decision to treat.

Alongside this, further core commitments remain and include strengthening demand management practices, optimising outpatient and theatre capacity, reducing rates of missed appointments and cancellations, enhancing patient outcomes and transforming the delivery of follow up care. We maintain a continued focus on earlier diagnosis for cancer, capitalising on the additional capacity facilitated through our two Community Diagnostics Centres and will drive the productivity and excellent patient outcomes being achieved through The Princess Royal Bristol Surgical Centre, which is a cornerstone of the future delivery of elective care in BNSSG.

Our commitments remain to:

Do more – We aim to expand our capacity through workforce development, waitlist initiatives, partnerships with independent providers and estate improvements. We will always seek ways to increase what we deliver.

Do more, better – Our goal is to work efficiently and proactively to improve patient outcomes, focusing on optimising clinic and theatre use, increasing throughput, flexible bed management and ensuring patients receive timely, appropriate care. Initiatives include demand management, digital tools, perioperative support and reducing health inequalities.

Do more, differently – We are committed to innovation and new approaches, such as learning from others, refining clinical pathways, shifting care to community settings and planning for Neighbourhood models that emphasise prevention and early intervention.

What will elective, diagnostics and cancer care and support look like in 5 years?

1. **Our acute NHS hospitals will transform:**

The Bristol NHS Group will drive forward a full convergence of all key systems over the next 5 years. This will enable clinicians and their colleagues to work and deliver services across the Group estates (wherever they may be), with shared platforms for collaboration and greater flexibility to meet the needs of the public.

2. Care will be available closer to home:

Building on progress made to date on providing care in community settings, such as through Community Diagnostic Centres, the development of opportunities for elective and cancer care that does not require a hospital setting will move forward.

3. Digital transformation will enhance services:

Digital solutions will be embedded throughout, from patient engagement and communications to patient and clinician access to their records and appointment management. Digital technologies will support clinicians with clinical and non-clinical tasks, digital care delivery and AI will be tested and implemented, and digital hospital will come online.

4. Integrated, holistic support will become more common place:

The system wide approach to integrated community models will join up services across physical health, mental health and social care, providing holistic support that addresses all aspects of a person's wellbeing.

5. Prevention and early intervention will be prioritised across the system:

The system will focus more on care in preventative terms, early identification, intervention and support, building on long standing commitments and achievements in areas such as cancer care.

6. Reduced health inequalities:

By targeting resources and support to those that experience health inequalities and inequity, the system will make significant progress in reducing health inequalities

What will we do and when?

Across each year of the Medium-Term-Plan we will:

- Commission services and activity to achieve the performance milestones set out in national planning guidance.
- Develop and deliver capital plans that enable the delivery of our commitments.
- Continue to embed Getting it Right First Time (GIRFT) to maximise on opportunities for improvement, productivity, efficiency and alignment in our services.

- Continue to work with system partners to design, commission and deliver transformation of elective pathways in line with the ambitions set out in the 10 Year Health Plan, with a particular focus on demand management, demand mitigation and models of Neighbourhood Health as a vehicle for prevention, early intervention and delivery.
    - We will continue to learn from and expand the transformation achieved to date, including telederm, eye care and community-based clinics led by GPs with extended roles; specialist advice and guidance; and digital platforms for communication, engagement and delivery.
    - We will look at new opportunities for change, including where our acute services could deliver care in a community setting or re-imagining the way care is accessed and provided.
- Continue 'enabler' programmes of work:
    - Digital infrastructure and development – including patient communication, patient clinical services, business functions, clinical support tools, administrative support tools (e.g. Ambient Voice Technology), AI and more.
    - Estates – new estate, refurbished estate, optimised estate and decommissioned estate.
    - Equipment development and expansion – assuring maintenance and seeking opportunities for development and technological innovation.
    - Workforce (see workforce section).
    - Non-NHS provider services – commissioning with non-NHS providers to support the delivery of elective care to the population of BNSSG.
- Continue to work with NHSE to ensure robust plans and oversight of the delegation of specialised commissioning with specific attention to fragile tertiary services.
- Continue the golden thread of health inequalities across all areas of work.
- Continue programmes of work dedicated to Children and Young People (see Children's section).

What will we do and when?

In Year 1 (2026/27) we will:

- Drive performance as per our operational plan, across elective care, cancer care and diagnostics.
- Progress the alignment and integration of acute services.
- Further develop and embed strengthened demand management practices.
- Implement referral management changes and Single Point of Access (SPOA) in at least 10 specialities. Through the Single Point of Access model, specialists in secondary care will continue to provide advice that enables General Practice (and other referrers) to maintain care in the community and avoid referrals into secondary care unless needed.
- Drive forward digital development and transformation in key areas including DrDoctor, the NHS App and in areas such as Ambient Voice Technology. The Bristol NHS Group will continue to improve communication and interaction with patients both administratively and clinically, and in 2026 patients will be able to initiate changes to their appointments in the NHS App.
- Deliver plans for existing and new estate.
- Explore and plan for opportunities to deliver care outside of a hospital setting.
- Work with system partners in the development of Neighbourhood Models of Care.
- Continue addressing health inequalities with targeted interventions, including building on success to date in improving ethnicity recording; rolling out learning about reducing missed appointments for global majority and IMD1 groups; and tackling tobacco dependency.

In Years 2-3 (2027/28 and 2028/29) we will:

- Drive performance as per our operational plan, across elective care, cancer care and diagnostics, achieving by the end of Year 3 the constitutional standards for RTT, DM01 and the Cancer Wait Time standards.
- Continue to drive forward various commitments described in Year 1, including but not limited to digital development and transformation in key areas; estate plan delivery; driving reductions in health inequalities.
- Begin testing plans and early delivery of opportunities to deliver care outside of a hospital setting.
- Work with system partners in the early implementation of community-based and integrated and neighbourhood care models.

In years 4-5 (2029/30- 2030/31) we will:

- Sustain compliant performance against the constitutional standards for RTT, DM01 and the Cancer Wait Time standards.
- Continue to expand and consolidate the various commitments described in Years 1-3.
- Drive ongoing improvement and innovation, with new models piloted and scaled as appropriate.
- Demonstrate reductions in health inequalities and improved outcomes for all groups.

Elective, Diagnostic and Cancer: key objectives (2026–2031)

Key measures	Year 1 (2026/27)	Year 3 (2028/29)	Year 5 (2030/31)
RTT	83.2%	92%	92%
Diagnostics	1%	1%	1%
Cancer • 28 Day Faster Diagnosis Standard • 31 Day decision to treat Standard • 62 Day Referral to Treatment Standard	• 80% • 94% • 80%	• 80% • 96% • 85%	• 80% • 96% • 85%

3.4.8 Medicines optimisation

Our overarching aim is to deliver safe, efficient, digitally enabled, sustainable medicines-optimisation across BNSSG that improves patient outcomes, reduces harm, increases value for money and supports care closer to home through modernised infrastructure, digital transformation, advanced therapies and consistent system-wide pathways.

This aim is reflected across all programmes through themes such as:

- **Improving patient safety** (e.g. medicines in pregnancy safety, antimicrobial stewardship)
- **Increasing capacity and modernising services** (e.g. aseptic services, radiopharmacy)
- **Supporting care closer to home** (e.g. community pharmacy services, Discharge Medicines Service (DMS))
- **Digital transformation** (e.g. Electronic Prescribing Service (EPS), shared medication record, Electronic Prescribing and Medicines Administration (ePMA))
- **Ensuring sustainability and value** (e.g. green agenda, savings and value programmes)
- **Equitable access to innovative treatments** (e.g. genomics, weight management, diabetes technologies)

What will care and support look like in 5 years?

Based on the direction of travel described in the document:

1. More care delivered closer to home

- Community pharmacy will manage more minor conditions, hypertension case finding, contraception and independent prescribing.
- Hospital-at-home models will expand due to increased aseptic capacity and ready-to-administer products.

2. A fully digital, integrated medicines pathway

- ePMA will be fully implemented across acute trusts.
- EPS will be live across acute, mental health and community providers.
- A single shared electronic medication record will support seamless transitions of care.
- DMS from secondary care to community pharmacies and Pharmacy First referrals from general practice and Urgent and Emergency Care (UEC) to community pharmacies will be automated and routine.

3. Safer, more personalised medicines use

- Pharmacogenomic testing will be embedded in pathways to tailor treatment to individual patients. Gene therapies will be available locally across multiple specialties.
- Hybrid closed loop systems will be standard for type 1 diabetes.
- Medicine safety processes will be fully embedded for safe use of medicines in pregnancy.

4. A more sustainable and efficient system

- Lower-carbon inhaler use will be normalised.
- Anaesthetic gas decarbonisation will be complete.
- Medicines waste will be reduced through structured medication reviews and improved pathways.
- Cost-effective prescribing will continue to be embedded.

5. Expanded specialist services

- A new radiopharmacy unit will support diagnostics and treatment across the South West.
- A regional aseptic model will increase capacity for cancer treatments, clinical trials and innovative therapies.
- Specialist stoma services will be fully embedded across the Integrated Care Service.

What will we do and when?

2026/27 – Q1 and ongoing (specific areas of focus)

- Radiopharmacy: options appraisal underway, Project Initiation Document approved.
- Aseptic services: Outline Business Case approved for BNSSG hub.
- Genomics: Specialist pharmacist in post; multiple Advanced Therapy Medicinal Products (ATMPs) services active.
- Antimicrobial stewardship: targets met; continue to ensure compliance with national targets.
- Weight management: increasing access to weight management medicines across BNSSG in line with National Institute for Health and Care Excellence (NICE) and NHS England guidance.
- Hybrid closed loops: pathways published; implementation progressing.
- ePMA: University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) live; North Bristol NHS Trust (NBT) partially live.
- Electronic repeat dispensing (eRD): project completed with 11 practices; toolkit to be shared. This will conclude by Q1 2026.
- DMS: improvements linked to EPMA and GP Connect.

- Community pharmacy services: expansion of clinical services including Patient Group Directions, hypertension case finding and contraception.
- Green agenda: asthma guidelines implemented across BNSSG; waste campaign evaluated.
- Savings plan and predicted cost pressures: in place and monthly monitoring undertaken.
- Formulary adherence: monitoring ongoing.
- Medicines safety: Programmes of work in Primary and Secondary care, data reviewed on an ongoing basis and learning shared across system.
- Addressing problematic polypharmacy: Prescribing project for primary care continue to promote appropriate deprescribing.
- Continued progress on aseptic services, radiopharmacy, genomics, diabetes technologies and digital programmes.
- Stoma service and formulary adherence continue to be evaluated.
- EPS rollout across acute trusts will start 2026/27.

Beyond 2026/27 (based on stated expectations however elements of above will continue)

- Shared electronic medication record expected via NHS App by 2027/28. As an aspiration for NHS England.
- Regional aseptic model dependent on national funding timelines.
- ATMP expansion continues as new therapies receive NICE approval.
- Green agenda projects continue as part of ICS Net Zero commitments.
- Increase the uptake of biosimilar medicines across the system.
- Support shift to Neighbourhood Care as medicines optimisation will be a key component.

SECTION FOUR – HOW WE WILL DEVELOP A STRATEGIC COMMISSIONING APPROACH

Developing the Integrated Care Board as a strategic commissioner

Over the next year we will be developing a new approach for our ICBs focusing on strategic commissioning - planning, purchasing, monitoring and evaluating services to meet the three strategic ambitions that we have established within this plan. Our vision is to become a leading strategic commissioning organisation. This will start with 'clustering', meaning that we will operate as far as we can as a single organisation but remain as two statutory bodies as we formally merge and create a new organisation, formed of the existing NHS Gloucestershire ICB and Bristol, North Somerset and South Gloucestershire ICB.

We will be guided by the strategic commissioning framework setting out the principles for how ICBs will understand local need, prioritise areas for change and assess the impact of commissioned services. In doing so, we will follow the four steps to ensure all our decisions are well informed and make the best use of the resources available:

1. **Understanding the local context through health needs analysis:** linked, person-level data and insights to build an Integrated Needs Assessment
2. **Develop long-term population health strategy**: building on the understanding of the population and current service delivery
3. **Deliver the strategy through the way we allocate resources and commission services**: allocate resources effectively in a way that meets strategic priorities
4. **Evaluating impact**: track service quality, access, cost and outcomes.

To support this transition, we have established a series of workstreams that will both support the functional changes needed to establish our cluster (e.g. finance, workforce, digital and governance) as well as determine how our cluster will work in accordance with the strategic commissioning framework. This work involves establishing a baseline assessment of where we are in strategic commissioning across both organisations and developing a plan for how we transition to the future target operating model.

Alongside continuing to deliver statutory and clinical services, such as All Age Continuing Care and Safeguarding, we will also need to ensure that we have the skills in the organisation to lead as a strategic commissioner. This includes capabilities in strategic leadership and partnership working, broad clinical and care professional leadership, access to high quality data and insight, and a strategic ability to establish clear priorities. We will need to use market management to deliver improved outcomes through contracts and have an ability to ensure that current and newly commissioned services enable healthy lives, tackle health equity and ensure best value.

Over the next year we will set out our target operating model and reshape our organisational structures and ways of working so that we become a leading strategic commissioner. We will

also both help shape and, at the appropriate time, draw on the strategic commissioning support being developed nationally to support ICBs with this role.

We will also work to evolve both Population Health and Strategic Commissioning Plans into a new plan for publication in March 2027. Within this, we will continue to ensure a focus on "place", taking account of new Neighbourhood Plans. Our indicative timescales for developing the single plan are as follows:

- Developing a single needs assessment by September 2026
- Developing commissioning intentions by October 2026
- Bringing both plans into a single plan for the system by mid-December 2026
- Provider Integrated Delivery Plans to respond to commissioning intentions by February 2027
- Publish the Population Health and Strategic Commissioning Plan by March 2027.

References

1. Bristol Health Partners (n.d.) *Bristol Health Partners – Academic Health Science Centre.* Available at: https://www.bristolhealthpartners.org.uk/ (Accessed: 30 January 2026).
2. Bristol North Somerset and South Gloucestershire ICB (2022) *Green Plan for Bristol, North Somerset and South Gloucestershire ICS: 2022–2025.* Available at: https://bnssghealthiertogether.org.uk/wp-content/uploads/2023/06/Green-Plan-for-BNSSG-ICS-2022-23-v1.3.pdf (Accessed: 30 January 2026).
3. Bristol North Somerset and South Gloucestershire ICB (2023) *BNSSG ICS Strategy.* Available at: https://bnssghealthiertogether.org.uk/wp-content/uploads/2023/08/ICS-Strategy-300623_.pdf (Accessed: 30 January 2026).
4. Bristol North Somerset and South Gloucestershire ICB (2023) *VCSE Vision and Framework for Action.* Available at: https://bnssghealthiertogether.org.uk/voluntary-community-and-social-enterprise-vcse/vcse-vision/ (Accessed: 30 January 2026).
5. Bristol North Somerset and South Gloucestershire ICB (2023) *Maternity and Neonatal Equity and Equality Action Plan.* Available at: https://bnssghealthiertogether.org.uk/maternity-and-neonatal-equity-and-equality-action-plan/ (Accessed: 30 January 2026).
6. Bristol North Somerset and South Gloucestershire ICB (2024) *Healthier Together 2040.* Available at: https://bnssghealthiertogether.org.uk/ht2040/ (Accessed: 30 January 2026).
7. Bristol North Somerset and South Gloucestershire ICB (2022) *Our Future Health Report.* Available at: https://bnssghealthiertogether.org.uk/library/our-future-health-report/ (Accessed: 30 January 2026).
8. Bristol North Somerset and South Gloucestershire ICB (n.d.) *System Outcomes Framework.* Available at: https://bnssghealthiertogether.org.uk/knowledge-hub/system-outcomes-framework/ (Accessed: 30 January 2026).
9. Cyber Security Operations Centre (n.d.) *Cyber Security Operations Centre (CSOC).* NHS England. Available at: https://digital.nhs.uk/cyber-and-data-security/services/cyber-security-operations-centre-csoc (Accessed: 30 January 2026).
10. Health Foundation (2023) *Health in 2040: Projected Patterns of Illness in England.* Available at: https://www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england (Accessed: 30 January 2026).
11. Health Foundation (2024) *Health Inequalities in 2040.* Available at: https://www.health.org.uk/reports-and-analysis/reports/health-inequalities-in-2040 (Accessed: 30 January 2026).

12. Healthwatch (2023) *The Public's Perspective: The State of Health and Social Care.* Available at: https://www.healthwatch.co.uk/public-perspective-report (Accessed: 30 January 2026).
13. Joint Strategic Needs Assessment – Bristol City Council (n.d.) *About the Joint Strategic Needs Assessment (JSNA).* Available at: https://www.bristol.gov.uk/council/policies-plans-and-strategies/social-care-and-health/joint-strategic-needs-assessment/about-the-joint-strategic-needs-assessment (Accessed: 30 January 2026).
14. Joint Strategic Needs Assessment – North Somerset Council (n.d.) *Joint Strategic Needs Assessment Overview.* Available at: https://n-somerset.gov.uk/council-democracy/north-somerset-insight-data-statistics/joint-strategic-needs-assessment-jsna-health-social-care/joint-strategic-needs-assessment-overview (Accessed: 30 January 2026).
15. Joint Strategic Needs Assessment – South Gloucestershire Council (n.d.) *JSNA.* Available at: https://www.ourareaourfuture.org.uk/health-and-wellbeing-board/joint-strategic-needs-assessment/ (Accessed: 30 January 2026).
16. MBRRACE-UK (n.d.) *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK.* Available at: https://www.npeu.ox.ac.uk/mbrrace-uk (Accessed: 30 January 2026).
17. Nesta (2024) *UK 2040: Options.* Available at: https://www.nesta.org.uk/project/uk-2040-options/ (Accessed: 30 January 2026).
18. NHS England (n.d.) *Strategic Commissioning Framework.* Available at: https://www.england.nhs.uk/long-read/strategic-commissioning-framework/ (Accessed: 30 January 2026).
19. NHS England (n.d.) *Fit for the Future: 10-Year Health Plan for England.* Available at: https://www.england.nhs.uk/long-term-plan/ (Accessed: 30 January 2026).
20. NHS England (n.d.) *Dynamic Support Registers and Care (Education) and Treatment Review Code of Practice.* Available at: https://www.england.nhs.uk/long-read/dynamic-support-registers-and-care-education-and-treatment-review-code-of-practice/ (Accessed: 30 January 2026).
21. Pier Health Group (n.d.) *One Weston Integrated Care Home Hub.* Available at: https://pierhealth.co.uk/our-services/innovation-in-general-practice/care-home-hub-and-frailty (Accessed: 30 January 2026).
22. Second Step (n.d.) *MINT Teams – Recovery Navigators.* Available at: https://www.second-step.co.uk/our-services/community-and-wellbeing/mint-teams-recovery-navigators/ (Accessed: 30 January 2026).

23. SELF, G. (2025) *Have Your Say Survey Report of Findings.* Available at: https://bnssghealthiertogether.org.uk/wp-content/uploads/2022/12/Have-Your-Say-Report-of-Findings.pdf (Accessed: 30 January 2026).
24. Why Weight? (2025) *Why Weight? Pledge for Creating Healthier Places Together.* Available at: https://bnssghealthiertogether.org.uk/why-weight-pledge/ (Accessed: 30 January 2026).

Appendix 2 – Joint Forward Plan legal requirements

Duty	How we have / are delivering this requirement
1. Duty to promote integration	The Health and Wellbeing Boards promote greater integration and partnership between the NHS, local authority, and wider partner organisations, paying regard to and challenging partners to work collaboratively and agree joint areas of focus.
2. Describing the health services for which the ICB proposes to make arrangements	The health services for which the ICB proposes to make arrangements are set out in this document.
3. Duty to consider wider effect of decisions	To support the delivery of our ICB functions and ambitions we have developed a series of principles with the System Executive Group which oversees the work of our Health and Care Improvements Groups (HCIGs). HCIGs comprise representatives from organisations from across our ICS who come together in service of the BNSSG population we serve and to progress the activities associated with our system plan. The principles recognise the complexities of working across the ICS where individual organisations will have their own governance arrangements to follow. They are intended to promote timely and responsive ways of collaborative working. Our principles: 1. ICS groups (operational or oversight) are collaborations of ICS partner representatives. 2. ICS groups will make decisions by consensus that best serve our population, not the interest of individual ICS partner organisations. 3. Decisions made by ICS groups will require action from ICS partners organisations. 4. It is ICS partner organisations' responsibility to ensure that the right people with the appropriate delegated authority attend ICS groups to agree and action the decisions. 5. If ICS partner representatives do not have delegated authority to agree and action ICS group decisions, they must escalate through their organisation's governance processes. 6. Hierarchy of decision-making to be respected.
4. Implementing any Joint Local Health & Wellbeing Strategy	Please refer to section 2 for information.
5. Financial duties	Full details of the system finance resource implications are discussed as part of the system planning process. At the time of writing in January 2026, we remain on track to meet the financial duty requirements of ICBs for 2025/26.
6. Duty to improve the quality of services	The Joint Clinical Strategy between NBT and UHBW refers to: • Developing new models of care and pathways that are clinically led, evidence-based, aligned to best practice and consistently implemented on all sites. • Making best possible use of the collective capacity of all of our hospitals and all of our people to reduce waiting times. • Keeping waiting times to a minimum through single points of referral access and joint management of waiting lists

	• Delivery of care closer to home wherever possible and consolidating expertise and technology. • Learning from each other to enhance quality and experience wherever possible. • Developing new models of care that transform how we support patients with long-term conditions. • Working together with partners in primary and community care to integrate services around the needs of patients, not organisational boundaries. • Moving from treating illness to preventing it and playing a greater role in reactive monitoring helping patients to live well at home for longer. • Working to deliver more targeted education that allows patients to better understand and take care of their health. • Improving communication channels and referral pathways between organisations. • Use the scale of both acute trusts to enable innovation, pioneering clinical practice and technology-enabled care.
7. Duty to reduce inequalities	Our planning process specifically challenges contributors to articulate the impact of their plans on health inequalities, with specific reference to addressing race equity. Actions are managed under the relevant programme governance groups. Please refer to section 3 for further detail.
8. Duty to promote the involvement of each patient	Patient and public involvement has been incorporated into the development of the system strategy, HT2040 programme, and the relevant programme areas which inform the contents of the plan.
9. Duty to involve the public	Patient and Public involvement has been incorporated into the development of the system strategy, HT2040 programme, and the relevant programme areas which inform the contents of the plan.
10. Duty as to patient choice	We actively promote patient choice by ensuring that: • GPs offer patients choice of providers at the point of a clinically appropriate referral • Clarity that self-referrers can go back to their GP and restart their pathway with a GP referral and if a patient is referred, and finds themselves on a pathway longer than 18 weeks, they can go back to the GP and request a referral to another provider cancelling the original referral • Clarity that if a patient will not be seen within the 18-week target, they have a right to contact the ICB and request to be seen by an alternative provider who can see them sooner, if available. As part of the ICBs legal responsibility, BNSSG will make reasonable attempts to find alternative providers • If a referral is deemed ‘clinically appropriate’ (which is decided by the GP), it is understood that the patient can choose to be seen by another alternative provider if the alternative provider has an NHS Standard Contract with another ICB and are able to see them • Primary Care Remedy is developed to ensure all services are in scope including children’s services

	• The processes of providers are reviewed to ensure they are making patients aware of patient choice/right to choose at the appropriate places in the referral process • The performance of each contract is reviewed against the patient choice/right to choose criteria as set out above • Appropriate providers under patient choice are accredited via the ICB accreditation process.
11. Duty to obtain appropriate advice	Within Bristol, North Somerset and South Gloucestershire (BNSSG), we have cross-organisational, system-wide working in health and care leadership (HCL) and this leadership is integral to the function and delivery of our ICB. The Health and Care Professional Executive (HCPE) in BNSSG provides leadership and advice on health and care matters, focusing on improving outcomes and quality for residents. The HCPE aims to provide a professional interface for local and regional change proposals, offer strategic advice on health and care matters, review and endorse policies, and oversee strategic transformation activities. Although the HCPE has no direct delegated authority within BNSSG ICS, its chairs can exercise executive authority to discharge collective decisions and escalate potential system risks. BNSSG also has a Risk and Ethics Advisory Forum (REAF), which is an advisory group that aims to assist and support decision-making on aspects related to risk and associated ethical challenges, arising from BNSSG strategic and operational delivery. REAF acts as a 'sounding board' and a forum for discussion, providing direct advice on specific issues upon request. The responsibility for any decisions made following REAF discussion rests with the responsible decision-making authority.
12. Duty to promote innovation	The ICS Research and Innovation Steering Group (RISG) is provided by Bristol Health Partners (BHP) and Academic Health Science Centre (AHSC). The Steering Group formally aligns and integrates academic expertise in population and applied health research with the ICS priorities.
13. Duty in respect of research	As an ICS, BNSSG is performing very well in terms of research collaborations. As measured by NIHR investment, BNSSG is by far the most research active ICS in England. We will continue to build on our multidisciplinary collaborative research whereby research is designed and delivered by people in our communities along with people working in the health and care system and academics from our University Partners. This approach, embodied by the Bristol Health Partner's delivery vehicle of our 20+ Health Integration Teams, is delivered across all our research development activities.
14. Duty to promote education and training	The ICB is committed to learning and development, as outlined in our learning and development strategy. The ICB prioritises the development of individuals, teams, and groups, allowing employees to enhance their skills and knowledge, enabling the organisation to meet current and future business needs. As part of our commitment to learning and development, outlined in our Learning and Development Strategy, ICB staff are entitled to half a day per month of personal development time which is protected time to complete any training and development. The ICB continues to introduce new training modules, such as the Oliver McGowan training which aims to provide staff with the right skills and knowledge to provide safe, compassionate and informed care to autistic

	people and people with a learning disability. The ICB has also recently introduced a Trauma-Informed Practice mandatory training module, which provides an overview of the importance of using a trauma-informed approach within our system.
15. Duty as to regard to climate change and adaptation to impacts	Our planning process specifically challenges contributors to articulate how their plans support the sustainability agenda. Actions are managed under the relevant programme governance groups. Please refer to section 3 for further detail.
16. Addressing the particular needs of victims of abuse	The ICB has a clear line of accountability for promoting the welfare of and safeguarding children, young people and adults, this also includes addressing the particular needs of victims of abuse which is undertaken in partnership across the system. In addition, the ICB has a responsibility to support their own staff who may be experiencing abuse. The ICB safeguarding team have created policies and user guides for managers on how to manage these incidents. Quarterly reports are submitted through the Board's Outcome, Quality and Performance Committee to provide assurance against its statutory duties. A Safeguarding Annual Report is also written each year to capture what has been delivered in line with the ICB's statutory duties. The ICB is also a key statutory partner for the Local Safeguarding Adults Boards and Community Safety Partnerships where there are responsibilities to collaborate in order to prevent serious violence, domestic abuse, and radicalisation and counter terrorism.
17. Addressing the particular needs of children and young people	Please refer to section 3 for information.