



# Population Health and Strategic Commissioning Plan

Our plan for improving health and care  
in Gloucestershire

**2026-2031**

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# Section 1

## Moving towards a shared vision and plan

# Introduction from ICB Chief Executive Officer and ICB Chair

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

In developing this plan, we have worked at pace to bring together a broad range of evidence, insights and established strategies into a single, coherent 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 Bristol, North Somerset and South 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 Integrated Care Board takes shape.

By building on trusted relationships and established practice, we are laying the foundations for a 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 reduce unacceptable gaps in health outcomes that persist between communities, ensuring that where people live, work and grow has less impact on inequalities in quality or length of life.

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 improvements in life expectancy, healthy life years and lived experience for all, but particularly for those who need it most.

In pursuit of that, we will be united by three strategic ambitions that we will put at the forefront of our work:

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

As we create a new Integrated Care Board, 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

Chief Executive Officer of NHS Gloucestershire ICB and NHS Bristol, North Somerset and South Gloucestershire ICB Cluster



## Jeff Farrar

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

# Endorsement from Health and Wellbeing Board

**As Chair of the Gloucestershire Health and Wellbeing Board, I am pleased to confirm that the Gloucestershire Health and Wellbeing Board supports the Gloucestershire Integrated Care Board's new Strategic Commissioning Plan.**

The Board has been glad to help shape the plan. We share the same aim: to help everyone in Gloucestershire live well, be healthy, and thrive. The plan makes it clear that no single organisation can achieve this alone. In Gloucestershire we already have a strong history of working well together, and this is shown in the close partnership between the Health and Wellbeing Board and the Integrated Care Partnership.

Making sure that we all have the same opportunity to enjoy good health and wellbeing is at the heart of our Joint Local Health and Wellbeing Strategy. We welcome the Strategic Commissioning Plan's focus on reducing health inequalities, and ensuring that health outcomes, experience and access are fairer for everyone. It's also important that we continue to invest in work to address the social factors which influence our health —such as housing, access to jobs, and safe neighbourhoods.

The plan also recognises that, although many of our health and care services perform well, rising demand is putting pressure on some areas. Gloucestershire is making good progress to make sure people can get the right care at the right time. Preventing poor health is just as important, and we must help people to take steps to look after their own health. A good example is dental care: we are working not only to improve access to dentists, but also to support better oral health.

Preventing illness and helping people lead healthy lives are central goals of both the new Strategic Commissioning Plan and our Joint Local Health and Wellbeing Strategy. Our Board's seven priorities include healthy weight, good mental wellbeing, and physical activity—important areas that help improve health for everyone.

We also welcome the plan's commitment to working closely with local communities and the voluntary sector. Value is defined by people's experiences and outcomes, not just numbers. It's important that local people remain at the centre of all our work.

Neighbourhood health will play a big role in meeting our shared goals, as set out in the Government's 10-year health plan. The Health and Wellbeing Board will help lead the development of our local Neighbourhood Health Plan, creating more joined up, person-centred care close to home.

On behalf of the Board, I look forward to continued partnership working to deliver the commitments in the Strategic Commissioning Plan, and to improving the health and wellbeing of people across Gloucestershire.



**Cllr Dr Kate Usmar**

Chair of the Gloucestershire Health and Wellbeing Board  
Cabinet Member for Adults' Support & Independence  
Gloucestershire County Council

# Purpose of our Population Health and Strategic Commissioning Plan

The [10 Year Health Plan](#) describes the role that Integrated Care Boards (ICBs) will have as strategic commissioners with responsibility for ensuring that the money available to each local care system is put to the best use. This means improving population health, reducing health inequalities, and improving access to consistently high-quality services.

Although this is our first Population Health and Strategic Commissioning Plan, it continues and builds on previous plans (such as our Joint Forward Plan). Improving health and wellbeing is not solely the responsibility of the NHS. This plan describes the contribution that the NHS will make and our work with others to improve population health.

Therefore, this plan supports delivery of the [Gloucestershire Joint Health and Wellbeing Strategy](#) (2020-2030). Our work in the NHS makes important contributions to the priorities within the Joint Health and Wellbeing Strategy, including in relation to physical activity, mental wellbeing, social isolation and healthy lifestyles.

With forthcoming changes to ICBs, by April 2027 we will create a single plan covering both Gloucestershire and Bristol, North Somerset and South Gloucestershire (BNSSG). To support this transition, we are this year aligning the approach and structure of both the Gloucestershire and BNSSG plans.

This Plan has been informed by publication of the NHS Strategic Commissioning Framework. The plan describes our local context, sets out our long-term population health priorities and describes how we will allocate resources to meet local health and care priorities.

As an ICB, we are grateful for the input and engagement that partners have had into this plan as well as the feedback from public engagement that we carried out over winter 2025. The Plan is intentionally high level, pointing towards the areas we are prioritising.

This Population Health and Strategic Commissioning Plan is described in four sections. Sections 1 and 2 provides our Population Health Strategy. It describes the local need, our vision, and our strategic ambitions for improving health and healthcare. Sections 3 and 4 comprise our response (our Strategic Commissioning Plan).

## ▶ Section 1 introduces this plan:

We describe our vision and values for improving health and care with an overall aim of improving healthy life expectancy for all.

## ▶ Section 2 sets out our strategic ambitions:

We summarise the evidence from our integrated needs assessment, and what we have heard from the public through engagement. We set out three strategic ambitions and describe how and where we intend to deliver care to realise these ambitions.

## ▶ Section 3 details the areas that we will prioritise:

We describe our commissioning intentions, the key changes we intend to deliver, the timelines and the way we will measure impact.

## ▶ Section 4 sets out the arrangements for delivering this plan:

We describe our approach to managing risk and how we will develop and grow the capabilities needed for strategic commissioning within the Integrated Care Board.

# Our vision and values

**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.**

In delivering this vision, we have a headline ambition for Gloucestershire to have the highest number of years spent in good health in the country (what we term “healthy life expectancy”) and to reduce inequalities of life expectancy that exist between the most and least deprived areas. We want people to have the opportunity to live more years in healthy life regardless of factors such as how old they are, where they live, or how much they earn. These ambitions are shared with the Joint Health and Wellbeing Strategy for Gloucestershire.

It is positive that people are living to older ages with overall life expectancy at birth higher than the national average. However, like other areas in the country, for the number of years spent in good health Gloucestershire has seen a drop of 3.6 years for females and 3.1 years for males since the pre-COVID period (2017-2019). In Gloucestershire, men currently live just over 16 years of their life in poor health and women just over 20 years.

There are also significant variations in health outcomes in the county. Overall life expectancy shows a gap of almost 7 years for women and 8 years for men between the most and least deprived areas and it is likely that there are similar trends for healthy life expectancy (although data is unavailable for areas within Gloucestershire).

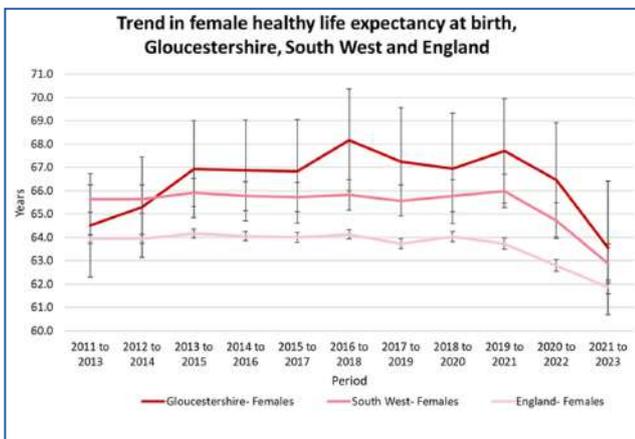
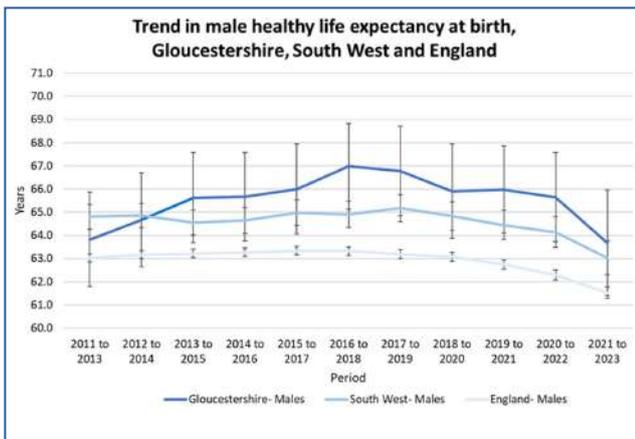
As an ICB, we are committed to playing a role in reversing this downward trend in healthy life expectancy and closing the inequalities gap in life expectancy.

Healthy life expectancy is influenced more by the conditions people live in than by healthcare itself. We all have our own part to play in creating good health, whether as individuals, as local communities or as organisations.

This plan describes the role the NHS will play.

We have a role in early prevention and helping people live healthy lives through our work with partners such as the Voluntary, Community and Social Enterprise (VCSE) sector. This is a key area of focus for the Joint Local Health and Wellbeing Strategy that the ICB will continue to support the delivery of.

We also have a role in improving access to healthcare services and ensuring that the care people receive is safe, clinically effective and personalised around what matters to them. We want every person to have a positive experience when they have contact with health and care services in the County, and to have the best possible outcomes.



This plan describes the role that we will play in delivering the national 10 Year Health Plan and the three shifts it outlines:

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

Delivering these shifts requires a fundamental change in how we think about, enable and deliver health and care in the County. It will also require us to make difficult decisions to ensure that health and care services are sustainable both now and in the future.

This plan sets out our shared direction of travel, recognising that whilst we may strengthen care in some areas we will need to de-commission or reduce services in others to be sustainable over the long-term.



## **As partners together across Gloucestershire, we will work inclusively and collaboratively to deliver the vision set out.**

We will all need to work together to meet this vision for good health and wellbeing in our County. In Gloucestershire, we have been bold and ambitious in setting ourselves these stretching objectives as an ICB. This will require us all to rethink how we deliver or receive health and care. It will also mean re-balancing where NHS funding goes as we shift more towards prevention.

As we increasingly step into the strategic commissioner role, we will act as a system convenor, bringing together partners and local communities to co-create the conditions that support delivery of our shared vision.

In our strategic commissioning work, we will increasingly take a **“user design-led approach”** where we start by understanding groups of the population with health needs (using population health data and insight from the public) and use this to test new ways of working.

Whilst we recognise that there are metrics, standards and targets that will need to be delivered, we want to be a system that learns from what we do rather than merely manages performance. We live in a complex system where many solutions are not linear. We also recognise that we do not have all the answers within the NHS, but that by coming together with system partners we can design and shape an exciting future together.

The commissioning priorities laid out within the 5 Year Population Health and Strategic Commissioning Plan are those that are important to local people and evidence-based, reflecting what we have heard through engaging with local people and where approaches are known to be effective. The areas we describe also play to the strengths of the different organisations in the County.

As a result, this Population Health and Strategic Commissioning Plan is a **“joint compact”**. Our strategic commissioning will bring organisations together to help realise the ambitions set out within this plan. It will require all organisations to think and act in a way where we recognise strengths in one other and where we take shared ownership for the contributions that we each will make.



# Section 2

## Our population health strategy for Gloucestershire



# Our problems to solve

## **Our assessment of current and future health and care needs has been informed by our integrated needs assessment.**

The full integrated needs assessment can be found [here](#). We have formed our integrated needs assessment from the following:

### ▶ **Joint Strategic Needs Assessment (JSNA):**

On behalf of the Health and Wellbeing Board, Gloucestershire County Council lead on production of the [JSNA](#). This is a broad assessment of the current and future health needs of the population.

### ▶ **Population Segmentation and Dynamic Population Model:**

We have undertaken work to understand our local population health by dividing the Gloucestershire population into segments. This has used the Johns Hopkins Model with 11 distinct groups that are based on the complexity and intensity of healthcare needs.

### ▶ **Performance and Quality of NHS Commissioned Services:**

We have undertaken a review of NHS commissioned services that are particularly challenged whether because of high demand, workforce related challenges and other factors.

Working with Public Health in Gloucestershire County Council and other partners, we will update the integrated needs assessment annually and use it to inform priorities. This plan covers both the Gloucestershire population resident (652,666) in the County, as well as people registered (697,380) at a GP Practice in the County.

## We have identified five themes that help us understand population health.

### Theme 1:

#### Gloucestershire is a comparatively healthy county, but the population is growing and ageing (*population trends*).

The overall health of the population in Gloucestershire is generally good, with higher life expectancy at birth (80.0 years for males and 83.8 years for females: 2021-2023) and more years spent in healthy life than the national average.

Our population health modelling shows that of the patients registered with a GP Practice in Gloucestershire, 73% (508,381) are currently living with low health need compared to 24% (166,184) in moderate health need and 3% (22,815) with high health needs - either people living with highly complex multi-morbidities or older people over 65 living with frailty.

However, we know that the population of Gloucestershire is changing with significant growth expected. We expect to see a 17.5% increase in the resident population of the County from 2022 to 2047 (growing by almost 114,000 people). This projection is substantially higher than England (12.7% growth over the same period). By 2047 the Stroud population is projected to be larger than Gloucester. Whilst natural change will lead to more deaths than births (decreasing the population by 46,383), the overall growth is heavily impacted by people from other parts of

the country moving into the County. This inward net migration will increase the population by almost 150,000 people.

New housing developments will add additional homes into the County. If all housing targets are successfully delivered, this will be equivalent to adding two additional towns into the County. District Councils have a combined housing target of 85,500 additional homes to build by 2043 (note that some of these are in the planning pipeline). Strategic and Local Plan engagement is underway across most Districts in 2025/26 that will help to determine sites for these.

Alongside population growth, the age profile of the population is also changing. The highest areas of population growth among those living in Gloucestershire will be amongst people over the age of 65 with a projected increase of 43% between 2022 and 2047 (111% growth for people over 85). This will mean that the Older Age Dependency ratio, currently at 370 people in retirement age for every 1,000 people of working age will increase to in every area of the County – the highest in Cotswolds (496 per 1,000) and Forest of Dean (302 per 1,000).

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%	High: 22,815 (3.3%)
10: Multi-Morbidity High Complexity	14,145	2.03%	
11: Frailty	8,670	1.24%	
<b>Total</b>	<b>697,380</b>		

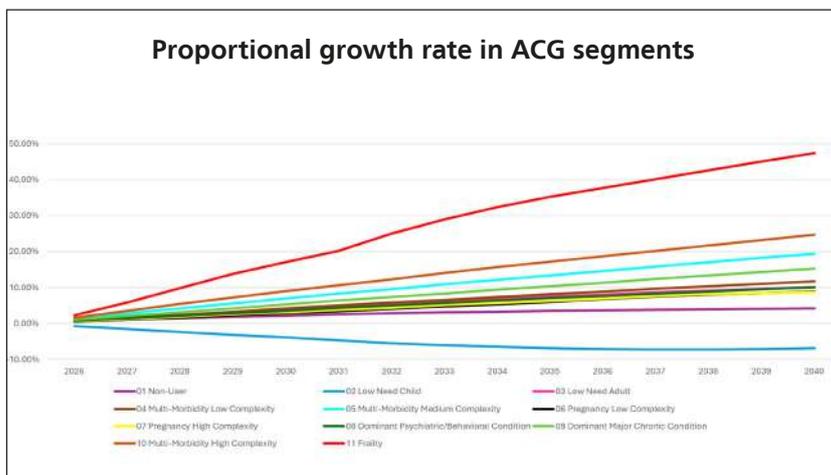
## Theme 2:

### As people live longer, more will experience long-term conditions - but how we age is as important as how long we live (*health in later life*).

The impact of a growing and ageing population means the prevalence of long-term conditions will increase. The probability of developing many conditions (such as cardiovascular disease and dementia) increases with age. Furthermore, since many health conditions are chronic and incurable the levels of illness are cumulative.

Our population health modelling shows that the greatest growth will be amongst people with high health needs - older people living with frailty (46% percentage increase from 2025 to 2040) and people living with complex multiple long-term conditions (30% percentage increase).

However, the rate of growth is not inevitable. Around 1 in 5 deaths in England are avoidable, a similar pattern to Gloucestershire. Of these, 65% are preventable deaths (could be prevented by public health measures and/or individual lifestyle choices) with the remaining 35% considered



treatable (could be prevented with timely and effective healthcare). Avoidable mortality is higher in more deprived areas. The Global Burden of Disease Study from 2021 showed that the greatest risk factors by cause of death in Gloucestershire were high blood pressure, tobacco and dietary risks.

Similarly, whilst premature death (mortality occurring under the age of 75) is lower in Gloucestershire compared to England, there are areas where further attention is needed. For example, people under 75 living with severe mental illness in Gloucestershire are over 5 times more likely to die prematurely than the general population.

Key to healthy ageing (and therefore enabling people to remain in good health for longer) is the primary prevention of long-term conditions such as the adoption of healthy behaviours including physical activity, healthy diet, and the reduction of risky behaviours such as smoking and excess alcohol consumption. Alongside this is the importance of secondary prevention through early diagnosis, treatment, and supporting people to manage their long-term conditions. For example, if 80% of people in Gloucestershire with high blood pressure were treated to target then 148 heart attacks and 99 strokes could be prevented each year.



## Theme 3:

### Some groups of people experience worse health outcomes than others, leading to inequity across the county (*health inequalities*).

Whilst the county overall is healthy, this masks variation in health outcomes for different groups of people and between different areas. Health and wellbeing are impacted by who you are and where you live.

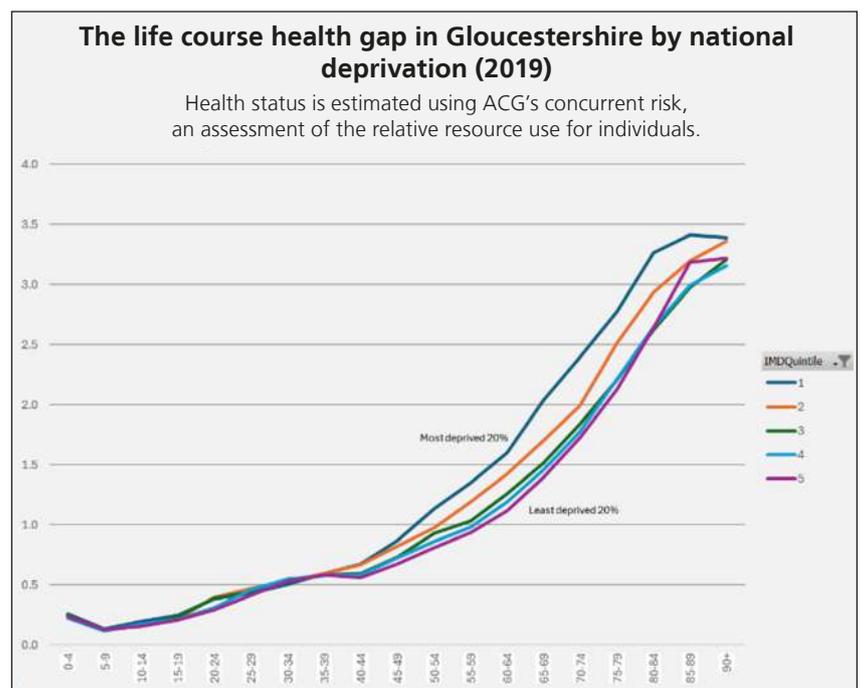
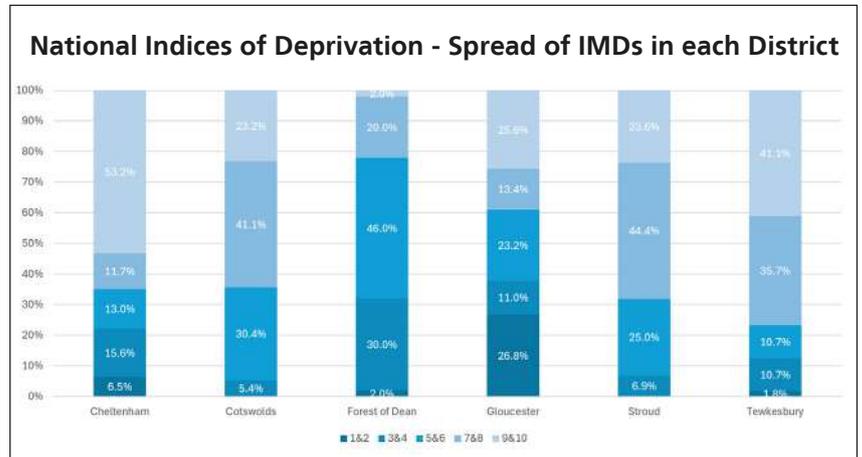
In 2025, Gloucestershire had 12 local areas (3% of the total) in the 10% of most deprived areas in the country. These are spread across Gloucester (9), Cheltenham (2) and Tewkesbury (1). Overall, there are proportionally higher levels of deprivation in Gloucester, Forest of Dean and areas of Cheltenham.

Overall life expectancy at birth for people living in Gloucestershire varies by just over 8 years for men and almost 7 years for women between the most and least deprived areas of the County. Circulatory (25%), Cancer (15-17%) and Respiratory (12-13%) drive this variation.

As people get older, our population health analysis shows that people living in more deprived areas of the County will fall into poorer health faster than those people living in more affluent areas (an average score gap of 0.35). This life course health gap is most prominent at retirement age (65-69 with a gap of 0.82) but starts increasing from the ages of 40-44.

People living in more deprived areas are more likely to be diagnosed with high blood pressure and more likely to be overweight or obese, which are risk factors for long term conditions. Premature death rates from CVD are almost twice as likely in the 10% most deprived areas than the least.

The variation is not just reflected in where people live but also between people with different protected characteristics. For example, people from Asian or Asian British ethnicities are more likely to have dominant psychiatric / behavioural diagnoses compared to other groups.



We also see this variation in who and how people access healthcare services. Individuals in Gloucester and the Forest of Dean for example are more likely to be on elective waiting lists, more likely to be admitted for an emergency to hospital, and more likely to access both children's and adults' mental health services.

# Theme 4:

## Health and care services perform well, but rising demand (particularly from people with complex needs) creates pressure (healthcare pressure).

Many of our NHS commissioned services already perform and benchmark well to others.

Results from the GP Patient Survey continue to show high overall levels of patient satisfaction in Gloucestershire (80%), above the England average of 75%. This is exceptional given appointments to General Practice have increased by 21% since 2019 (vs 16% nationally). We are seeing a growing gap between Gloucestershire and England with an average of nearly one more primary care appointment per person per year (driven by increases in people seeing GPs multiple times). We are exceeding planned targets for the number of general practice appointments offered but know there is more to do to improve access.

Whilst satisfaction with dentistry is below the national average, it did show an improvement from 2024 to 2025, increasing from 58% to 66%. We are continuing to increase the number of urgent appointments in Gloucestershire (with a new Dental Access Centre opening in Gloucester City) as well as work with Gloucestershire County Council to improve oral health.

We have made significant progress in lowering waiting times for people waiting for elective

care with virtually all 65 week waits eliminated and good progress on reducing 52 week waits. Increasing the speed of referral to treatment to 18 weeks remains a priority in line with the 92% national commitment by March 2029 (70% in November 2025).

Despite these improvements, with increasing demand and/or workforce pressures in some areas there are challenges in some NHS commissioned services. Demand for diagnostic services has continued to increase which, compounded by workforce shortages in some areas (such as echocardiography), has caused growing waiting lists. Demand increases have also been seen in all areas of urgent care including in community settings (for example Integrated Urgent Care and Minor Injury and Illness Units), the ambulance service, and the Emergency Departments.

We also continue to experience significant demand for some community and mental health services such as Autism and ADHD with long waiting times for assessment as well as Community Speech and Language Therapy – caused by challenges in workforce recruitment and/or growing demand. This is a similar pattern to other areas around the country.

	Percentage of Population	Primary Care	Community Care	Mental Health	111	MILU	ED Attendance	Emergency Admission	Elective Admission	Outpatient Procedure	Outpatient Appointment	Non-Elective (Total) Bed Days
01 Non-User	5.48%	0.05	0.04	0.01	0.02	0.02	0.02	0	0	0.03	0.04	0.00
02 Low Need Child	15.15%	2.25	0.66	0.18	0.19	0.16	0.21	0.03	0.02	0.1	0.4	0.03
03 Low Need Adult	34.02%	2.66	0.12	0.04	0.1	0.09	0.1	0.01	0.02	0.09	0.28	0.03
04 Multi-Morbidity Low Complexity	18.25%	6.86	0.57	0.1	0.2	0.13	0.21	0.09	0.11	0.26	0.89	0.12
05 Multi-Morbidity Medium Complexity	12.18%	11.38	1.2	0.14	0.28	0.19	0.35	0.21	0.31	0.6	2.04	0.49
06 Pregnancy Low Complexity	0.99%	7.23	1.56	0.19	0.4	0.09	0.3	0.14	0.06	0.96	3.61	0.10
07 Pregnancy High Complexity	0.25%	12.58	2.58	0.71	0.8	0.15	0.7	0.52	0.13	1.63	6.19	0.53
08 Dominant Psychiatric/Behavioral Condition	1.82%	10.49	1.1	5.26	0.58	0.19	0.54	0.17	0.13	0.28	1.37	0.54
09 Dominant Major Chronic Condition	8.60%	11.36	2.13	0.45	0.28	0.14	0.3	0.2	0.5	0.66	3.09	0.60
10 Multi-Morbidity High Complexity	2.03%	21.03	8.89	1.23	0.93	0.31	1.3	1.16	1.24	1.52	6.59	6.01
11 Frailty	1.24%	23.54	21.48	1.34	1.01	0.18	0.95	0.78	0.34	0.74	2.53	9.81

Number of contacts per person per year for each of the population segments in Gloucestershire.

Our population modelling shows that demand for healthcare grows significantly as health deteriorates. People in good health have between 2-3 contacts per person per year across all healthcare services. There is a significant increase to between 15-20 contacts for people in higher need groups, such as multi-morbidity with high complexity and frailty groups.

Demand is higher in areas such as primary and community settings for people with more health complexity. This includes people living with complex multiple long-term conditions or

older people living with frailty (23 contacts per year in primary care and a similar number in the community). Both groups also account for a significantly higher use of Emergency Department attendances and admissions (per person per year) than all other groups.

These two groups (making up just over 3% of the population) account for 60% of non-elective bed days in our acute hospital. Similarly, outpatient appointments are high for people living with complex multiple long-term conditions (almost 7 per person per year).

## Theme 5:

### **These changing demographic patterns mean that continuing to deliver care in the same way will not be sustainable to meet future need (*transformation need*).**

It is evident that delivering health and care as we do today is not sustainable, given the projected increases in demand, and that new ways of working and innovation are needed to ensure that our resources are targeted to best improve population health and the experiences of all those using health services, wherever they live and work within Gloucestershire.

We already have services where recruitment and retention of staff can be particularly challenging including general practice, nursing (district nursing, midwifery and mental health), allied health professionals, healthcare support workers, and consultant doctors.

Even if the workforce supply was available, it will not be affordable to deliver more care in the same way. We continue to have an underlying financial deficit in Gloucestershire of £23 million. This will need to be addressed over the course of this plan whilst we balance this with maintaining or improving high quality care for our population.

If we continue as we are, growth in costs of delivering healthcare will significantly outstrip what we receive in funding.

To be able to continue to provide a comprehensive health service to all, improve the equity of health outcomes, and achieve our ambition of improving population health, we need to work differently, changing the trajectory of both costs and outcomes by pursuing the Government's three shifts. This will mean making some difficult decisions as the way we provide services today will not be sustainable in the future. Whilst we will grow in some areas, we are going to need to reduce in others for health and care to be sustainable.

**The way in which we deliver care needs to change now**



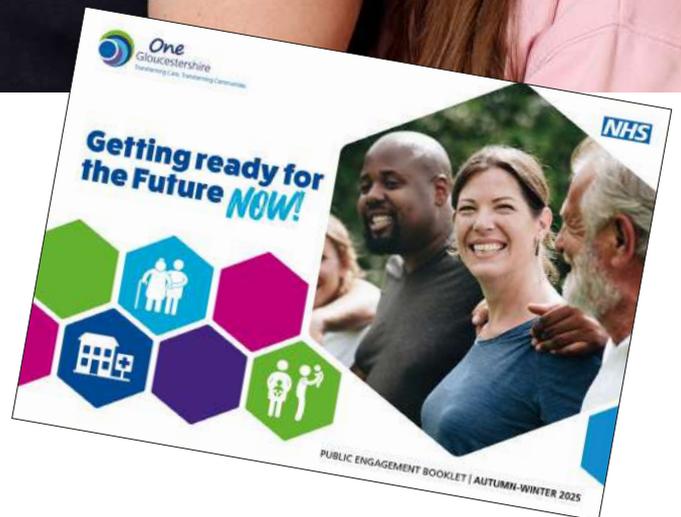
# What matters to local people

As we respond to the challenges described above it is important that we listen to what matters to people (both the public and our staff) in Gloucestershire. We have a long history in Gloucestershire of public engagement about how and where we deliver services.

Between November 2025 and January 2026, we undertook engagement with the public to listen to views on the significant challenges now and the opportunities ahead. **Getting Ready for the Future NOW!** was our engagement plan with conversations that aligned with the three 'shifts' in the 10 Year Health Plan and focused on:

- ▶ Neighbourhood health and care
- ▶ Online digital and technology
- ▶ Wellbeing, prevention and maintaining health independence

We also used this engagement to revisit the principles for the delivery of health and care that we have heard from Gloucestershire residents over the last 10 years. These principles have guided us well, informing the way we develop services to this day. We asked people if these



principles still hold true, explored whether anything has changed and encouraged people and communities to share their ideas on how the NHS, individuals and communities, could do things differently.

## Who has been involved

Information and opportunities to get involved were shared via our online participation space - [Get Involved in Gloucestershire](#). Engagement booklets were distributed through GP Practices, local hospitals, community hubs, children's centres and leisure centres across the County. Information was also shared widely with community partners.

In addition, the following has been undertaken:

- ▶ The Information Bus has visited venues across Gloucestershire such as Lydney, Cirencester, Stroud, Tewkesbury, Stow-on-the-Wold, Cheltenham and Gloucester.

- ▶ We have spoken with voluntary sector representatives, Patient Participation Groups, Young Influencers and people from underserved communities (e.g. people at the All Nations Community Centre, South Asian communities, and people living in rural areas of the County).
- ▶ We have engaged with the People's Panel – around 1,000 members of the public who are a representative sample of people living and/or accessing services in Gloucestershire.

In total we had 499 responses to the survey with additional themes arising from direct engagement with the public and groups described above.

The full engagement report can be found at [Get Involved in Gloucestershire](#).

**We have grouped what we have heard into three themes:**

### **Theme 1: Wellbeing, Prevention and Digital Access**

We asked people about the ways that they were actively maintaining their own personal health and wellbeing. Whilst a high number of people responded positively, there were **still a significant number of people who said that they were not aware of local activities, community groups or local clubs that could support them to manage their health** (29% of respondents).

Social isolation was recognised as a particular challenge in our engagement when out with people in the County. There were people we met who were active in their community however and well connected. **Many people highlighted the important role of the voluntary sector and community groups as being important to health and wellbeing.**

Responses to the survey suggested that there was some caution expressed about the shift to digital. Whilst most people had digital devices and have the knowledge and skills to do things online, there were **concerns expressed that the shift to digital would replace face-to-face access or appointments.** Many of those responding said that they had used technology to access some healthcare services but cited concerns about the lack of personal contact (68%), information security (41%) and confidence that information would be monitored (51%) as barriers.

### **Theme 1: What we heard**

- ▶ Significant numbers of people are not aware of local activities to support their health.
- ▶ We heard that 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).

### **Theme 2: Healthcare services today**

Through the engagement events and visits many people wanted to express their views about the existing delivery of health and care in the County. This helps us to identify the priorities that are important to local people.

**Many people told us that they reported receiving good care in the County.** However, there were several consistent messages in the feedback received.

People felt that **waiting times remained too long across many services.** In particular, this included being able to access a timely appointment with a GP.

There were **concerns raised about consistency in how services are delivered.** For example, being able to book appointments in different ways at different services (including variation between General Practice). There was also confusion about different ways people could interact with the healthcare service.

We also **heard from people in historically marginalised communities that face-to-face information sharing and group discussions / presentations were important** in helping them understand services that are available and to have the opportunity to ask questions.

### **Theme 2: What we heard**

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

### Theme 3: Designing healthcare for the future

Over the last 10 years we have been guided by a set of principles developed with the public that we have used to help design how and where healthcare services are delivered in Gloucestershire. We tested whether these principles still apply.

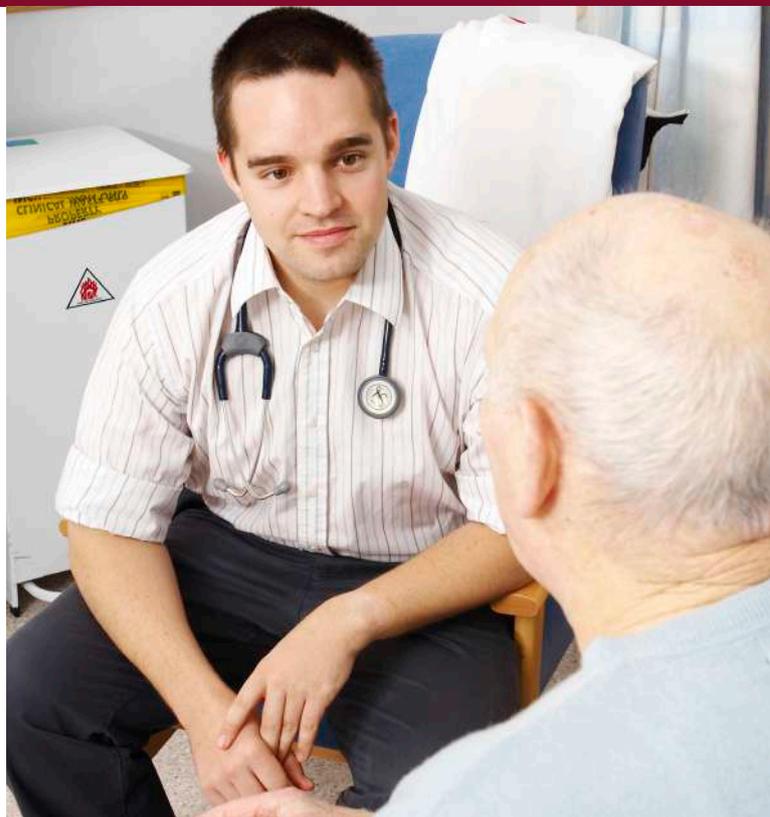
Overwhelmingly the response confirmed that they do. People agreed<sup>1</sup> there **should be a focus on prevention and self-care** (96%), agreed that we should be **continuing to develop joined up community health and care services** (97%), agreed that **more of the budget should be spent on supporting people to take more control over their own health and care** (90%), and that we **should be continuing to bring some specialist hospital services together in one place** (80%) whilst **caring for people with the greatest health and care needs** (78%).

In times when resources are limited, we also discussed with the public that this means prioritising how and where we might deliver healthcare in the future.

We heard that **people wanted services that they use regularly to be close to where they live**. In asking people about the things that we should prioritise when resources are tight, this was ranked highest. 79% of people agreed that this was the case and that they would be willing to travel further for services they do not need as frequently (including more specialist care).

People told us that they felt that there should be a focus on **funding for medicines that have the greatest impact** (ranked second in areas that we should prioritise). People would also prioritise **targeting services that ensure greater consistency in people's health, wellbeing, and life expectancy** (ranked third) and ensuring a focus on **caring for people where they live, even if this meant making decisions around reducing beds in larger hospitals** (ranked fourth).

During times **when people need more urgent care and support** (either for physical or mental health) people told us that what was important to them was **getting a prompt assessment and decision making about the treatment they would need** (37% of people would prioritise



this) and **having the ability to access these services 7 days a week** (26% of people would prioritise this). This was seen as more important than the distance people travel (only 5% would prioritise this).

This mirrored what people told us about times when they may need to see a specialist. What was **most important to people is the expertise of the specialist they want to see** (42% would prioritise this) **as well as the time they spend waiting for appointment** (30% would prioritise this) as opposed to having **as few appointments as possible**, being able to agree the time and date of appointment, or the distance needed to travel (only 1%, 6% and 6% respectively would prioritise this).

#### Theme 3: What we heard

- ▶ People want the services they use regularly to be close to where they live.
- ▶ People want care at home even if this means reducing bed numbers in larger hospitals.
- ▶ People want quick assessment and 24/7 access for urgent care more than local services.
- ▶ People want expertise and low waits for a specialist rather than fewer appointments or these services close by.

<sup>1</sup>Percentage of people who responded, 'strongly agree' or 'agree'.

# Our Response: Strategic ambitions and priority programmes

In response to the population health analysis and public feedback, we are setting three strategic ambitions (shared between Gloucestershire and BNSSG). We have purposefully chosen these strategic ambitions since they align with the three shifts described in the 10 Year Health Plan. We describe **what** these three strategic ambitions are and three Flagship Priority areas of work. The remainder of this Plan then goes on to describe how the ambitions will be delivered.

## Strategic Ambition #1:

### Healthy Lives

People live healthier lives for longer, by preventing avoidable illness and decline

## Strategic Ambition #2:

### Health Equity

Health outcomes, experience and access are fairer across all communities

## Strategic Ambition #3:

### Best Value

What we value is defined by people's experiences & outcomes, within a sustainable system

## Strategic Ambition #1 – Healthy Lives

### People live healthier lives for longer, by preventing avoidable illness and decline.

We know that there is a movement into poorer health over time. We want people to remain in as good health as possible for longer. We will therefore commission for healthy lives.

**Our aim is to at least maintain the proportion of people living in good and moderate health groups relative to those in poorer health.** Gloucestershire has 73% of people living in low health need (508,381) and 24% (166,184) living in moderate health need. Our aim is to at least hold this in future years considering demographic changes.

Addressing this is about ensuring that we are doing the right things. Slowing the movement of people currently living in good health ("low need") into moderate health cannot be delivered by the NHS alone.

We describe interventions where evidence suggests these will have greatest impact. This includes working alongside Public Health and through the VCSE sector in areas such as physical activity, smoking cessation and weight management. We will continue to work with Gloucestershire County Council through the Joint Local Health and Wellbeing Strategy and delivery of the seven priorities to enable this.

We will support the work of partners to address the wider and social determinants of health (such as housing and employment) which have an impact on health and life chances.

Our immediate focus will be on slowing the movement from moderate health into poorer health through Neighbourhood Health. Given the growing number older people living with frailty, our Flagship Priority programme in this area will be Neighbourhood Proactive Frailty Care.

## Flagship Priority Programme:

### Neighbourhood Proactive Frailty Care

Building on work within Primary Care Networks and following additional investment in 2025, we will expand the clinical and care approach for people living with frailty and dementia to slow rising need and enable people to receive good care at end of life. We will prioritise areas of the County where people live in poorer health.

#### This will involve:

- ▶ Teams of practitioners working together within Neighbourhoods to proactively identify people living with rising needs.
- ▶ A new model of dementia services that will involve a timelier diagnosis enabling people to access treatment and support, and plan for the future.
- ▶ Changing the model of care for older people so we prioritise a home by default approach and reduce bedded intermediate care.

## Strategic Ambition #2 – Health Equity

**Health outcomes, experience and access are fairer across all communities.**

We want to ensure that no-one in the County has worse health outcomes, poorer experience, or finds it harder to access services because of where they live or who they are. We will therefore commission for health equity.

**Our aim is to reduce the health inequalities gap between the most and least deprived areas as well as between different groups of people.** Our needs analysis shows that people living in more deprived areas of Gloucestershire move into poorer health groups faster than those in living in the least deprived areas. We want to close this gap, particularly in ages where this gap is greatest (between the ages of 55-85).

The evidence tells us that health outcomes vary significantly, particularly for the 10% of our population who live in the more deprived areas in the County. This includes reducing variation not just in outcomes, but variation in how people access services.

For example, some areas of the County have a proactive and personalised model of community care built around Primary Care Network geographies that is showing evidence of reducing

the need for secondary care services, keeping people independent and healthy for longer.

We also know that different groups of people (such as people from Black, Asian and Minority Ethnic Communities) experience worse health outcomes or experience differential access to healthcare services.

Addressing health inequalities in both adults and children, remains a priority. This is a key responsibility of all partners.

We will therefore continue to deliver against the commitments set out in Core20PLUS5. This framework focuses on five areas of clinical focus for adults (maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case finding) and five for children (asthma, diabetes, epilepsy, oral health and mental health) which require accelerated improvement.

Our immediate focus in this area will be on improving health outcomes for people of all ages living in poor mental health, particularly for children and young people.

### **Flagship Priority Programme: All Age Community Mental Health**

It is estimated that nearly 15% of people over 16 in the County live with a common mental health disorder. Over half of mental health problems in adulthood begin by the age of 14 and 75% by the age of 18 and people living with severe mental illness are 5 times more likely to die prematurely in Gloucestershire.

#### **This will involve:**

- ▶ Continuing the rollout of Young Minds Matter – mental health advice and support in schools across the County.
- ▶ Joining up with Gloucestershire County Council on the Families First Programme to identify needs early in children and young people and coordinate across organisations.
- ▶ Developing our Mental Health Neighbourhood offer to ensure support for people closer to home. This will ensure that there is timely, appropriate care during acute crises.



## Strategic Ambition #3 – Best Value

**What we value is defined by people's experiences and outcomes within a sustainable system.**

We want to ensure that regardless of the health and care needs of individuals, care provided improves outcomes whilst working sustainably. We will commission using principles of best value.

**Our aim is to improve outcomes and experience for people whilst achieving this within the resources available to us.** We will focus on improving productivity against national expectations (2% year on year) whilst prioritising areas where performance or people's experience is not meeting local expectations. We will benchmark ourselves with others to achieve this whilst developing this as a strategic metric over the next year.

In practice this means making the best use of our resources by doing things differently to improve outcomes and reduce waste. Addressing this is about ensuring that we are **doing things right**.

This means looking at opportunities to deliver care more productively. NHS partners are expected to deliver against the national ask for a 2% productivity increase.

It will also mean changing how frontline care is provided. Whilst we seek to provide health and care closer to where people live, it may be appropriate (clinically as well as economically) to deliver some services through more central locations in the County and for these to be more streamlined.

Whilst the focus of this plan is predominantly on frontline care, partners will need to identify opportunities to make better use of supporting infrastructure to work within the financial envelope available. This may include reviewing how support services are provided as well as how organisations make better use of the estate.

Our immediate focus here will be on designing new ways to support people living with multiple-long term conditions. An element of this will be transforming outpatient services and, in line with the ambition in the 10 Year Plan, moving two thirds of hospital appointments to be delivered in other ways and other care settings. This will be our Flagship Priority Programme in this area.



### Flagship Priority Programme: Transforming Care for People with Multiple Long-Term Conditions

We will fundamentally transform care for people living with multiple long-term conditions. This is a rapidly growing area of population need in Gloucestershire.

This will involve proactive personalised care built around existing work within Neighbourhoods. This will include seeking to reduce the number of patients attending traditional outpatient appointments.

#### This will involve:

- ▶ Expanding multi-disciplinary team working based around Primary Care Networks for people living with multiple long-term conditions to slow rising health risks.
- ▶ Testing new ways of delivering specialist advice and care for these groups of people, where possible reducing the need for multiple appointments for each individual condition.
- ▶ Increasing the rollout of Patient Initiated Follow-Ups and offering digital options where clinically appropriate.

# The conditions for success

To deliver these ambitions there are three conditions for success that we will need to get right as a system together. These have been based on what we have heard from partners and the direction for ICBs. Below we describe these three areas and the actions that we will take to put these in place.

## 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

## Strategic Partnerships

Delivering our three strategic ambitions will require us to be clear on the roles that we all play. Changes with the Integrated Care Board will mean that we will increasingly step into a role as strategic commissioner focusing on population health and commissioning across care pathways. Changes taking in place in Local Government with an increasing role for Combined Authorities (covering larger geographies, although not yet determined for Gloucestershire) as well as Local Government Devolution will also have a significant impact.

**Our aim is to expand commissioning that is outcomes focused and commissioned across care pathways** (therefore across multiple providers). In Gloucestershire we have a total of 312 live contracts/grants (excluding primary care contracts). Where appropriate, we want to move more of these to being outcomes-based and across multiple partners.

The Integrated Care Board will set strategic direction, working closely with partners such as Gloucestershire County Council. We will bring partners together around population health needs, but it will increasingly be the responsibility of local health and care organisations (including VCSE, Primary Care (including General Practice) as well as Community and Mental Health and our Acute Provider) to work together to organise and deliver in response. This will rely on strong relationships, better use of data and insight as well as incentives that foster and enable collaboration.

Neighbourhood Health will be central to these aims. This will build on the well-established work within Primary Care Networks that has developed over the last few years and ensure that Primary Care and General Practice help shape Neighbourhood ambitions. The role of the GP Collaborative (bringing a stronger and single voice for General Practice) and the development of new VCSE models alongside existing partnerships with Gloucestershire County Council, Gloucestershire Health and Care Foundation Trust and Gloucestershire Hospitals Foundation Trust will be key.

### How we will do this:

- ▶ As an ICB we will prioritise the development of commissioning that is outcomes-focused and across care pathways. We will start by focusing on older people living with frailty.
- ▶ We will prioritise investment of time in supporting the development of new or evolving partnerships that will facilitate better collaboration across the system. This includes development of the VCSE model and newly established GP Collaborative to ensure a strong unified General Practice (as well as wider Primary Care) voice in the system.

## Financial Framework

It is evident that we must change where we spend our money on healthcare services if we are to deliver the three strategic ambitions described above. The public have told us that more of the budget should be spent on supporting people to take control over their own health and care and we agree.

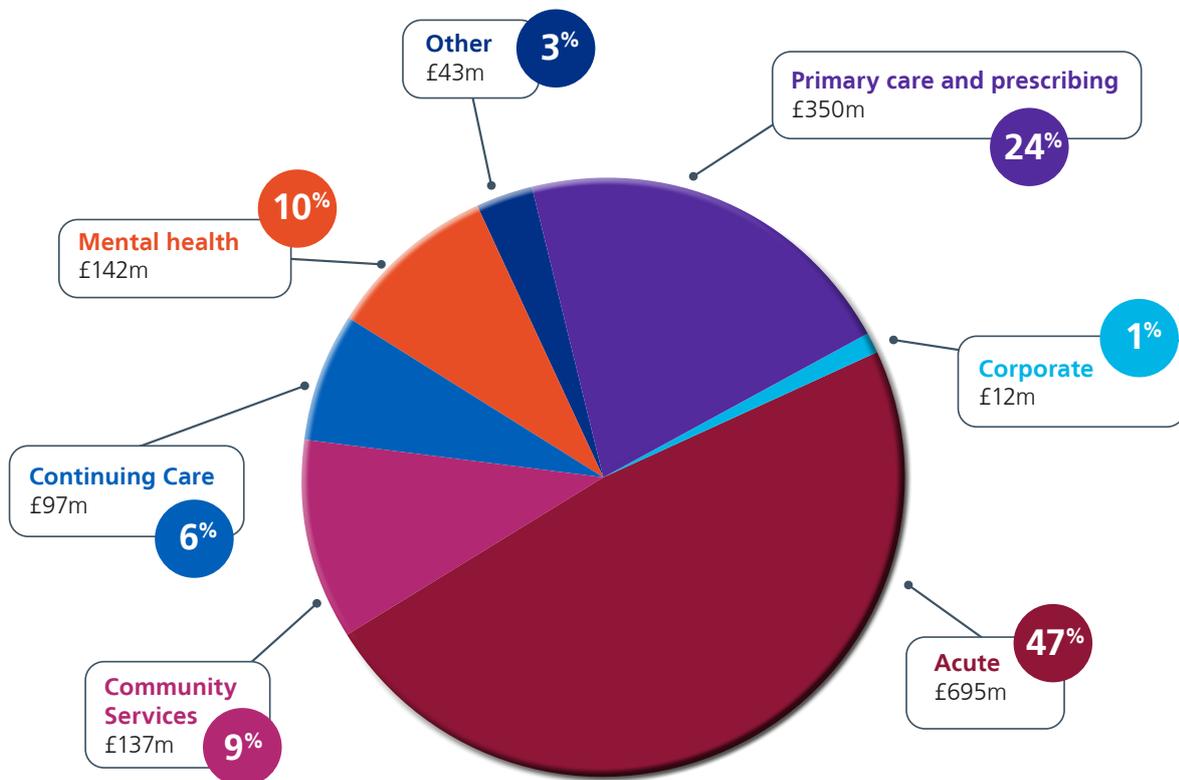
Delivering a change in the proportion of this spending will not be straightforward to deliver, but as we prioritise prevention and Neighbourhood delivery (including valuing the important role that the VCSE has in supporting health and wellbeing in the County) we will move the proportion of funding accordingly.

We also must return to underlying financial balance across the system. This will be even harder to achieve with the changing demographic profile described earlier. As a result, this means making difficult decisions as we will need to decommission or reduce some services whilst prioritising others. Our engagement with the public has given us the principles that are important for them as we make these changes.

**Our aim is to shift the proportion of spend 'left' from acute and into community.** In 2024/25 almost half of the spend in the system (47%) went to the acute sector in Gloucestershire. This proportion has been consistent over many years. We will aim to reduce this proportion of spend over the lifetime of this Plan.

**How we will do this:**

- ▶ Each year, we will hold the level of acute expenditure so that a greater proportion of growth and investment flows into prevention, community, primary care and neighbourhood care (including VCSE).
- ▶ We will maintain the proportion of spend on Mental Health, Learning Disabilities, Dementia and Neurodivergence Services in recognition of population health need and to ensure that more of this funding goes towards neighbourhood care.
- ▶ Our commissioning intentions set out areas where choices will be needed. For example, as we prioritise a home by default approach, we will look at how we reduce bedded care and shift towards care closer to home, resulting in a more streamlined secondary care sector. We will listen to and involve the public in this.
- ▶ We will set aside a non-recurrent reserve that we will grow year on year to support delivery of the commissioning intentions set out in this Plan (particularly those in support prevention). Our aspiration is for 3% of the programme allocation to be committed to this by the end of the Plan. We will also create a reserve to ensure that new medications (approved by NICE) are prioritised.



Based on 2024/25 financial outturn position

## Our Resources

We will commission in a way that enables better use to be made of our resources – this includes our workforce, but also our estates and digital, data and technology. Through this we will support the shift in the 10 Year Health Plan from analogue to digital.

**With the move to Neighbourhood health, we will shift the proportion of staff that are either working in or supporting Neighbourhoods.** This will mean that secondary care will over time reduce as a result (in line with the financial changes described above).

Partners will need to work together in a way that maximises the use of estate (such that it increasingly becomes an asset that can be used by multiple organisations) and support the shift from analogue to digital in line with the 10 Year Health Plan.

Our people are our most important asset. This has been the case since the NHS was founded over 75 years ago and demonstrated by health and social care colleagues in our response to the pandemic. We have over 13,000 staff working in the NHS in Gloucestershire and over 20,000 staff working

in social care (including care providers) and other services such as Primary Care.

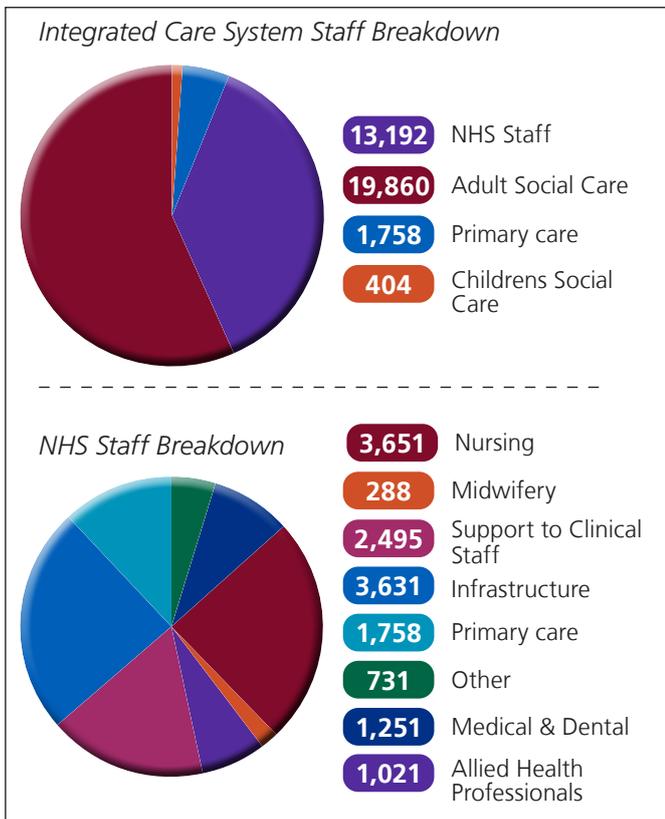
It is imperative that clinical and care models within individual health and care organisations in Gloucestershire are developed collaboratively with partners to realise the workforce ambitions set out in the 10 Year Health Plan.

This will require partners to work together to understand their workforce pipeline and, through strategic planning, to attract and retain staff. This includes widening participation (such as engaging with Get Britain Working strategies), supporting health and social care education pathways and supporting staff to adapt to new ways of working, particularly staff who will either work within, or provide wrap-around support to Integrated Neighbourhood teams. We will continue to strengthen our relationship with University of Gloucestershire to maximise the opportunities of the education and skills of our workforce and support the shift towards Neighbourhood health.

Work to design more integrated and local services will happen alongside a shift from analogue to digital. We will expect partners to maximise the use of technology, ensuring that information is shared effectively – whether with the public (using functionality such as the NHS app) or between staff working in health and care across organisations. Partners will invest in upskilling staff to thrive in a digitally enabled health system including embedding digital literacy across roles and reducing duplication to improve efficiency and service quality.

### How we will do this:

- ▶ Through our Neighbourhood health plans we will develop new models of care that require different ways of working. This will include multi-disciplinary team working within Neighbourhoods where identity is as much about where you work as it is about the organisation you work for.
- ▶ We will continue to value the expertise that specialists have, but new models of care will develop ways of working so that specialists may also act as coordinators where people live with multiple long-term conditions.
- ▶ We will develop our digital plans and ensure that information sharing underpins the delivery of Neighbourhood health including proactive and personalised care, e-prescribing and outpatient electronic ordering.



Gloucestershire's health and care workforce (2025/26)



# Our Commissioning Priorities

We have described that we need to change the way that we deliver health and care. We have heard that people want us to focus more on prevention, supporting them to live healthy lives for longer. We have heard that they want services that they use to be regularly accessible and available in their local areas. In a county the size and breadth of Gloucestershire, we recognise that rurality can present challenges for some people in how they access services. We know that people also want to ensure that specialist care and treatment is available when it is needed most.

We will therefore promote a 'left shift', enabling people to live as independent and as healthy a life as possible in a place they call home.

We will continue to adopt the principle of **'local where possible, centralised where necessary'** for healthcare services, reflecting our commitment to delivering services that are close to where people live where that is possible and appropriate to do so. We will apply this as a principle to all service planning and re-design work we undertake, recognising the importance of addressing barriers to access (including in rural areas) whilst balancing this with ensuring healthcare services are safe for patients. We will work with partners in application of these principles.

We will **increasingly take a population health approach** so that we understand specific groups of people and design and commission effective services around their needs.



**We will prioritise the following four areas on which our commissioning intentions are based.**

## **1. Supporting people to stay healthy at home**

We will play our part in supporting people to remain healthy for longer. Where possible, we want to help people to adopt healthy behaviours (such as physical activity and healthy diet, as well as the reduction of risk behaviours such as smoking and excess alcohol consumption).

Part of our response to this is supporting people to connect in their local areas, accessing things they enjoy (such as people/groups/clubs and physical places such as green spaces, community facilities) that help them remain independent and healthy for longer. We want people to play their own role in looking after their health wherever possible.

We will also take action to detect disease/illness at an early stage to prevent it from getting worse. This includes early diagnosis and treatment. Community pharmacies will have an important role to play in health promotion that will also ease some of the pressure in General Practice. This will also include digital access and use of digital apps and devices where appropriate that can help people manage and monitor their own health and care.

### **What this will look like**

- ▶ Community assets (people and physical places / areas) will be available in local areas to help people remain healthy.
- ▶ Developing the VCSE infrastructure and adopting a 'Make Every Contact Count' approach will connect people to support them to maintain positive physical and mental health
- ▶ Community pharmacies will play a more important role in prevention and wellness including at early stages, helping people to self-care.
- ▶ Digital access will be available where people want it such as self-care health monitoring and ease of booking appointments.

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

In line with commitments in the 10 Year Health Plan, we will continue to prioritise Neighbourhood Health on a 30-50,000 footprint based around Primary Care Network geographies.

This will include the development of Integrated Neighbourhood Teams (INTs) who work together within these geographies to provide proactive and person-centred care for people with rising or complex health needs. This will also include specialist in-reach advice and support to INTs to help people manage their conditions that they live with. Over time, services will be available from hubs operating 12hrs a day 6 days a week.

### **What this will look like**

- ▶ Integrated Neighbourhood Teams (e.g. health, social care, VCSE) will bring together professionals around people and take a more preventative, holistic care approach.
- ▶ 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.

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

We will deliver on the commitment to move more of care outside of hospital and into community settings. It means that where it is appropriate to do so, not only will care shift into the community, but we will transform the way that it is delivered so it is not simply a case of moving care from one place to another.

Earlier assessments and diagnostics in the community will be available, building on the success of our Community Diagnostic Centre.

Step-up and step-down care will help people avoid a mental health or physical health admission and help people back to independence.

#### What this will look like

- ▶ 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.

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

It is appropriate that some services are delivered in more central locations in the County. People have told us that they are willing to travel for specialist care and treatment. Protecting specialist care was one of the core principles of our work in Gloucestershire on Fit for the Future.

Specialist care settings will be streamlined whilst also protecting people when during an emergency or crisis. We will ensure that care in these settings is safe and gets people home quickly when appropriate.

#### What this will look like

- ▶ 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.
- ▶ De-risked settings will enable delivery of key performance and quality standards for the public.

**Our commissioning intentions on the following pages describe what we will do to realise this plan.**



## Section 3

# Our strategic commissioning plan for Gloucestershire

# Our Commissioning Intentions: What we will do and how we will evaluate impact

## A population health approach for different groups of people

A population health approach means looking beyond individual episodes of care to understand and improve the health of different groups of people or communities. This means using data insights and people's experience to inform commissioning decisions about the design and location of care services in the county.

We have developed an Integrated Needs Assessment to build a picture of current and future population health and used this analysis to identify the groups to prioritise first.

We will develop this approach over time, but these groups also reflect a life-course approach – recognising that what we do today to support people to live healthy lives will bring benefits in the future.

This approach has and will continue to inform our commissioning intentions. The commissioning intentions and actions that partners will take in response have been developed both to address the needs of these four population groups as well as respond to the national commitments in the NHS 10 Year Health Plan and Medium-Term Planning guidance.

Our commissioning intentions are a response to population health needs for these cohorts. For example, outpatient transformation will predominantly focus on changing the way that care is delivered for people with multiple long-term conditions, whilst improving much of our urgent care pathway (including intermediate care) will improve care for older people living with frailty.

## We will prioritise the following groups of people first

### 1. Older people living with frailty

Given the changing demographics in the county and that this group will see the fastest growth rates, we will prioritise this group first within the population health segments.

### 2. People with rising levels of risk (living with multiple long-term conditions)

As more people live with long-term conditions, we will focus on prevention for conditions that occur frequently together: Chronic Kidney Disease (CKD), Coronary Heart Disease (CHD), Heart Failure and Diabetes. We will particularly focus on people living with less complex multi-morbidity to keep them in as good health as possible for longer.

### 3. Women and birthing people

We have pressures in Maternity services which make it important for us to prioritise this work and use it to design the future of maternity services in the County. This group predominantly focuses on the two population health segments – women with low risk and women with high risk in pregnancy.

### 4. Children and young people

We will prioritise health for the longer-term with a focus on children and young people. Given the significant increases in mental health needs we will ensure that the needs of children living with either physical or mental health complex needs are addressed. This group will cross multiple population segments.

# 1. Supporting people to stay healthy at home

## What this will look like

- ▶ Community assets (people and physical places / areas) will be available in local areas to help people remain healthy.
- ▶ Developing the VCSE infrastructure and adopting a 'Make Every Contact Count' approach will connect people to support them to maintain positive physical and mental health.
- ▶ Community pharmacies will play a more important role in prevention and wellness including at early stages, helping people to self-care.
- ▶ Digital access will be available where people want it such as self-care health monitoring and ease of booking appointments.

## Our Commissioning Intentions

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 will 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.

## What are the major changes we will commission to deliver this?

Working with Gloucestershire County Council and wider partners, we will prioritise health promotion and prevention for people of all ages. This will help people to remain healthy for longer as well as support management of health conditions at early stages when they arise to stop or slow them getting worse. This will help to slow progression towards complex multimorbidity and frailty.

The NHS cannot tackle this alone, but working in partnership with others in the Voluntary, Community and Social Enterprise (VCSE) sector as well as Education (for children and young people in schools) we can make a much greater difference.

To achieve this, we will work alongside VCSE colleagues to complete the co-design of a new **VCSE Partnership Model** that will strengthen and sustain the VCSE sector in the County. We will do this in partnership with Gloucestershire County Council so that strategies align. Through long-term investment in this model, we will

## Key Change Programmes

- ▶ 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

recognise the role this sector has in both service delivery and as a strategic partner.

As we grow a thriving VCSE sector, we will help ensure that people have knowledge and access to support that enable them to live healthy lives. The NHS is spending increasing amounts of funding on medication to support people when health needs arise. Whilst this is important, we want people to remain healthy for longer without health conditions arising.

To support this, we have already delivered changes to our social prescribing model as a way of prioritising investment into the VCSE sector itself, ensuring there are support pathways for Link Workers to signpost people to. As we develop and build capacity directly into the VCSE Sector, this will help people connect into activities/spaces that can help them remain healthy and active for longer (without the need to go through NHS services to access these). A primary focus will be on people living in or moving into older age (including those living with mild/moderate frailty), reflecting our priority cohort focus.

We will also help to ensure that when conditions arise people can care for themselves and either stop or slow deterioration of health. Because of the long-term impact of primary prevention, this plan focuses on secondary prevention to respond to the changing health and care needs in our population. We will build on commitments in the Integrated Care Strategy relating to blood pressure checks as well as smoking and skills / employment. We will respond to the Modern Service Framework for CVD when published in 2026. This will help meet the national ambition to halve premature mortality from CVD over the next 10 years.

Building the capacity of the VCSE sector will also enable better integration and collaboration with NHS and other statutory sector services. Using principles from **Making Every Contact Count (MECC)**, we will work with frontline teams to promote local connectivity, starting with Integrated Neighbourhood Teams as they are established with a focus on the priority population cohorts. Our teams will not only consider the immediate health needs in front of them but have awareness of local assets that people can connect into.

We will also improve communication regarding the self-care opportunities to the public, raising awareness of the different options people have. This will also help to reduce the low-level reasons that people occasionally attend A&E for. It is believed that 16,000 people already access their Community Pharmacy every day in the County. Through **Pharmacy First** we will expand the role that Community Pharmacies have in areas such as independent prescribing, long-term condition management and point-of-care testing. To support this, we will ask partners to prioritise information sharing, including the rollout of Electronic Prescribing. This will help to ease pressure on General Practice, freeing capacity to help with improving access and support our priority cohorts of people living with multiple long-term conditions.

The work with Community Pharmacy sits alongside work to **Modernise General Practice** and expand Dentistry access through our Centre of Dental Excellence programme. We will complete the commissioning and establishment of a **new Dental Access Centre** in Gloucester City, sitting alongside the Community Diagnostic Centre. This will directly improve availability of dentistry in the County, including urgent dental access.

Where appropriate we will ensure that there are digital options that enable people to manage their own health and care and easily access appointments when they need them. Through our **Digital Strategy**, we will work together to maximise opportunities for the use of technology and develop the digital confidence of staff and the public. This will include expansion of the **NHS app** in line with the commitments in the 10 Year Health plan as we look to expand use beyond the 51% of people in Gloucestershire who already use the NHS app.

## Where we expect to be and when

The delivery programme for these major changes is as follows:

Year 1 – 2026/27
<ul style="list-style-type: none"> <li>▶ Complete development of the VCSE Model - developing capacity helping people connect into activities/ spaces that help them to remain healthy.</li> <li>▶ Open the Dental Access Centre in Gloucester in summer 2026 and determine next steps for the Centre of Dental Excellence.</li> <li>▶ 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.</li> </ul>
Years 2-3 – 27/28-28/29
<ul style="list-style-type: none"> <li>▶ Through Modern General Practice programme, ensure consistent expansion across all General Practice locations NHS app integration and online consultation platforms.</li> <li>▶ Expanded rollout of the NHS app in line with the 10 Year Plan commitments including seeing who is involved in care, communicating with professionals, booking/holding appointments, and leaving feedback.</li> </ul>
Years 4-5 – 29/30-30/31
<ul style="list-style-type: none"> <li>▶ 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.</li> </ul>

## How we will evaluate impact

We have identified a core set of metrics we will use to assess the impact we are having:

Our Aim	Where are we	Our Ambition
<b>Outcome: People remain in good health for as long as possible (strategic ambition)</b>		
Maintain the proportion of people who are living in "good health" groups (population segments 1-4)	73% (December 2025)	Maintain 73% over the 5-years
<b>Outcome: More people accessing support that enables them to self-care</b>		
More people accessing community pharmacy (Pharmacy First consultations) (OP) ★	76,489 (Forecast 25/26)	93,342 (in-year 26/27) 104,857 (in-year 27/28) 122,667 (in-year 28/29)
<b>Outcome: People can easily access first line healthcare advice locally when needed</b>		
More people who are registered to use the NHS app in Gloucestershire	68% (January 2026)	74% by 2028/29
More people describe it as easy to make contact with their GP practice	2025 results: 59% describe it as easy (by phone) 55% (via GP website) 51% (via the NHS app)	Maintain in line with England average
Improved access to urgent dental appointments (OP) ★	25,867 (Forecast 25/26)	35,168 each year for the next 3 yrs
<b>Outcome: More people who can, make decisions that support healthy lifestyles</b>		
More eligible people are referred to the Digital Weight Management Programme	88% (November 2025)	80% by end of 2027/28 90% by end of 2028/29
Sustained reduction in levels of inactivity (children and adults)	CYP inactivity baseline (24/25): 26.4% Adults baseline (23/24): 21.8%	By 2030/31: CYP: 24% Adults: 20%

★ **Breakthrough Metric** – these are the metrics that we will prioritise delivery against.

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

### What this will look like

- ▶ Integrated Neighbourhood Teams (e.g. health, social care, VCSE) will bring together professionals around people and take a more preventative, holistic care approach.
- ▶ 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.

### Our Commissioning Intentions

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 and review Adult All Age Speech and Language Therapy services to support longer-term 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.

### What are the major changes we will commission to deliver this?

We have an ambitious programme of work for Neighbourhood Health. In line with our population health approach, we will prioritise work two groups: older people with frailty and people with rising risk.

We will establish new **Neighbourhood Care models**, bringing together Integrated Neighbourhood Teams around these people so that care is better coordinated and designed around their needs.

The start will be a focus on **older people living with frailty and dementia and people living with rising levels of risk** (living with multiple long-term conditions). These teams will take a personalised proactive care approach, identifying people at rising levels of need. This will be based around the national framework for proactive care. We will align work to extend our urgent community offer – such as expanding the provision of Rapid Response to assist people if they fall.

We will explore new commissioning arrangements for services that support these groups of people,

### Key Change Programmes

- ▶ Neighbourhoods Proactive Care:
  - 1). older people living with frailty and dementia.
  - ▶ 2). people living with rising risk (living with multiple long-term conditions)
  - ▶ 3). Community Mental Health including Family First Partnerships for Children and Young People (Led by Gloucestershire CC).
- ▶ Weight Management Pathway.
- ▶ All Age Speech and Language Therapy Review.
- ▶ Neurodiversity Transformation and SEND Reform.

moving away from commissioning individual providers and instead commissioning across care pathways, asking partners to work collectively together to best meet the needs of these groups of people. We will seek to ensure that commissioning of these new models of care is **outcomes**

**focused and that funding flows in a way that enables partners to work together** to manage care across whole care pathways rather than on in individual care settings.

We expect plans to be developed between partners for these groups of people that enable effective **digital transformation and information sharing to support Neighbourhood Health**.

This may include access to proactive care registers, personalised digital care plans and knowledge of the care team that are supporting people with more complex needs.

Alongside this, **Neighbourhood workforce development and culture change** will be required for these new Integrated Neighbourhood teams as people come together from across organisations.

We expect these teams to work together across organisational boundaries and have as much affiliation with the place they work and the people they support as they do their professional or organisational background. This is not limited to community and primary care but will include VCSE as strategic partners as well as specialist secondary care services.

Our **estates will need to support these new models of Neighbourhood care**.

We are committed to the direction of travel for Neighbourhood Health Centres. Specific opportunities have been identified in Central Cheltenham, Forest of Dean and Cirencester over the next few years. We will prioritise capital and revenue investment in these areas. These will sit alongside maximising the benefit in Gloucester City where Gloucester Dental Access Centre, Community Diagnostic Centre, Gloucester Health Access Centre (GHAC) and Quayside House Pharmacy are located on the same site whilst maximising connections with the Arts, Health and Wellbeing Hub at the University of Gloucestershire City Campus to create a Neighbourhood Health Centre Network. In the future we will also explore opportunities in Tewkesbury (supporting the large-scale housing developments planned for Garden Communities) and the Stroud area to ensure coverage across the County.

## Where we expect to be and when

The delivery programme for these major changes is as follows:

### Year 1 – 2026/27

- ▶ 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.

We will also continue work to ensure **Community Mental Health** support that provides timely, coordinated and personalised care for people of all ages with poor mental health. This includes continued development of teams that support people to be supported close to where they live. We will also develop this support through work to develop 24/7 Neighbourhood Community services for people so that they receive effective support without need for admission (where this is clinically appropriate)

This Community Mental Health offer extends to children and young people in line with the Children's One Plan. We will work with Gloucestershire County Council to implement the **Families First Partnership Programme**, developing stronger multi-agency working for children, young people and families. We will agree future commissioning arrangements for the single point of access for children and young people as part of this and continue to take action to reduce pressure on Children's Adolescent Mental Health Services (CAMHS). We will also continue the commissioning of Young Minds Matter (Mental Health Team in Schools) to reduce anxiety and poor mental health in children and young people.

In recognition of the growing levels of obesity in the County we will prioritise the delivery of a new **care pathway for adults living with obesity (weight management)** whilst also completing the evaluation of the integrated healthy weight service for children. We expect this to be one of the first outcomes-based commissioning approaches across the a whole care pathway. We will also review All-Age Speech and Language services to support long-term sustainability of the service given particular demand pressures seen.

We have seen significant demand for **Autism and ADHD (Neurodiversity) Services**. We have already invested in these services and will review the impact this has had and will ask our community provider to continue to work with partners to review the quality of referrals and ensure people are accessing support both before and after diagnosis. We will also ask health partners to work together to respond to the national findings and recommendations for **Special Educational Needs and Disabilities (SEND)** when published.

### Years 2-3 – 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 4-5 – 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 and debt advice).

## How we will evaluate impact

We have identified a core set of metrics we will use to evaluate impact in this area:

Our Aim	Where are we	Our Ambition
<b>Outcome: People remain in moderate health &amp; inequalities are reduced</b>		
The proportion of people who are living in moderate need (segments 5-9) is maintained	24% (December 2026)	24% over the 5 Year Plan
Average health score (Patient Need Group) between most deprived and least deprived areas is reduced	0.35 average score gap (all ages) 0.82 (65-69 yrs)	Reduction over the 5 Year Plan
<b>Outcome: People wait less time for care and support in the community</b>		
People have low waiting times to see community health services (waiting less than 18 weeks) (OP)	83% (November 2025)	83.03% to be held across all 3 years
<b>Outcome: More people receive proactive and personalised care in the community</b>		
Increase in number of patients on the Personalised Proactive Whiteboard care coordination system ★	26,760 (December 2026)	30,700 (December 2030)
<b>Outcome: More care in Neighbourhoods reduces the need for acute / specialist care</b>		
Reduction in the rate of emergency hospital admissions for people aged 65+ per 1,000 (BCF Metric) ★	2,477 per 100,000 65+ population (2025/26)	TBC (awaiting BCF guidance)
Reduction in the rate of long-term admissions to residential / nursing homes for people 65+ (BCF Metric)	545 per 100,000 65+ population (2025/26)	TBC (awaiting BCF guidance)
<b>Outcome: Staff and the public have a positive experience of care delivery</b>		
Staff experience - within Integrated Neighbourhood Teams	<i>Metric to be developed</i>	<i>Metric to be developed</i>
Patient experience	<i>Metric to be developed</i>	<i>Metric to be developed</i>

★ **Breakthrough Metric** – these are the metrics that we will prioritise delivery against.

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

#### What this will look like

- ▶ More care will be delivered outside of hospital settings and 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.

#### Our Commissioning Intentions

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 care at 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.

#### What are the major changes we will commission to deliver this

We want to ensure that there are effective services in the community that can either help people avoid acute, more specialist care or which can help people step down after they have received inpatient care.

In many cases this will involve reconfiguring and redesigning services so that they are no longer delivered in acute, inpatient settings but rather enhancing support in the community. This is fundamental in delivering the acute to community shift and responding to the growing number of people living with complex multiple long-term conditions.

Many of these services will sit therefore in the space between Neighbourhoods (of 30-50,000 people) and services that are delivered once across the County (such as acute hospital sites).

#### Key Change Programmes

- ▶ Long-Term Condition Management (incl. Outpatients)
- ▶ Urgent Care Pathway Review (General Practice, UTCs, MIIUs and A&E)
- ▶ Long-Term Intermediate Care Model
- ▶ Learning Disabilities Pathway
- ▶ Urgent and Emergency Mental Health Pathway
- ▶ Mental Health Intensive and Assertive

Integrated Neighbourhood Teams will be supported by specialist advice and guidance from secondary care. We will embark on **fundamentally transforming our approach to Long-Term Condition Management**.

A core part of this will be changes to outpatient care, including a significant shift to digital where appropriate. This will focus on two areas.

Firstly, where people's condition can safely be provided in settings other than secondary care we will support and enable these changes to happen. In many cases this will need to be undertaken on a single condition basis and will be led by our acute provider working with partners – it will include delivery of new approaches such as Community Appointment Days.

Secondly, and perhaps more importantly, we know that more people are living with multiple long-term conditions. For these people our intention is to move away from an approach based on seeing specialists for every single condition. This isn't helping these people and is using our resources badly. We will expect partners to work together, optimised using digital technology where appropriate to coordinate care for these patients. This will also consider opportunities to reduce unnecessary over-testing of patients.

We will also commission care in a way that supports older people living with frailty. We will focus on keeping people well at home for longer and keep A&E for genuine emergencies.

As part of this work, we will **scope and start to review population health needs starting in 2026/27 and use this to review the way we provide urgent care**. Part of this work will involve consideration of most suitable configuration for Same Day GP Access, Minor Injury and Illness Units as well as Urgent Treatment Centres (including urgent access to diagnostics) to improve access and access times for patients, whilst keeping A&E for genuine emergencies. We will need to hear from the public as well as staff as we seek to balance access with clinical quality and safety as well as workforce availability and cost.

We will also ask partners to prioritise a home by default approach that focuses on enabling step up

care in the community and getting people home quickly and safely after a period in hospital or other bedded care settings. Our work here will include a **review of intermediate care aimed at reducing bedded care and promoting home to maximise independence for people**. We will work closely with Gloucestershire County Council in this.

We will take action to support people living with mental health and/or learning disabilities. We will respond to the First Modern Service Framework for Mental Health when published.

**We will strengthen community-based support and reduce inpatient admissions to learning disability settings**. This may result in changes to the way we commission and deliver inpatient care for people with learning disabilities. We will ensure that when hospital care is needed that it is safe, person-centred, and therapeutic, with tailored approaches to support re-integration and avoid prolonged stays.

For people with rising mental health needs, **we will further develop support closer to where people live and improve Urgent and Emergency Mental Health access**. This could include wrap-around support and overnight crisis care to avoid and reduce stays in inpatient care settings. It will expand work in place supporting people with Serious Mental Illness and consider the need for a **Mental Health ED** in the County in line with national ambitions.

We will also ensure that people requiring more intensive support are assisted by commissioning a **more assertive outreach approach for people living with psychosis** (which we term 'Mental Health Intensive and Assertive'). This will aim to keep people safe and consider holistic needs and enable people to be supported in the community through principles of least restrictive practice.

## Where we expect to be and when

The delivery programme for these major changes is as follows:

### Year 1 – 2026/27

- ▶ 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 2-3 – 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 4-5 – 29/30-30/31

- ▶ Where needed, improvements made to urgent care – building on existing offer such as same day 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.

## How we will evaluate impact

We have identified a core set of metrics we will use to assess the impact we are having:

Our Aim	Where are we	Our Ambition
<b>Outcome: People wait less time for diagnostic tests / results</b>		
Fewer people waiting over 6 weeks for diagnostics across all modalities (DM01) (OP) ★	21.51% in 6 weeks (November 2025)	17.8% (26/27) 12.8% (27/28) 7.8% (28/29)
Faster time to be seen and to have received a result (28 day) as well as receiving treatment (31 and 62 days) (OP)	<b>28D:</b> 80.31% (latest available) <b>31D:</b> 94.11% (November 25) <b>62D:</b> 75.96% (November 25)	<b>28D:</b> 80.37% (26/27) 84.15% (27/28) 84.16% (28/29) <b>31D:</b> (average across year) 95.15% (26/27) 96% (27/28) 96% (28/29) <b>62D:</b> 81.34% (26/27) 84.34% (27/28) 85.2% (28/29)
More cancers diagnosed at stages 1 and 2	60.3% (Jan 26)	63% by 2028
<b>Outcome: Fewer admissions are needed to inpatient care settings</b>		
Reduce the rate of admissions to inpatient care for people with a learning disability and autistic people (OP)	Maintain at a minimum rate <b>Adults:</b> Baseline: 0 1 (26/27) 1 (27/28) 1 (28/29) <b>Children:</b> Baseline: 0 1 (26/27) 0 (27/28) 0 (28/29)	
Reduce the rate of admissions to inpatient care for people with mental health (OP)	<b>Adults with LD in MH inpatient care:</b> 15 <b>Autistic adults in MH inpatient care:</b> 5	<b>Adults with LD:</b> 11 (26/27) 12 (27/28) 10 (28/29) <b>Autistic adults:</b> 3 (26/27)
<b>Outcome: When people leave hospital they go back to their usual place of residence</b>		
More people over the age of 65 discharged from hospital (with reablement provided partly or solely by local authorities) who remained in the community within 12 weeks of discharge. (BCF Metric) ★	TBC	TBC (awaiting BCF guidance)

★ **Breakthrough Metric** – these are the metrics that we will prioritise delivery against.

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

### What this will look like

- ▶ 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.
- ▶ De-risked settings will enable delivery of key performance and quality standards for the public.

### Our Commissioning Intentions

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 **approach to mental health inpatient care** continues to deliver safer and person-centred environments alongside community alternatives to reduce long-stays and inappropriate admissions.

### What are the major changes we will commission to deliver this?

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 to deliver against constitutional standards.

This will present opportunities to streamline secondary care services, further centralising specialist services where necessary (in line with our design principle of 'local where possible, centralised where necessary'). We will continue to engage with the public wherever changes to services may be considered.

We will continue to adopt a 'Centres of Excellence' approach that seeks to maximise productivity and performance alongside improving clinical safety and practice.

### Key Change Programmes

- ▶ System Wide Theatre Review (including temporary test of change)
- ▶ Future Model for Maternity Services
- ▶ Improved coordination of the urgent care access (Single Point of Access) and discharge process (Integrated Flow Hub)
- ▶ Adult Inpatient Mental Health Care

We will **conclude our System Wide Theatre Review and take a commissioning decision that seeks to deliver best value.** We will seek to deliver maximum theatre capacity that helps to reduce elective backlogs and makes best use of what we spend, without significantly impacting on the experience and satisfaction of patients. This commissioning decision will take into consideration the impact of the test of change in Cirencester and hearing from staff as well as patients.

This will sit alongside continued work to improve productivity and performance in elective services to continue to reduce the length of time that people wait for elective treatment. We have already made significant progress in this area but will continue towards the national commitment of 92% of treatments taking place within 18 weeks of referral by 2029.

One of our priority cohorts for this plan are women and birthing people. We have spent time over the last year understanding the views of people who have used maternity services in Gloucestershire. We have also undertaken a full review of population health needs in the County, both now and also future projections. **We will clearly set out the challenges in a case for change and co-design with people a new approach for Maternity Services in Gloucestershire.** This will consider national reviews being undertaken to improve quality and safety standards such as the Baroness Amos Maternity Reviews. We want people in Gloucestershire to have confidence of consistently high quality and safe care when they need to access maternity care.

Our commissioning in this area will also seek to streamline and improve urgent and emergency care both within and out of hospital. This will particularly support people living with frailty needs and complex multimorbidity, as we know that 3% of the Gloucestershire population use around 60% of the acute bed days. Changing

the way that we support these people during their stay in hospital will deliver better outcomes for them. This includes improving the patient experience – ensuring that people receive compassionate, person-centred care and support when they need it most.

For example, the development of our **Single Point of Access (SPOA) for healthcare professionals** will enable people to access the most appropriate support as soon as possible in their care pathway.

For people who are admitted to hospital, the **approach to discharge planning will start on the day of admission (supported by the Integrated Flow Hub).** We will ask partners to prioritise work that better coordinates the discharge process and gets people home (or on to another care setting where appropriate) as quickly as possible.

We will also ensure that people receive the best possible care in **Adult Inpatient Mental Health Care settings.** We will develop our work in this area, ensuring that we continue to meet population health need over the longer-term and ensure that these care settings remain fit for purpose. This includes working closely with people who have lived experience with a particular focus on creating more therapeutic and person-centred environments. We will support people when in those settings but will also ensure that there is effective transition back into the community.

## Where we expect to be and when

The delivery programme for these major changes is as follows:

### Year 1 – 2026/27

- ▶ 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 2-3 – 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 4-5 – 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.

## How we will evaluate impact

We have identified a core set of metrics we will use to assess the impact we are having:

Our Aim	Where are we	Our Ambition
<b>Outcome: People wait less time for emergency care as well as treatment</b>		
Lower waiting times for urgent and emergency care: <ul style="list-style-type: none"> <li>▶ % of people waiting under 4hrs (OP)</li> <li>▶ Number of people waiting over 12hrs (OP)</li> </ul>	<b>All age 4-hr A&amp;E</b> 76.68% (Nov 2025)  <b>All age 12-hr A&amp;E:</b> 90.78% (Sep 2025)	<b>All age 4-hr A&amp;E</b> 86.4% (by March 2027) 83% (27/28 average) 87% (28/29 average)  <b>All age 12-hr A&amp;E:</b> 95% (by March 2027) 97.9% (by March 2028) 98.1% (by March 2029)
Fewer people waiting for elective treatment and reduction in the time that people wait (OP)  Fewer people waiting for treatment – RTT in 18 weeks performance  Total waiting list size (elective care)	70.11% (Nov 2025)  70,374 (Nov 2025)	81.4% (March 2027) 90.1% (March 2028) 92% (March 2029)  62,715 (March 2027) 49,800 (March 2028) 46,428 (March 2029)
<b>Outcome: When people require inpatient stays, they only remain as long as needed</b>		
Lower length of stay (bed days): <ul style="list-style-type: none"> <li>- Acute hospital</li> <li>- Community hospital</li> <li>- Mental Health (OP)</li> </ul>	Average LoS of 6.1 days (November 2025)  TBC  <b>Average LoS for patients in adult acute and PICU</b> <b>MH acute beds:</b> 50.04 days  <b>MH acute beds:</b> 118.83 days	5.2 days (April 2027) 4.8 days (April 2028) 4 days (by April 2029)  TBC  <b>LoS Adults:</b> 49.72 days (26/27) 48.72 days (27/28) 47.72 days (28/29)  <b>LoS Older adults:</b> 106.83 days (26/27) 103.83 days (27/28) 100.83% (28/29)
Fewer adult people waiting in acute hospital who are ready to go home (discharge delay from acute hospitals) ( <i>BCF Metric</i> )	Average delay days: 8.3 (2025/26)	TBC (awaiting BCF guidance)
<b>Outcome: When people receive care, it is safe and high quality</b>		
Number of neonatal deaths and stillbirths per 1,000 total births	Neonatal deaths: 0.96 per 1,000 live births (2025)  Stillbirths: 2.9 per 1,000 births (2025)	Neonatal deaths: Maintain no more than 1.0 per 1,000  Stillbirths: No more than 2.5 per 1,000 (March 2027)

★ **Breakthrough Metric** – these are the metrics that we will prioritise delivery against.



# Section 4

## Delivering this plan

# Our Learning and Evaluation Framework

We have described earlier in this Plan our ambition to be a system that learns from what we do rather than merely manage performance given the complex world in which we live.

We do want to set clear aims and ambitions and have a small number of areas that we will ask partners to prioritise together. The detail is described earlier in this plan, but our learning and evaluation framework is based around the following ambitions:

## ▶ Two Headline Ambitions:

We have set two overall aims. The first is to increase the number of years spent in good health and the second is to reduce the life expectancy gap between the most and least deprived areas. This reflects our overall vision to make Gloucestershire the healthiest place to live and work and ensure equity in life chances and best health and care outcomes for all.

## ▶ Six Strategic Metrics:

These reflect our three strategic aims (healthy lives, health equity and best value) and the three conditions for success (strategic partnerships, financial framework and our resources) set out within this Plan. Specific measures have been put in place to track overall progress.

## ▶ Eight Breakthrough Metrics:

We describe eight breakthrough metrics that are our priority metrics that we will give attention to in 2026/27. These are supported by a small number of additional metrics in each section. Many of these are either national NHSE priority metrics (e.g. constitutional standards) and/or metrics that Integrated Care Boards are expected to be measured against from 2026/27. We have also sought to ensure continuation with metrics from our 2025/26 Joint Forward Plan insofar as possible.

### How we will evaluate and assess progress



# Monitoring and Delivering this Plan

Over the next year with the creation of a new Integrated Care Board for Bristol, North Somerset, South Gloucestershire and Gloucestershire our governance arrangements will need to change with the move to a single organisation.

However, we remain committed to working in partnership through this transition with organisations responsible for the delivery of the commissioning intentions set out within this plan. In Gloucestershire we have a strong legacy of working together across organisations and well-formed governance arrangements that will help us to deliver this plan.

Governance and delivery of this plan in 2026/27 will be as follows:

## 1. Delivery via ICS Transformation Portfolios

In 2025/26 we established ICS Transformation Portfolios that have responsibility for delivering strategic commitments in our plan. This is one of the mechanisms for ICS organisations to work together on delivery of commitments in this plan.

These Portfolios are:

- ▶ Neighbourhood Health
- ▶ All Age Mental Health, Neurodivergence, Learning Disabilities and Autism
- ▶ Urgent and Emergency Care (Working as One)
- ▶ Planned Care, Cancer and Diagnostics
- ▶ System Quality

These Portfolios are supported by enabling functions such as estates, digital and workforce.

Each Portfolio has one or two individuals with overall leadership (known as Senior Responsible Officers) and is guided by professional leads to ensure a strong clinical and care voice in the way we redesign services. The involvement of clinical and care leadership from across the whole system is critical.

These will evolve with the move towards strategic commissioning in the ICB.

## 2. Oversight via Executive Led-Boards

Existing executive-led Boards which bring together partner organisations will have regular oversight for the delivery of this plan. This includes oversight of and management of risk.

## 3. Accountability via Integrated Care Board and Committees

Progress will be reported regularly to the Integrated Care Board against commitments within this plan. The Integrated Care Board provides information on progress against the performance and financial aspects of the plan. ICB Committees will have an oversight and assurance role on behalf of the Board for specific ICS Transformation Portfolios and against progress in delivering against the commitments.

Gloucestershire County Council Health Overview and Scrutiny Committee also has a key role in reviewing progress against the plan.

Progress will be reported in the annual report, and this plan will be refreshed annually.



# 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.

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