Joint Cluster Board - Open

Date: Wednesday 27th May 2026

Time: 12:00 – 13:45

Location: St Michael's Centre, North Rd, Stoke Gifford, Bristol BS34 8PD

Agenda Number:	4	
Title:	Chief Executive Report	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	Yes/No

Purpose: For Information

Key Points for Discussion:

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.

The main areas of discussion this month are;

- ICB Organisational Changes
- Planning Priorities for 2026/27

Recommendations:	To discuss and note
Author(s):	Shane Devlin

Sponsoring Director / Clinical Lead / Lay Member:	Shane Devlin

Agenda item: 4

Report title: Chief Executive Report

Introduction

The purpose of this paper is to provide the Integrated Care Board meeting with an update of key issues, from the Chief Executive's perspective, of importance to the successful delivery of the ICB's aims and objectives.

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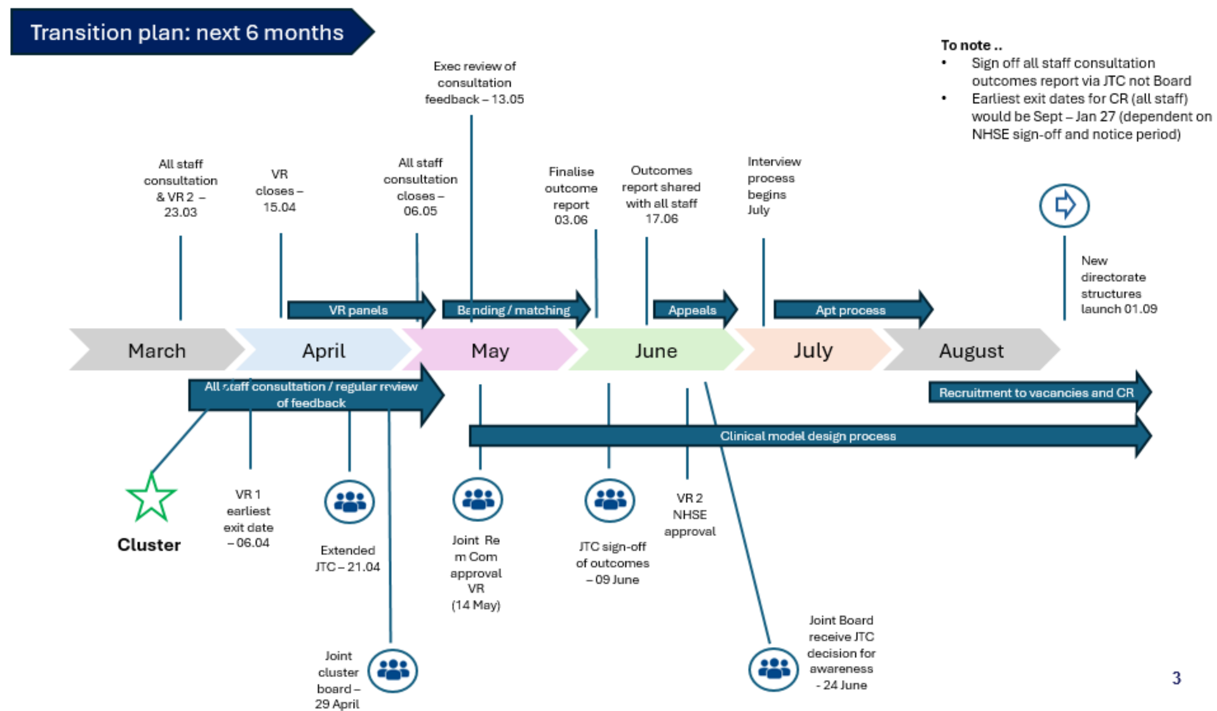
- ICB Organisational Changes
- Planning Priorities for 2026/27

ICB Organisational Changes



As per the timeline above the main focus for the organisational change programme, since the last board meeting, has been the all-staff consultation process.

The all-staff consultation process was undertaken in line with the organisation's organisational change policies and NHS Terms and Conditions of Service. The purpose of the consultation was to formally seek feedback on the proposed organisational changes, including the target operating model, proposed structures and associated job descriptions,

and to ensure that affected employees had meaningful opportunities to engage, ask questions and influence the final proposals.

The consultation formally commenced on 23 March 2026 and closed on 6 May 2026, running for a total of 45 days. Prior to the start of the formal consultation, the consultation document was shared with the Staff Partnership Forum and recognised trade unions on 20 March 2026. The consultation document was then issued to all staff.

For the purposes of the consultation, affected employees were defined as those whose substantive roles may be impacted by the proposals. This included employees potentially at risk of redundancy, those whose terms and conditions, role responsibilities or reporting lines may change, and employees subject to TUPE during the consultation period. Staff whose roles were not directly affected by the proposals were defined as out of scope and were therefore not offered individual consultation meetings, although they were able to engage through other channels.

Throughout the consultation period, affected employees were offered a combination of directorate and team meetings and/or individual 1:1 meetings with nominated directors, supported by HR representatives. These meetings provided opportunities for staff to raise confidential concerns, seek clarification on the proposed structures and job descriptions, discuss contractual implications, and provide direct feedback on the proposals. A schedule of nominated directors and directorate meetings was made available as part of the consultation documentation.

In addition to face-to-face and virtual meetings, a Microsoft Forms consultation feedback form was made available to enable affected employees to submit written feedback. The form allowed respondents to provide comments and observations, which were considered alongside feedback captured through meetings. Staff who were out of scope of the consultation were also able to submit written feedback via the form. To support effective collation and analysis of responses, feedback was reviewed by the Transition and HR teams, supported by Microsoft Copilot.

Following the close of the consultation on 6 May 2026, the Executive Team have been carrying out a formal review of all feedback received. This review will inform decisions on whether amendments are required to the proposed structures and job descriptions. The outcomes of this process will be documented in the Consultation Outcome Report, which will been shared with staff, the Staff Partnership Forum and trade unions.

Planning Priorities for 2026/27

On the 1st April 2026 Sir Jim Mackey, Chief Executive of NHS England, wrote to all ICB Chief Executives (annex a) to thank the service for all of the work that had led to a successful 2025/26 year and to set out a clear direction and request that ICBs provide great detail for with regards to the future commissioning direction. The letter specifically asked four questions.

- what strategic commissioning means in your local system and how you intend to develop this over the next 3 years?
- how you intend to develop neighbourhood care, what your strategic ambition is and how this links to your key challenges?
- whether you would like us to agree changes to financial flows and/or payment systems to help deliver this and, specifically, what these changes are?
- whether there is anything further we need to do at the centre to help accelerate the pace of change locally, including getting out the way where necessary?

The full cluster response in attached in annex b. However, the summary is as follows:

The letter outlines that we are setting out a clear and deliberate shift in how we commission and deliver care across Gloucestershire and BNSSG over the next three years. Our response to NHS England's 2026/27 planning guidance reflects both the scale of the challenge we face and the opportunity created through clustering to act more coherently as a single system.

The case for change is unequivocal. We are seeing sustained population growth, particularly in older age groups, alongside rising levels of multimorbidity and widening inequalities. Healthy life expectancy is falling, and too many of our residents—particularly those in the most deprived communities and some minority ethnic groups—experience poorer outcomes and higher use of urgent care. A small proportion of our population accounts for a disproportionate share of demand and resource use, while a much larger group is at risk of progressing into more complex need. Without fundamental change, our system will not be sustainable.

In response, we have defined three system-wide ambitions: to improve healthy lives through prevention and early intervention, to reduce inequities in access, experience and outcomes, and to deliver best value through more effective use of our collective resources. These ambitions guide all of our commissioning and delivery decisions and represent a decisive shift away from reactive, hospital-centred care towards a proactive, population health approach.

We will achieve this through a step change in strategic commissioning. Over the period 2026 to 2029, we will organise our commissioning around defined population cohorts where need, inequality and system impact are greatest. We have deliberately chosen to focus on frailty as our primary redesign lens, recognising that it is one of the clearest indicators of how well our system is performing. A relatively small cohort of people living with frailty accounts for a significant proportion of admissions and bed days. By improving care for this group, we can deliver better outcomes for individuals while also improving flow and sustainability across the whole system.

To support this shift, we will establish a clearer and more explicit framework for risk, decision-making and accountability across neighbourhood, place and system levels, with full implementation by April 2027. Alongside this, we will develop a robust, data-led approach to understanding need, tracking outcomes and informing investment decisions. This will be underpinned by a strengthened organisational capability in population health, analytics and partnership working, enabling us to operate as a more coordinated and outcomes-focused system.

Neighbourhood health will be the primary way in which we deliver this transformation. We will build integrated, multidisciplinary teams aligned to defined populations, bringing together primary care, community services, mental health, social care and the voluntary sector. These teams will take shared responsibility for the health and wellbeing of their communities, with a stronger focus on prevention, continuity of care and addressing wider determinants of health. Our initial priority will be those with the greatest need—particularly people living with frailty, multiple long-term conditions and multiple disadvantage—with the model scaling over time. By 2030, we expect people to experience coordinated, relationship-based care delivered by named teams, supported by shared care plans and rapid, community-based responses when needs escalate.

Our financial strategy supports this direction through a phased and risk-managed approach to payment reform. We will begin by testing shadow outcomes-based models, focusing initially on frailty and community services. This will allow us to build confidence in our data, understand the implications for providers and ensure that financial incentives support prevention, integration and value, while maintaining stability during the transition.

Our operational priorities, including outpatient transformation, reduction in hospital bed days, urgent care reform and digital productivity are integral to this strategy. They are the practical mechanisms through which we will reduce unnecessary activity, improve access and flow and deliver more proactive, coordinated care.

We recognise that delivery will not be without risk. Success will depend on our ability to strengthen data and digital infrastructure supported by our recent investment in the intelligence centre, develop our workforce at scale, and navigate a complex system context, including local government reform. It will also require consistent partnership working and disciplined execution across a large and diverse system.

We are therefore seeking national support in key areas, including greater flexibility to enable innovation, support for developing and testing new payment and contracting models, and investment in the infrastructure required to deliver neighbourhood-based care.

Overall, we are proposing a fundamental reorientation of our system—from activity to outcomes, from organisational boundaries to population need, and from hospital-based provision to neighbourhood delivery. We are clear with our ambition, but success will depend on sustained leadership focus, collective accountability, and our ability to translate this strategy into consistent delivery for the populations we serve.

NHS England

To:
- ICB chief executives
- Trust chief executives

cc.
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

1 April 2026

Dear colleagues,

As we get to the end of the year it's worth taking a moment to reflect on your leadership response to the challenges we've faced over the last year – dealing with the £4.5 billion deficit, embracing the broader financial reset, completely changing the operating model and genuinely creating a renewed sense of ambition about what we can achieve, together.

The fact that we are now within a cat's whisker of delivering our key operational imperatives on RTT and UEC, having landed the money in 2025/26, and navigated IA and winter is pretty extraordinary. It was also genuinely encouraging to see this reflected in last week's British Social Attitudes survey which showed that, while we still have a long way to go, our patients have seen and felt a big improvement this year after two terrible years. So, well done for everything you have done, and continue to do, and I hope you can take pride in this.

Looking forward, we now have plans that work in aggregate on the key metrics for 2026/27 and outline plans for the two following years. Regional teams will continue to refine these with you over the coming weeks and, through the new Intensive Recovery Programme, start working with colleagues with the most stubborn challenges to develop sustainable solutions to these long-standing problems.

What we absolutely need to avoid is the risk that, while we are rightly focused on making 2026/27 a success, we miss maximising the opportunity the multi-year planning process gives us to stretch ourselves over the medium term and really bring the benefits of the 10 Year Health Plan to life.

So, to enhance and augment the plans that you have submitted, we would like you to build out your strategic commissioning narratives to describe better how, as commissioners and providers, you intend to do this together, with particular emphasis on:

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- what strategic commissioning means in your local system and how you intend to develop this over the next 3 years
- how you intend to develop neighbourhood care, what your strategic ambition is and how this links to your key challenges
- whether you would like us to agree changes to financial flows and/or payment systems to help deliver this and, specifically, what these changes are
- whether there is anything further we need to do at the centre to help accelerate the pace of change locally, including getting out the way where necessary

The key in all of this is to maintain the momentum, energy and discipline on delivery we've generated in the last year and equally apply it to shaping a more sustainable future model.

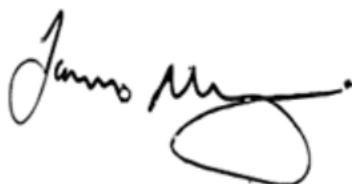
To help with this, we've been working through some key priorities that will support the next set of "big leaps", such as a full reset of outpatient care and bringing scheduling and appointments into urgent care. I've attached an overview of these areas in Annex A and we'll have a chance to talk them through at the regional roadshows in the second half of April.

We would like each ICB to provide us, via regional teams, a single document to summarise the above, by Friday 15 May. In doing so, we expect all local partners to work together to ensure a strong degree of alignment and clear identification of gaps and barriers that can be worked through together, and how you intend to do so.

Hopefully, all this makes sense. As always, get in touch with your Regional Director or any of us here at the centre if you need to.

Finally, and seriously, thanks for all you have done this last year and for your support and challenge throughout. The progress made is starting to be visible and palpable for our patients, so I hope you can take confidence from all of this to continue building a service we can be proud of in the future.

Thanks and keep going…



Sir Jim Mackey
Chief Executive Officer
NHS England

Annex A

Building on stronger foundations

Eight key areas where, collectively, we can make a big difference this year and beyond:

1. **Outpatient transformation** – shifting away from traditional outpatient models through a major expansion of Advice and Guidance and a reduction in unnecessary follow-ups.

2. **A step-change in reducing hospital bed-days for highest-risk cohorts** – with neighbourhoods playing a central role in implementing proactive care models for high-risk groups.

3. **Scheduling and access reform for urgent care** – making it easier for patients to book urgent care appointments in GP practices, urgent treatment centres, or other appropriate settings, reducing avoidable ED attendances.

4. **Technology-enabled productivity improvements** – expanding the deployment of Ambient Voice Technology and a suite of tools to improve theatre utilisation, discharge flow, RTT validation, community waiting lists, Advice and Guidance, electronic prescribing in all trusts, and crisis response.

Nationally, we will be taking action to support these and related improvement efforts, including:

5. **The NHS App** – accelerating efforts to expand the role of the App as the digital front door into the NHS, supporting more convenient and effective triage and navigation for patients.

6. **Payment reform** – realigning the payment system to the service changes you are seeking to deliver, including new payment models for urgent and emergency care.

7. **Quality** – putting quality back at the heart of everything we do, including the publication of a new quality strategy, the development of modern service frameworks focused on mental health, sepsis, cardiovascular disease and frailty, and testing new delivery models for secondary prevention to tackle variations in the uptake of high-impact CVD and diabetes interventions.

8. **Capability building and a focus on our people** – launching the new Leadership College, which will be the most radical change to leadership development and talent management that the NHS has seen in over a decade.

NHS Gloucestershire
Integrated Care Board

NHS Bristol, North Somerset and South Gloucestershire
Integrated Care Board

14th May 2026

Sir James Mackey
Chief Executive
NHS England

Cc NHS England South West Regional Team

Dear Sir Jim,

Re: Gloucestershire and Bristol, North Somerset and South Gloucestershire ICB Cluster response to next steps on planning and priorities for 2026/27

Please find enclosed our system response to the 1 April 2026 letter on next steps for planning and priorities for 2026/27.

We welcome the direction set out in your letter and the opportunity to respond in a way that reflects both our local context and our shared ambition for the future of health and care. We are an ambitious system, with a strong track record of partnership working and a clear commitment to improving outcomes, tackling inequalities, strengthening neighbourhood health and using our collective resources to best effect for the populations we serve.

At the same time, we are responding at an important point in our development as a newly clustered system. This creates both challenge and opportunity. We are bringing together different histories, relationships and ways of working, while also creating the conditions for a more coherent, strategic and delivery-focused model across a wider footprint. We see this as a moment to build on the strengths already present in our places and organisations, while shaping a stronger shared approach to commissioning, transformation and delivery over the next three years.

Our response therefore reflects both ambition and realism. It sets out the progress we want to make, particularly in developing strategic commissioning and neighbourhood health, while being candid about the barriers we will need to work through together. It also reflects our intention to use this period of clustering not simply as an organisational change, but as an opportunity to accelerate improvement, simplify where we can and create a clearer basis for joint accountability and collective action.

We have developed this response with system partners and have sought to identify where there is strong alignment, where there are still issues to resolve, and where national support or flexibility would help us go further and faster. We would welcome the opportunity to continue that conversation as arrangements develop.

Thank you for the opportunity to contribute to this next phase of planning and reform.

Yours sincerely,

Shane Devlin
Chief Executive
Gloucestershire and Bristol, North Somerset and South Glouceatershire ICB

System context: population need and our shared ambitions

Across the clustered system, the case for change is clear. Population growth, ageing and increasing multimorbidity are changing the pattern of need, while inequalities in outcomes, experience and access remain too wide.

In BNSSG, the population of around 1 million is projected to grow by over 100,000 (10%) by 2032. In Gloucestershire, the population of 650,000 people will grow by 17.5% by 2047, including a 43% increase in those aged over 65 and a 111% increase in those aged over 85[1]. Without a shift in how care is delivered, this will drive significant additional demand, particularly for people with multiple long-term conditions and frailty.

At the same time, outcomes are worsening. Healthy life expectancy has declined, with people now spending around 18 years (males) and 22 years (females) in poor health. Inequalities are stark: people in the most deprived communities experience the same level of ill health in their early 50s as those in the least deprived areas in their late 60s, and are significantly more likely to use urgent and emergency care.

Furthermore, we know that ethnicity is a fundamental dimension of health equity and historic service decisions have unintentionally favoured some groups over others because of biases linked to ethnicity, language, immigration status, income, disability, gender and age. In BNSSG 15% of the population is from a minority ethnic group, more than 90 languages are spoken, and poorer health outcomes are evident for some communities, including higher diagnosed ill-health among Pakistani, Bangladeshi and Caribbean communities and poorer maternity outcomes for Black, Asian and Mixed Ethnicity women. This means we need to build ethnicity into our population health analysis, outcomes frameworks and commissioning decisions, so that we can better identify inequity, target action and hold ourselves to account for reducing differences in access, experience and outcomes.

Population health modelling shows that need and demand are highly concentrated. In Gloucestershire, 3% of the population accounts for a disproportionate share of activity, while 24% are at moderate risk and 73% at low risk. This creates both a clear imperative and opportunity: to intervene earlier for the majority, while delivering more coordinated, proactive care for those with the greatest needs.

Furthermore, we know that major illness is expected to increase by 37% to 2040, driving demand for health and care services. Our current health and care system is unsustainable and must change to meet both current and future needs. We have therefore anchored our approach to strategic commissioning around key population groups who experience the poorest outcomes and whose needs are not yet consistently met by the way our system is currently designed. By understanding their experiences, needs and patterns of service use,

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[1] Note – BNSSG and Gloucestershire currently have two separate Integrated Needs Assessments so data are not comparable. Further detail available in the Strategic Commissioning Plans with references at the end of this document

we can better identify where the system needs to change, improve outcomes and reduce avoidable pressure over time, positively benefiting the whole population.

Our three strategic ambitions are a direct response to this evidence and define where measurable change is required:

Healthy Lives
The increase in years spent in poor health, combined with a large proportion of the population at low or moderate risk, requires a shift towards prevention and earlier intervention. We will prioritise reducing the progression from low and moderate need into higher levels of complexity, particularly for children and young people, maternity populations and those at rising risk of long-term conditions.

Health Equity
The gap in healthy life expectancy and higher urgent care use in deprived communities show where outcomes and access must improve most. Resources will be directed toward those experiencing the most significant disadvantages, often with ethnicity as a key factor. This includes people who are living with or at risk of frailty and have multiple needs, aiming to reduce differences, improve results, and prevent unnecessary demand.

Best Value
The concentration of demand within a small proportion of the population demonstrates that current models are not sustainable. We will focus on cohorts with the highest levels of need, particularly people living with frailty and complex conditions, to reduce avoidable demand, improve flow and shift care towards more proactive, neighbourhood-based models.

Finally, our system is preparing for a changing provider and partnership landscape, with providers increasingly expected to take greater responsibility for population health, outcomes and resource use across defined communities. We are designing our population health approach with this future in mind, including the potential development of Integrated Health Organisations and other neighbourhood-based provider arrangements.

This will be developed in close partnership with local government, recognising the central role councils play in prevention, place-shaping, social care, housing, public health and wider determinants of health. The forthcoming local government review adds further complexity and uncertainty to this landscape to navigate, particularly around future geographies, accountabilities, leadership arrangements and the alignment of health, care and place-based planning.

Our approach therefore will be sufficiently disciplined to provide clarity of direction, but flexible enough to respond to changes in local government structures and partnerships. This means building the data, governance, commissioning, contracting and accountability frameworks needed to support providers and partners to act collectively around shared outcomes, manage risk appropriately, and deliver more proactive, preventative and integrated care for local populations.

What Strategic Commissioning means in our system and how we intend to develop it over the next 3 years

In summary: We will make population health focused commissioning core business over the next three years across Gloucestershire and BNSSG enabling a shift from reactive, hospital-based provision to proactive, population-focused support delivered closer to home.

To make this change real for our system, we will focus on five things:

1. **cohort-based commissioning**
2. **single system-wide focus on frailty**
3. **clearer risk and decision-making framework**
4. **data-led outcomes model**
5. **organisational development to embed population health capability and new ways of working.**

This is not only a technical change to commissioning; it is a response to the fact that, too often, people with the greatest needs have been failed by fragmented services, repeated handovers, poor coordination and a system that has expected them and their carers to navigate complexity on their own.

Our approach to strategic commissioning is rooted in system stewardship. This means using population health insight, resource allocation and partnerships to shape services around improved outcomes, reduced inequalities and long-term sustainability. As we form our new organisation, we will use this opportunity to set the conditions for change from the outset, building the capabilities, governance and partnerships needed to support a more strategic, system-shaping approach. Neighbourhoods will sit at the heart of this transformation, with services coordinated around people so individuals no longer have to navigate a complex web of services themselves. Hospital, community, mental health, primary care, social care and the voluntary sector will increasingly work together as parts of a single, joined-up delivery system.

1. Cohort-based commissioning to drive outcomes and neighbourhood development

We will organise commissioning around a small number of cohorts of strategic importance, reflecting where need, inequality and resource use are most concentrated. This is about making a deliberate choice to focus first on the people and communities who experience the poorest outcomes, the greatest disadvantage and the highest levels of unmet need.

This will include:

- identifying and prioritising cohorts in medium-long term planning
- build a comprehensive understanding by connecting with communities about people's needs, especially in cases where ethnicity leads to poorer health outcomes

- aligning commissioning, neighbourhood development and outcomes frameworks around these cohorts;
- using segmentation tools to ensure share understanding of the same groups of people across the system and deeper understanding of how they interface with different services
- shifting from commissioning services in isolation to commissioning holistic, proactive models of care;
- using population health insight to rebalance investment towards prevention, early intervention and neighbourhood-based support;
- aligning incentives and resources to measurable improvements in population health, experience of care and reduced inequity.

In BNSSG, the priority cohorts include **children and young people, adults experiencing multiple disadvantage, working-age adults with multiple long-term conditions or rising risk, and older people with frailty and complexity**. In Gloucestershire, they include **older people with frailty, people with multimorbidity, those at rising risk and people with mental health needs.** The ICB will also work closely with Gloucestershire County Council to support the development of care and support for children and young people, in line with national reforms and local partnership responsibilities. These cohorts will become the foundation for neighbourhood health redesign, ensuring we shape services around people's needs rather than organisational boundaries or single-service pathways.

This approach is driven by clear evidence that a small proportion of the population accounts for a disproportionate share of poor outcomes and system use. For example, in Gloucestershire, around 3% of the population accounts for almost 60% of bed days, with the highest-need groups also requiring significantly more outpatient and primary care support. Behind this data are people whose care has too often been reactive, fragmented and difficult to navigate. Our commissioning approach must respond to that reality.

2. A single system-wide redesign focus: people who are frail and at risk of frailty

As a health and care system, we are united in placing a relentless focus on redesigning care for frail older people and those at increased risk of frailty irrespective of age. This is not one priority among many; it is the primary lens through which we will develop and test our approach to strategic commissioning over the next three years.

The experience of this population is one of the clearest tests of whether our system is safe, humane and joined up. Too often, we have failed people living with frailty, their families and their carers. Current models have not consistently met their needs and, in some cases, have contributed to poorer outcomes and poorer experience. People have faced long waits, fragmented services, repeated handovers, avoidable crises, and the frustration and distress of having to tell their story again and again.

This will include:

- Ensuring a shared definition of population segments across Gloucestershire and BNSSG – enabling system-wide identification of people who are complex and frail or high-intensity service use, people with moderate frailty, and those at rising risk;
- developing integrated neighbourhood models end to end across health and social care for these three groups;
- supporting people through named multidisciplinary neighbourhood teams and shared care plans;
- improving proactive identification, early intervention and rapid community response;
- reducing avoidable admissions and supporting people to remain independent at home;
- recognising carers and families as central partners in care.

Across Gloucestershire and BNSSG, we estimate that around 8–10% of the adult population are living with moderate or severe frailty, or are at high risk of developing it. Within this, a much smaller group, approximately 3% of the population, accounts for a disproportionate share of non-elective admissions and bed days, with Gloucestershire modelling indicating this group alone accounts for around 60% of bed days.

Addressing frailty is therefore not a narrow service priority. It is a shared system responsibility and one of the most direct routes to improving dignity, safety, prevention, independence, flow and overall system performance. In BNSSG specifically, this work will be developed through **2026/27** and **2027/28** using a development fund with a key driver being the recommissioning of adult community health services from **2030**. Across the clustered system, it will provide a consistent foundation for wider transformation.

3. A clear risk and decision-making framework to support long-term, outcome-based choices

If we are serious about changing outcomes, we must also change how decisions are made. We cannot continue to make short-term, transactional choices that reinforce existing patterns of provision and leave people experiencing the same fragmentation. We will establish a clear and explicit risk and decision-making framework to support longer-term, outcome-focused investment.

This will include:

- defining and evolving system risk appetite aligned to new care models, the three shifts and key strategic commissioning decisions;
- clarifying where decisions are made across neighbourhood, place and system levels;
- establishing where accountability is held, where it is shared, and how decisions are escalated and agreed;
- working with the four Health and Wellbeing Boards to clarify roles, responsibilities and governance within the neighbourhood health model;
- aligning decisions across commissioning, workforce, capital and digital;
- strengthening analytical capability to inform trade-offs;

- supporting partnership-based approaches with providers.

This framework will help us make more coherent and confident choices about how resources are used, how risk is shared, and how decisions are aligned across neighbourhood, place and system levels. It will also support coordinated leadership while maintaining local accountability for delivery. We intend for this framework to be in place by **April 2027**.

4. A data-led, outcomes-focused model for prioritisation, performance and investment

Data and outcomes will provide the foundation for strategic commissioning, but our purpose is not simply to measure more. It is to understand need more clearly, see where the system is not working for people and act on that insight. We will use data, segmentation and community insight to identify need, target interventions, track impact and inform investment decisions.

This will include:

- developing a new Integrated Needs Assessment to establish shared segmentation, outcomes frameworks and KPIs aligned to the three shifts with a focus on the cohorts we are prioritising;
- developing outcome sets for priority population cohorts in preparation for outcomes-based commissioning;
- creating a clear outcomes framework for the frailty cohort, grounded in a small number of meaningful measures to track impact of neighbourhood health model of care;
- agreeing baselines and trajectories over the next three years;
- aligning outcomes with neighbourhood delivery and commissioning frameworks;
- designing and developing our Intelligence Centre to provide ongoing population health surveillance;
- using insight to track outcomes, identify emerging risks or improvements, and course-correct strategy and commissioning decisions.
- setting up indicators, creating mid-term plans for activities and finances, and putting monitoring processes in place to track progress on three shifts - especially how resources are directed toward prevention, community, and digital areas

For the frailty cohort, the outcomes framework will reflect what matters to people and how integrated services are for them. It will support improvement, accountability and future payment reform. Our intention is to establish this framework during **2026/27**, with shadow tracking in place ahead of any formal move to outcomes-based commissioning.

We will create balanced scorecards at system, place and neighbourhood level to track progress against our three ambitions: equity, health and value. They will bring together outcomes, inequalities, access, quality, experience, activity, demand, workforce and finance

measures, alongside modelling of expected impact on demand, capacity and the financial position. This will allow us to track whether our strategy is being delivered, whether it is having the intended impact, and where we need to adapt, accelerate or change course.

This will ensure that strategic commissioning is evidence-driven, measurable and responsive, while keeping the focus on people's lived experience, not just system activity.

5. Organisational development to embed population health capability and ways of working

Delivering this shift requires a step change in both capability and culture. Becoming a population health-led system is not just about structures or frameworks; it is about how our people think, work and lead differently across organisational boundaries. It also requires us to be honest that the way we have worked in the past has not always served people well.

This will include:

- building expertise in population health, outcomes and data-driven decision-making;
- working in partnership with Directors of Public Health to embed population health approaches and to learn from their expertise
- strengthening the ability to work across neighbourhood, place and system levels;
- developing leaders and teams who can operate in a distributed, partnership-based model;
- investing in workforce development and nurturing talent;
- creating clear development pathways and supporting multidisciplinary working;
- improving consistency and standardisation in segmentation, outcomes, commissioning cycles and performance management;
- retaining flexibility for local innovation;
- developing a more diverse workforce that reflects and understands our communities;
- embedding a collaborative, insight-led and outcomes-focused culture.

Through this, we will build the capability to translate insight into action and use evidence confidently to shape commissioning decisions. We will strengthen shared accountability, continuous learning and improvement, with a clear focus on population outcomes and reducing inequalities. We will also support staff and leaders to work as part of one system, with a shared responsibility to improve care for people who have too often been left to navigate complexity alone.

Together, we believe these five areas will create the conditions to enable us to drive forward sustainable transformation. With a laser focus on them all within the ICB, we will shift care closer to home, improve outcomes for people with the greatest needs, reduce inequalities and build a more resilient, affordable and effective health and care system. This is a deliberate choice to focus where change matters most, and to build a model of care that is more humane, more coordinated and more accountable to the people and communities of Gloucestershire and BNSSG.

Our neighbourhood health ambition

In summary: Our ambition is to make neighbourhood health the primary organising model for care, shifting the centre of gravity from reactive, hospital-based provision to proactive, population-focused support delivered closer to home.

We will build integrated neighbourhood teams around defined populations, with a particular focus on frailty, multiple long-term conditions, rising risk, mental health needs and multiple disadvantage.

We intend to develop neighbourhood care around defined populations, typically aligned to natural communities. These neighbourhoods will bring together multidisciplinary teams spanning primary care, community services, mental health, social care, wider local authority support, the voluntary and community sector, and specialist clinical input. Teams will take shared responsibility for the health and wellbeing of their local population, with a stronger focus on continuity, prevention, early intervention, personalised care and addressing the wider determinants of health.

Our initial focus will be on the key population cohorts, including people living with frailty, those at risk of frailty, people with multiple long-term conditions, individuals with mental health needs, and those experiencing multiple forms of disadvantage. For these groups, care will need to be more coordinated, proactive and relationship-based, reducing fragmentation and ensuring people are supported by consistent teams rather than being passed between services.

We will start first with designing neighbourhood health services for people who are the most complex and frail, then evolve the model to ensure a whole-spectrum approach to frailty, recognising not only those with established or severe frailty, but also people with mild, emerging, hidden or prematurely developed frailty whose needs are often missed by traditional service models.

As such, from 2030, people living with frailty should experience a fundamentally different model of care. Instead of navigating fragmented services, they will be supported by a named, multidisciplinary neighbourhood team that holds shared responsibility for their care. Care will be organised around a single, shared plan used consistently across services, improving continuity and reducing the need for people to repeat their story. When needs escalate, the response will be rapid and community-based wherever possible, reducing avoidable admissions and supporting people to remain independent at home.

In BNSSG, the Neighbourhood Development Fund will be a key enabler of this shift over the next three years. It will provide targeted investment to accelerate the establishment and impact of integrated neighbourhood teams, initially focused on people living with the most complex frailty. As BNSSG does not currently have a standardised integrated neighbourhood team model, this funding will support local innovation, co-design with

communities, multidisciplinary workforce development and testing of new proactive care models for priority cohorts.

The fund will also help develop the infrastructure needed for effective neighbourhood working. This includes population health management capability, shared data, local analytical support, and new approaches to contracting and incentivising collaboration around outcomes. Together, these enablers will support a more consistent, scalable and evidence-informed approach to neighbourhood development across BNSSG.

BNSSG's partnership with Alaska's Nuka System of Care provides important learning for our system in these developments. Nuka demonstrates how personalised, relationship-based care rooted in trust, community ownership and deep understanding of people's needs can be delivered reliably at scale. Our aim is for people with complex needs to be supported by a consistent team, with care that is proactive, coordinated and tailored to what matters to them. We are working to commission and provide this kind of equitable, personal care for key population cohorts across BNSSG and Gloucestershire.

In parallel, Gloucestershire is progressing a similarly ambitious programme of neighbourhood development. Including embedding multidisciplinary team working, expanding anticipatory care models, and using population health data to systematically identify and support people most at risk of deterioration, creating a consistent and scalable model across localities.

Workforce

Delivering neighbourhood health will require a significant workforce shift. Staff will increasingly work as part of integrated neighbourhood teams focused on local population health needs, rather than solely through the lens of their employing organisation. We will mobilise a workforce movement that places relationship-based care at the heart of how people are recruited, trained, supported and incentivised across health and care. This includes enabling specialists to work beyond hospital settings, supporting neighbourhood teams directly, influencing care models, and informing best practice clinical care closer to home.

To enable this transition, our workforce will need a comprehensive programme of organisational development, training and support. This will include strengthening relational skills, digital and data capability, care coordination, system navigation and multidisciplinary working, so that teams can deliver more proactive, person-centred and coordinated care. By investing in these capabilities and embedding a culture of relationship-based practice, we will support the move away from fragmented, reactive provision towards scalable and affordable neighbourhood care that better meets the needs of people and communities.

Financial flows and payment reform

In summary: We will reform financial flows and payment systems in a phased, risk-managed way to support the shift towards proactive, preventative, neighbourhood-based care.

We propose starting with frail older people and those at risk of frailty, using a shadow outcomes-based model to test data, costs, behaviours, risks and impact before any formal contractual implementation.

Current payment models do not fully support our ambitions for earlier intervention, joined-up care, improved independence, better support for carers and fewer avoidable crises. Our five-year strategic commissioning plans therefore set out an ambition to move, over time, towards outcomes-based commissioning for defined population cohorts.

We are not proposing an immediate large-scale shift to outcomes-based payment. Instead, we want to work on a staged, risk-managed approach that strengthens the foundations for change first: data quality, outcomes measurement, cost accuracy, population segmentation, modelling capability, workforce skills and financial agreements that support shared accountability across partners.

We still start by aligning with the neighbourhood development focus upon frail older people and people at risk of frailty as the initial population cohort for this work. The immediate opportunity is to test how payment and contracting models could better support these behaviours through adult community health provision, alongside wider neighbourhood development work and future planning for the adult community health contract in BNSSG from 2030 onwards.

Over the next two years, we propose developing a shadow or developmental outcomes-based model, with clear gateways to test segmentation, cost modelling, outcome selection, data confidence, provider readiness and system appetite for risk before any substantive changes are made to payment systems. This should include a phased and protected approach to reforming block contracts, recognising that some costs will take longer to adjust and that provider stability must be maintained.

We would welcome NHS England's support with any technical expertise, assurance and oversight needed to develop this model safely. This would allow providers to participate confidently, help us test and minimise unintended consequences, and ensure that future payment mechanisms incentivise prevention, integration, equity and value rather than simply activity or organisational cost-shift.

What we need from NHS England

To support delivery of our strategic commissioning ambitions, we are seeking NHS England's active partnership in creating the conditions for innovation, particularly around payment reform, contractual models and neighbourhood-based care. Our ask is not for permission to move faster without safeguards, but for the space, expertise and national support to test new approaches in a deliberate, risk-managed way.

Specifically, we would welcome NHS England support in the following areas:

1. Creating the policy and regulatory conditions for transformation

- **Improving flexibility in compliance reporting:** allowing proportionate flexibility from short-term compliance requirements where we are deliberately testing new approaches in line with our five-year strategic commissioning plans, particularly where standard requirements may unintentionally constrain innovation, neighbourhood development or longer-term transformation.
- **Supporting national conversations on procurement and contracting:** involving us in discussions about the balance of risk and benefit within procurement rules and contractual mechanisms, so local systems can innovate while remaining compliant and transparent.
- **Clarifying the role of Health and Wellbeing Boards:** providing national policy guidance on the role Health and Wellbeing Boards should play in the future health system, particularly in relation to place-based leadership, shared outcomes, local government reform and alignment with ICB strategic commissioning.

2. Enabling new commissioning, payment and contracting models

- **Creating space for contractual innovation:** providing the psychological safety and assurance needed to test new contractual and payment mechanisms locally, including shadow or developmental models before formal implementation.
- **Maintaining and expanding support on payment reform:** continuing the national working group on payment reform, with a stronger focus on practical local development, testing and implementation using national evidence and specialist expertise.
- **More transparent costing data:** a discussion about making comprehensive Patient Level Costing (PLICS) data available to ICBs to support a more accurate and representative understanding of the 'true' cost of healthcare services delivered to the resident population.
- **Reviewing national incentives that may work against transformation:** working with systems to identify and address national perverse incentives, such as activity-

based elective tariffs, where these risk reinforcing hospital-based activity rather than enabling prevention, integration and care closer to home.

3. Strengthening the practical enablers of neighbourhood-based care

- **Strengthening digital and data infrastructure:** supporting and accelerating the development of linked data and digital infrastructure, including by simplifying data sharing across the public sector.

- **Enabling capital and estates flexibility:** supporting active engagement from NHS Property Services and creating clearer incentives for timely asset transfers, lease changes and estate reconfiguration. We would also welcome genuine delegation of capital decision-making to regional teams, so priority schemes can progress at the pace needed to support strategic commissioning and care closer to home.

- **Providing access to national expertise and peer learning:** bringing in expertise from national teams and supporting partnerships with other ICBs working on similar priorities, to help us accelerate delivery and learn from best practice at scale.

Taken together, these asks would help us move from ambition to implementation while managing risk appropriately. They would enable us to test new models locally, learn with others nationally, and ensure that payment, procurement, digital infrastructure and national incentives support — rather than constrain — the shift towards proactive, preventative, neighbourhood-based care.

Response to National Priorities (Annex A)

We will address the local priorities set out in Annex A through a single, coherent approach aligned with our broader ambitions for strategic commissioning and neighbourhood health. As set out above, we are shifting towards population health commissioning, organising care around priority cohorts, delivering through neighbourhood models, and aligning incentives to outcomes. The four areas below are not standalone programmes; they are interdependent components of this transformation. Together, they describe how we will redesign pathways, deploy digital capability and focus delivery on proactive, coordinated care. We have drawn out key system initiatives to demonstrate how this approach is being implemented in practice and to provide further detail about delivery plans.

Outpatient Transformation

Outpatient transformation is being delivered through whole pathway redesign, shifting away from activity-driven models towards care that is centred on value, outcomes and sustainability. As Integrated Neighbourhood Teams develop, specialists such as cardiologists, endocrinologists and chronic pain specialists will increasingly work as part of multidisciplinary teams, supporting both people and professionals closer to home. Where there is no clinical need for a traditional outpatient appointment or routine disease-specific review, specialists will review people remotely and work in partnership with GPs and community teams to support secondary prevention, proactive care and treatment planning.

Community-based specialists, including nurses and Allied Health Professionals, will also move beyond single-condition pathways towards a more integrated role within neighbourhood multidisciplinary teams. This will support more coordinated management of people with long-term conditions, particularly those with multiple needs reducing the need for separate appointments with individual specialities.

We are also reducing unnecessary follow-ups through expanded Advice and Guidance and Patient Initiated Follow-Up, while increasing the use of remote and community-based care. These changes will be underpinned by standardised pathways, multidisciplinary working, digital tools and streamlined access models, ensuring people receive the right support earlier and in the most appropriate setting.

Reducing Hospital Bed Days for Highest Risk Cohorts

Reducing bed days is being driven through our cohort-based commissioning approach, with neighbourhood teams playing a central role in proactively managing those at highest risk.

Key system initiatives include improving discharge flow, reducing patients with no criteria to reside, and expanding alternatives to admission such as virtual wards, Home First, NHS@Home and crisis response services. These are complemented by investment in VCSE infrastructure, social prescribing, and improved segmentation to enable shared identification and coordinated support for individuals. Together, this supports more proactive, holistic care and reduces avoidable escalation.

Scheduling and Access Reform for Urgent Care

Urgent care access reform is being delivered through integrated neighbourhood pathways and simplified system navigation. We are implementing Single Points of Access, expanding urgent community response services and strengthening alternatives to ED, including mental health crisis hubs. Improvements in workforce scheduling and deployment are supporting more responsive capacity, while clinically triaged pathways ensure people are directed to the most appropriate setting first time.

We also have a number of digital and community-based access routes already in place, including direct booking from NHS 111 into same-day GP appointments across BNSSG, Pharmacy First booking from NHS 111 and general practice into community pharmacy slots, and NHS 111 access to UTC remote clinical assessment, where clinicians advise whether patients need face-to-face care or can be managed safely by telephone. BNSSG has been an early mover on Pharmacy First and has one of the highest usage rates nationally. Our next step is to understand whether these routes are providing equitable access across different population groups and improving outcomes without widening inequalities. Further expansion will be based on assurance that these models are accessible, effective and fair across communities.

Technology-Enabled Productivity Improvements

Digital capability underpins all priorities, acting as a key enabler of productivity, access and service redesign.

We are deploying Ambient Voice Technology to reduce administrative burden, alongside tools to improve theatre utilisation, RTT performance and discharge flow. Advice and Guidance, electronic prescribing and digital triage models are being expanded, supported by shared data platforms and real-time analytics.

Crucially, these technologies are being implemented alongside pathway redesign and workforce development, ensuring that improvements translate into increased capacity, reduced variation and better outcomes.

References

Gloucestershire Population Health and Strategic Commissioning Plan - read

BNSSG Population Health and Strategic Commissioning Plan - read

High Level Action Plan

Area	Summary	Timeframe
1. Strategic commissioning model	Shift to population health, cohort-based commissioning, with frailty as the main redesign focus.	**2026–2029**
2. Frailty redesign	Build a system-wide frailty model using segmentation, neighbourhood teams, proactive care and admission avoidance.	**2026–2029**; recommissioning from **2030**
3. Risk and decision-making	Establish clear system governance, risk appetite, decision rights and accountability.	By **April 2027**
4. Data, outcomes and intelligence	Develop the Integrated Needs Assessment, outcomes framework, KPIs, segmentation and trajectory tracking.	**2026/27**, then ongoing
5. Neighbourhood health model	Develop integrated neighbourhood teams as the main delivery model for frailty, demand reduction and equity.	**2026–2029**; target state by **2030**
6. Workforce and organisational development	Build population health, analytical, leadership and MDT capability.	Ongoing **2026–2029**
7. Financial flows and payment reform	Test shadow outcomes-based payment models, initially for frailty and community services.	Test **2026–2028**; inform **2030** contracts
8. Operational priorities	Progress outpatient transformation, bed-day reduction, urgent care access reform and digital productivity.	Within overall transformation period