One Gloucestershire
Transforming Care, Transforming Communities

Our Five Year Population Health and Strategic Commissioning Plan 2026-2031

Our plan for improving health and care in Gloucestershire

Summary

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Our plan for improving health and care in Gloucestershire

Our vision is to make Gloucestershire the healthiest place to live and work where there is equity in life chances and to ensure that best health and care outcomes are available for all.

We want people living in Gloucestershire to have the highest number of years spent in good health in the country and reduce the life expectancy gap between the most and least deprived parts of the County. However, we have seen a drop in the number of years spent in good health since pre-COVID and the inequalities gap is at 8 years.

Healthy life expectancy is influenced more by the conditions people live in than by healthcare itself. Achieving this requires everyone to play their own part. This plan describes the role the NHS will play. We are supporting three areas of national and local priority:

- Preventing sickness, not just treating it
- Moving more care to the community rather than in hospital
- Making better use of digital technology

Our Population Health and Strategic Commissioning Plan sets out our ambitions and plans for how we will commission partners to deliver this change over the next five years.

It has been informed through engagement with partners and the public.

What we know of local health and care needs

The assessment of our local health and care needs has been informed by our integrated needs assessment.

This draws on the following:

- Joint Strategic Needs Assessment
- Population Segmentation and Dynamic Population Model
- Performance, productivity and quality of NHS commissioned services

Theme 1 – Gloucestershire is a comparatively healthy county, but the population is growing and ageing.

- The overall health of the population is good with life expectancy and years spent in healthy life above the national average.
- Significant population growth is expected influenced heavily by internal migration.
- Population growth is fastest amongst older people resulting in significant changes in the ratio of working age to older people.

Theme 2 – As people age, more will have long-term conditions, but how we age as is as important as how long we live.

- A growing and ageing population means the prevalence of long-term conditions will increase.
- Older people with frailty and people with complex multiple LTCs will rise the most.
- 1/5 of deaths are avoidable – preventable by public health measures and treatable by timely and effective healthcare.

Theme 3 – Some groups of people experience worse health outcomes than others, leading to inequity across the County.

- The health of our population is not evenly spread across the County with inequalities in life expectancy of 8 years.
- People in deprived areas fall into poorer health faster than those in affluent areas. The age is most prominent at 65-69.
- People from Asian/Asian British ethnicities are more likely to be diagnosed with psychiatric/behavioural.

Theme 4 – Health and care services perform well, but rising demand (particularly from people with complex needs) creates pressure

- We have good performance across many healthcare services in Gloucestershire.
- Primary care services in the county are well regarded, and we have comparatively low waits for elective care and treatment.
- But we have seen increased demand in many areas - demand for healthcare is significantly higher in frailty and complex multiple LTCs cohorts.

Theme 5 – These changing demographic patterns mean that continuing to deliver care in the same way will not be sustainable to meet future need.

- We already have challenges in recruiting in certain areas - this will become more challenging over time.
- We must also address an underlying financial deficit in the County. Doing nothing is not affordable as this deficit will grow.
- The way we all approach healthcare needs to change to be sustainable.

What people have told us

During Winter 25/26, we carried out engagement with the public about how together we can meet our local challenges.

Through the period of engagement, we have also been revisiting the principles developed with input from local people and communities 10 years ago. We have been testing whether these principles still hold true. Almost 500 responses were received.

Who has been involved

- Members of the People's Panel who are a representative group of people living and/or accessing services in the County.
- Engagement booklets circulated and community venues visited.
- Public and partner engagement including voluntary sector, patient groups and people from underserved communities.

What we have heard

Wellbeing, prevention & digital access

- Significant numbers are not aware of local activities to support their health.
- People see an important role for voluntary sector organisations in helping with people's health and wellbeing.
- Some people are concerned that the shift to digital means these become the norm (rather than face-to-face).

Healthcare services today

- People generally reported receiving good care.
- People want consistent communication and timely access to GP services and lower treatment waiting times.
- People in underserved communities value face-to-face information sharing and group discussions.

Designing healthcare for the future

- People want the services they use regularly to be close to where they live.
- People want care at home even if this means reducing hospital bed numbers.
- Quick assessment & 24/7 access for urgent care more than local services.
- Expertise & low waits for a specialist rather than fewer appts or distance.

Our Five-Year Population Health & Strategic Commissioning Plan

Our Purpose

Our **vision** is to make Gloucestershire the healthiest place to live and work where there is equity in life chances and to ensure that best health and care outcomes are available for all

Our Strategic Ambitions

Strategic Ambition #1:
Healthy Lives
People live healthier lives for longer, by preventing avoidable illness and decline.

Flagship Priority: Proactive Frailty Care

Strategic Ambition #2:
Health Equity
Health outcomes, experience and access are fairer across all communities.

Flagship Priority: All Age Community MH

Strategic Ambition #3:
Best Value
What we value is defined by people's experiences & outcomes, within a sustainable system.

Flagship Priority: People with multiple LTCs

The conditions for Success

Strategic Partnerships
We will facilitate health and care delivery across whole care pathways focused on outcomes.

Financial Framework
We will grow the proportion of spend into prevention and Neighbourhood health.

Our Resources
More of the workforce will support Neighbourhood health and with better use of digital.

Our Commissioning Plan: What we will do

How care will be delivered
The way care is delivered will be underpinned by a principle of "local where possible, centralised where necessary"

Our Commissioning Intentions

A population health approach for different groups of people

Supporting people to stay healthy at home

Proactive personalised high-quality care in Neighbourhoods for people with rising risk

Specialist and high-quality care and support across multiple Neighbourhoods

More streamlined secondary care services that enable high quality care

Our strategic ambitions and the conditions for success

Our strategic ambitions
We are establishing 3 strategic ambitions that will help us to improve health and care for all people. We will ensure that our strategic commissioning intentions respond to one or more of these areas.

#1: Healthy Lives
We want people to remain healthy for longer. Through a focus on prevention, **our aim** is to at least maintain the proportion of people living in good health and moderate health groups.

#2: Health Equity
We want to improve health equity for different groups of people. **Our aim** is to reduce the health inequalities gap between the most and least deprived areas as well as between different groups of people.

#3: Best Value
We can deliver better value by doing things differently and reducing waste. **Our aim** is to improve outcomes and experience for people whilst achieving this within the resources available to us.

The conditions for success
There are three key conditions that are key for us to get right as we deliver on our vision for better healthcare in Gloucestershire. We will prioritise delivery of these three areas.

Strategic Partnerships
Our strategic partnership arrangements will look different in the future. **Our aim** is to expand commissioning that is outcomes focused and commissioned across care pathways.

Financial Framework
Our aim is to shift the proportion of healthcare spend within Gloucestershire, resulting in a smaller acute sector. We will hold the level of acute expenditure & flow investment into non-acute settings.

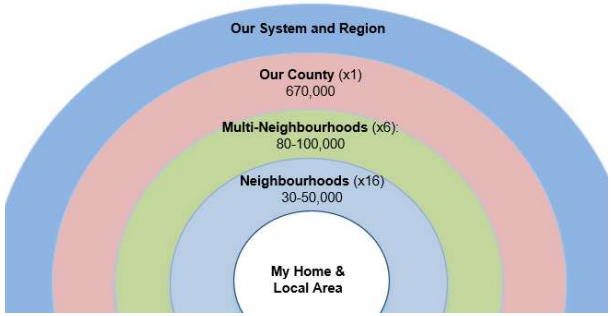
Our Resources
Our aim is that more of our workforce will work in or provide support to Neighbourhoods. Partners will also ensure that we make best use of digital and share our estate to support integrated care ambitions.

How care will be delivered

A population health approach for different groups of people

We will take an approach that starts with priority groups of people:

- Older people living with frailty
- People with rising risk (Multiple LTCs: CKD, CHD, Heart Failure & Diabetes)
- Women and birthing people
- Children and Young People (including those living with complex needs)



Supporting people to stay healthy at home

- Community assets will be available in local areas to help people remain healthy.
- VCSE capacity will be developed and a 'make every contact count' approach will connect people to help with physical and mental health
- Community pharmacies will play a more important role in prevention and wellness.
- Digital access will be available where people want it such as monitoring and appointment bookings.

Proactive personalised high-quality care in Neighbourhoods for people with rising risk

- Integrated Neighbourhood Teams (e.g. health, social care, VCSE) will bring together staff around the person.
- Proactive care and continuity of care will be provided for people with rising risk & complex needs.
- Specialist in-reach advice, and guidance will help people to manage their conditions.
- Person-centred conversations will focus on what matters to people through discussions with them.

Specialist and high-quality care and support across multiple Neighbourhoods

- More care will be delivered outside of hospital settings and therefore closer to home.
- Earlier assessment and diagnostics will help determine the care and treatment needed.
- Support for people with higher needs will be accessible, avoiding inpatient care when not needed.
- Step-up or step-down care will support people quickly back to independence.

More streamlined secondary care services that enable high quality care

- People will receive the right care and treatment when it is needed most.
- Specialist sites are streamlined and will provide care in emergencies / for patients with high acuity (physical or mental health).
- Safety, quality and patient experience will remain core to care and support.
- De-risked settings will enable delivery of key performance and quality standards for the public.

Some specialist services will continue to be delivered from locations wider afield (such as Bristol or Birmingham). Through the regional commissioning hub, we will influence outcomes for patients accessing these.

What this means for Emma

Emma is 78 years old. She has lived in Gloucester for most of her life. She grew up in a time when the city felt very local and closely knit.

Emma spent much of her working life in roles working with people – retail work and supporting in local primary schools. Emma and her husband have 2 children who have now all grown up and left home. Emma is retired and lives alone as her husband sadly died 4 years ago. Her circle of friends has become smaller, and she feels the absence at times.

Emma's health is manageable at present but not perfect. She doesn't see herself as "ill" but she does recognise aspects of her health are getting worse. Her strength and balance have declined, and she now walks more slowly, impacted by growing arthritis in her knees and hands. She has mild high blood pressure which she is taking medication for. She has started to show signs of forgetting recent conversations but can reminisce about the past.

What would be different:

- Discussions with Emma about what she enjoys – she's now part of an intergenerational group taking place in her local school which she enjoys and has helped her mental wellbeing.
- More proactive monitoring of her frailty and memory symptoms by the Neighbourhood team visiting her at home or offering scheduled check-ups in her Neighbourhood hub to help prevent crises that lead to urgent primary care or hospital visits.
- The Neighbourhood team includes physiotherapy that supports Emma with her mobility and reduces the risk of falls.
- Physiotherapist advice is provided by the Neighbourhood team who can support Emma with her arthritis – they can access that specialist advice and support when needed to avoid multiple visits for Emma.
- If she gets unwell, Emma is assessed and treated in her home with virtual monitoring when it is needed to help her remain independent at home.

A population health approach for different groups of people

As part of strategic commissioning, we will take a population cohort approach - understanding the needs of different groups of people. We will seek to understand the views and healthcare needs of these groups and use it to design future services.

We will prioritise work with different groups of people and we will develop this over time. Our approach below also reflects a life-course approach – recognising that what we do today to support people to live healthy lives will benefit in the future.

We will prioritise the following groups of people first:

1). Older people living with frailty

Given the fastest growth rate is older people living with frailty, we will prioritise this group of people.

2). People with rising levels of risk (multiple LTCs)

As more people live with multiple long-term conditions (LTCs) we will focus on prevention for conditions that occur frequently together: CKD, CHD, Heart Failure & Diabetes.

3). Women and birthing people

We have work underway to understand the needs of women and birthing people and will use this to design the future of maternity services in Gloucestershire.

4). Children and young people

We will also focus on children and young people given significant increases in mental health needs and ensure children with complex needs are addressed.

To better understand the health of Gloucestershire people we have segmented people into 11 groups.

Health Group	No. of People	% of Pop.	Low / Med / High
01: Non-User	38,208	5.48%	Low Need: 508,381 (72.9%)
02: Low Need Child	105,685	15.15%	
03: Low Need Adult	237,226	34.02%	
04: Multi-Morbidity Low Complexity	127,262	18.25%	
05: Multi-Morbidity Medium Complexity	84,938	12.18%	Moderate Need: 166,184 (23.8%)
06: Pregnancy Low Complexity	6,905	0.99%	
07: Pregnancy High Complexity	1,713	0.25%	
08: Dominant Psychiatric/Behavioural Condition	12,669	1.82%	
09: Dominant Major Chronic Condition	59,959	8.60%	
10: Multi-Morbidity High Complexity	14,145	2.03%	High: 22,815 (3.3%)
11: Frailty	8,670	1.24%	
Total	**697,380**		

1). Supporting people to stay healthy at home

Our Commissioning Intentions

We want people to feel connected in their local areas, accessing the activities and assets. We will prioritise factors that influence how long people live in good health (such as access to primary care and prevention).

Work here is commissioned or delivered by others (such as the Local Authority Public Health and VCSE). We will align our commissioning plans here whilst also supporting the management of health conditions at an early stage:

1. Working with Gloucestershire County Council and wider partners we will take action that enables the voluntary sector to help people to remain healthy and **connects people with local support and resources in their local area**. We will help to build capacity of the sector and co-design structures that facilitate partnership working in the system.

2. **We will expand the preventative role of Community Pharmacies, enable a more Modern General Practice and expand Dentistry access to ensure people can easily access** the right advice and support close to where they live when conditions or health needs arise.

3. **We expand digital options (alongside traditional face-to-face)** that help people to look after their own / family health (self-care). This will include improved information sharing and NHS App expansion and rollout to the Gloucestershire population.

Significant programmes we will prioritise together

Portfolios	Neighbourhood Health	System Enablers
	• VCSE Partnership Model • Pharmacy First including Long Term Condition Management • Modern General Practice • Dental Access Centre and Centre of Dental Excellence	• Digital Strategy delivery including NHS app expansion

1). Supporting people to stay healthy at home

When we will do it

Year 1 – 26/27

- Complete development of the VCSE Model - developing capacity helping people connect into activities/spaces that help them to remain healthy.
- Open the Dental Access Centre in Gloucester in summer 2026 and determine next steps for the Centre of Dental Excellence.
- Continue expansion of services in Community Pharmacy including early detection of hypertension for patients and enhanced roles within community pharmacy for long-term condition management.

Years 2 and 3 – 27/28 - 28/29

- Through Modern General Practice programme, ensure consistent expansion across all General Practice locations, NHS app integration and online consultation platforms.
- Expanded rollout of the NHS app in line with the 10 Year Plan commitments including seeing who is involved in care, communicating with professionals and booking appointments and leaving feedback.

Years 4 and 5 – 29/30 - 30/31

- Significantly more people saying that they are aware of and use local assets (e.g. groups/activities) that enable them to manage their health and care.

Strategic Outcomes

- **People remain in good health for as long as possible**
  - **Metric**: Maintain the proportion of people who are living in “good health” groups (pop. segments 1-4).

Sub-Outcomes

- **More people accessing support that enables them to self-care**
  - **Metric**: Community Pharmacy First consultations*
- **People can easily access first line healthcare advice locally when needed**
  - **Metric:** People registered to use the NHS app
  - **Metric:** Experience of booking a General Practice appointment
  - **Metric:** Provision of Urgent Dental Appointments*
- **More people who can, make decisions that support healthy lifestyles**
  - **Metric:** People referred to Digital Weight Management Programmes
  - **Metric:** Reduction in levels of inactivity (children and adults)

**Priority Breakthrough Metrics*

2). Proactive personalised high-quality care in Neighbourhoods for people with rising risk

Our Commissioning Intentions

With our partners, we will co-create the conditions that enable the delivery of Neighbourhood Health and Care. This will include the development of a shared vision to support the future commissioning of Neighbourhood Health and Care.

1. We will **commission new Neighbourhood models of care for priority groups of people** so that care is proactive and personalised. We will commission for these groups against defined outcomes: 1). Older people living with frailty, 2). People living with moderate and complex multimorbidity (rising risk) and 3). People of all age with mental health needs
2. We will expect **Neighbourhood plans to be developed for estates, digital and workforce** in support of these groups of people. This includes the establishment of Neighbourhood Health Centres acting as hubs and digital information sharing across integrated neighbourhood teams.
3. We will **re-commission Weight Management services for people in Gloucestershire**, enabling people to receive effective Neighbourhood-based support as well as specialist care and treatment. We will also review **Speech and Language Therapy services** to support sustainability.
4. We will **review the impact of investment in Neurodiversity services for people with Autism and ADHD and take action to ensure timely needs-led neurodiversity support**. We will respond to the national SEND Reform plans when published.

Significant programmes will prioritise together

*Potential Major Service Reconfiguration

Portfolios	**Neighbourhood Health**	**Mental Health, Neurodivergence, LD & Autism**	**Other** (NHS contributes….)
	• Neighbourhoods for older people with frailty & dementia • Neighbourhoods for people with rising levels of risk (multiple LTCs) • Weight Management Pathway • Speech and Language Therapy	• Community Mental Health • Neurodiversity Transformation and SEND Reform.	• Family First Partnerships (Children and Young People) - led by Gloucestershire CC

2). Proactive personalised high-quality care in Neighbourhoods for people with rising risk

When we will do it

Year 1 – 26/27

- Agreed how and which teams (incl. specialists) will come together around agreed population groups. The model of care will be being tested and outcomes developed.
- Groups of staff in Integrated Neighbourhood Teams will come together in Neighbourhoods to determine local priorities.

Years 2 and 3 – 27/28 - 28/29

- Integrated Neighbourhood Teams will be established for the priority population groups based on a personalised proactive care approach.
- Incentives have been identified and outcomes developed to enable commissioning across these pathways with supporting funding flows.
- Workforce development in place for people working within Neighbourhoods.
- The first Neighbourhood Health and Care Centres are established.
- Fully implemented Countywide model for weight management / obesity.

Years 4 and 5 – 29/30 - 30/31

- Fully embedded Neighbourhood teams covering priority groups – including children and young people through Families First Partnerships.
- INTs exploring how to align with other services outside of health & care (e.g. other Local Government services such as employment, debt advice).

**2 Priority Breakthrough Metrics*

Strategic Outcomes

- **People remain in moderate health and inequalities are reduced**
  - **Metric:** The proportion of people who are living in moderate need (segments 5-9) is maintained.
  - **Metric**: Average health score between most deprived & least deprived areas is reduced.

Sub-Outcomes

- **People wait less time for care and support in the community**
  - **Metric**: Increase in the number of patients on the Personalised Proactive Whiteboard*
- **More people receive proactive and personalised care in the community**
  - **Metric**: People have low waiting times to see community health services (waiting less than 18 weeks)
- **More care in Neighbourhoods reduces the need for acute / specialist care**
  - **Metric**: Reduction in rate of emergency hospital admissions for people aged 65+ per 1,000*
  - **Metric**: Reduction in rate of long-term admissions to residential/nursing homes for people 65+
- **Staff and the public have a positive experience of care delivery** (Metrics in development)

3). Specialist and high-quality care and support across multiple Neighbourhoods

Our Commissioning Intentions

We will work together to deliver care closer to where people live where it is appropriate to do so. Care will be provided not only to help people to help people remain independent and well but also help people back to independence after a period of illness.

1. We will **commission a new approach to long-term condition management that includes outpatient care**. Optimised by digital where appropriate, we will move more care for people with single conditions into the community. As more people live with multiple conditions we will change the traditional single condition approach to care.
2. **By understanding population health needs, we will review the way we provide urgent care**. We assess against best value principles and work with stakeholders to determine the most suitable arrangements for minor injuries and illnesses that improves access and performance and keeps A&E for genuine emergencies.
3. **We will prioritise a 'home by default' approach**, adopting that mentality and mindset with staff that enables people to return quickly to independence in a place they call home. We will undertake a review of intermediate care aimed at reducing our use of bedded care and promoting home to maximise independence.
4. We will commission **simplified pathways that help to prevent urgent and/or emergency escalation for people living with learning disability or mental health and care needs**. For mental health and learning disabilities, principles of least restrictive practice will uphold people's rights and independence whilst keeping people safe.

Significant programmes will prioritise together

*Potential Major Service Reconfiguration

Portfolios	Urgent and Emergency Care	Planned Care, Cancer and Diagnostics	Mental Health, Neurodivergence, LD & Autism
	• Urgent Care Pathway Review (General Practice, UTCs, MIIUs, A&E)* • Long-Term Intermediate Care Model*	• Long-Term Condition Management (including Outpatients)	• Learning Disabilities Pathway* • Urgent and Emergency Mental Health Pathway • Mental Health Intensive and Assertive

3). Specialist and high-quality care and support across multiple Neighbourhoods

When we will do it

Year 1 – 26/27

- Needs analysis work scoped and commenced to support a review of the urgent care pathway in Gloucestershire.
- The case for change will be complete for intermediate care provision.
- Early testing will take place for long-term condition management – both for people living with single conditions (e.g. pain and dermatology) as well as for people living with multiple long-term conditions.

Years 2 and 3 – 27/28 - 28/29

- A new community offer will be in place for people with learning disabilities and intensive and assertive outreach for people with psychosis.
- New approaches to care will be commencing in the first localities for intermediate care and people living with multiple long-term conditions.
- Engagement will be taking place with the public regarding the future of urgent and emergency care services in the County.

Years 4 and 5 – 29/30 - 30/31

- Where needed, improvements made in urgent care building on existing offers such as General Practice, Integrated Urgent Care Service / NHS 111 and Minor Injury and Illness Units to keep A&E for genuine emergencies
- Both diagnostic and outpatient activity will increasingly be being delivered outside of the acute hospital, optimising the use of digital technology.
- Specialists will consistently be working alongside Integrated Neighbourhood teams.

Sub Outcomes

- **People wait less time for diagnostic tests / results**
  - **Metric:** Fewer people waiting over 6 weeks for diagnostics across all modalities*
  - **Metric:** Faster time to be seen and to have received a result (28 day) as well as receiving treatment (31 and 62 days)
  - **Metric:** More cancers diagnosed at stages 1 and 2
- **Fewer admissions are needed to inpatient care settings**
  - **Metric:** Reduce the rate of admissions to inpatient care for people with a learning disability and autistic people
  - **Metric:** Reduce the rate of admissions to inpatient care for people with mental health
- **When people leave hospital, they go back to their usual place of residence**
  - **Metric:** More people over the age of 65 who are discharged back to their usual place of residence*

**2 Priority Breakthrough Metrics*

4). More streamlined secondary care services that enable high quality care

Our Commissioning Intentions

By acting on our ambitions around Neighbourhood Health, we will seek to slow the rate of growth in secondary care services.
The result of this left shift will be that we will de-risk these services enabling them to deliver the best possible care and treatment and enable them to deliver against constitutional standards. This will present opportunities to streamline secondary care services.

1. **As we prioritise Neighbourhood Health and Care, we will continue to review where and how specialist treatment and skills are needed**. We will adopt a 'Centres of Excellence' approach, centralising specialist services where necessary and de-risk care settings to help achieve constitutional standards.
2. We will focus on **safety and quality improvements across acute and specialist services starting with care for women and birthing people**. We will co-design and commission a new model of maternity care that improves patient experience and clinical safety.
3. We will commission services that helps people get the right care at the right time during a time of crisis (such as Single Point of Access in Urgent Care) and continues to improve urgent care performance in Gloucestershire. **We will commission services that improve flow, with discharge planning starting on day of admission.**
4. We will ensure that **our approach to mental health inpatient care** continues to deliver safer and person-centred environments alongside community alternatives to reduce long-stays and inappropriate admissions.

Significant programmes we will prioritise together

*Potential Major Service Reconfiguration

Portfolios	Urgent and Emergency Care	Planned Care, Cancer and Diagnostics	Mental Health, Neurodivergence, LD & Autism	System Quality
	• Improved Coordination of the urgent care access (Single Point of Access) and discharge process (Integrated Flow Hub)	• System Wide Theatre Review (including community theatre temporary test of change)*	• Adult Inpatient Mental Health Care	• Future Model for Maternity Services*

4). More streamlined secondary care services that enable high quality care

When we will do it

Year 1 – 26/27

- Review of Maternity Services undertaken and options for future service delivery complete through co-design and engagement.
- Final decision on plans to maximise theatre utilisation in Gloucestershire following temporary tests of change.
- Commence implementation of a Single Point of Access for Healthcare professionals and considered future commissioning of an Integrated Flow Hub for Urgent Care.
- Mental Health Inpatient Strategy developed with action plan for delivery.

Years 2 and 3 – 27/28 - 28/29

- New maternity model is live in the County with patient feedback and reviews being undertaken.
- Improvements being made to Mental Health crisis pathway.

Years 4 and 5 – 29/30 - 30/31

- New models of care described above are working well and this is having an impact on outcomes and experience for people.
- Centres of Excellence Models are embedded, protecting capacity and ensuring non-elective and elective standards are being delivered.

Sub Outcomes

- **People wait less time for emergency care as well as treatment**
  - **Metric**: Lower waiting times for urgent and emergency care (4hrs and 12 hrs*)
  - **Metric**: Fewer people waiting for elective treatment and reduction in the time that people wait*
- **When people require inpatient stays, they only remain as long as needed**
  - **Metrics**: Lower length of stay – acute hospital, community hospital, mental health
  - **Metric**: Fewer adult people waiting in acute hospital who are ready to go home (discharge delay from acute hospitals)
- **When people receive care, it is safe and high quality**
  - **Metric**: Number of neonatal deaths and stillbirths per 1,000 total births

**2 Priority Breakthrough Metrics*

How we will evaluate and assess progress

Two Headline Ambitions

Average number of years spent in good health (Healthy Life Expectancy at Birth)
Life expectancy gap between most and least deprived areas (Inequality in Life Expectancy)

#1: Healthy Lives	#2: Health Equity	#3: Best Value
At least maintain the proportion of people in good/moderate health relative to poorer health	Reduce the health inequalities gap between areas and groups of people.	Improve health access, experience & outcomes whilst keeping spend the same or lower

Six Strategic Metrics

Strategic Partnerships	Financial Framework	Our Resources
Expand commissioning that is outcomes focused and across care pathways (multi-provider)	Shift the proportion of spend "left" - from acute into community	Increase the proportion of roles that are community-based and/or focused

Eight Breakthrough Metrics

Supported by a small number of additional metrics for each section.

A population health approach for different groups of people	Self-care, prevention and digital access at home	Keeping well through proactive and coordinated care	Getting specialist advice and care closer to home	Timely care and support when needs are highest
	Patients accessing Pharmacy First	Adoption of Personlised Proactive Care	Timely diagnostics for patients	Waiting Times in ED (4 hour and 12 hour)
	Urgent Dental access for patients	Non-elective admission rate for people over 65	People discharged to their usual residence	Time waiting for elective treatment (18 weeks)