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

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Partnership Board Meeting

1.30 – 4.00 pm, Thursday 10 July 2025

The Loft @ The Stable, 3-6 Wadham Street, Weston-super-Mare, North Somerset BS23 1JY

Agenda

1. Welcome from the Chair (and to note any apologies)

2. Minutes of previous meeting held on 24 April 2025
To approve the minutes of the previous meeting.

3. Public forum items
Any items received will be circulated.

4. ICB update (1.35 pm)
- To include update on ICB changes.

5. Health and Wellbeing Board and Locality Partnership updates (1.45 pm)
- Updates from the respective Chairs of the Health and Wellbeing Boards (5 mins)
- Locality Partnership update (25 mins)

6. Winter planning update (2.15 pm)
- Verbal update from Shane Devlin, CEO, BNSSG ICB plus input from Directors of Public Health

7. Healthier Together 2040 – progress update (2.30 pm)
Update to be presented by Gemma Self, Programme Director - Strategic Projects

8. ICP Board forward agenda plan (included for information)

Meeting finish time – approx. 2.45 pm

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Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Partnership Board Meeting

24 April 2025

Meeting room 1, Bradley Stoke Active Lifestyle Centre, Fiddlers Wood Lane, Bradley Stoke BS32 9BS

Minutes

Attendance list

Partnership Board Leadership Group:
Cllr John O'Neill (Chair, BNSSG ICP Board and Chair, South Gloucestershire Health and Wellbeing Board)
Cllr Jenna Ho Marris (Chair, North Somerset Health and Wellbeing Board)
Cllr Stephen Williams (Chair, Bristol Health and Wellbeing Board)
Jeff Farrar (Chair, BNSSG Integrated Care Board (ICB))

Community and VCSE Voices:
Rebecca Mear (CEO Voscur/VCSE Alliance)
Mark Graham (CEO, For All Healthy Living Centre)
David Smallacombe (CEO, Care and Support West)
Kay Libby (Chief Executive, Age UK Bristol, VCSE Alliance representative working with older adults)
Dominic Ellison (WECIL/VCSE Alliance)
Mandy Gardner (Voluntary Action, North Somerset)
Fiona Mackintosh (ACFA advice network/VCSE Alliance)

Council, Constituent Health and Care Organisations:
Matt Lenny (Director of Healthy and Sustainable Communities, including Director of Public Health, North Somerset Council)
Hayley Verrico (Director – Adult Social Services & Housing)
Joanne Medhurst (Chief Medical Officer, BNSSG ICB)
Chris Sivers (Executive Director - People, South Gloucestershire Council)
Ingrid Barker (Chair, UHBW NHS Foundation Trust & NBT NHS Trust)
Barbara Brown (Chair, Sirona Care & Health

Locality Partnerships:
Kirstie Corns (South Gloucestershire Locality Partnership)
David Moss (Woodspring & Weston Locality Partnership)
Alison Findlay (South Gloucestershire Locality Partnership)
Sharron Norman (Chair, North & West Bristol Locality Partnership)
Huda Hajinur (Chair, Inner City & East Locality Partnership)
Joe Poole (Head of Locality Development, BNSSG ICB)

Other attendees:
Sally Hogg (Consultant in Public Health, Bristol City Council)
Adele Vowles (Senior Public Health Specialist, Bristol City Council)
Trudi Oak, Senior Business Planning & Development Manager, AWP NHS Trust
Karen Llewellyn (Bristol Health Partners)

Apologies for absence:
Shane Devlin (Chief Executive Officer, BNSSG ICB)
Sarah Truelove (Deputy Chief Executive, BNSSG ICB)
Ruth Hughes, (CEO, One Care)
Stephen Beet (Chair, South Bristol Locality Partnership)
Alun Davies (Voices in the Community/Lived Experience representative)
Mark Coates (CEO, Creative Youth Network)
Sarah Weld (Director of Public Health, South Gloucestershire Council)
Aileen Edwards (CEO, Second Step/VCSE Alliance)
Rosie Shepherd (Chief Nursing Officer, BNSSG ICB

1. Welcome & Introductions

The Chair welcomed all present to the meeting and led introductions from attendees.

2. Minutes of previous ICP Board meeting held on 27 February 2025

The minutes of the meeting of the previous ICP Board meeting held on 27 February 2025 were confirmed as a correct record.

3. Public Forum

It was noted that no public forum items had been received for this meeting.

4. ICB update

The written update, as included in the agenda papers for the meeting, was noted.

Summary of main points raised/noted in discussion of this item:

1. Jeff Farrar highlighted the following points:

a. As per recent government announcements, NHS England was to be abolished. ICBs nationally were also required to reduce their running costs by 50% during the 2025/26 financial year. This 50% cut was on top of the 30% reduction already delivered, as required by the government in 2023.

b. Given the scale of the further cost reduction required, the BNSSG ICB would not be viable in its current form. Discussions would be progressed as a matter of urgency across ICBs covering the south-west region on the response to the situation. It was anticipated that ICB structures would need to be reviewed, most likely resulting in organisational 'join-up' or mergers to create a smaller number of ICBs with larger geographical footprints.

c. It was likely that the future role of ICBs would be focused more specifically on strategic commissioning.

d. The restructure of ICBs would inevitably result in a review of ICP structures.

2. It was noted that ICB structure changes would need to be progressed at pace in order to deliver the required cost reductions to the set timescale. The ICB was committed to transparency and would share as much information as possible with partners as decisions on structure were taken and implemented.

3. Notwithstanding the structural changes, it was noted that there would still be a firm commitment to further develop the system approach to improving population health and tackling health inequalities.

4. It was suggested that organisations represented within the ICP should take the opportunity to lobby government about seeking improved alignment between and, where appropriate, coterminous geographical boundaries/footprints in relation to health and local authority governance structures.

5. It was noted that unless there was a change in statutory requirements, the ICB would retain its statutory safeguarding responsibilities. The ICB was also committed to maintaining its proactive approach to equality, diversity and inclusion and to maintaining its partnership with community, lived experience and VCSE voices.

5. Health and Wellbeing Board and Locality Partnership updates

a. Bristol Health and Wellbeing Board update:

The written update, as included in the agenda papers for the meeting, was noted.

Cllr Stephen Williams, Chair of the Bristol Health and Wellbeing Board, also highlighted that on 23 April, the Board had engaged in a development session on the Joint Local Health and Wellbeing Strategy

b. North Somerset Health and Wellbeing Board update:

The written update, as included in the agenda papers for the meeting, was noted.

Cllr Jenna Ho Marris, Chair of the North Somerset Health and Wellbeing Board also highlighted that North Somerset's refreshed Joint Health and Wellbeing Strategy 2025-2028 and action plan had now been published.

c. South Gloucestershire Health and Wellbeing Board update:

The written update, as included in the agenda papers for the meeting, was noted.

The Chair (in his capacity as Chair of the South Gloucestershire Health and Wellbeing Board) also highlighted that a development session had been held recently on the Joint Local Health and Wellbeing Strategy 2025-29. The strategy had been developed in collaboration with partners and the development session had taken place during a formal 8-week period of stakeholder engagement to gather views on the draft.

d. Locality Partnerships update:

The written update, as included in the agenda papers for the meeting, was noted.

Summary of main points raised/noted in discussion of this item:

1. It was noted that the BNSSG Locality Partnership Collaborative had been actively planning their approach to formal reporting of Locality Partnerships' work into the respective Health and Wellbeing Boards, and subsequently into the ICP Board. It was felt that this formal reporting line presented an opportunity to move beyond traditional reporting formats and include innovative and creative ways to demonstrate impact and celebrate community achievements.

2. The approach to reporting would include case studies demonstrating positive local / community impacts. At this point in the meeting, a video was viewed highlighting positive engagement across the VCSE sector and communities within the South Bristol Locality Partnership.

3. The suggested approach to reporting was supported although it was noted it would also be important to ensure ongoing engagement with local stakeholders as part of this reporting process. It was agreed generally that it would be important to demonstrate and showcase successful community outcomes and experiences, and to listen to local voices, perspectives and insight.

6. Damp, Mould and Fuel Poverty Toolkit

The Board considered a report providing an update on and raising awareness of work in Bristol to develop a Damp, Mould and Fuel Poverty Toolkit for health, care and VCSE staff working across Bristol, North Somerset and South Gloucestershire. The ICP Board was asked to review and provide feedback on the Toolkit and to support implementation across the BNSSG health and care system.

Summary of main points raised/noted in discussion of this item:

1. The Damp, Mould and Fuel Poverty Toolkit had been co-developed by a Bristol task and finish group which included representation from health, housing and Voluntary, Community and Social Enterprise (VCSE) staff.

2. It was noted that this work recognised how the environmental conditions in which people live have an impact on their health and wellbeing, including having a home safe from harm. The aim was to take a 'making every contact count' approach to signpost and support people in accessing support for damp, mould and/or fuel poverty issues, and to support action to deliver on the 5 opportunities identified within the Bristol, North Somerset and South Gloucestershire ICS System Strategy:
- Tackling inequalities.
- Strengthening the building blocks of good health and wellbeing - Commitment 4: "actively identifying people whose health and wellbeing is at risk due to cold or poor-quality homes and helping them to access support".
- Preventing illness and treating people earlier.
- Working alongside communities to support healthy behaviours.
- Managing conditions better once people were ill.

3. The toolkit specifically aimed to:
- Support staff in identifying people at risk of/experiencing damp, mould and fuel poverty.
- Increase recording of damp, mould and fuel poverty in health systems.
- Support staff in responding to concerns identified, including increased signposting and referrals into fuel poverty advice, and increased confidence to provide simple housing signposting.

4. The toolkit was designed to be a resource for use by staff working across the health and care system and could be used flexibly depending on the role.

5. It was suggested that these issues were relevant across the local authority and wider housing sector and details about this work could be usefully shared with housing associations.

6. The work taken forward on developing the toolkit was welcomed and partners generally agreed that it would be important to collectively raise awareness of this work, noting the related impacts, and potential for collaborative approaches across the health and housing sectors.

7. Progress update: Integrated Care System All Age Mental Health Strategy Pledge for creating Healthier Places Together

The Board considered an update setting out progress in taking forward the ICS all age mental health strategy pledge for creating healthier places together.

Summary of main points raised/noted in discussion of this item:

1. The progress update was generally welcomed. Partners were reminded that the strategy has 6 ambitions:
- Holistic care for people of all ages.
- Prevention and early help, in the right place and as early as possible.
- Quality treatment, closer to home, so people can stay well in their communities.
- A sustainable mental health system.
- Reduction of health inequalities by improving equity of access to services.
- An inclusive, trauma-informed and stable workforce across the system.

2. A clear governance structure was in place to oversee the strategy implementation plan.

3. In response to questions, further detail was outlined on the work and achievements so far in relation to holistic care. This included ensuring that people with serious mental illness could access an annual physical health check, with follow-up, and developing an intensive community mental health action plan to ensure provision was in place across BNSSG for those individuals who would benefit from a more assertive outreach approach to engage them in treatment in community services and reduce risk of harm.

4. It was noted that further detail was available on specific metrics that would be used to assess success against the 6 strategy ambitions.

5. In relation to the aim of reducing health inequalities, it was noted that this included improved reach to diverse communities through targeted support for marginalised groups.

8. ICP Board forward agenda plan

The Board noted the latest update of the forward agenda plan.

Meeting finish: 4.20 pm

Healthier Together
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Integrated Care Partnership Board

Agenda item	4	Meeting date	10 July 2025

UPDATE – BNSSG INTEGRATED CARE BOARD

1. Embedding the VCSE in integrated care - our progress, vision and next steps

An online discussion event was held on 19 June to help define the collective vision and strategy for the Voluntary, Community and Social Enterprise (VCSE) sector in Bristol, North Somerset and South Gloucestershire health and care system.

Since the formation of Integrated Care Boards and the launch of the Bristol, North Somerset and South Gloucestershire VCSE Alliance, we have made **good progress** in embedding diverse VCSE organisations within our local health and care system. VCSE organisations and health partners work together to improve the health and wellbeing of people in our communities.

At a time of change for the NHS, we want to reaffirm our collective vision by continuing to work in partnership with VCSE organisations to tackle health inequalities and support people to live well for longer. Using a national quality development tool co-designed with VCSE organisations, we will reflect on the progress made and discuss practical ideas for further embedding the VCSE sector within our local health and care system.

This event was for VCSE leaders and partners, including NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board, local authorities, locality partnerships, acute trusts, primary care, community providers and those who want to work with VCSE organisations in communities.

2. Changes to ICB arrangements in response to the requirement for ICBs nationally to reduce their running costs by 30% during 2025/26

A verbal update will be given at the meeting on the latest position.

Healthier Together
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Integrated Care Partnership Board

Agenda item	5a	Meeting date	10 July 2025

UPDATE – BRISTOL HEALTH AND WELLBEING BOARD (HWB)

1. The most recent in-public meeting of the Bristol Health and Wellbeing Board (HWB) was held on 22 May 2025. All the papers can be viewed at: ModernGov - bristol.gov.uk

2. The main issues considered at the 22 May meeting were:

a. Updates from the recent and planned work of the three Bristol Locality Partnerships.

b. A presentation (and subsequent discussion) from Sirona Care and Health on their Clinical Strategy 2025.

c. An update on the progress in producing the revised Bristol Pharmaceutical Needs Assessment 2025.

d. Sign-off of the Better Care Plan, noting that the BCF Plan will continue to promote the best use of joint health and social care resources; support increased prevention approaches across the city; ensure Bristol residents return to and are maintained in their own homes and communities whenever possible; and promote community resilience and improved outcomes for and with people.

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Integrated Care Partnership Board

Agenda item	5b	Meeting date	10 July 2025

UPDATE – NORTH SOMERSET HEALTH AND WELLBEING BOARD

1. The most recent North Somerset Health and Wellbeing Board meeting was held on 21 May 2025. All the papers can be viewed here: Agenda for Health and Wellbeing Board on Wednesday, 21st May, 2025, 2.00 pm | North Somerset Council

2. The main items discussed at the meeting were as follows:

(i) Public participation

Two people addressed the meeting.

(1) Alan Rice, who represented Weston Housing Action (WHA) spoke about the link between poor housing and poor health. He highlighted local cases where accommodation is a threat to health and ask for closer working with NHS clinicians and the Housing department to agree acceptable standards of accommodation. He asked the Board to support the introduction of selective landlord licenses in Central Weston super Mare. In the response, the Head of Housing and the HWAB Chair suggested approaching the Locality Partnerships to explore the consequences of housing conditions, and also to refer the question to the ICB and the ICP of whether there should be a working group between the NHS and NSC to explore health standards for housing.

(2) Amy Jones, CEO of North Somerset Citizens Advice Bureau (NSCAB) briefed the meeting about the Government's proposed major reforms to disability and health-related benefits. NSCAB modelled the reform proposals in relation to local population impacts, in terms of health inequality, prevention, and to understand the changes and the risks posed to population health. NACAB had estimated that the impact of these reforms would put increased pressure on all Local Authorities, in the areas of public health, equality and inclusion, service demand, support for carers, deprived wards, mental health and suicide prevention services. In discussion, members commented on the expected increased demand for services in North Somerset Council (NSC) and how the increased flow of service need would be mitigated by NSC and Local Partners.

The briefing paper with this analysis has been shared with all Board Members. It was agreed that the Chairperson of the Health and Wellbeing Board look to update the corporate risk register to take account of this data and information presented and that the address from NSCAB be circulated to members.

(ii) Maximising health and wellbeing through delivery of the Local Plan

The Director of Healthy and Sustainable Places (NSC), the Planning Policy Manager and Consultant in Public Health presented the report which set out the local strategy and requirements for housing, employment and other land used in the plan period.

They described the North Somerset Local Plan 2024 and how it aligns to the National Planning Policy Framework aims. He highlighted the significant change, in the North Somerset area that would result through increased housing and the potential for long-term damage to the population. Highlights were shown from the Planning for Healthier Places guidance document developed by the Town and Country Planning Association, Academic bodies and local authorities which is being used in North Somerset as a framework for maximising health and wellbeing benefit through delivery of the Local Plan.

The board were invited to provide feedback from four workshop groups which used the following questions:

- What opportunities in developing new communities would be established?
- What identification of risks in the built environment would be mitigated?
- How can communities be involved?
- What contribution of ideas could be made by members of the board for the Local Plan development?

Some of the comments from the workshop discussion were:

- For sustainable communities to be real we need to ask local people what this looks like for them?
- We need to create early opportunities to engage and set out what is possible
- We are conscious that the 5/6 year olds of today are the ones who will be living with decisions made in this plan so we need to have children and family engagement as part of that process.
- Use our housing needs assessment to describe what is the right mix of housing. What is the evidence we are using to guide decisions.
- Let people talk about their lived experience. Talk about the space available, how to access free space, deal with parking and transport issues etc.
- We know that as well as new development there are issues that we have now. How will changes help to address those too? Describe what investment is and how developer contributions will provide value to everyone.
- We need clear policy and visibility of that policy around Section 106 and CIL. What flexibility do we have to adapt to local needs/opportunities? Needs to be an outcomes-based model of investment, based on local priorities. Can we use EIA tools to test the investment of that money. Show what type of impact we are having?
- How do we keep people well at home? Design flexibility to meet changing needs, future proof for disability for example, or designing for inclusivity?
- Many people feel decisions have already been made. Need to get out and challenge that perception, whilst also being honest about what changes people can influence.
- Talk about a vision of what do you want? E.g. 2040 view of the world for you, your parents, your children etc. Collective vision of what help us all.
- Ensure honesty about the rate of building and how some projects will be fast, others will take a long time to be built if at all. Talk about commercial reality of building houses.

- Can we use our engagement with communities to help lobby for what we need from Government or other agencies? In particular, look for capital to build the sort of housing we need. Do we (as a local authority and/or other local partners) take the risk and build ourselves?
- Use policy to help define what is good, and manage appeals process well.
- How can we ensure we have genuinely health promoting neighbourhoods where the reality matches up with the approved plans on paper. For example, can we look back at recent developments and assess development plans vs reality? This could then inform planning policy development.
- Community infrastructure needs to be thought of at the start of major developments. Can we ensure early delivery?
- Openness to increasing the variety of housing stock, for example, higher density housing should be considered appropriately. Also improving the stock of smaller, well built, affordable housing seems beneficial to younger people and those downsizing if accessible.
- Green spaces should be community spaces. Beneficial to physical and mental health.Are their lessons from the walkable neighbourhoods work to include within local plan?
- Walking and cycling infrastructure and public transport are vital, safe and attractive routes with schools as a priority.
- Affordable housing needs to be well built and integrated into wider development. For example, supportive of tenure blind policies within North Somerset and ensuring targets are met – sense that viability assessments need to be robustly reviewed and challenged when appropriate.
- Energy efficiency – wanting to tackle climate change but clear co-benefits for health. Cheaper and more economical to run. Helps tackle fuel poverty.
- Food environment - what get built should be reflective of community needs and diversity. Consider what are we encouraging/discouraging through our planning policy? Can we do this better and learn from best practice?
- Concern that a one size fits all approach is not appropriate as in local cases there are needs for different types of housing, such as a need for one bed flats in Weston Central ward.
- Housing standards and running costs included a discussion around models such as Passivhaus, more expensive to buy, but cheaper running costs in the longer term.
- Health impacts of construction were identified with a concern that the building of houses and infrastructure causes impacts on the local communities, mud, dust, noise pollution etc. Discussed how construction management plans are a tool to address this.
- Open spaces are key to people's health and wellbeing. Should be delivered as early as possible in developments and maintained to a good standard.
- Active travel is focussed on how we can embed sustainable travel choices, walking, cycling and public transport from the outset to establish healthy behaviours.
- A concern that consultations are often difficult to penetrate, with a hard balance to strike between satisfying planning regulations and legislation and making them easier to understand. Discussed targeting young people as ultimately the homes we are planning for will be for the next generation. Important to engage with town and parish councils as early on in the process as possible, as local representatives.

It was resolved that the Board's feedback and recommendations on how the Local Plan could support Health and Wellbeing outcomes (as set out in the minute appendix) will be considered in the further development of the policies and processes used to confirm the Local Plan and its implementation. Members agreed that the feedback should be referred to the relevant Policy and Scrutiny Committees for comment.

(iii) Joint Health and Wellbeing Strategy 2025-2028 Status Report

The Consultant in Public Health, Healthy and Sustainable Communities Directorate delivered an update on the implementation of the new strategy and delivery of projects to date. She reported on the key points in Phase 2 and 3 which supported the new Joint Health and Wellbeing Strategy 2025-2028, which included 27 projects.

She reported the majority of workstreams were underway and in progress.

There was discussion around the presentation, Members commented on and raised queries about the following issues:

- More detail on benefits and impacts of peer support for Adults with Mental Health
- Reduced waiting time at red traffic lights had reduced traffic speed and was welcomed by walkers. Seen as a welcome benefit for active travel.
- The Children and Young People community-based funding could help tackle health inequalities. A good example of joint working around a shared outcome.
- A provider has been identified for Self-Harm support to address local needs.
- Good outcomes achieved for children's food / nutrition and oral health by the provision of 5,000 distributed toothbrush packs and 100 persons trained in advice and guidance.
- New insights were required through an inequality lens to understand emotional wellbeing and support provision to Children and Young People

It was resolved that the status report for Phase 2 and Phase 3 of the Joint Health and Wellbeing Strategy Projects report be approved. The Board also agreed to publication of the new Joint Health and Wellbeing Strategy 2025-2028 and linked Action Plan.

A status report of the Health and Wellbeing Strategy 2025-20-28 Action Plan will be provided later in the year.

(iv) Working with Avon Fire and Rescue Service

The Area Manager of the Avon Fire and Rescue Service (AF&RS) reported on prevention strategies through its legal duties to prevent and protect communities, as inspected by the National Fire Chief Council.

The service prioritises 7,500 of the most vulnerable people in the service area. The strategy described, focused on the challenge of social isolation and pledged assistance to the Health and Wellbeing Board within the scope of the Fire and Rescue Service. He explained since the Grenfell disaster; legislation has changed which offered greater protection to communities and this came with increased investment in the service.

The AFRS service as described has:

- A duty of collaboration.
- A duty for the identification of vulnerable groups at risk, e.g. hoarders, older persons, people with Dementia.
- The mitigation of Climate Change risks, in relation to garden fires and wildfires.
- The provision of Home Fire Safety visits.
- An informative website on Fire Safety informed by research and evaluation.

There was discussion around the presentation, Members commented on and raised queries about the following issues:

- Persons socially isolated would live in both affluent and deprived areas so a whole area approach is required.
- The importance of linking the Health and Wellbeing strategy and how AFRS would support its activities through identification of vulnerable people. The Area Manager of the Avon Fire and Rescue Service offered to meet with all members to share ideas, research, and evaluation.
- Home Office education programmes are delivered to Children and Young People at schools and in further education.
- In relation to Adult Social Care a joint investment in digital care monitoring for vulnerable persons is welcomed. New services commissioned in the Autumn 2025 will provide technical solutions to care monitoring as an example.
- Maintenance of electrical products guidance is given through Home Fire Safety visits.
- A challenge to supply Personal Emergency Evacuation Plan (PEEPS)through social care providers.
- Dementia training to AFRS officers was delivered.
- Recognition given to Milton community residents who highlighted risks of garden bonfires in the hot dry weather, which helped to reduce risk
- Negligible risk of wildfires as few open spaces in North Somerset.

The Board confirmed its support for the AF&RS's request to work together to develop opportunities to support its work and the Health and Wellbeing Board partners.

(v) Developing the Joint Strategic Needs Assessment

The Director of Healthy and Sustainable Places introduced the Specialist Public Health Registrar who described the Joint Strategic Needs Assessment dashboard's potential as a tool to support delivery of the Health and Wellbeing Strategy and the Council's corporate plan 2024-2028 as well as other local strategies and plans. When regularly updated with strong evidence it provides access to data designed to inform service decisions.

The core aim of the Joint Strategic Needs Assessment (JSNA) was to develop local evidenced based priorities for commissioning, to improve the public's health and reduce inequalities. The dashboard gathered and organised information by themes and subjects and used best practice across England. Although there are some strengths in the way the JSNA is currently configured, a review has showed that it could be better used by local stakeholders if key conclusions were easier to understand and the latest evidence and data was applied more consistently.

The Board were asked for support of leadership of a review through a Steering group to develop the resource and contribute to future action planning to secure the desired improvements. Members were asked to nominate representatives to join the Steering group which would enable key conclusions to be arrived at promptly and then shared. A half day workshop was proposed for steering group members, which provided templates to report to the Health and Wellbeing board through a workplan.

The Chairperson encouraged the production and visibility of clear shared outcomes. The Director of Healthy and Sustainable Places agreed and added that clear outcomes would ensure the commissioning of services was clearly informed. Community engagement would provide information to build the template. It was agreed that the steering group are asked to agree a six-month cycle update, including adoptions of a clear template, to monitor, evaluate and agree the forward workplan. All members were encouraged to use the and share thoughts on the current model.

Members commented on and raised queries about the following issues:

- The link to the Integrated Care Board (ICB) intelligence centre is paused at present.
- The best way to ensure outcomes and recommendations are communicated in a simple visual way and shared with all.
- The JSNA has a strong role around informing future commissioning.

(vi) Healthier together 2040

A written update was shared with the Board, welcomed and noted.

(vii) Other items

The Locality Partnerships Director presented an information flyer on the opportunity to develop a Creative Health Board (CHB) described as a people driven forum to embed creativity as a central part of the Health System. The event is scheduled on Friday 11th July from 2:00pm – 5:30pm at a variety of venues in Weston-super-Mare.

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Integrated Care Partnership Board

Agenda item	5c	Meeting date	10 July 2025

UPDATE – SOUTH GLOUCESTERSHIRE HEALTH AND WELLBEING BOARD

1. The most recent South Gloucestershire Health and Wellbeing Board meeting was held on 1 May 2025. All the papers can be viewed here: Agenda for Health & Wellbeing Board on Thursday, 1st May, 2025, 10.00 am - South Gloucestershire Council. An overview of the agenda items is set out below.

Joint Local Health and Wellbeing Strategy 2025-29

2. The Health and Wellbeing Board agreed the final South Gloucestershire Joint Local Health and Wellbeing Strategy (JLHWS) 2025-29; accountability and monitoring arrangements; and terms of reference for the Senior Officer Group and Joint Strategic Needs Assessment Steering Group.

3. The JLHWS sets out a shared vision for the Health and Wellbeing Board 2025-2029.

Vision for South Gloucestershire residents
South Gloucestershire is a healthy and inclusive place, where current and future generations feel safe, supported and empowered to lead healthy lives.

Vision for the South Gloucestershire health and care system and partners
The Health and Wellbeing Board, its partners and local communities will work closer together to reduce inequalities and hold ourselves to account on our commitments to create a healthier and more inclusive place for all.

4. To deliver this vision, the JLHWS has five strategic commitments about how the Health and Wellbeing Board can use its unique role and membership to lead and advocate for health and wellbeing locally and develop ways of working. These are:

5. Each year the Health and Wellbeing Board will produce an action plan setting out up to four annual focus areas. These areas for collective action will be an opportunity to drive forward best practice with local partners and to deliver on the strategic commitments.

6. The principles for the selection of areas of focus are:
- Target local need identified in the South Gloucestershire Joint Strategic Needs Assessment (JSNA)
- Offer an opportunity for the Health and Wellbeing Board to deliver on its five commitments
- Be able to benefit from Health and Wellbeing Board support to drive progress
- Be focused and achievable within a 12-month period
- Be the next development of previous Health and Wellbeing Board focus areas OR a new policy priority which requires system leadership
- Be local, system or national priorities

7. The focus areas for year 1 (2025-26) have been agreed as:
- **Place-based working and Neighbourhood Health** - work as a Board to develop a shared vision for place-based working and Neighbourhood Health in South Gloucestershire and support actions to implement this.
- **Healthy Weight** – sign up to the Bristol, North Somerset and South Gloucestershire 'Why Weight?' Healthy weight pledge and support actions to implement it across South Gloucestershire.
- **Housing and Wellbeing** – work as a Board to develop a Housing and Wellbeing Strategy for South Gloucestershire and support actions to implement this.
- **Children and Young People** – work with partners to develop our integrated local approach for maternity and early years to support families and carers before and during pregnancy and with children up to the age of 5 years.

Better Care Fund end of year report and planning for 2025-26

8. The Health and Wellbeing Board received an update on the Better Care Fund Plan 2025-26. In response to how the Board could go further in delivering the identified

approaches during 2025-26 and 2026-27, members commented that there were opportunities to develop care closer to home within existing resources, rather than waiting for funding; there were links with the strategic commitments in the JLHWS 2025-29; and GP practices and primary care would be key in delivering the goals along with insights from JSNA data. The update was noted and it was agreed that the final plan would be formally ratified at the next Board meeting on 8 July.

South Glos Carers Advisory Partnership update

9. The Health and Wellbeing Board received an update in relation to the South Gloucestershire Carers Advisory Partnership and Carers Strategy 2022-27. The item was led by the Carers Advisory Partnership Co-Chair, who is also a carers representative for Bristol & South Glos Carers' Support.

10. Hearing first hand from a person with lived experience was incredibly powerful. Members heard about the need for carers to be supported and for their voices to be heard with 'hot topics' being discussed at the Carers' Advisory Partnership. In addition, the Board heard how 'Accelerating Reform Funding' (ARF) was being used to link to the four key areas within the Carers' Strategy and the current focus was on carers of people with dementia.

11. It was noted that ARF funding was not expected to continue longer term so it was important to embed developments to make them sustainable. It was also agreed that carers needed much more recognition and Board members could help by ensuring the needs of carers is 'everybody's business'.

12. The Health and Wellbeing Board agreed to continue to support the Carers' Advisory Partnership in providing strategic oversight of the Carers' Strategy and Board member organisations would take on the role of 'carer champions' and facilitate all partners to engage in the carers agenda, ensuring carers are considered in the whole system.

The Why Weight? Pledge for creating healthier places together

13. The Health and Wellbeing Board received a report on the Why Weight? Pledge for creating healthier places together, which set out plans for a system-wide healthy weight pledge for BNSSG and how the Board could support its implementation.

14. Members welcomed the trauma-informed, more compassionate approach being taken to weight. It was commented that a GP practice outside of South Glos had looked into the barriers to people attending health checks, which included patients feeling stigmatised and judged about their weight. It was also suggested that the healthy weight work should be integrated with the Mental Health & Wellbeing Integrated Network Teams (MINTs).

15. Members noted that a 'community of practice' on healthy weight was in development to support organisations signing up to the pledge and the Council's Public Health team could also provide support. Members were encouraged to attend the joint development session on healthy weight in the autumn and consider how to bring this work alive within their own organisations.

16. The Board endorsed the pledge and agreed that all member organisations would work together, through the Board and Locality Partnership, to implement the system wide actions across South Gloucestershire, including through the planned joint development session in September 2025.

Final report of the review of the role of locality partnerships and an update from the South Glos Locality Partnership

17. The Health and Wellbeing Board considered and agreed the final report of the BNSSG review of the role of locality partnerships, which proposed for formal reporting of the work of the Locality Partnerships to be via the three local Health & Wellbeing Board reports at the BNSSG Integrated Care Partnership Board.

18. The Board also received an update from the South Glos Locality Partnership on its recent work, which included a short film about its innovative Health and Happiness Hubs: https://youtu.be/0bnn_04oNr8 (a South Gloucestershire Prevention Fund initiative). This was a great example of how future updates and reports could be provided in a non-traditional way, showcasing a bottom-up perspective to understanding communities and what is important to them. Other ideas include inviting local partners and members of communities to Board meetings to share lived experience, particularly where services have worked in a different way to help the community.

DPH Annual Report 2024

19. The Health and Wellbeing Board noted the Director of Public Health Annual Report 2024, which focused on the commercial determinants of health.

BNSSG Integrated Care Partnership Board Item 5d

Cover Paper: North Somerset Falls Collaborative Panel Session

Date and time of Meeting: Thursday 10 July 2025, 1:30–4:00pm

Location: The Loft @ The Stables, 3–6 Wadham Street, Weston-super-Mare, BS23 1JY

Presented by: David Moss, North Somerset Locality Director

Title: Demonstrating Collaborative Innovation: North Somerset Falls Prevention and Proactive Falls & Fracture Screening & Prevention Service (PROFFS) Integration

Purpose:

To showcase the North Somerset Falls Collaborative and PROFFS initiative as a model of locality-led innovation, trust-based partnership, and system learning. This session will be delivered as a live panel Q&A, chaired by David Moss, with key contributors from the collaborative.

Background:

Following the Locality Partnership (LP) Review and the ICP's request for greater visibility of LP work, the six Locality Partnerships have opted to present their progress through interactive, narrative-led formats rather than traditional reporting. This session will spotlight the North Somerset Falls Collaborative, which integrates the PROFFS digital screening tool with Age UK's OTAGO-based strength and balance classes, supported by a multi-agency team. Sitting beside this interactive session the summary work plans for each of the 6 Locality Partnerships have been shared alongside this cover paper to support the Integrated Care Partnership having oversight of the full spectrum of initiatives underway in each Locality.

Session Format:

- 20-minute panel Q&A chaired by David Moss
- Panel members will include representatives from Pier Health Group, Voluntary Action

North Somerset, and community health partners
- 10-minute open Q&A with ICP members

Key Themes:

- How the Falls Collaborative was formed and has evolved
- The establishment of a innovative proactive model designed to find fallers before they fall.

- What has worked well and where challenges remain
- Reflections on collaboration, data sharing, and system learning

- The approach cross sector approach to learning and outcomes

Strategic Relevance:

This work aligns with the NHS Long Term Plan's focus on prevention and community-based care. It also supports the ICP's ambition to foster innovation at the edges of the system and scale what works. The Falls Collaborative is funded through the BNSSG Anticipatory Care budget and is part of the One Weston Localities Falls & Fracture Screening & Prevention Service contract (2025–2027).

Recommendation:

The ICP Board is invited to:
- Note the outcomes and learning from the North Somerset Falls Collaborative
- Reflect on how similar approaches could be supported or scaled across BNSSG
- Consider how ICP members can help remove barriers to collaboration and innovation

INNER CITY & EAST LOCALITY PARTNERSHIP PLAN ON A PAGE 2025/26

Joint Local Health and Wellbeing Integrated Care Strategy

	Starting well	Living well	Aging well	Enabling	LP Development
Tackling Inequalities	• Funded Caafi Health to support 80 families at risk of food poverty • Funded Black Mothers Matter to deliver healthcare training and community support	• Nilaari continuing to deliver the Community Link Worker project in partnership with Bristol Black Carers and Somali Resource Centre to provide targeted mental health support	• Focused engagement on training Strength and Balance instructors from global majority communities to further the Falls Prevention agenda	• Investment in academic support to evaluate efficacy of local innovation projects across localities	• Invested our recurrent Health Inequalities (HI) fund in 7 local VCSE organisations • Filming 6 HI organisations to create legacy videos of their projects
Strengthening the building blocks in our community	• Engaging with the Bristol Family Hubs teams • Undertake engagement with faith-based organisations • Member of National CYP Mental Health Coalition	• Supporting the ICE MINT mobilisation and GP referrals process • Funding green social prescribing projects to improve health and wellbeing of local population to engage with nature.	• Chinese Community Wellbeing Society (CCWS) piloting cultural humility GP training and develop a proforma to submit BP readings to GP surgeries	• Participated and contributed to the Bristol Active City Network • Input into Physical Activity Strategy • Working with GPs at the Deepend	• Provided platforms and engagement opportunities for our HI fundees to attend and present at • Engaged with over 30 new VCSE partners through in person events and engagement in 24/25
Focus on preventing ill health	• Promotion of the Why Weight declaration • Provided feedback on improvements to Bristol NCMP letters	• Engaging with the BNSSG Trauma informed practice lead has connected them with local community partners in ICE to develop trauma informed resources.	• Procurement for Provider to oversee Strength and Balance classes in Bristol	• Re- establishing the Bristol Falls Collaborative	• Established a BNSSG Falls Steering group to oversee funded activity
Supporting healthy behaviours	• Coordinate a working group to standardisation language used around mental health in ICE • Engage with BCC's Schools team to address EBSA	• Funded SARSAS to deliver community drop in and outreach sessions in ICE	• Supporting roll out of Dementia CLEAR training to care home staff.	• Working with Sirona to trial the use of a Patient Activation Measure to support simplified reporting for VCSE organisations • Engaging Faith based organisations	• Involvement and support of the ICE MINT hub through Welcome days, networking and support through the MH Transformation Group (monthly)
Managing conditions better	• Support and promotion of Beezee bodies local 8 – 15yro offer • Support Beezee Maximus with their Test and Learn pilots in ICE	• Promotion of local health literacy events through monthly newsletters and ICE Community Network group	• HI funding to support (CCWS) to deliver Dementia Support project for E & SE Asian, South Asian and Afro Caribbean & African communities who are at greater risk of developing	• Procurement of a new Community Clinic and Outreach offer in ICE which will address the gap of individuals not currently accessing healthcare	• Presenting findings and recommendations from Caafi Health's Early Onset Type 2 Diabetes project in ICE Locality work to the LTC ODG

NORTH & WEST LOCALITY PARTNERSHIP PLAN ON A PAGE 2025/26

Joint Local Health and Wellbeing Integrated Care Strategy

	Starting well	Living well	Ageing well	Enabling	LP Development
Tackling Inequalities	• Emotionally-Based School Avoidance (EBSA) Programme starting August 2025 • Specific focus on children from traveller community	• Ensure focus on those experiencing poorest outcomes and access to support • Develop the N&W mental health offer including links to police & non-custodial service	• Ensure focus on those experiencing poorest outcomes and access to support , particularly N&W outer wards	• Investment in academic support to evaluate efficacy of local innovation projects across localities. • Support for VCSE engagement	• Ensuring co-design from individuals and communities experiencing inequalities, and representative organisations
Strengthening our community	• Delivery of EBSA led by N&W VCSE umbrella org., Southmead Development Trust, involving local schools		Development of a N&W Asset Directory, owned by the community	• Participated and contributed to the Bristol Active City Network. • Input into Physical Activity Strategy	• Work in partnership with VCSE and community partners, including N&W umbrella org. Southmead Development Trust
Focus on preventing ill health	• Promotion of the Why Weight declaration	• Signing up to the Trauma Informed Pledge • Develop a targeted intervention to improve diabetes self-care and management in North & West • Reduce self-harm in older adults (25+) in outer N&W.	• Procurement for Provider to oversee Strength and Balance classes in Bristol • Develop interventions to improve diabetes self-care and management in North & West	• Participating in the Bristol Falls Collaborative • Partnerships with LA and AWP	• Linking into the BNSSG Falls Steering group to oversee funded activity
Supporting healthy behaviours	Target and reduce incidences of self-harm in children and young people (CYP) (10-24yrs). The Student Liaison Service will be integrated into MINT.	• Deliver Community COPD programme offering information sessions, peer support and COPD passport	• Healthy Ageing Programme to launch later this year, providing more social prescribing for people 50y-70 y with 2 LTCs or less but high unplanned care use.	• Partner with BCC around healthy behaviour activity such as Stop Smoking, Healthy Weight and Health Checks • COPD procurement • HARP procurement	• Involvement in MINT development with CMH programme
Managing conditions better		• Supporting North & West MINT mobilisation and GP referrals process. • Improve access to pulmonary rehab in BS11	• Support for staff working with people with dementia to access CLEAR training		• Work with ICB LTC ODG to support system-wide improvements in CVD and diabetes

South Bristol Locality Partnership Plan on a Page 2025/26

STARTING WELL

- Developed a strong collaborative network of partners to support promotion of child healthy weight across South Bristol
- Working closely with Public Health, VCSE and Families to improve uptake of City-wide tier 2 weight management offer aimed at families for healthy lifestyles
- Actively supporting South Bristol This Girl Can initiative working with mums and girls to increase access to physical activity
- Active members of the Bristol Active City Network, joining up local and system priorities on healthy lifestyles
- Funded four community projects for children to engage in physical activity in South Bristol

LIVING WELL

- Working with new Bristol Horizons Partnership, local partners and health data to target impacted by alcohol harms in South Bristol
- Linked local alcohol and drug partners into Mental Health and Integrated Network Teams (MINT) to ensure wrap around support available for people with dual mental health needs and alcohol dependency
- Supporting development of South Bristol MINT mobilisation and GP referral process
- Working with Changes Bristol to deliver peer support groups across South Bristol
- Funded Richmond Fellowship and Rethink to do targeted 1:1 mental health support for people in Hartcliffe and Withywood where demand is high
- Funded community engagement and co-production of a South Bristol prediabetes delivery plan that will inform commissioning of local diabetes and prediabetes prevention

AGEING WELL

- Funded Community Anchor Organisations in South Bristol to pilot falls prevention activities with Health Inequalities funds. Funding has ended however many of the activities continue to run self-sustaining. This helped raise the priority across South Bristol community settings.
- Procurement for Provider to oversee Strength and Balance classes in Bristol
- Supporting roll out of Dementia CLEAR training.

REDUCING HEALTH INEQUALITIES

- Developed two Community Innovation Lead roles to work across South Bristol forming networks across health and community sectors, supporting targeted collaboration and outreach work with PCNs, VCSE and Faith organisations
- Host quarterly Community Engagement workshops for health and community partners to share priorities, challenges faced in communities and opportunities to connect and find solutions
- Developed Community Connecter roles to work in hyper local communities in South Bristol working directly with people to tackle isolation, increase connection and engagement with health and wellbeing offers, developing community and individual resilience etc.
- Developed strong network of Community Anchor Organisations across south Bristol supporting our priorities, feeding up community insights and challenges. This partnership has enabled these organisations to access external funding to support healthier lifestyles in community.
- Working closely with Population Health and Census data alongside our community partners to inform our approach to reducing health inequalities

ENABLING

- Regularly monitor and assess health population data to further refine priorities and activity, working across system data sets
- Investing time in relationships with local partners and community organisations across South Bristol to join up areas of work and resources where relevant, sharing learning to inform delivery.
- Linked with system priorities and strategies to reduce duplication and maximise impact and learning. E.g. BNSSG 2040 plan, Bristol City Council One City Plan
- Investment in academic support to evaluate efficacy of local innovation projects across localities.
- Working with Sirona to trial the use of a Patient Activation Measure to support simplified reporting for VCSE organisations

LP DEVELOPMENT

- Developed five-year locality priorities with South Bristol Partners
- Increased and strengthened our networks across South Bristol VCSE sector, expanding support and promotion of our wellbeing and health priorities
- Developed strong locality governance and engagement with primary care, VCSE, general practice, local authority, Public Health and acutes represented on our Locality Board enabling joint decision making
- Annual and quarterly reports developed to monitor our progress against priorities and workstreams

SOUTH GLOS LOCALITY PARTNERSHIP PLAN ON A PAGE 2025/26

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

SOUTH GLOUCESTERSHIRE JOINT HEALTH & WELLBEING STRATEGY: 5 COMMITMENTS

	STARTING WELL	LIVING WELL	AGEING WELL	ENABLING	LP DEVELOPMENT
STRENGTHENING COMMUNITY INVOLVEMENT	• Supporting & coordinating a Mental Health offer with strong links to schools	• Integrated / connected Health & Happiness Hubs (HHH) to other community interventions	• Delivered Wave-1 Dementia Training to SG Care Homes • Planned Wave-2 Dementia Training for SG front-line staff	• Embedded the SG Asset Based Community Development (ABCD) Framework	• Improved integration and connection with VCSE partners & VCSE Alliance • Improved integration and connection with General Practice
BUILDING A PROGRAMME OF PLACE-BASED WORKING	• Improved partnership through the first 1,001 days of life • Supported the implementation of Children's Integrated Neighbourhood Teams	• Embedded CMH specialist pathway services into SG • Supported transformation of PCLS service model to align with CMH	• Delivered key elements of the SG Dementia Delivery Plan • Delivered a training matrix / support offer to Care Homes	• Proactively contributed to the System-wide strategic development of Integrated Neighbourhood Teams and the NHS 10-Year Plan • Delivered Year-1 of the SG Joint Health & Wellbeing Strategy	• Defined what Place and Neighbourhood mean for South Glos and developed an infrastructure blueprint for service delivery and funding allocation • Review Locality Partnership governance arrangements for 2025/26
DOING MORE TO REDUCE INEQUALITIES	• Support to care leavers and young homeless people	• Developed a model to deliver physical health checks for people with SMI not receiving these • Expanded the Chronic Pain & Wellbeing service model to all 6 PCNs	• Supported delivery of a Carers Support Strategy & Action Plan		
SHIFTING UPSTREAM WITH A FOCUS ON PREVENTION	• Prevention, early intervention and treatment for Eating Disorders, Self-harm and suicide • Interventions to support resilience in pre-school children	• Scoped and launched additional CVD interventions	• Falls Prevention: Strength & Balance classes • Falls Prevention: Continuation of SG Walking Groups • Falls Prevention: Distribution of Falls Information leaflet	• Considered future opportunities to redirect Better Care Fund to support joint working and a shift towards more personalised & pro-active care • Approved and implemented a SG LP prevention fund (including identification of non-statutory sources of funding)	• Strategically define our priorities for Starting Well
STRENGTHENING OUR USE OF DATA & INSIGHTS IN DECISION-MAKING	• Use of the SGC Children and Young People's Needs Assessment and the Best Start in Life intelligence available via the Population Health Intelligence portal.	• Completed Year-1 of the 4PCN Leg Club pilot • Completed and evaluated the EOT2 Diabetes project to understand the barriers people face in SG and inform future interventions and support	• Identification of additional falls prevention interventions • Developed a business case to expand and sustain the Falls 24/7 community response service	• Approved and implemented a SG LP decision making framework	• Developed a systematic approach to the use of Data & Insights to inform the Partnership's work

SOUTH GLOUCESTERSHIRE JOINT HEALTH & WELLBEING STRATEGY: 2025/26 Focus Areas

1. Place-Based working 2. Healthy Weight 3. Housing and wellbeing 4. Children and young people

Version: 2.0 FINAL 21st May 2025

By 31 March 2025, we said we would have…

C Complete
G Green - on track
A Amber - experiencing obstacles
R Red – at risk
N Not started
Health Inequalities focus

Starting Well

- A Rolled out Parental workshops for managing anxiety in CYP across WS
- C Distributed the CYP MH poster to WS communities
- C Completed and evaluated the CYP GSP to reduce self-harm (Portishead pilot)
- G Scoped and launched a GSP project to reduce Health Inequalities for CYP in Pill
- G Scoped and launched additional CYP GSP pilots to reduce health inequalities
- G Expanded WS Social Prescribing offer to include CYP & families
- G Established a Baby Clinic & HV presence in Pill
- N Reduced anti-depressant prescribing for CYP
- N Improved CYP Asthma diagnosis and coding in general practice

Living Well

- C Launched the WS CMH Small Grants Scheme
- C Completed an evaluation plan & proposal for future funding for the NS Together Virtual Hub
- C Invested HI funding in Community Development Worker (Power to Pill)
- N Rolled out face to face Sequoia (PD) sessions in WS (CMH)
- A Embedded CMH specialist pathway services into WS
- G Completed and evaluated our CVD outreach pilot
- N Scoped and launched additional CVD interventions (HCIG £)
- N Scoped and launched Chronic Pain interventions (HCIG £)

Ageing Well

- G Launched Dementia training programme
- N Identified and scoped Dementia interventions and secured funding (HCIG £)
- G Developed Age Friendly communities in WS
- A Identified funding for our business case, and mobilised a WS Complex Care Team
- A Funded and sustained a NS Falls Collaborative and WS collaborative response to falls in the community
- G Established a NS mechanism for older persons' involvement & co-production
- N Identified funding for an older person's MH Nurse integrated with the WS MINT

Dying Well

- G Started to pilot improvements to the EoL pathway (test & learn)
- G Increased the number of people discussing their end of life wishes
- G Formally and sustainably extended the Good Grief Festival into WS
- C Embedded the NS EoL Community of Practice
- G Created the conditions to increase non-medical environments for more advanced care planning discussions

Enabling

- G Embedded the Theory of Change Framework in WS
- A Established the NS HWB Board Operational Group
- A Refreshed our WS Locality 3–5-year strategy and plan
- A Launched a new NS Directory of Services (Digital Community Connectors and NSOD)
- G Initiated the WS Health Inequalities strategy with focus on Pill
- G Proactively contributed to the System wide review of Locality Partnerships
- A and defined a new operating model / way of working for the WS LP

Woodspring Locality Partnership

One Weston - 2024/25 in review

C Complete
G Green - on track
A Amber - experiencing obstacles
R Red – at risk
N Not started
Health Inequalities focus

Starting Well

- G Community Connectors recruited in South and Central wards. Focus on early years.
- G North Somerset CYP Wellbeing Fund launched, proposals evaluated and awards made. Delivery to start from 1 April 25.
- G Coastal Communities Creative Health programme: priority area Young People's Mental Health.

Living Well

- C CVD Prevention Programme completed. 15 community events delivered in Weston. Evaluation report due end of March.
- G MINT: Moving on after Trauma (MOAT) group started January 2025.
- G MINT: 0.5 wte Youth Transitions Worker now based in the team in partnership with Off The Record and AWP CAMHS Transitions team.
- A MINT: development of a peer support offer joint funded with public health delayed due to removal of 24/25 ICB funding. Plans being developed for 25/26 onwards.
- C Community Diagnostic Centre opened at FAHLC.
- G Coastal Communities Creative Health programme: priority area Substance Misuse

Ageing Well

- G Community Frailty Hub: 2 years funding secured for Falls & Fracture Screening & Prevention Service. Mobilisation in progress with go live on 1 April 25.
- A Funding secured to extend falls classes to 31 March 25. Go ahead now received to draw down NS share of BNSSG falls funding to continue from 1 April 25.
- G Improving Ageing in North Somerset project. State of Ageing Report delivered, AW strategic leadership and co-ordinators in post.
- C NHS Confed supported Primary/Secondary Urgent Care Interface discovery project completed. Next steps tbc.
- A Dementia training business case approved. Provider procurement in progress.
- C Dementia Community of Practice embedded.

Dying Well

- C Embedded the NS End of Life Community of Practice.
- C Good Grief Festival held in May 24. 30 events over four days, for people to come together to talk, reflect and learn about grief and death.
- G Coastal Communities Creative Health priority area: Life-Limiting Illness and Bereavement.

Enabling

- G Embedded the Theory of Change Framework in OW.
- A Weston ED attendance and admissions data discovery work commenced.
- A Digital Vanguard/Brave AI work commenced.
- G Joint ICB/NSC Funding secured for a Local Authority Research Practitioner (LARP). Recruitment in progress.
- C Contributed to the System wide review of Locality Partnerships
- G Regular reporting to Health & Wellbeing Board.
- C Public Health and Locality Partnership teams undertook a priority alignment exercise, with some funding streams merged as a result.

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

Integrated Care Partnership Board

Agenda item	7	Meeting date	10 July 2025

Title	**Healthier Together 2040 – Progress Report**			
Scope: System-wide or Programme?	Whole system	**X**	Programme area (Please specify)	
Author & role	**Emily Parkinson- Strategy and Planning Coordinator** **Gemma Self – Programme Director** **Kate Lavington – Head of Design** **BNSSG ICB**			
Sponsor / Director	**Dave Perry – Chair of HT2040 Steering Group** **Sarah Truelove – Exec Lead for HT2040**			
Presenter	**Gemma Self**			
Action required:	Decision / **Discussion** / Information			
Discussion/ decisions at previous committees	*Please list below all relevant Steering Groups/Boards, along with dates and what decisions/endorsements were made)*			
	Regular involvement of HT2040 Advisory Group (reports into System Executive Group) **Currently sharing with each Local Authority Health and Wellbeing Board and the ICB Board for discussion and ongoing support of the process.**			

Purpose:

This presentation aims to:

- Provide the Integrated Care Partnership (ICP) Board with a reminder of the progress of the Healthier Together 2040 approach to date; specifically, the process taken, the outputs identified and the next steps in the journey.
- Share emerging thoughts about the future of Neighbourhood Health and Care and how the Healthier Together 2040 approach can support the development of population needs based models of care.

Summary of relevant background:

At the November 2024 Board, the ICP endorsed the intended delivery plan and the emerging impact of the Locality Partnership Review and national 10-year plan development.

Since then, the following actions have taken place:

1. The 'Understanding Phase' has been undertaken to identify key populations cohorts of interest. The full evidence review including data analysis, insights generated from interviews and surveys and review of evidence for this population health need can be found here.

2. The 'Design Phase' is well underway with Two Design Events and several Focus Groups being undertaken to move us through to setting our Strategic Intentions 3. Working up a plan for alignment with the Neighbourhood Health agenda
Discussion / decisions required and recommendations:
1. Review and discuss the progress being made to date through the Healthier Together 2040 approach 2. Review and provide feedback on the intention to use the population need based approach being tested through Healthier Together 2040 to develop models for future neighbourhood health and care 3. Review and discuss the recommendation that the role of Locality Partnerships in BNSSG be considered as part of a wider strategic programme of work

1. Background

Policy

National: The NHS's 10-year plan (due to be released July 2025) is a government initiative to reform the health system by making three strategic shifts: moving care from hospitals to communities, making better use of technology, and focusing on preventing sickness, it is anticipated a new approach to integrated neighbourhood health and care will be a key mechanism for this.

Local: Healthier Together 2040 (HT2040) has been delivering, over the last year, a population health-based approach delivering on the following principles:

1. Creating the environment and conditions for large scale coordinated change for whole system
2. Use of population cohorts (people, their lives, their health) to organise work differently and holistically
3. Focus sequentially on target population cohorts to enable work at depth
4. Define opportunities for prevention at every level
5. Enable long term planning: 3 – 15 years
6. Aim of creating sense of hope, alignment and clearer future with golden thread to improving healthy life expectancy

Also of note: one of the key outputs from the Locality Partnership Review was the ICP Board and ICB Board approval for the recommendation that the role of Locality Partnerships in BNSSG be considered as part of a wider strategic programme of work i.e. NHS 10-Year Plan, HT2040, Neighbourhood Health & Care.

HT2040 Background

HT2040 seeks to develop the long-term strategic plan for Bristol, North Somerset and South Gloucestershire Integrated Care System rooting it in the needs of the key population groups driving current and future demand.

The overall goals of Healthier Together 2040 align with the three strategic shifts defined as the goals of the national 10-year plan: hospital to community, analogue to digital, treatment to prevention. The main difference is that Healthier Together 2040 has used local data to identify target local population cohorts and has the intention of defining specific next steps by population cohort, we anticipate that these next steps will be embedded within a new neighbourhood health and care approach. The intention is to ensure Healthier Together 2040 increasingly aligns to the national direction as more information emerges.

Healthier Together 2040 Working Age Population Cohort Focus

Phase One: Understanding phase

The initial analysis phase used linked data and modelling approaches which identified four cohorts of the population who are currently experiencing poor outcomes, high users of multiple types of services, where there is an opportunity to prevent further deterioration of health and understand the risk factors to prevent future waves of people entering that cohort.

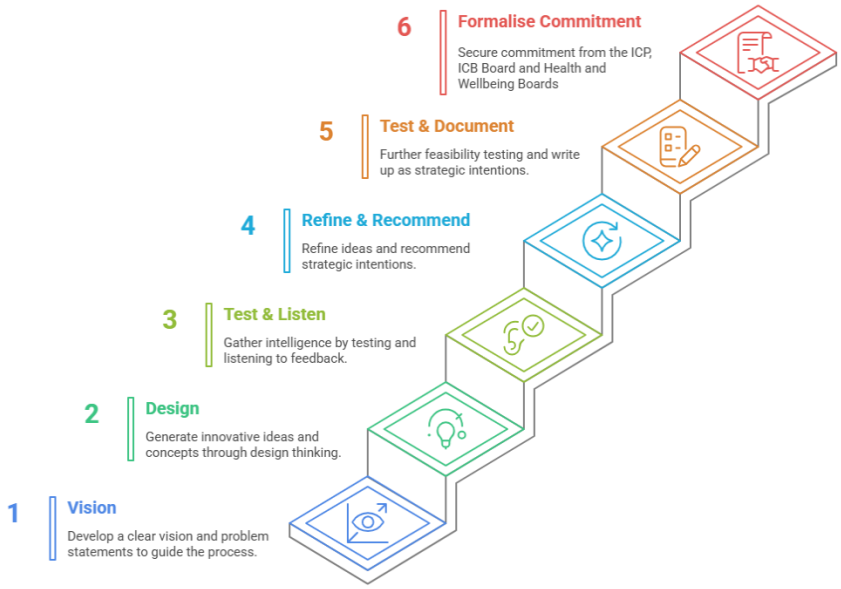
These groups are characterised by their frequent reliance on urgent and emergency health and care services, signalling that their ongoing needs are not being adequately met within the existing system.

In winter 2024, work started on the understanding the needs of the first population cohort focused upon, the Working Age population living with multiple health challenges.

The full evidence review including data analysis, insights generated from interviews and surveys and review of evidence for this population health need can be found here.

Phase Two: Design Phase

We are currently at stage three of the Design Phase (see below) where we are running focus groups and testing activities arising from the second design event.



Design Event One

Design Event One was held on 8th May and was well attended by 57 participants, from a range of roles and organisations across the system, who brought a wealth of energy, cautious optimism and expertise. Delegates were introduced to the 3 Horizons model and asked for contributions detailing the issues with the current system, how we want the system to function in the future, and then ideas outlining the innovations that will get us there.

A total of 328 entries were recorded during the session, allowing us to have a firmer grasp of our biggest problems and what people believed the solutions would be.

114 of these were suggestions of innovative interventions which centred around themes of community-based wellbeing, models of care, technology, workforce training and working with employers. Further analysis of these outputs was then used as a basis to create several problem statements, which were taken to the second event for attendees to flesh out ideas more thoroughly.

We learnt that professionals in the system were keen for a change to the status quo. There was a consensus that the current system was ill-suited to deal with the needs of this cohort. Common issues raised included conditions being treated in silo in a disjointed system, a lack of a focus on prevention and the social determinants of health, and a lack of continuity of care. The future vision outlined by the group was that of a holistic, fully integrated service with a strong foundation in the community, but the key outputs from the group were the innovations highlighted for Horizon 2. Through some analysis of these outputs, we identified that there was a lot of interest in proactive community- and VCSE-based interventions, interventions that put mental health at the forefront, and interventions promoting physical activity and lifestyle advice.

Some of the quotes directly from participants captured on video can provide a flavour of the aspirations for the future, developed at the event:

> *"...moving from a de-personalised reactive crisis, one-size-fits-all model into something that's much more holistic, community based and wraps resources around you. We want to move into a more sort of proactive prevention space that is where people are experts in themselves, and they have a sense of agency"*
>
> *"...moving far more from dependence on the system to an interdependence on each other, which is achieved through continued collaboration and co-production"*
>
> *"Then we were looking at things that we wanted to keep, and one of the main ones was around that we've got a motivated workforce and staff...we have people that have the right values of their hearts."*
>
> *"...having a trusting relationship between users and providers, so those who are looking after people's services, professionals, and that people are supported in a really holistic way...we felt that what supports people to do that is that they are educated and motivated to make a change in their behaviour"*
>
> *"Unfortunately, we find ourselves currently in this place where there's no time or space for the system to think, there's no flexibility or adaptability in the system, and the infrastructure's not there"*

This event started to set the vision for the future and the outcomes expected to achieve over time.

Design Event Two

Event Two built upon the themes identified during Event One and focused on design and developing strategic improvement ideas to address key problem statements using Design Thinking Techniques. Held on 3rd June, it was attended by 45 people from various professions and organisations most of whom attended Design Event One.

Participants engaged in discussions to generate strategic improvement ideas that emphasised holistic, community-based approaches and proactive prevention and were based around four key themes identified during Event One:

- Culture shift toward whole-person approaches
- Addressing risk factors for at-risk groups
- Work and health
- Radical redesign for community-based care

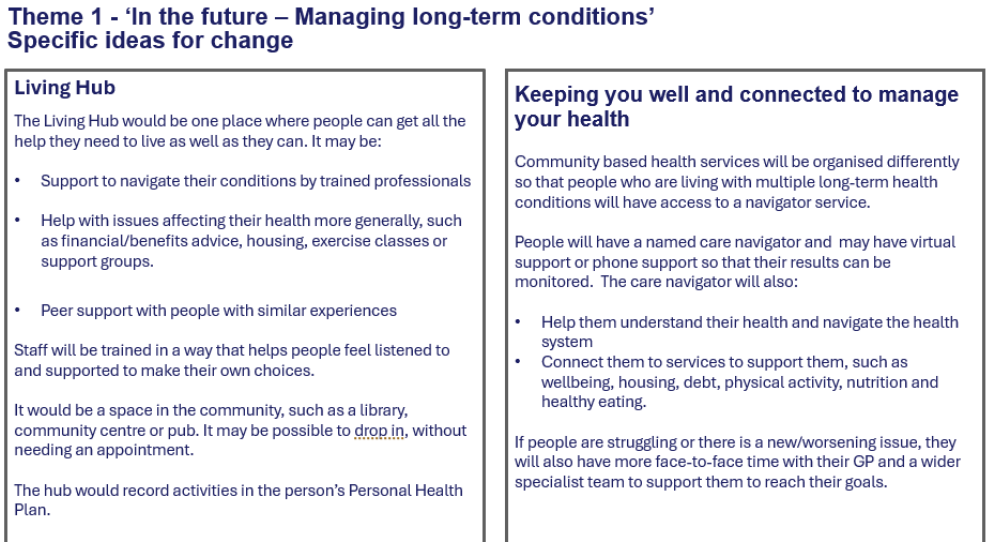
During the Event, 353 ideas were generated under each theme were then further explored by assessing feasibility vs impact and examples include:

- Services in local community centres

- Have a joined-up system e.g. Remedy but for VCSE which is regularly maintained
- Embed community workers in GP practices
- Every employment opportunity has a connected health and wellbeing plan which is co-created

These ideas were then ultimately developed into 'Concepts', providing a brief proposal of what the future could look like which could be tested with members of the public with lived experience through Focus Groups held over June.

The concepts range from individual care plans, community hubs, and strategic inclusion of VCSE (Voluntary, Community and Social Enterprise) organisations, to health and wellbeing coaches, family health co-ordinated care, and work and health standards specifically for long-term conditions. An example of one of the proposed concepts is shown below:



Theme 1 - 'In the future – Managing long-term conditions'
Specific ideas for change

Living Hub

The Living Hub would be one place where people can get all the help they need to live as well as they can. It may be:

- Support to navigate their conditions by trained professionals
- Help with issues affecting their health more generally, such as financial/benefits advice, housing, exercise classes or support groups.
- Peer support with people with similar experiences

Staff will be trained in a way that helps people feel listened to and supported to make their own choices.

It would be a space in the community, such as a library, community centre or pub. It may be possible to drop in, without needing an appointment.

The hub would record activities in the person's Personal Health Plan.

Keeping you well and connected to manage your health

Community based health services will be organised differently so that people who are living with multiple long-term health conditions will have access to a navigator service.

People will have a named care navigator and may have virtual support or phone support so that their results can be monitored. The care navigator will also:

- Help them understand their health and navigate the health system
- Connect them to services to support them, such as wellbeing, housing, debt, physical activity, nutrition and healthy eating.

If people are struggling or there is a new/worsening issue, they will also have more face-to-face time with their GP and a wider specialist team to support them to reach their goals.

The event highlighted the participants' commitment to creating a more interdependent system, fostering trust between users and providers, and ensuring that the infrastructure supports flexible and adaptive solutions for holistic care. There was a sense of hope and sustained energy for change which we hope to continue through to the final stages of the Design Phase.

Test and Listen Phase

The 'Test and Listen' phase following Design Events One and Two has been underway throughout June. This involves testing and refining the concepts through Focus Groups and Public interviews, an independent assessment of good practice and evidence, a review of contractual and procurement risks and opportunities, a cost assessment and an Executive Review.

At the time of writing, there are still focus groups taking place and full analysis of the concepts has not been pulled together.

However, some initial insights provide a flavour of the direction of track:

- Feedback that there is a need for a package of support for people living with several conditions and wider factors
- Having a human coordination function with supporting digital infrastructure available to all people living with complex health needs – international evidence and focus group feedback
- Addressing the reasons why someone can't focus on their health first, whilst being supported by a neighbourhood-based health function felt like a better use of resources, rather than requiring people to have condition specific reviews and managing the wider social factors separately.

Assimilating the outputs and reflecting on the journey of Design Events One and Two more broadly there has been clear consensus about values, outcomes and culture. There is a strong theme recognising the importance of employer contributions, including our Organisations as employers, to the health and wellbeing of the population.

A general theme through conversations with the public has been about a want for things to be easier and less rather than more (particularly considering interactions with health services). Therefore, many of the initial concepts being developed are building, scaling and connecting current examples of good practice and 'getting the basics right' with holistic care to improve healthy lives at the epicentre.

Design Event 3 and next steps

The third event will be held on 2nd July which will bring together the concepts generated, and the feedback gathered to create a more detailed picture of a future. At the event we will then focus on the conditions required to get to that future – such as how to organise for collaboration, change incentives, harness collective intelligence and make it matter through a galvanising message to the public and wider workforce.

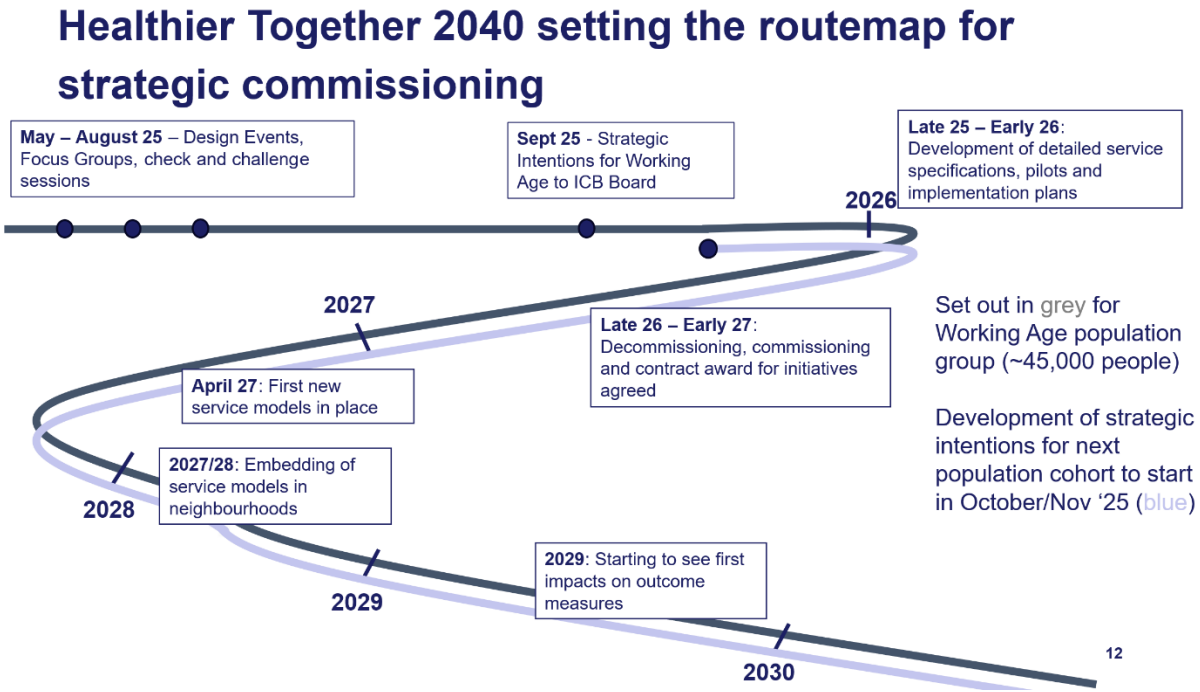
Over July, a Strategic Intentions document will be developed that will bring together a plan setting out the priority actions to address the needs of this population cohort based on the design phase. It will be tested with key stakeholder groups over August and continue to be shared whilst in development. It will then go to ICB Board for approval on 4th September.

It is intended that this document will:

- Articulate a vision for the future for this population need and start to set out the vision for a neighbourhood model for people living with complex health and social needs
- Describe the sentinel level outcomes we are aspiring to improve
- Set out the conditions required to be able to progress to this future state
- Map out alignment with the 10 Year Plan
- Provide options for next steps, given the changing context of the role of ICBs and other system partners

The purpose of these Strategic Intentions will be to set out a direction of travel to anchor the system to a longer-term future focus whilst triggering the next phase of work – to develop

detailed commissioning and development plans to move forward towards that shared vision.



Proposed approach to embedding our design approach for integrated neighbourhood health and care within Healthier Together 2040

1. The development of strong neighbourhood health and care is a priority for our system, building on the strong foundations of work done Locality Partnerships over the past seven years.

2. At the start of this year, NHS England published guidance requiring ICBs and Local Authorities to jointly plan a neighbourhood health and care model for their local populations, which will contribute to delivering the three shifts. More information about this is expected to be set out in the 10-year plan.

3. In April, in preparation for this, the System Executive Group commissioned a short life neighbourhood health and care discovery to consider for BNSSG;
    1. What is the problem we are trying to solve with an integrated neighbourhood approach and what would success look like

2. What do we already know about what matters to people
3. Neighbourhood health and care isn't new, we have been doing this work for many years, what has worked well and what have the barriers been.

4. To do this discovery, we held over 100 discovery interviews with stakeholders from across our system—including colleagues in health, local authorities, senior system leaders, and our VCSE sector. We also conducted a literature review to explore relevant policy, evidence, and previous learning from BNSSG. Building on our existing insights and engagement, we identified what matters most to our population. Finally, we carried out an 'as is' review of the current landscape, mapping existing projects, commissioned services, and improvement programmes related to integrated neighbourhood health and care.

5. The next step will be to share our key findings with stakeholders to check that we've accurately reflected their input and that the conclusions resonate. This will include sharing the full report with the Health and Wellbeing Board.

6. These are some of the emerging conclusions:

- **An integrated neighbourhood approach should move beyond standard illness-based services, focusing instead on joined-up support built around what matters to the individual—driving shared outcomes rather than transactional, input-based care.**

- **Significant overlaps exist between solutions being generated through the HT2040 approach and ideas and themes from the integrated neighbourhood health discovery phase.** The Integrated Neighbourhood Health & Care Discovery Report's conclusions reinforce HT 2040's design principles, emphasising holistic, community-based care, addressing health inequalities, and fostering the right 'conditions for change' to embed the approach.

- Integrated Neighbourhood Health and Care demands a **profound cultural transformation**, moving beyond minor adjustments to reconfigure the NHS through sustained leadership commitment and a shift in deeply ingrained practices.

- **Stakeholders share a clear understanding of the core problems** in the health and social care system, which a new approach to integrated neighbourhood health and care has the potential to address. Again, mirroring HT2040 themes, these include fragmented care due to a lack of integration, unaddressed health

inequalities, over-reliance on acute services, and organisation-centric design, leading to duplicated efforts and service gaps.

- There's **strong consensus on what success looks like:** people living well, accessing seamless, holistic, local care, promoting self-management, and wise resource investment. It envisions a stronger, more connected system with rewarding staff collaboration across all organisations and communities.

- However, the main **obstacles arise from the underlying conditions for change**, widely recognised by all stakeholders. Key barriers include a lack of shared outcomes, joint governance, short-term funding, shared data analysis, workforce development, and inadequate digital infrastructure and interoperability.

- Despite these challenges, the report **highlights existing strengths** like Locality Partnerships and the Healthier Together 2040 approach. Strong local relationships are key enablers, alongside valuable assets such as existing community-based integrated service models and robust Population Health Management data.

- **Risks and challenges to overcome** persist despite the positive outlook. These include potential disruptions from ongoing NHS reform and ICB restructures, financial constraints, a lack of capacity for strategic planning, and the risk of repeating past mistakes. Challenges in establishing unified visions and consistent approaches across the complex commissioning landscape were also raised.

7. It is recommended that the design phase of neighbourhood health and care should be integrated with the HT2040 programme. This is because there are clear links between the content, the type of work being undertaken in the two areas of work and the next steps that are required.

8. Bringing these two strands of work together will enable the design of system-wide models, with local tailoring, wrapped around clusters of people with similar needs, rather than traditional condition-based care pathways. This will enable a robust

design of the consistent elements of a neighbourhood model which will have the most impact across BNSSG.

9. This does not mean that the plan to develop neighbourhood health and care will be 'top down' or 'one size fits all'. While the BNSSG neighbourhood health model must have elements of consistency, it will also need to be sufficiently flexible, with sufficient degree of delegated authority and resource, to enable local areas to respond to the particular priorities of each neighbourhood based on their expert knowledge of hyper-local neighbourhood needs.

10. The plan for neighbourhood health and care will also be heavily influenced by the national policy direction and requirements set out in the 10 year plan.

11. The neighbourhood health plan will be developed over the coming months and is expected to become a key delivery mechanism for the strategic intentions outlined for the HT2040 population cohorts. Its implementation will be supported by dedicated programmes focused on enabling elements such as estates, digital infrastructure, and partnership-based contractual arrangements. The plan will also be informed by the detail set out in the 10-year plan and enable sufficient flexibility to allow local areas/ neighbourhoods to tailor the approach to meet their specific population needs.

The Integrated Care Partnership Board are asked to note progress and share any reflections.

BNSSG INTEGRATED CARE PARTNERSHIP BOARD
FORWARD AGENDA PLAN
(subject to any changes to ICB/ICP structures that may be forthcoming)

1.30 pm – 4.00 pm, 11 September 2025
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
- Healthier Together 2040 – project delivery progress report
- Update on NHS 10 year plan and implications
- Corporate Parenting (Corporate Parenting is central to the work of local authorities with Children's Social Services responsibilities; this item will raise awareness about the responsibility that the councils within the BNSSG footprint hold as Corporate Parents, and the positive benefits offered in supporting these children)

1.30 pm – 4.00 pm, 13 November 2025
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
- Healthier Together 2040 – project delivery progress report

1.30 pm – 4.00 pm, 12 February 2026
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
- Healthier Together 2040 – project delivery progress report
- Update on Why Weight? Pledge

1.30 pm – 4.00 pm, 16 April 2026
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
- Healthier Together 2040 – project delivery progress report