Social Care Workforce Development Project

Part 1

Supporting the workforce to deliver integrated, person-centred care

Bristol, North Somerset and South Gloucestershire

2026

CoProduce Care

NHS England

Inform, Represent & Celebrate care and support west Promoting quality in Health, Social Care & Support Services

Executive Summary

The need for health and social care to work more closely was never more evident than during the COVID-19 pandemic, which 'turbo-charged' the adoption of system collaboration across the sector. This research examined how health and social care are working together in Bristol, North Somerset and South Gloucestershire to deliver person-centred, integrated care, and what the workforce needs in order to make this work on the ground.

> *"One in 3 patients admitted to hospital as an emergency has 5 or more health conditions, up from one in ten a decade ago"*
> (Steventon et al., 2018. p.6-7)

The aim of this research has been to look at how health and social care are working together in Bristol, North Somerset and South Gloucestershire to deliver person-centred care in a way that is seamless to the person receiving care. Several critical areas emerged from this research, highlighting where collaborative working needs to happen to improve outcomes.

Contents

Two interconnected areas emerged as critical:

1. The Workforce in Integrated Care

Social care staff need professional parity with health colleagues to work as equal partners. This requires accredited qualifications, clear career pathways, and recognition of expertise. Staff also need digital skills training to confidently use technology solutions, and opportunities for cross-sector learning to understand integrated working in practice.

2. Systems and Technology Supporting the Workforce

Technology and coordinated systems are essential to enable the workforce to deliver integrated care. This includes: digital tools that allow services to communicate and share information seamlessly; Technology Enabled Care (TEC) and CareTech solutions that support independence; coordinated service delivery to reduce fragmentation; and interoperability so different systems can exchange data effectively.

These two parts are deeply interconnected. Effective systems require a skilled workforce to use them. A skilled workforce needs effective systems to enable integrated working. Achieving person-centred, coordinated care requires addressing both simultaneously.

Summary of Recommendations

This research has generated recommendations across two interconnected areas: supporting the workforce to work in integrated ways and improving the systems and technology that enable collaborative working. These recommendations should be pursued together, as the workforce could benefit from both professional development and functioning systems to deliver the integrated care that people receiving care require.

13 Recommendations for Integrated Care

A comprehensive approach addressing workforce development and system transformation

PART ONE

Workforce Development

6 Recommendations

1. Ensure social care workforce representation in ICS planning
2. Develop coordinated professional development pathways
3. Implement systematic digital skills training
4. Expand cross-system learning opportunities
5. Improve communication about development opportunities
6. Support providers with varying capacity

PART TWO

Systems & Technology

7 Recommendations

7. Coordinate community-based service provision
8. Accelerate digital care records adoption
9. Ensure interoperability across systems
10. Establish clear technology funding models
11. Address connectivity infrastructure
12. Coordinate digital transformation efforts
13. Improve communication about initiatives

These 13 recommendations must be pursued together — workforce development enables effective technology adoption, while functioning systems enable the workforce to deliver excellent care

Part One: The Workforce in Integrated Care

These recommendations focus on developing the workforce to work effectively across health and social care, based on what frontline staff and providers told us about the support they need.

1. **Ensure social care workforce representation in ICS planning** – Social care must have meaningful voice in Integrated Care Board and Partnership workforce planning decisions.
2. **Develop coordinated professional development pathways** – Create accessible routes for social care staff to gain accredited qualifications enabling parity with NHS colleagues and supporting cross-system working.
3. **Implement systematic digital skills training** – Provide tailored training building workforce confidence with technology-enabled care and digital care records, addressing the finding that only 40% of care staff feel securely confident in their digital skills.
4. **Expand cross-system learning opportunities** – Create structured opportunities for health and social care staff to learn from each other and understand different working contexts, building on successful initiatives like Trusted Assessor programmes.
5. **Improve communication about development opportunities** – Ensure all providers know about available training, funding, and collaborative programmes through systematic communication channels.
6. **Support providers with varying capacity** – Recognise that small providers face workforce development challenges and provide coordinated support, including cooperative arrangements and shared resources.

Part Two: Systems and Technology Supporting the Workforce

These recommendations address the systems, technology, and infrastructure improvements that the workforce identified as essential for delivering integrated care effectively.

7. **Coordinate community-based service provision** - Establish clearer coordination reducing the fragmentation where multiple services visit in quick succession rather than coordinating appointments.

8. **Accelerate digital care records adoption** - Continue encouraging providers to transition to digital care records with coordinated support for Data Security and Protection Toolkit compliance and NHS secure email setup.

9. **Ensure interoperability across systems** - Primary care and social care must use compatible, communicating systems to eliminate the duplication of work that frustrates staff when not everyone uses the same platforms.

10. **Establish clear technology funding models** - Address the disconnect where care providers pay for technology, but the NHS sees return on investment from reduced hospital admissions.

11. **Address connectivity infrastructure** - Lobby for better broadband, Wi-Fi, and mobile signals that are essential for technology to function reliably.

12. **Coordinate digital transformation efforts** - Establish single point of contact supporting care providers in digital transformation, connecting suppliers with providers and coordinating ICS and local authority programmes.

13. **Improve communication about initiatives** - Ensure all providers know about collaborative projects and programmes system-wide, not just pilot participants, addressing the concern that 'always the same care providers' are involved.

This report examines how the social care workforce in Bristol, North Somerset and South Gloucestershire (BNSSG) can be supported to enable person-centred, integrated care. The central question is: How can we equip social care staff to work collaboratively across health and social care boundaries for improved outcomes and experiences?

Key Findings: By the Numbers

Critical statistics from 12 months of research in BNSSG

45%

of care providers report staff lack necessary digital skills

NHS Transformation & Ipsos MORI

80%+

DSPT compliance achieved locally in BNSSG

Good news story — above national average

50%

reduction in ICB running costs mandated

£12.6m saving from £33m total spend (BNSSG)

1 in 3

patients admitted to hospital as emergency have 5+ health conditions

Up from 1 in 10 a decade ago (Steventon et al., 2018)

60%

of care providers have moved to digital care records

Digitising Social Care Programme

13

recommendations across workforce development and systems transformation

6 workforce + 7 systems/technology

Research Methodology

- **12** months of comprehensive research
- **50+** participants in workshops and consultations
- **2** questionnaires across BNSSG providers

This research project ran over twelve months and employed a comprehensive mixed-methods approach to collect data and analyse what is happening locally to integrate services. The methods were deliberately designed to capture multiple perspectives - from front-line care staff to senior managers, from small independent providers to large organisations, from health professionals to social care workers. This multi-layered approach ensured our findings reflected the complex reality of delivering integrated care in BNSSG. It included responses from over 50 people working in the care community during 2024.

The report is structured in two interconnected parts:

Part One: The Workforce in Integrated Care

Focuses on professionalising the social care workforce through accredited qualifications, career pathways, and recognition of expertise. We examine barriers preventing staff from working at the top of their skillset and recommend workforce development strategies that build confidence and capability.

Part Two: Systems and Technology Supporting the Workforce

Examines the infrastructure needed to enable integrated working. One provider described the current situation powerfully: community-based services are delivered like 'different crews digging up the roads' - uncoordinated, duplicative, and exhausting for people receiving care. We recommend coordinating services more effectively and implementing technology that genuinely supports frontline staff.

These two parts are deeply interconnected: effective systems require a skilled workforce, and a skilled workforce needs effective systems. This report brings both perspectives together because achieving integration requires addressing workforce development and systems change simultaneously.

About This Report

Why this project?

Health Education England (now within NHS England) allocated funding to Bristol, North Somerset, and South Gloucestershire (BNSSG) to explore three workforce

development initiatives. This report examines the third: best practice in working collaboratively between health and social care.

The project is led by Care and Support West and delivered in partnership with Coproduce Care. Care and Support West is the representative body for social care providers across Bristol, North Somerset and South Gloucestershire. Coproduce Care is a social enterprise working to support the social care through evidence-based research and sector engagement.

The overarching project has produced three reports:

1. The Trusted Assessor role in health and social care
2. Using Apprenticeships and the Apprentice Levy for funding training and how this can be improved within health and social care
3. **Best practice in working collaboratively between health and social care - caring together**

As highlighted above in green, this current report looks specifically at how community-based care is working more collaboratively to provide integrated care solutions which support the person-centred approach to providing care for people in the BNSSG area. The focus throughout is on understanding what the workforce needs to deliver this collaborative care effectively, and what systems and infrastructure must be in place to enable them to do so.

Why integration matters

Integration is not about organisational restructuring for its own sake but is about ensuring that when someone needs care, the support they receive is coordinated, efficient, and truly person-centred. People do not experience 'health' and 'social care' as separate entities; they experience their needs holistically. Our systems should reflect this reality.

Project aims

This project maps current interfaces and collaborations between health services and community-based social care in BNSSG, identifies barriers to integrated

working, and develops practical recommendations to enhance collaboration for better outcomes.

1. Project Overview and Context

This twelve-month project employed a comprehensive mixed-methods approach combining qualitative insights with quantitative data to understand integration from multiple perspectives.

Our approach

We established a Core Group of local care, health, and service providers who guided the research throughout. We ran workshops with frontline staff and managers, conducted two rounds of questionnaires across the sector, attended national conferences and webinars, and held in-depth conversations with commissioners, NHS managers, and technology suppliers.

This mixed methods approach allowed us to triangulate findings across different data sources. Consistent themes emerged whether providers were speaking in workshops, responding to questionnaires, or in one-to-one conversations, giving us confidence in the validity of our findings.

The twelve-month timeframe enabled iterative engagement: we tested emerging findings with participants, refined our understanding based on feedback, and ensured recommendations are grounded in the lived reality of those delivering and commissioning care.

2. The Changing Landscape of Health and Social Care

The imperative for integration

The COVID-19 pandemic highlighted the critical importance of health and social care working closely together. Collaborative working between the NHS and adult social care was essential in attempting to reduce the pandemic's impact across the health and care system. This period 'turbo-charged' the adoption of system collaboration across the NHS and social care sector, accelerating developments that had been slowly emerging over previous years. The pandemic made visible what had long been understood by those working in care: that artificial boundaries between 'health' and 'social care' serve administrative convenience rather than the needs of people receiving care.

"One in 3 patients admitted to hospital as an emergency has 5 or more health conditions, up from one in ten a decade ago"

The growth in major illnesses has substantial implications for the NHS and wider public services. This increasing complexity means that person-centred care must be delivered through integrated systems where services work collaboratively, looking holistically at the delivery of care for the complex health conditions which the population presents with. A person with diabetes, heart disease, mobility issues, and dementia cannot be effectively supported by services operating in isolation. Their care must be coordinated across multiple interfaces, requiring a workforce capable of working collaboratively across organisational boundaries.

Person-centred care and the coordination principle

Social care has adopted, as part of the Care Act 2014, a person-centred approach to care, where the person is put at the centre and their needs are considered holistically. It is important to consider the whole person within their normal setting, for example their home and then within their community. Person-centred care is built on principles of dignity, respect, compassion, and recognizing people as individuals with complex, interconnected needs.

"Ensuring continuity of care when a patient is transferred between providers is an important part of the overall patient experience."

The person-centred approach can only really work with an integrated approach to delivering care, as all aspects of someone's needs must be taken into consideration. The coordination of care - support and treatment - is one of the four key principles of person-centred care. Whilst the person-centred approach has been adopted in the care sector, it is still being integrated into the fabric of the NHS, which traditionally has been based on treating by discipline or illness specialty areas. This cultural difference between health and social care creates challenges for integration that cannot be solved through structural reforms alone,

they require workforce development that helps professionals from different backgrounds understand and respect each other's approaches.

3. Why Workforce Development Matters for Integration

Integration cannot be achieved through structural reforms alone. Integrated Care Systems provide the legal framework for collaboration, and digital systems offer the technological infrastructure, but frontline staff deliver the reality of integration. Care workers, nurses, therapists, and support staff must be able to communicate effectively, use shared systems, understand each other's roles and constraints, and feel confident working across traditional boundaries. This requires investment in workforce development across multiple dimensions.

Professional recognition and parity

Social care roles need parity with health roles through accredited qualifications. Currently, care staff often feel undervalued compared to NHS colleagues. This undermines confidence and morale, creating a barrier to effective integrated working. Providers reported that staff lack formal recognition of their expertise, making it difficult to be seen as equal partners in multidisciplinary teams. Accredited training pathways would professionalise the workforce and ensure staff feel valued and capable of contributing their expertise.

Digital competence and confidence

Staff must be confident using digital care records and technology-enabled care solutions. Research by the NHS Transformation Directorate and Ipsos MORI found that only 40% of care staff were securely confident in their digital skills, with particular gaps among those in frontline care roles. This is not about technical ability. Most care staff are comfortable using smartphones and social media, but lack confidence with care-specific systems, understanding why digital tools matter for care quality, and having ongoing support when things go wrong. As one workshop participant noted, technology often ends up ‘gathering dust’ when the person trained to use it leaves and no one else feels able to pick it up.

Cross-system understanding

Health and social care staff need opportunities to learn from each other and understand different working contexts. Currently, opportunities for cross-system learning are limited and often accidental, occurring through specific initiatives like integrated discharge teams rather than being systematically embedded in professional development. Staff from our workshops described the value of working alongside colleagues from different sectors:

> *"Understanding how health services work has made me better at my job. I know who to call and what information they need."*
>
> *"Working alongside social care staff in the discharge hub has taught me so much about what happens after patients leave hospital."*

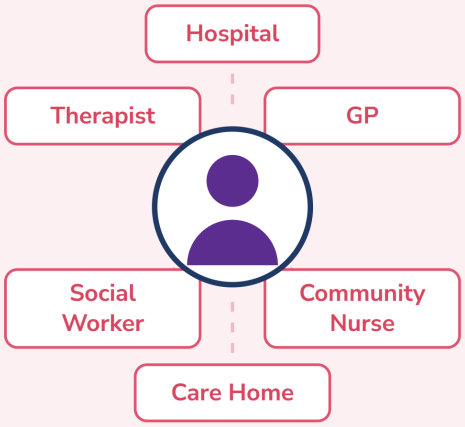
These insights only emerged because specific initiatives brought people together. Systematising such opportunities would multiply these benefits across the workforce.

Why Integration Matters

The real-world impact on people receiving care and support

CURRENT EXPERIENCE

Fragmented Services



What the Person Experiences:

Services arrive without coordination. The person tells their story repeatedly. Different professionals give conflicting advice. Appointments clash.

- Multiple people asking the same questions
- No one seems to know what the others are doing
- Gaps in care at critical transitions
- Confusion about medications or treatment plans
- Feeling like a collection of problems, not a whole person

DESIRED EXPERIENCE

Coordinated Care

What the Person Experiences:

Services work as a coordinated team. Everyone has access to shared information. Visits are scheduled to minimise disruption. Handovers are smooth.

- Tell their story once — everyone has the information
- Services communicate and coordinate with each other
- Smooth transitions between settings
- Consistent messages about care and treatment
- Feeling supported by a coherent team

“Joining up care leads to better outcomes for people”

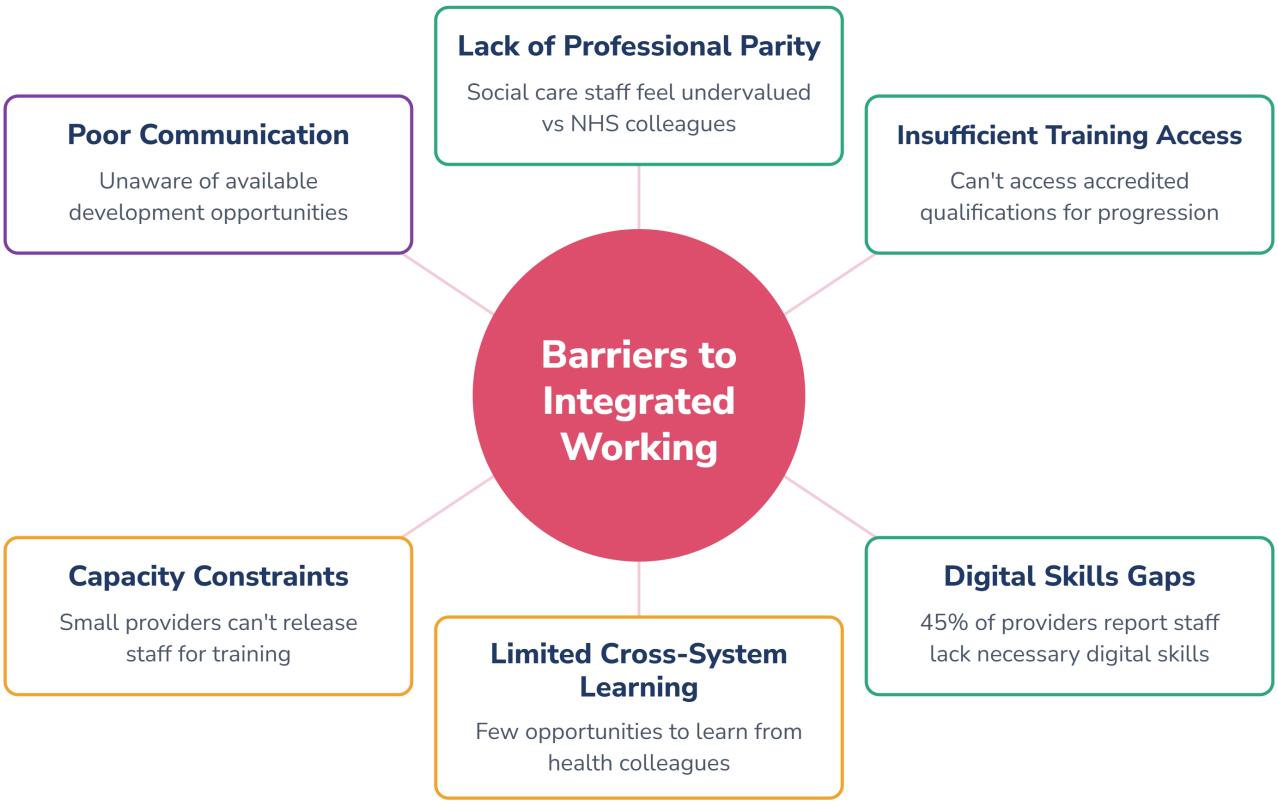
Integration isn't just an organisational nicety — it fundamentally changes people's experience of care. When services work together, people feel supported rather than overwhelmed. They receive coherent, person-centred care instead of navigating a fragmented system alone. This is why integration matters.

4. Current Workforce Challenges

Our research identified significant workforce barriers to effective integration. These barriers operate at multiple levels, from individual staff members lacking confidence or skills, to organisational constraints around training capacity, to system-level issues around professional recognition and career pathways. Understanding these barriers is essential to developing effective solutions.

Interconnected Workforce Barriers

These challenges don't exist in isolation — they reinforce each other



Breaking this cycle requires coordinated action. Addressing one barrier in isolation won't work — these challenges reinforce each other. The Part One recommendations tackle multiple barriers simultaneously to create positive momentum toward a professionalised, confident workforce capable of integrated working.

Lack of professional parity

Social care staff feel undervalued compared to NHS colleagues, with fewer professional development opportunities and limited recognition of their expertise. This is not just about pay, though pay differentials certainly matter, but about professional respect and recognition. The government's announcement of £500 million in funding for the first Fair Pay Agreement in adult social care, negotiated through a new adult social care negotiating body, represents an important step toward addressing pay and conditions. Care staff described feeling that their assessments and observations were sometimes discounted by health professionals, despite their intimate knowledge of the people they support. This undermines confidence and creates power imbalances that hinder genuine collaborative working.

Insufficient training pathways

Care workers struggle to access accredited qualifications that would enable progression and cross-system working. Small providers in particular lack the resources to coordinate apprenticeships or release staff for training. Even when funding is available, the practical challenges of maintaining staffing levels while staff attend training can be insurmountable for small organisations operating on tight margins. The result is that professional development becomes concentrated in larger organisations with dedicated training capacity, exacerbating inequalities across the sector.

Digital skills gaps and technology anxiety

Our research found that only 40% of care staff were securely confident in their digital skills. This reflects a multifaceted challenge beyond basic digital literacy. More commonly, staff feel anxious about using care-specific systems, worry that making mistakes could harm people in their care, and lack confidence troubleshooting when things go wrong.

Our research found widespread staff apprehension about new systems, with concerns that technology might replace human intervention and reduce care quality. One workshop participant described how their organisation had invested in a falls monitoring system, but staff had 'unplugged it from the wall' because they didn't understand how it worked and worried it would miss a fall that they would have noticed. This example illustrates how technology anxiety can undermine even the most promising innovations.

5. Findings from BNSSG: The Workforce Perspective

Positive attitudes toward collaboration

Our research found overwhelmingly positive attitudes toward working more collaboratively. Both health and social care respondents understood the need for integration and wanted to work together more effectively. When asked about collaborative working, responses were enthusiastic about the principle, with participants articulating clear visions of what good integration could achieve for people receiving care.

However, enthusiasm was consistently tempered by practical frustrations. Participants described daily experiences where good intentions collided with system barriers: having to duplicate work because systems don't communicate; missing opportunities for coordination because they didn't know which other services were involved with someone; feeling that their professional judgment was undervalued by health colleagues; struggling to access training that would develop their skills. As one participant put it, 'We all want the same thing - good care for people. But the system makes it harder than it needs to be.'

Workforce barriers to digital transformation

BNSSG has been proactive in implementing digital solutions, particularly through North Somerset Council's digital strategy. However, our research identified workforce-related barriers limiting the success of these initiatives. Staff described feeling overwhelmed by the pace of technological change, particularly in small providers without dedicated IT support. The concept of being Tech-Averse, often levied by some to the social care sector, was contested by participants. Instead, participants pointed out that staff use technology confidently in their personal lives but lack support using care-specific systems.

A recurring issue was that when not all services use the same systems, staff must duplicate work. One powerful example came from a workshop participant discussing the Whzan Blue Box deterioration monitoring system:

> *"The Whzan system is brilliant when everyone uses it. But only some GPs are signed up, so we have to duplicate our work - recording in Whzan and then calling the GP surgery separately. It would save so much time if everyone was on the same system."*

This illustrates a critical point: workforce frustrations with technology often stem from inconsistent implementation rather than the technology itself. Staff are willing to adopt new systems when they see clear benefits, but when partial adoption creates extra work, enthusiasm quickly turns to cynicism.

Staff turnover creates another challenge. Workshop participants reported technology 'gathering dust' after the trained person departed, with no one else confident enough to use it. This highlights the importance of training multiple staff members rather than relying on a single champion, and ensuring ongoing support is available when trained staff move on.

6. Part One Recommendations

Recommendation 1: Ensure social care workforce representation in ICS planning

Social care must have meaningful representation on the Integrated Care Board and Partnership, particularly in workforce planning decisions. The current structure risks perpetuating NHS dominance, with social care remaining a junior partner. Care & Support West should represent local providers with a unified voice. Currently, there are no adult social care providers represented on Health and Wellbeing Boards, further highlighting the need for formal social care representation in strategic planning structures. Care and Support West should ensure workforce development needs inform ICS strategy from the beginning rather than being added as an afterthought.

Actions:

- Establish formal Care & Support West representation on ICB workforce committees
- Create feedback mechanisms for workforce development concerns from frontline staff
- Ensure workforce implications are considered in all integration initiatives
- Include social care workforce data in ICS workforce planning

SOCIAL CARE WORKFORCE in ICS PLANNING

Ensuring social care has a seat at the table in integrated care system planning.

1 Voice in Strategic Decisions

Social care perspectives shape better integrated planning.

2 Strengthen ICS Collaboration

Health and social care teams work better together.

3 Valued Workforce Representation

Social care staff feel included in system-wide planning.

4 Whole-System Thinking

Understand community needs through social care insight.

5 Builds Integrated Care Excellence

Inclusion drives better outcomes for all.

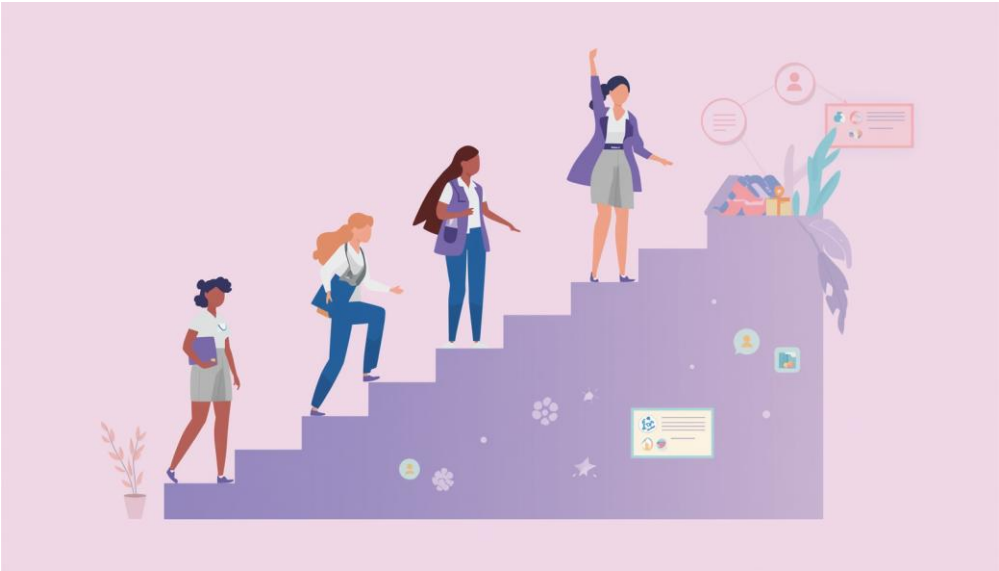
"A SEAT AT THE TABLE MATTERS"

Recommendation 2: Develop coordinated professional development pathways

Create clear, accessible pathways for social care staff to gain accredited qualifications that enable parity with NHS colleagues and support cross-system working. This requires coordination at BNSSG level to pool resources, share best practice, and enable smaller providers to access opportunities currently only available to larger organisations.

Actions:

- Establish a BNSSG-wide coordination point for apprenticeships and training programmes
- Support small providers to access levy-sharing arrangements for apprenticeships
- Create backfill arrangements to enable staff release for training
- Promote Skills for Care's Care Career Pathway and accredited qualifications
- Develop recognition for equivalence between health and social care qualifications



Recommendation 3: Implement systematic digital skills training

Provide tailored digital skills training that builds workforce confidence.

Actions:

- Develop a digital skills training programme specifically designed for care staff
- Train multiple staff members per provider to avoid single-person dependency

Recommendation 4: Expand cross-system learning opportunities

Create structured opportunities for health and social care staff to learn from each other.

Actions:

- Establish a BNSSG shadowing programme enabling social care staff to spend time in NHS settings and vice versa, building on the positive experiences reported through integrated discharge teams
- Create regular joint training sessions where health and social care staff learn together, normalising cross-system understanding as part of professional development
- Develop a mentoring scheme pairing NHS and social care professionals working with the same populations
- Build on the Trusted Assessor model by creating similar interface roles in other service areas where health and social care intersect

Recommendation 5: Improve communication about development opportunities

Many providers are unaware of available training, funding, and collaborative programmes.

Actions:

- Create a single BNSSG-wide directory of available training, funding, and collaborative programmes accessible to all providers regardless of size
- Address the concern that "always the same care providers" are involved in pilots and initiatives by actively reaching out to providers not currently engaged
- Ensure information reaches frontline staff, not just managers - use multiple channels including digital platforms, provider networks, and face-to-face events

Recommendation 6: Support providers with varying capacity

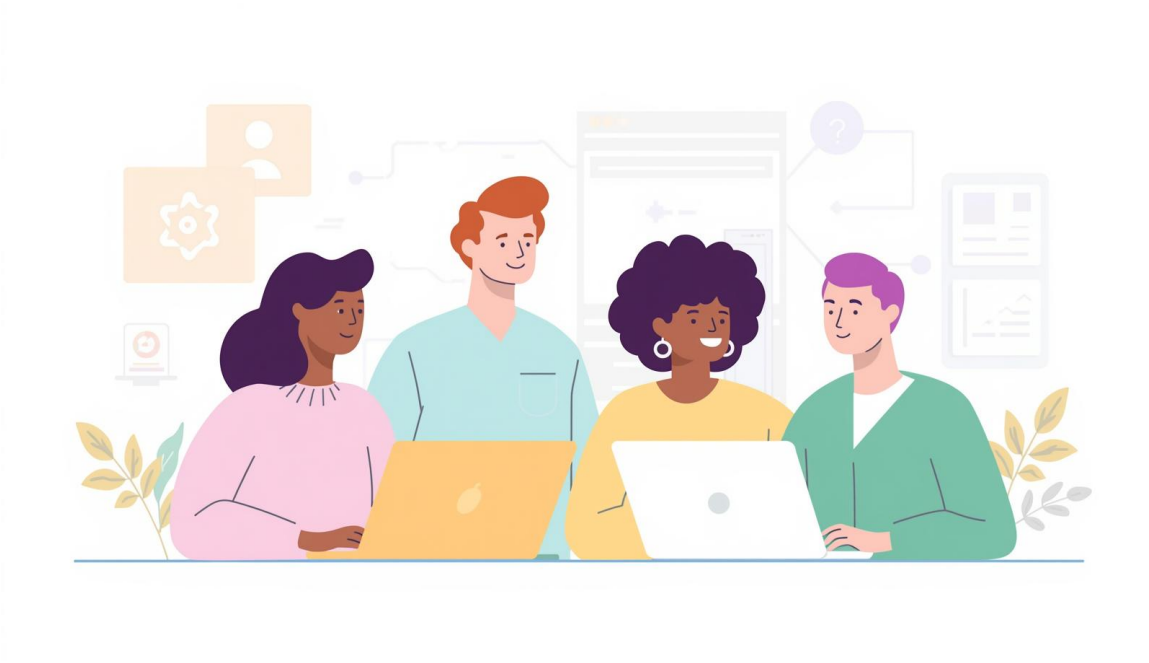
Small providers face particular challenges accessing workforce development.

Actions:

- Develop a tiered support model recognising that small providers without dedicated training coordinators or IT support need different approaches to large organisations
- Create shared-resource arrangements enabling small providers to pool training capacity and costs across a local area
- Consider flexible training delivery (online, evening, bite-sized modules) that allows small providers to maintain staffing levels while developing their workforce

Part 2

Systems and Technology Supporting the Workforce



Infrastructure, digital transformation, and service coordination to improve collaborative working

7. Integrated Care Systems

What are Integrated Care Systems?

The Department of Health and Social Care has been working toward greater integration of health and social care since social care was integrated into the ministerial brief in 2018. The Health and Social Care Act 2022 created Integrated Care Systems (ICSs) to replace Clinical Commissioning Groups, enabling a more integrated approach to commissioning and managing health and social care.

Forty-two ICSs were created across England in July 2022. The BNSSG ICS (Healthier Together) covers two NHS trusts: University Hospitals Bristol and Weston NHS Foundation Trust (including Bristol Royal Infirmary and Weston General Hospital) and North Bristol NHS Trust (including Southmead Hospital). Following the 10 Year Health Plan, integrated care boards (ICBs) will be aligned to share borders with strategic authorities wherever possible to create greater consistency and enable them to operate as strategic commissioners at an appropriate scale. These new ICB footprints will be implemented on 1 April 2026 and 1 April 2027, though some ICBs will cover more than one strategic authority.

ICS aims and benefits

ICSs are required to meet four aims: improve outcomes, tackle inequalities, enhance productivity, and support broader social and economic development. They bring together the NHS, local government, and voluntary sector organisations through Integrated Care Partnerships.

However, significant changes to ICB structures and funding have been announced. On 12 March 2025, it was announced that all integrated care boards, including NHS Bristol, North Somerset and South Gloucestershire ICB, would have to reduce their running costs by 50% (NHS BNSSG ICB, 2025). The indicative figure for BNSSG is a saving of £12.6 million from £33 million total spend. These reductions, coming on top of a 30% cut already delivered in 2023, will necessitate significant restructuring of ICB functions and may impact the capacity for collaborative working with social care providers.

Working together - “Bringing more people into the tent”

The introduction of ICSs is bringing together a wider group of participants into commissioning services and could be seen as a more considered approach to the inclusion of social care as a collaborative partner in providing person-centred care to those in the community. Since their introduction ICSs have brought

together the NHS, Local Government, local partners including voluntary, charity and social enterprise (VCSE) organisations through the integrated care partnerships (ICPs) to work together across a locality to improve health outcomes for that local population. This also includes the Care Quality Commission (CQC) who also has a new role within Integrated Care Systems to assess the quality of the ICSs provision (Care Quality Commission, 2022).

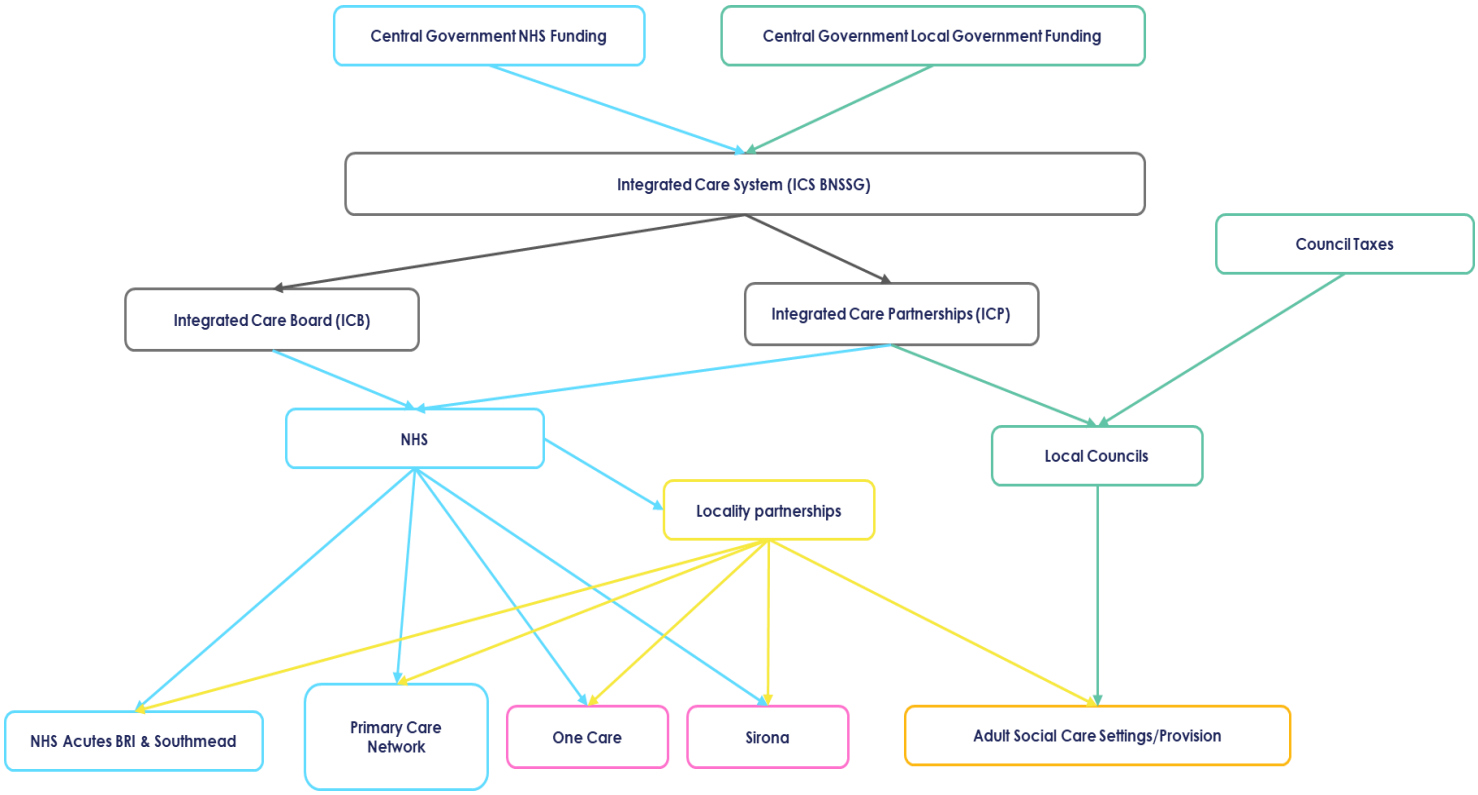
The King's Fund argue that the ICS model offers benefits including less fragmented services for people requiring both health and social care, particularly as services can be integrated at any level across the system. They suggest that by working together, the NHS and local government can tackle inequalities by addressing broader issues affecting local people, such as housing, with the potential to improve the health and wellbeing of communities. Better accountability and transparency through democratic oversight of service provision decisions is also identified as a benefit. (Charles, 2022)

However, the size and complexity of ICS governance raises concerns. The King's Fund and the Health Foundation have both cautioned that a power imbalance risks NHS bodies dominating decision-making at the expense of social care and voluntary sector partners, with the NHS holding greater responsibility and larger budgets. Alderwick et al. note "limited evidence" that these kinds of collaborative partnerships improve population health, highlighting the need for ICSs to demonstrate measurable improvements. These concerns were echoed in our own research findings.

The Model ICB blueprint references the development of 'neighbourhood health providers', suggesting that some primary care operations and support functions may be transferred to neighbourhood-level providers over time (NHS BNSSG ICB, 2025). This neighbourhood model represents an emerging approach to organising community-based services, though the implications for social care integration and the specific definition of 'neighbourhood' in this context remain to be fully defined.

What does it look like in BNSSG?

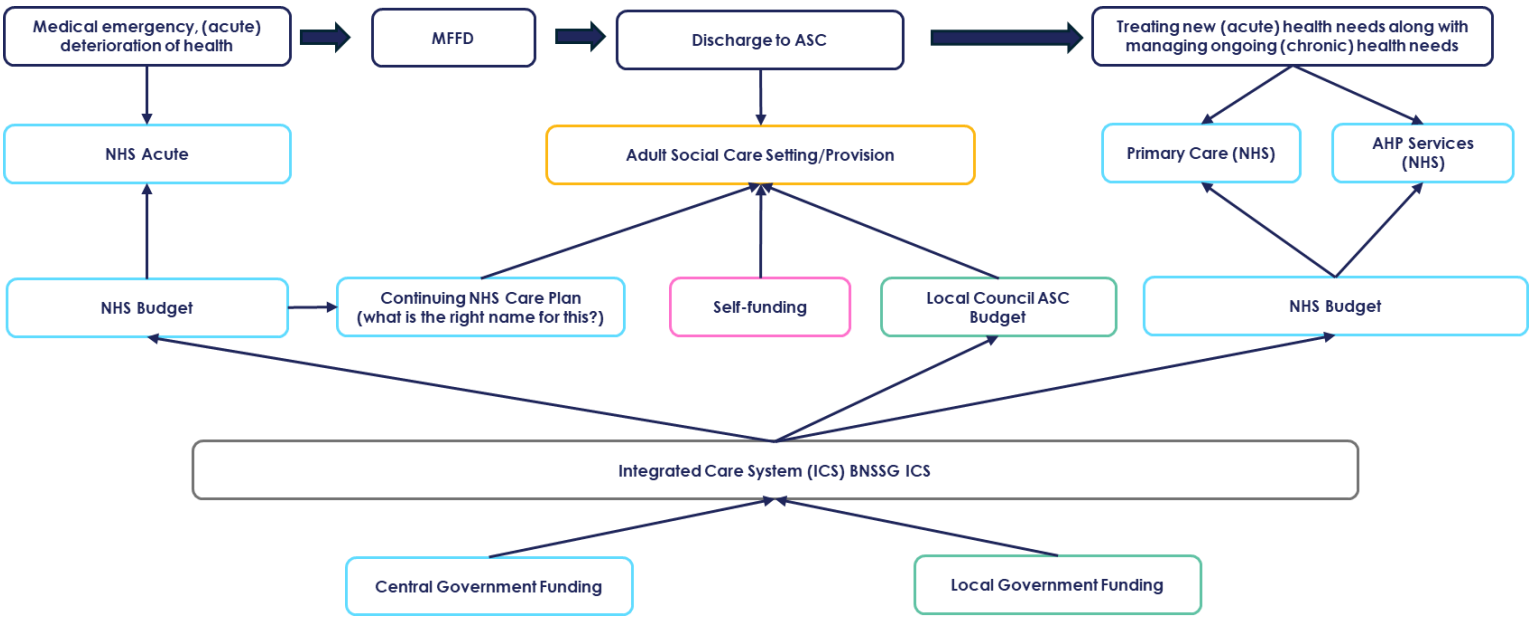
The image below attempts to explain the structure of the ICS.



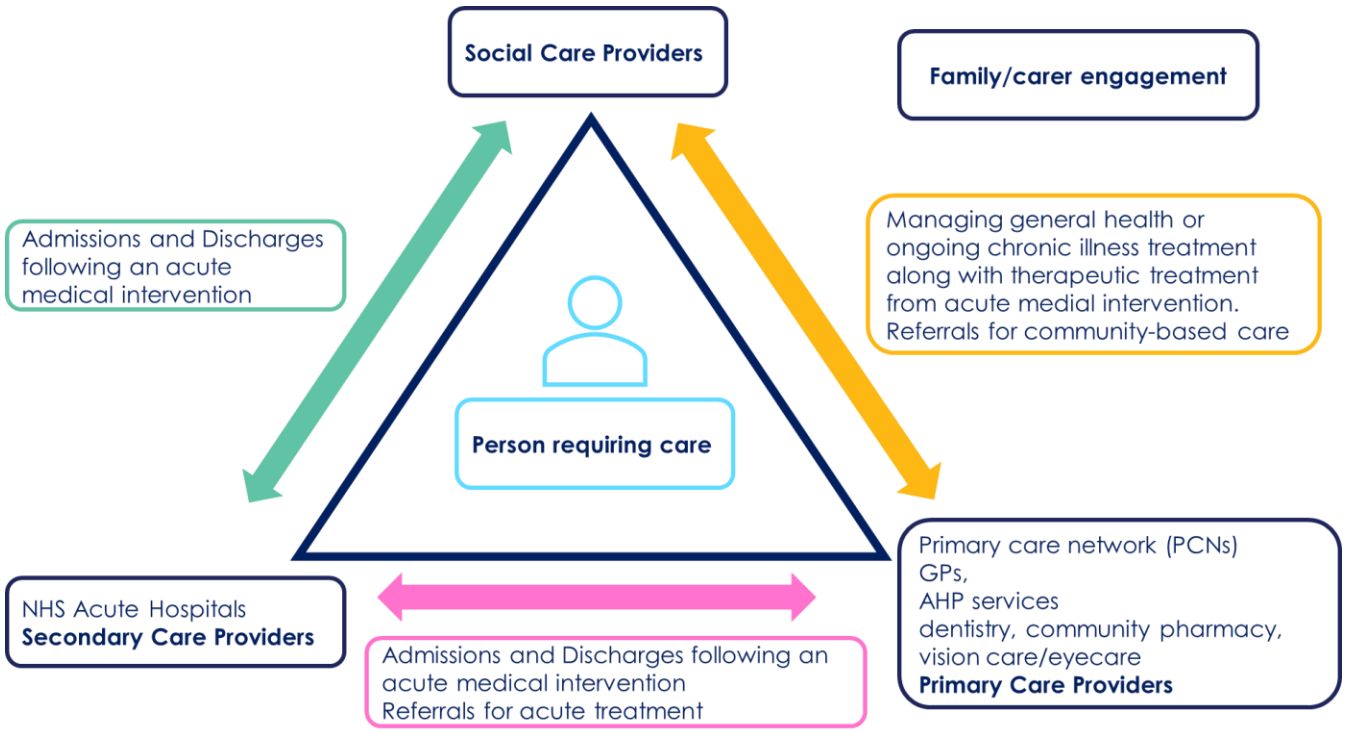
(Figure 1)

It is, however, a complex process where many teams, budgets and organisations need to come together to deliver that care.

Figure 2 below details the movement through the system of someone who is receiving care in adult social care and who has had an acute deterioration in health as an example of the complexity of the system which needs to work together and where the funding comes from to deliver that care:



(Figure 2)



(Figure 3)

Figure 3 is our representation of how a person-centred approach can focus services around individual need rather than systems and process.

The ICS in practice: implications for collaborative working

The ICS structure creates the framework within which health and social care providers in BNSSG are expected to collaborate. In principle, the ICS brings social care into strategic conversations about service planning and delivery that were previously dominated by NHS commissioning processes. In practice, our research found that the extent to which this potential is being realised varies considerably.

Providers we spoke with during our research were broadly supportive of the ICS model and its ambition to integrate health and social care commissioning. However, several raised concerns about whether social care has a genuinely equal voice in ICS decision-making, or whether the model risks perpetuating NHS dominance through the sheer scale of NHS budgets and organisational infrastructure. This concern is reflected in our first recommendation: that social care workforce representation in ICS planning must be meaningful, not tokenistic.

The complexity of the ICS structure also creates challenges for smaller providers who may struggle to engage with multiple layers of governance. Several workshop participants from smaller organisations described feeling overwhelmed by the number of forums, partnerships, and consultations they were expected to contribute to, particularly when they lacked the dedicated strategic capacity of larger providers. Ensuring that the ICS genuinely represents the diversity of the social care sector, and not just the largest and most well-resourced organisations, remains an ongoing challenge.

Community-based care in the ICS context

The move toward community-based care is central to the ICS vision. Community-based services, delivered through partnerships that include district nurses, occupational therapists, physiotherapists, speech therapists, specialist nurses, and services such as falls prevention, wound management, and oral care, are crucial for people with complex health and care needs living in the community, whether in their own homes or in residential and nursing settings.

The coordination of these community-based services emerged as a major theme in our research, and is addressed in detail in our recommendations. What became clear through our findings is that the structural integration promised by the ICS model has not yet translated consistently into coordinated service delivery on the ground. The workforce we spoke with described a gap between

the strategic ambition of integrated care and their daily experience of fragmented service provision.

8. Digital Transformation: Data and Digital Care Records

Why digital transformation matters

Digital transformation can dramatically improve the quality and safety of care through real-time data integrated across NHS and social care. Digital Social Care Records support care teams to deliver outstanding care by having accurate, up-to-date information at their fingertips. As of December 2025, approximately 80% of care providers have moved to digital care records, with the government confirming that this milestone has been reached through the Digitising Social Care Programme.

Interoperability challenges

Interoperability is the ability of different digital systems to exchange data effectively. It is the single greatest technical challenge facing integration. Providers use different care management systems, NHS trusts use different Electronic Patient Records, and these systems often cannot talk to each other. This forces staff to duplicate data entry, increases administrative burden, and creates risks of information being missed or errors being introduced. True interoperability would allow seamless data sharing across organisational boundaries.

The Digital Social Care Records programme

The Digitising Social Care Programme, funded by the Department of Health and Social Care through NHS England, has been supporting care providers to adopt digital care records through an Assured Supplier List and associated funding. Approximately 80% of care providers nationally have now moved to digital records, up from around 40% before the programme began. Despite this significant progress, variation exists. In BNSSG, progress has been supported by local digital strategies, particularly in North Somerset, but smaller providers often face barriers to adoption including cost, staff confidence, and the time required for implementation alongside ongoing care delivery.

Locally, Care and Support West is well-positioned to lead coordination of digital transformation efforts across BNSSG social care providers. As the representative body for the sector, Care and Support West can provide the single point of contact that providers need, connecting them with appropriate suppliers, coordinating ICS and local authority digital programmes, and ensuring smaller providers receive tailored support to navigate digital transformation successfully.

The Data Security and Protection Toolkit (DSPT) is a prerequisite for providers to connect with NHS systems and access funding for digital transformation. Completing the DSPT requires a level of technical understanding and

administrative capacity that can be challenging for smaller organisations. Nationally, DSPT completion has risen from just 15% in 2021 to 76% in 2025, representing significant progress but still leaving nearly a quarter of providers without compliance. Our research found that some providers were unaware of the DSPT requirements, while others found the process daunting. Supporting providers through this process emerged as an important enabler of digital transformation.

Connectivity as a foundational requirement

Underpinning all digital transformation is the need for reliable connectivity. Good broadband, Wi-Fi coverage, and mobile signals are essential for digital systems to function, yet connectivity remains inadequate in parts of BNSSG, particularly in rural areas of North Somerset and South Gloucestershire. Workshop participants described situations where digital care records could not be updated in real time because of poor internet connectivity, where Technology Enabled Care devices lost connection, and where video consultations were impossible due to insufficient bandwidth.

This is not a problem that the care sector can solve alone. It requires coordinated lobbying at local and national level to ensure that care settings, including residential homes in rural locations, are included in digital infrastructure investment plans. Without reliable connectivity, digital transformation cannot deliver on its promise, regardless of how good the systems or how skilled the workforce.

9. Technology-Enabled Care Solutions

Technology-enabled care and CareTech solutions can monitor health, record data, and help people maintain independence. Solutions range from wearable devices to acoustic monitors detecting falls, health deterioration monitoring, and prompts/alarms. The NHS spends over £2 billion annually on falls. Technology could significantly reduce this.

Barriers to TEC adoption

The concern that technology might replace human care was raised repeatedly in our research. Staff expressed worry that monitoring systems, automated alerts, and remote observation could reduce the personal contact that they see as fundamental to good care. Addressing this concern requires framing technology as supporting rather than replacing the workforce, thus freeing staff from routine monitoring to focus on the relational aspects of care that technology cannot replicate.

The funding disconnect

A significant barrier identified in our research is the misalignment between who pays for technology and who benefits from its outcomes. Care providers typically bear the cost of purchasing and implementing Technology Enabled Care solutions, yet the financial return on investment through reduced hospital admissions, fewer ambulance callouts, and shorter hospital stays, accrues primarily to the NHS. This creates a perverse disincentive: the organisations best placed to deploy preventive technology lack the financial motivation to invest, while the organisation that would benefit most does not bear the cost.

Resolving this funding disconnect requires system-level thinking that the ICS model should enable. If the ICS is genuinely working as an integrated system, investments should be evaluated on total system benefit rather than individual organisational costs. Our research found little evidence that this kind of system-level investment thinking had been embedded in practice.

TEC in practice: what is working

Despite these challenges, our research identified examples of Technology Enabled Care working effectively in BNSSG. The Whzan Blue Box deterioration monitoring system, deployed in several care settings, enables early identification of health deterioration through regular monitoring of vital signs. When fully adopted and consistently used, staff described it as transformative. Thus,

enabling earlier intervention that prevented hospital admissions and gave staff confidence in clinical decision-making.

Acoustic monitoring systems for falls detection, wearable devices tracking health indicators, and medication management technology were also identified as having significant potential. The common factor in successful implementations was consistent adoption across the relevant services, adequate staff training with ongoing support, and reliable connectivity. Where any of these elements was missing, technology underperformed or was abandoned.

The Technology Tipping Point

What tips the scales toward success or failure in digital transformation

✗ Tipping Toward Failure

When technology gathers dust

Poor Connectivity

Inadequate broadband, WiFi, and mobile signals prevent technology from functioning reliably. Particularly acute in rural areas and some care settings.

Inconsistent Adoption

When not everyone uses the same systems, staff must duplicate work across multiple platforms instead of benefiting from seamless integration.

Insufficient Training

Staff lack confidence using care-specific systems. When the trained person leaves, equipment sits unused because no organizational capacity was built.

Funding Disconnect

Care providers pay for technology but NHS sees return on investment from reduced hospital admissions. This misalignment disincentivizes investment.

Technology Anxiety

Staff worry technology will replace human care or that mistakes could harm people. This fear leads to resistance or disengagement.

✓ Tipping Toward Success

When technology transforms care

Reliable Infrastructure

Good broadband, WiFi, and mobile coverage enable technology to function dependably. Investment in connectivity infrastructure is worth lobbying for.

Interoperability

Systems that communicate with each other eliminate duplication of work. Everyone using compatible platforms means seamless information flow.

Comprehensive Training

Training multiple staff members (not just one champion) builds organizational capacity. Ongoing support available when issues arise maintains confidence.

Sustainable Funding

ICS-level investment frameworks that evaluate technology on total system benefit, not individual organizational budgets, enable strategic investment.

Staff Buy-In

When staff understand how technology supports better care (not replaces them), they become champions actively driving successful adoption.

> *The Whzan system is brilliant when everyone uses it. But only some GPs are signed up, so we have to duplicate our work - recording in Whzan and then calling the GP surgery separately. It would save so much time if everyone was on the same system.*
>
> **Workshop Participant**

10. Service Integration in BNSSG

BNSSG has numerous interfaces and collaborations. Community-based care involves NHS primary care, allied health professionals, and third-party providers like Sirona who provide assistive technology, diabetes care, virtual wards, and programmes for mouth care, falls prevention, and wound care.

Integrated discharge and Trusted Assessors

The integrated discharge hub brings together multidisciplinary teams. Bristol has adopted Trusted Assessors who act as interfaces between NHS acute settings and local care providers, reducing discharge delays through accurate, timely assessments.

The Trusted Assessor model represents one of the clearest examples of integrated working in BNSSG. By placing assessors who understand both acute hospital settings and community care provision at the interface between the two, delays are reduced and people move to appropriate care settings more quickly. Our research found broad support for this model among both health and social care participants, who described it as an example of how integration can work when properly resourced and supported.

However, it is important to note that BNSSG is no longer funding the Trusted Assessor pilot via Care and Support West. This represents a setback for integrated working, as the TA role had demonstrated the value of creating dedicated interface positions between health and social care settings.

Community health services and social care interfaces

Sirona Care and Health, the community interest company providing NHS community services across BNSSG, operates at a critical interface between health and social care. Their services include assistive technology provision, diabetes care, virtual wards, mouth care programmes, falls prevention, and wound care. They frequently involve working alongside social care providers. The quality of these interfaces varies significantly. Where relationships are established and communication channels clear, staff described effective collaborative working. Where services operate in parallel without structured coordination, fragmentation and duplication were common.

Primary care also represents a significant interface. GP surgeries are often the first point of contact for health concerns among people receiving social care. Our research found mixed experiences of GP engagement with care providers. Some

described excellent relationships with responsive, collaborative GPs, while others described difficulty getting timely clinical input and a sense that social care providers' observations were not always taken seriously.

Fragmentation in community-based service delivery

The 'roads being dug up' analogy used by one of our research participants captures a fundamental challenge in BNSSG: community-based services are often delivered in parallel rather than in coordination. Multiple professionals may visit the same person in a single day. This might include a district nurse, an occupational therapist, a care worker or a physiotherapist. Each professional focuses on their specific remit without necessarily knowing what the others are doing or when they are visiting. For the person receiving care, this can feel disruptive and exhausting rather than supportive.

Coordinating these visits and ensuring that professionals share relevant information would improve the experience for people receiving care and reduce wasted time for the workforce. Our research found that coordination tends to happen informally through personal relationships rather than through systematic processes, making it vulnerable to staff changes and inconsistent across different parts of BNSSG. Building systematic coordination into service delivery rather than relying on individual initiative is central to our recommendations.

11. Findings from BNSSG: Systems and

Where Health and Social Care Connect

Critical interfaces requiring seamless integration for person-centred care

CURRENT REALITY

Fragmented Interfaces

Hospital Discharge → Care Homes

Discharge planning, medication handover, care plan transfer

✗ Systems don't communicate — information re-entered manually

✗ Delays due to incomplete information transfer

GPs → Social Care Providers

Health updates, medication changes, deterioration alerts

✗ Some GPs use Whzan, some don't — staff duplicate work

✗ Phone calls and faxes still common

Community Nurses → Home Care

Wound care monitoring, mobility changes, health concerns

✗ Uncoordinated visits — multiple professionals in quick succession

✗ Different recording systems — no shared view

Therapists → Supported Living

Rehab plans, equipment needs, progress monitoring

✗ Paper-based handover notes

✗ Limited feedback loop on implementation

WHAT'S NEEDED

Integrated Working

Hospital Discharge → Care Homes

Seamless information transfer, coordinated handover

✓ Digital care records talk to hospital systems

✓ Trusted Assessors bridge the interface

GPs → Social Care Providers

Real-time health updates, shared care plans

✓ Interoperable systems — everyone on same platforms

✓ Automated alerts for medication or health changes

Community Nurses → Home Care

Coordinated scheduling, shared observations

✓ Visits coordinated to reduce disruption

✓ Shared digital records showing full picture

Therapists → Supported Living

Collaborative care planning, progress tracking

✓ Digital handover with multimedia evidence

✓ Regular feedback enabling plan adjustment

> *Community-based services are delivered like roads being dug up to replace a water pipe, then repaired, only for the road to be dug up again the following week to replace a gas pipe. If services coordinated, the disruption would happen once.*
>
> **— Provider participant, Caring Together research workshops**

Technology

Positive attitudes, practical frustrations

Research found optimistic attitudes toward collaborative working, but practical challenges create frustrations. The fragmented approach to community-based service delivery described in this report was a recurring concern, with providers emphasising that people receiving care experience multiple uncoordinated professional visits rather than a planned, joined-up approach.

Digital transformation challenges

The disparate marketplace, from large corporates with dedicated resources to small businesses without, creates implementation challenges. When not all services use the same systems, staff must duplicate work, causing frustration and undermining technology investments.

Providers consistently reported that the promise of digital systems is undermined when adoption is partial. As described in our findings on the Whzan Blue Box, when all parts of the care chain are connected, staff see transformative benefits. However, when one link is missing, staff must resort to phone calls and manual processes, negating the efficiency gains. Staff described this inconsistency as more frustrating than not having the technology at all, because it creates an expectation of seamless working that is then not delivered.

Technology implementation and workforce capacity

Our research identified a recurring pattern in technology implementation: initial enthusiasm followed by declining use when the trained ‘champion’ moves on or when connectivity issues create persistent problems. Small providers described particular difficulty sustaining technology adoption because they lack dedicated IT support. When a digital care records system malfunctions at a weekend, a large provider can call their IT team; a small provider may have no one available who knows how to fix it, leading to a return to paper records that undermines the entire investment.

Training emerged as critical but insufficient on its own. Staff need not just initial training but ongoing support, refresher sessions when systems are updated, and a culture where asking for help with technology is normalised rather than seen as a sign of incompetence. Several workshop participants described feeling embarrassed about their lack of digital confidence, particularly older staff who compared themselves unfavourably with younger colleagues. Creating supportive

learning environments around technology use is as important as the training content itself.

What the workforce told us about systems

When asked what would most improve their ability to deliver collaborative care, participants repeatedly returned to a small number of themes: systems that talk to each other so information does not need to be entered multiple times; reliable internet connectivity so digital tools actually work; coordinated service delivery so that visits to people receiving care are planned rather than haphazard; and clear communication about what services and initiatives are available, so that providers can access the support that exists rather than operating in ignorance of it.

These are not unreasonable requests, and none represents a novel insight. The workforce knows what it needs. The challenge is translating these clearly identified needs into coordinated action across a complex system with multiple stakeholders, competing priorities, and constrained resources. Our Part Two recommendations attempt to provide a framework for this coordinated action, grounded in what the workforce has told us about their practical experience of delivering care in BNSSG.

12. Part Two Recommendations

The following recommendations address the systems, technology, and infrastructure improvements identified through our research as essential for enabling the workforce to deliver integrated care effectively. Each recommendation emerges directly from what frontline staff and providers told us about the practical barriers they face daily. These recommendations should be read alongside the Part One workforce recommendations, as addressing systems and technology in isolation from workforce development will not achieve the integrated care that people receiving services need and deserve.

Recommendation 7: Coordinate community-based service provision

Establish clearer coordination reducing fragmentation where multiple services visit in quick succession.

Actions:

- Improve communication between primary care networks, community services, and social care

Recommendation 8: Accelerate digital care records adoption

Continue encouraging providers to transition to digital care records with coordinated support.

Actions:

- Build on the national achievement of 80% DSCR adoption by targeting the remaining 20% of providers with dedicated one-to-one support rather than generic guidance
- Provide practical assistance with DSPT compliance, which has now reached 76% nationally but still leaves nearly a quarter of providers unable to connect with NHS systems
- Fund backfill arrangements so small providers can release staff for digital records training without compromising care delivery
- Ensure training covers multiple staff members per provider to avoid the pattern identified in our research where technology ‘gathers dust’ after the trained champion leaves
- Connect digital records adoption to the government’s single patient record ambition so providers understand the long-term vision, not just the immediate compliance requirement

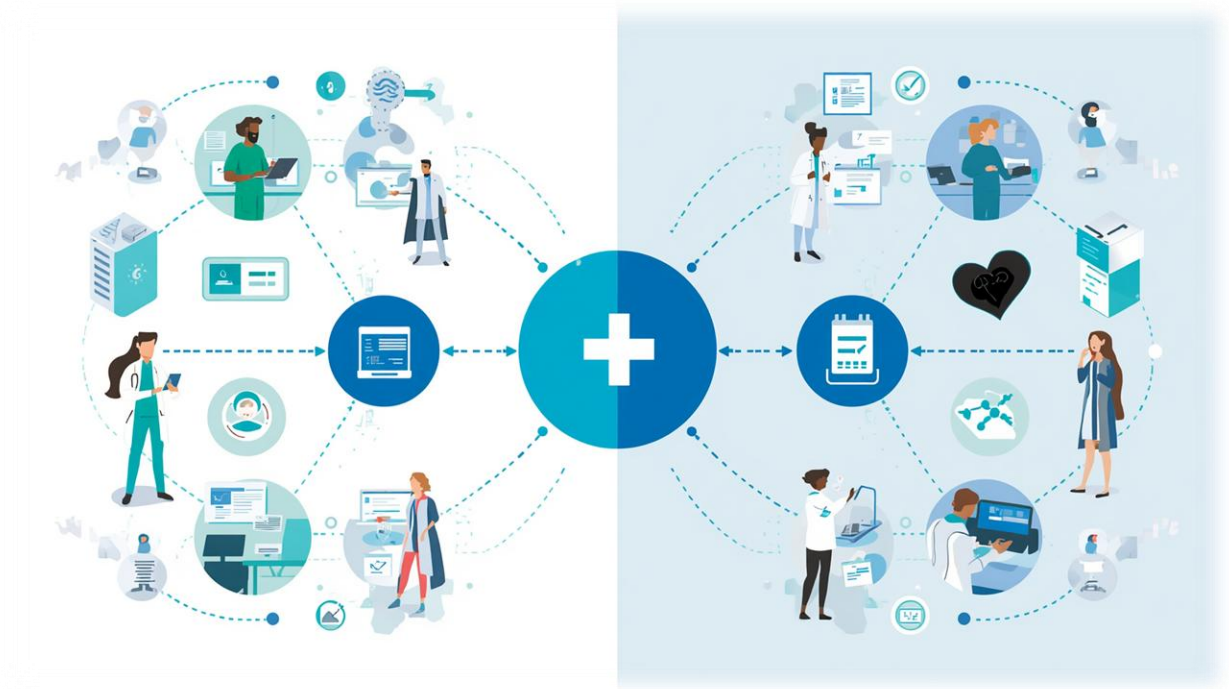
Recommendation 9: Ensure interoperability across systems

Primary care and social care must use compatible systems to eliminate duplication of work.

Actions:

- Engage with NHS England's digital interoperability platform to ensure BNSSG social care providers are connected from the outset
- Prioritise interoperability between GP systems and digital social care records, as this was the interface where our research found the most frustration, exemplified by the Whzan Blue Box working brilliantly when all parties are connected but creating extra work when they are not
- Advocate for the adoption of the minimum operational data standard across all BNSSG providers to enable consistent data sharing
- Map the current system landscape across BNSSG to identify where the most critical communication gaps exist and prioritise interoperability investment accordingly

Commission a Care and Support West pilot project focused on interoperability solutions that enable seamless data exchange between primary care and social care systems

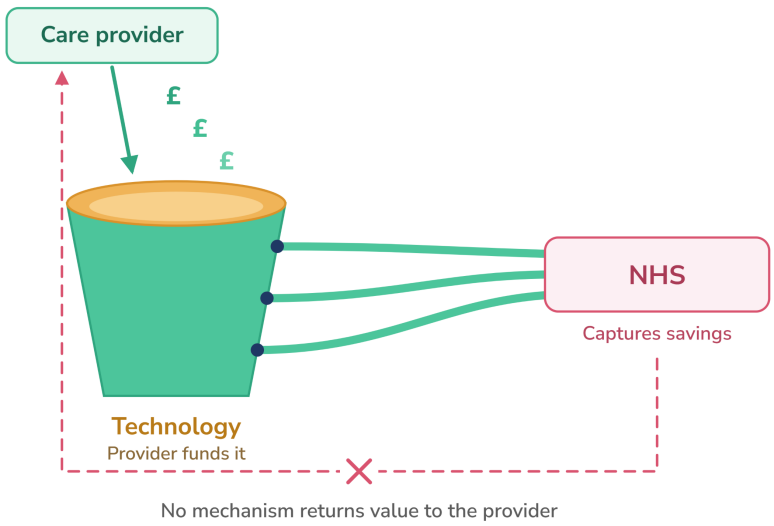


Recommendation 10: Establish clear technology funding models

Address the disconnect where care providers pay for their own improve technology system but NHS sees the return on investment due from this to reduced admissions.

Actions:

- Develop an ICS-level investment framework that evaluates technology on total system benefit rather than individual organisational cost, reflecting the principle that integrated care requires integrated investment
- Create a shared funding model for Technology Enabled Care where the NHS contributes to costs borne by care providers when the financial returns (reduced admissions, fewer ambulance callouts) accrue to the NHS
- Pilot a TEC investment fund within BNSSG ICS that care providers can apply to, with outcomes measured across the whole system rather than within individual organisations
- Ensure the Fair Pay Agreement negotiations consider the impact of unfunded technology mandates on provider sustainability



Recommendation 11: Address connectivity infrastructure

Lobby for better broadband, Wi-Fi, and mobile signals essential for technology to function.

Actions:

- Conduct a BNSSG-wide connectivity audit identifying care settings with inadequate broadband, Wi-Fi, or mobile signal, particularly in rural North Somerset and South Gloucestershire
- Coordinate lobbying with local authorities and MPs to ensure care homes and supported living settings are included in digital infrastructure investment plans, including Project Gigabit and the Shared Rural Network
- Explore interim solutions such as mobile data packages or satellite broadband for providers in areas where fixed-line upgrades are not imminent
- Include connectivity requirements in all ICS digital transformation planning so that technology is not deployed to settings where it cannot reliably function

Recommendation 12: Coordinate digital transformation efforts

Establish single point of contact supporting providers in digital transformation.

Actions:

- Establish a dedicated digital transformation coordinator role within BNSSG ICS (or Care & Support West) acting as a single point of contact for care providers navigating the digital landscape

- Create a supplier engagement programme connecting Technology Enabled Care suppliers directly with providers, reducing the current reliance on providers finding and evaluating solutions independently

- Align local authority digital strategies (particularly North Somerset's) with ICS-level digital transformation to avoid duplication and ensure providers receive consistent guidance regardless of which local authority area they operate in

- Coordinate the multiple overlapping programmes - Digitising Social Care, local authority digital strategies, ICS digital plans - into a coherent roadmap that providers can follow

Ensure any GP/NHS integration projects (such as Connecting Care - https://bnssghealthiertogether.org.uk/your-health/connecting-care/) include social care from the outset, not as an afterthought. Social care providers must be represented in planning and implementation of any systems designed to improve information sharing across health services

Recommendation 13: Improve communication about initiatives

Ensure all providers know about collaborative projects system-wide, not just pilot participants.

Actions:

- Create a BNSSG-wide register of all integration and digital transformation initiatives, accessible to every provider, so that participation is not limited to those who happen to be in existing networks
- Actively reach out to providers not currently engaged in collaborative projects, directly addressing the research finding that "always the same care providers" are involved
- Establish a regular communication channel (quarterly briefing, newsletter, or webinar) updating all BNSSG providers on ICS initiatives, pilot outcomes, and upcoming opportunities
- When pilots demonstrate success, develop a systematic rollout plan with clear timelines so that proven innovations reach all providers rather than remaining confined to the original pilot group

13. Conclusion

The urgency of addressing these integration challenges has been emphasised by Baroness Casey's Casey Commission, which in March 2026 called for a 'moment of reckoning' on adult social care (Casey Commission, 2026). This call to action underscores that the challenges identified in our research are not unique to BNSSG but reflect systemic issues facing social care nationally that require concerted action to resolve.

Integrated care requires more than structural reforms. Integrated Care Systems provide frameworks, but ground-level integration depends on workforce capability and functioning systems. This research found positive approaches to collaborative working in BNSSG, but also frustrations about achieving integration practically.

The workforce wants to work collaboratively and understands why integration matters. But barriers frustrate these ambitions: inaccessible training, non-communicating systems, unreliable technology due to poor connectivity, fragmented service coordination, and a sense that despite best efforts, integration remains aspirational.

Success requires addressing workforce development and systems improvement together. Professionalising the workforce through accredited qualifications creates parity with health colleagues. Building digital confidence through systematic training addresses the finding that only 40% of care staff feel securely confident in their digital skills. Expanding cross-system learning enables staff to understand different contexts.

On the systems side, coordinating community-based services reduces fragmentation. Accelerating digital care records adoption with interoperability enables information flow. Addressing connectivity infrastructure allows technology to function reliably. Establishing sustainable funding models addresses the disconnect where providers pay but NHS sees benefits.

With an estimated 470,000 additional posts needed by 2040 to match the growth of the population aged 65 and over, workforce development combined with functioning systems becomes essential for sector sustainability. The enthusiasm for collaboration is real. The barriers are significant but not insurmountable. With coordinated action on professional development, digital skills, cross-system

learning, service coordination, digital transformation, and infrastructure, BNSSG can build a workforce and system capable of delivering truly integrated care.

This research identified both challenges and opportunities. The foundations exist through ICS structures, digital transformation programmes, and innovative pilot projects. However, fragmentation persists: social care staff lack professional recognition, digital systems do not communicate, and services remain uncoordinated. The recommendations in this report address these barriers systematically. Implementation requires commitment from system leaders, adequate resourcing, and genuine partnership between health and social care.

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Appendices

Appendix A: Glossary of Terms

Glossary

Term	Description
AHP	Allied Health Professions. For example, Occupational Therapists, Physiotherapists, speech and language therapists
ARF	Accelerating Reform Fund (£42.6m from DHSC (Department of Health and Social Care)) – innovation, quality and accessibility
ASCOF	Adult Social Care Outcomes Framework
Assured Supplier List	The Digital Social Care Programme has an assured list of DSCR solution suppliers. To be eligible for funding for implementing a DSCR solution that supplier must be on the assured list. beta.digitisingsocialcare.co.uk
CareTech	Technology which assists care
CCGs	Clinical Commissioning Groups
DSCRs	Digital Social Care Record System – digital care plans
DiSC	Digitising Social Care programme
DSPT	NHS Data Security & Protection Toolkit (a requirement of having an NHS secure email address)
eMARS	Electronic Medication Administration Record
MARs	Medication Administration Record
ICB	Integrated Care Board
ICS	Integrated Care System
ICP	Integrated Care Partnership

NEWS & NEWS2	National Early Warning Score Deterioration monitoring tool that produces a score which can be used to escalate care using a common scoring system that is used across the health and care system.
OneCare	BNSSG GP federation supporting local GP practices to run their organisations
PCN	Primary Care Network
ReSPECT	Recommend Summary Plan for Emergency Care and Treatment
RESTORE2	Recognise Early Soft Signs, Take Observations, Respond, Escalate This is a monitoring system that detects potential deterioration of residents through
Section 75	This section of the Care Act 2014 allows partnership arrangements for NHS and LAs to provide services through pooling funding and resources
Sirona	BNSSG NHS community health service provider
TEC	Technology Enabled Care
WHZAN Bluebox	TEC solution which provides equipment to monitor patients with an interface which can communicate deterioration of patient with GP and ambulance using RESTORE2 and NEWS2 scores

Links to Further Information and Help

Digitising Social Care Programme – Assured Supplier List
beta.digitisingsocialcare.co.uk

Digital Care Hub - Better security, better care
https://www.digitalcarehub.co.uk/data-security-protecting-my-information/better-security-better-care/

Mortex centre in Weston Super Mare North Somerset equipment & demonstration centre https://n-somerset.gov.uk/my-services/adult-social-care-health/get-help-support/i-want-help-live-home/equipment-adaptations/equipment-demonstration-centre

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Appendix B: Research Method

This research project ran over twelve months and employed a comprehensive mixed-methods approach to collect data and analyse what is happening locally to integrate services. The methodology was deliberately designed to capture multiple perspectives - from frontline care staff to senior managers, from small independent providers to large organisations, from health professionals to social care workers. This multi-layered approach ensured our findings reflected the complex reality of delivering integrated care in BNSSG. It included responses from over 50 people working in the care community during 2024.

Core Group establishment

The project began by establishing a Core Group of local care, health, and service providers across BNSSG who were able to share their expertise with us to help direct our research. This group was carefully selected to represent the diversity of the BNSSG care landscape: it included representatives from residential and nursing homes of different sizes, home care providers, NHS community services, local authority commissioners, and voluntary sector organisations.

The Core Group met regularly throughout the twelve-month project period, providing invaluable guidance at key stages. They helped us refine our research questions, ensured our data collection methods would yield meaningful insights, reviewed interim findings, and challenged our interpretations to ensure they reflected the complexity of practice on the ground. This iterative engagement with practitioners throughout the research process was essential to ensuring our work remained grounded in practical realities rather than theoretical ideals.

Workshops with providers

We ran a number of workshops where we invited care providers to discuss their experiences of integrated services they had used locally. These workshops were designed to create safe, open spaces where frontline staff and managers could speak candidly about their experiences - both positive and negative - without fear that criticism would reflect badly on their organisations or affect relationships with commissioning bodies.

A recurring theme across the workshops was frustration. Participants wanted to work collaboratively, they understood why it mattered, they could articulate what good integration would look like, but they experienced daily barriers that prevented them delivering the care they aspired to provide. These ranged from practical issues (systems that don't communicate with each other, services

arriving uncoordinated) to more fundamental problems (lack of recognition for social care qualifications, inadequate training budgets). The workshops gave voice to these frustrations while also surfacing examples of effective practice that demonstrated integration is achievable when the right support is in place.

The workshops also revealed significant variation in experiences depending on provider size and resources. Large organisations with dedicated training coordinators, IT support, and strategic capacity described challenges but also successes in adopting new ways of working. Small providers, often running on very tight margins with minimal administrative capacity, described feeling overwhelmed by the pace of change and unable to access opportunities that seemed designed for larger organisations. This insight shaped our recommendations to ensure support is tailored to providers with different levels of capacity.

Questionnaires

We ran two questionnaires where we asked health and social care organisations to answer a series of questions about their use of local services and their experience of working collaboratively. These questionnaires combined quantitative and qualitative approaches, gathering both statistical data about service use and rich narrative responses about experiences of collaborative working.

The second questionnaire delved deeper into experiences and perceptions: how well providers felt integration was working, what barriers they encountered, where they saw opportunities for improvement, and what support they needed to work more collaboratively. The qualitative responses provided context and nuance to the quantitative data, revealing the 'why' behind the numbers.

The questionnaires provided high-level insight into integration approaches while also capturing specific examples and concerns from those working at the coalface of care delivery. Response rates were good, with representation from across the provider landscape.

Sector engagement

Throughout the project, we attended events, webinars, and conferences to understand what is happening across the sector nationally to integrate services and what solutions are being developed to help integration. This broader engagement was essential to ensure our research was informed by

developments beyond BNSSG, allowing us to understand how local challenges and opportunities compared with national trends and initiatives.

Direct conversations with stakeholders

We had further conversations and discussions where we spoke to local organisations, Technology Enabled Care suppliers, and service providers about the services they provide to the BNSSG region and how this is helping to integrate services. These direct conversations allowed us to explore specific initiatives in depth and understand implementation challenges that might not emerge through workshops or questionnaires.

We spoke with commissioners about their strategic vision for integration and the challenges they faced in commissioning services that genuinely work together. We interviewed NHS managers about their experiences working with social care providers and what they saw as barriers and enablers to collaboration. We had detailed discussions with technology suppliers about why some implementations succeeded while others failed, gaining insight into the practical realities of digital transformation that went beyond providers' formal responses.

Mixed methods approach and data triangulation

This project took a mixed methods approach, using questionnaires to gather both quantitative and qualitative data which helped to inform and direct further data collection. The questionnaires gave us insight into the high-level approach to integration across BNSSG. We then collected qualitative data through workshops with local care providers to understand their experiences of using integrated services and systems, giving us further insight and helping to draw out what integration has been happening locally to work more collaboratively, and to identify challenges to delivering integrated services and solutions.

The twelve-month timeframe allowed us to engage iteratively with participants, testing emerging findings and refining our understanding. Early workshops identified key themes which we explored through questionnaires; questionnaire findings highlighted areas for deeper investigation through targeted conversations; insights from conversations informed the focus of later workshops. This iterative approach meant our final recommendations are grounded in multiple rounds of engagement and validation with those who will need to implement them.