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

Bristol, North Somerset and South Gloucestershire

Our Future Health

3 years on

What's changed?

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Version: Final V 1.0

Date: February 2026

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Acknowledgements

With special thanks to Sam Coleborn, Cecilia Puech and Megan Minett-Smith at South Gloucestershire Council Public Health Team for their contributions to data, analysis and visualisations within this report

Thanks to our colleagues in ICB and public health teams for the many intelligence resources used in this report.

1. The top line - what has changed in BNSSG?

As in our original report, to save lives and improve health and wellbeing, our system should focus on three things:

- **Prevention** at each stage of life and every step of a care pathway
- Designing for the **clustering** of risks and ill health within individual people, families and communities
- **Reducing inequalities**

Life expectancy is no longer increasing, and in some areas has fallen a little

The **gap in life expectancy** between most and least deprived is increasing in some areas

People in BNSSG are spending more **years of their life in ill health**

People in the **most deprived areas still have the same level of ill health in their early 50's as people in the least deprived in their late 60's**. This has not changed

Anxiety and depression, and chronic pain are having the **biggest impact** on health in BNSSG. More accurate data on chronic pain shows it as even more significant than in our previous report and is one of the biggest impacts across all age groups

Early preventable deaths are falling but remain above pre-pandemic levels

Some **major causes of early deaths** are showing rising rates, including respiratory and liver diseases

There has been an increase in the proportion of **children living in relative low-income families** across all areas BNSSG

Smoking in pregnancy has declined, and the gap between most and least deprived areas has reduced

Overweight and obesity among children in reception year is increasing

There has been some reduction in **emergency admissions for self harm** among young people

Low birth weight of babies born at term has increased slightly, as has the gap by deprivation

The decline in **smoking prevalence** has stalled

Alcohol-related hospital admissions are increasing

Management of **high blood pressure** has improved with more people achieving treatment targets, but there are significant and widening inequalities with ethnicity and deprivation

Screening coverage rates for breast and bowel cancer have improved, while cervical screening coverage has fallen in line with the national trend

Early diagnosis of cancer at stages 1 or 2 appears to be improving

More people with **type 2 diabetes** are receiving all nine of the recommended care processes annually

Emergency admissions for COPD are rising

Prevalence of long-term conditions is projected to increase substantially, especially for diabetes and chronic pain

2. Introduction

3 years ago we published *Our Future Health* – an overview of key health and wellbeing issues and opportunities for our BNSSG population.

This report is a brief update on population health intelligence and insights in BNSSG using existing data sources. Much of the content and key messages in *Our Future Health* continue to be just as relevant now, with this update being focussed on what has changed since the original report in 2022.

The datasets informing this updated report span different time periods; however, the latest available data has been used throughout. This review, conducted three years after the original publication, compares the updated findings with the earlier report to assess how trends have shifted over time.

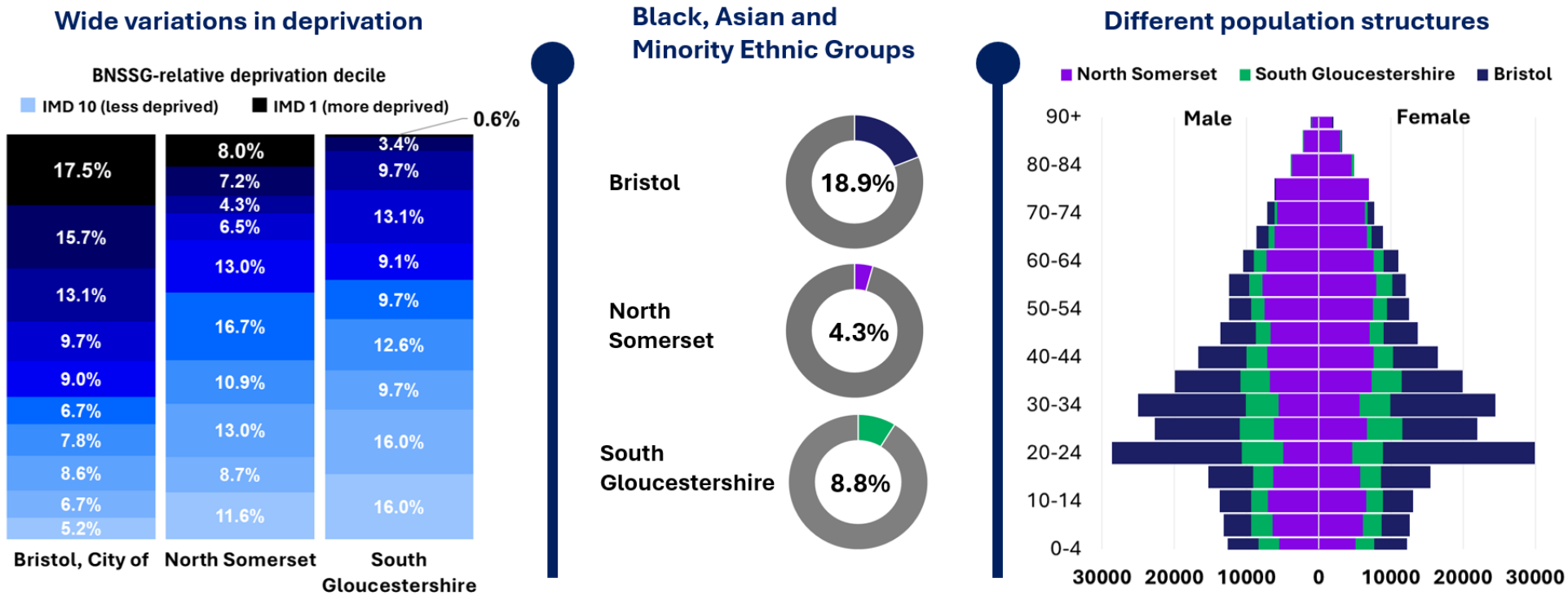
Taken together the two reports provide an integrated overview of health and wellbeing needs among the BNSSG population. They are based on a synthesis of intelligence from various sources, including local authority Joint Strategic Needs Assessments (JSNAs), Population Health Management (PHM) work using our system-wide dataset (SWD), and routinely available data.

3. The Big Picture

3.1 Overview of our population

There are around one million people living in BNSSG. Figure 1 below shows some key demographics across the three Local Authority areas that make up BNSSG.

Figure 1 Snapshot of BNSSG Population



Sources: ONS mid-2024 population estimates, MHCLG English Indices of Deprivation 2025, ONS Census 2021.

3.2 Life Expectancy and Healthy Life Expectancy

Figure 2 Over the last decade, gains in life expectancy have slowed or flattened out[1]

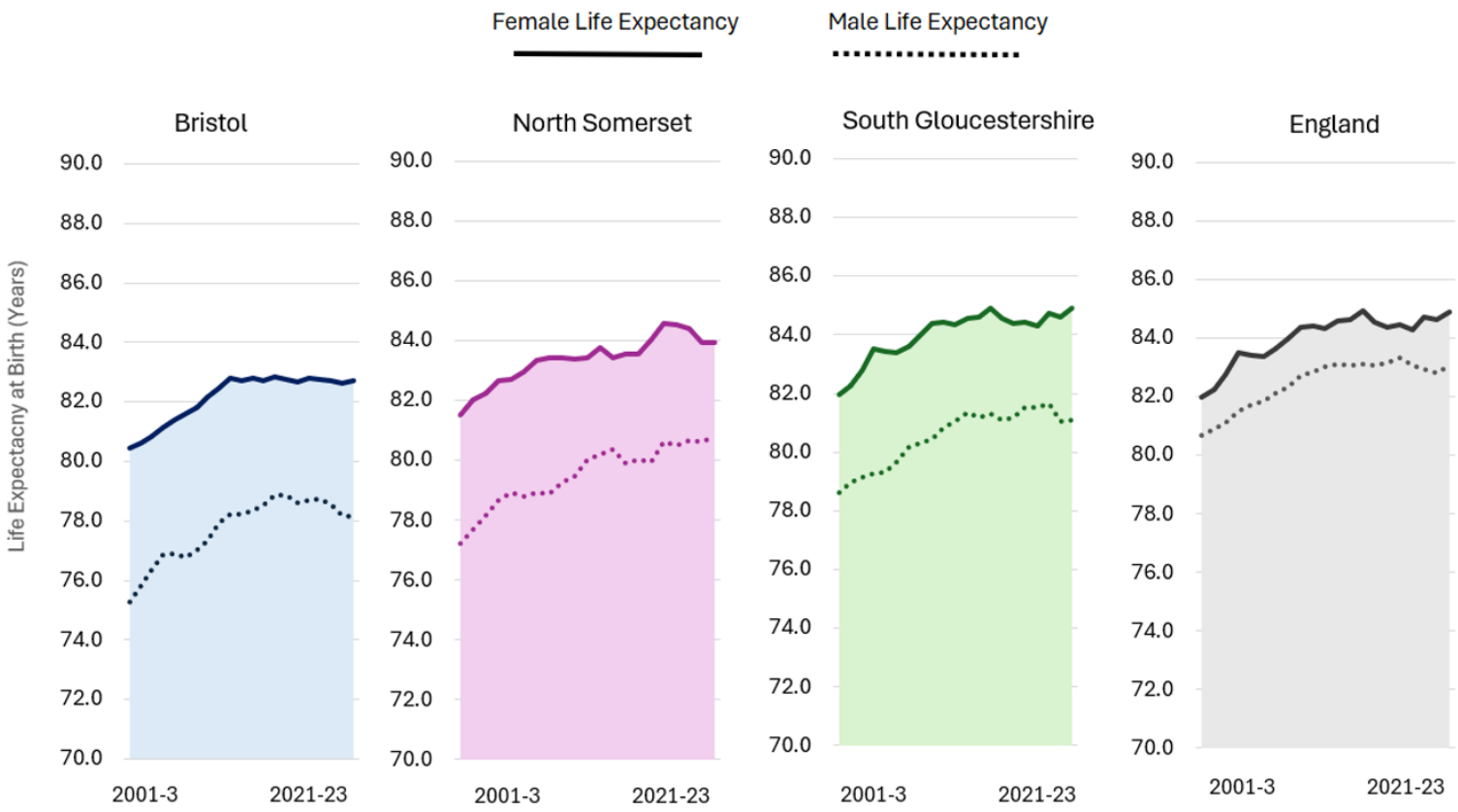


Figure 2 shows changes in life expectancy over time. There have been some small overall gains in life expectancy in North Somerset; South Gloucestershire has changed very little in recent years and Bristol has seen a decline among females.

Figure 3 The number of years spent in poor health is increasing[2]

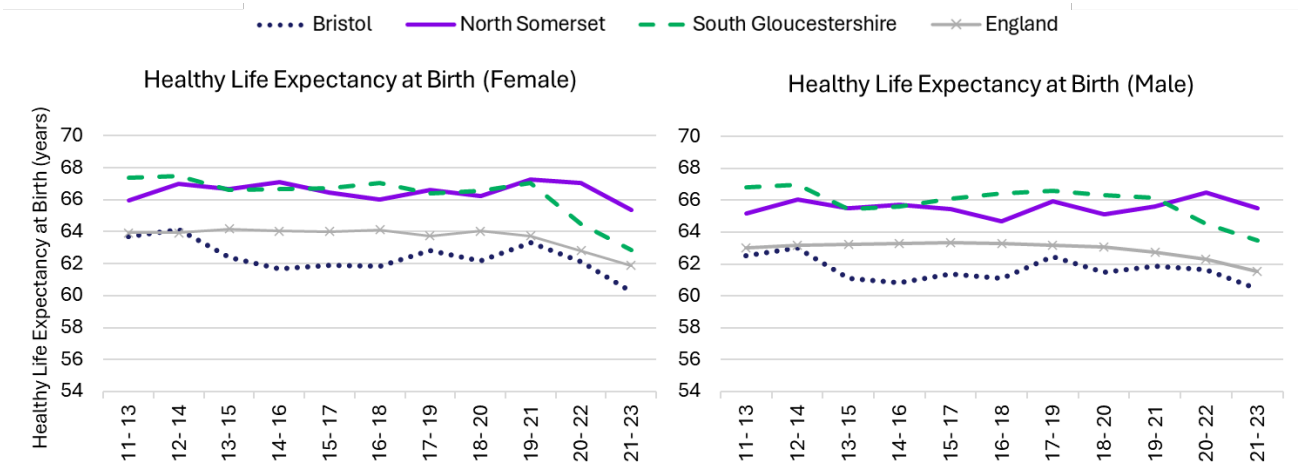


Figure 4 The gap in Life Expectancy between the most and least deprived areas[3]

Figure 3 shows that there has been a decline in Healthy Life Expectancy (HLE) across all three Local Authority areas. This trend is also seen at a national level.

For males nearly 18 years on average are spent in poor health, for females an average of 22 years are spent in ill health.

In BNSSG, the recent decline has been steepest in South Gloucestershire and Bristol, and steeper for females than males.

Through preventing or delaying the onset of preventable long-term conditions, we can reduce the amount of lifetime people are spending in poorer health and improve Healthy Life Expectancy

Figure 4 shows that there has been a recent **increase in the inequality in Life Expectancy between the most and least deprived areas**, particularly for males. This is apparent in all three Local authority areas with the steepest rise being among males in South Gloucestershire.

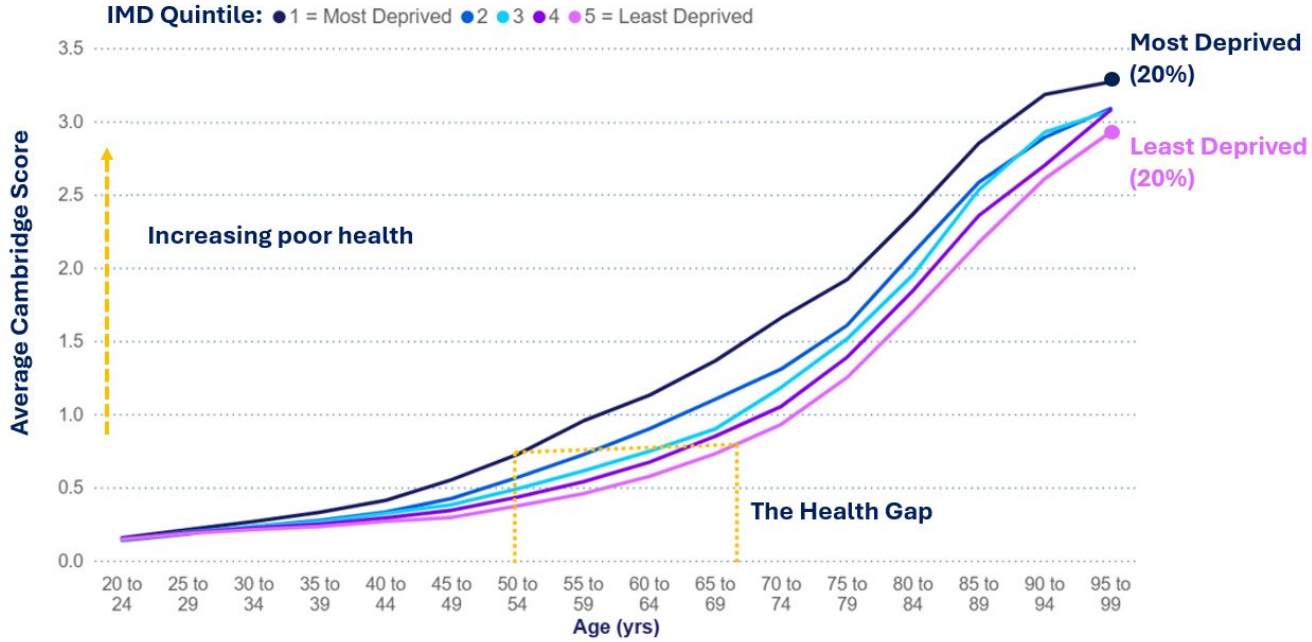
3.3 The health gap across the life course by deprivation

Using the Cambridge Multi-morbidity score* (CMS) to estimate health status, we see how ill health builds through people's lives, with the gap between more and least deprived beginning in early adulthood and widening through to older age.

In the first report, we first looked at the health gap in 2022. Figure 5 shows three years on we still see that overall people in the most deprived areas have the same level of ill health in their early 50s as people in the least deprived areas in their late 60s. This has not changed.

Ageing well, through better prevention, and improving health of the worst off faster, remain key missions.

Figure 5 The life course health gap in BNSSG by deprivation in 2025

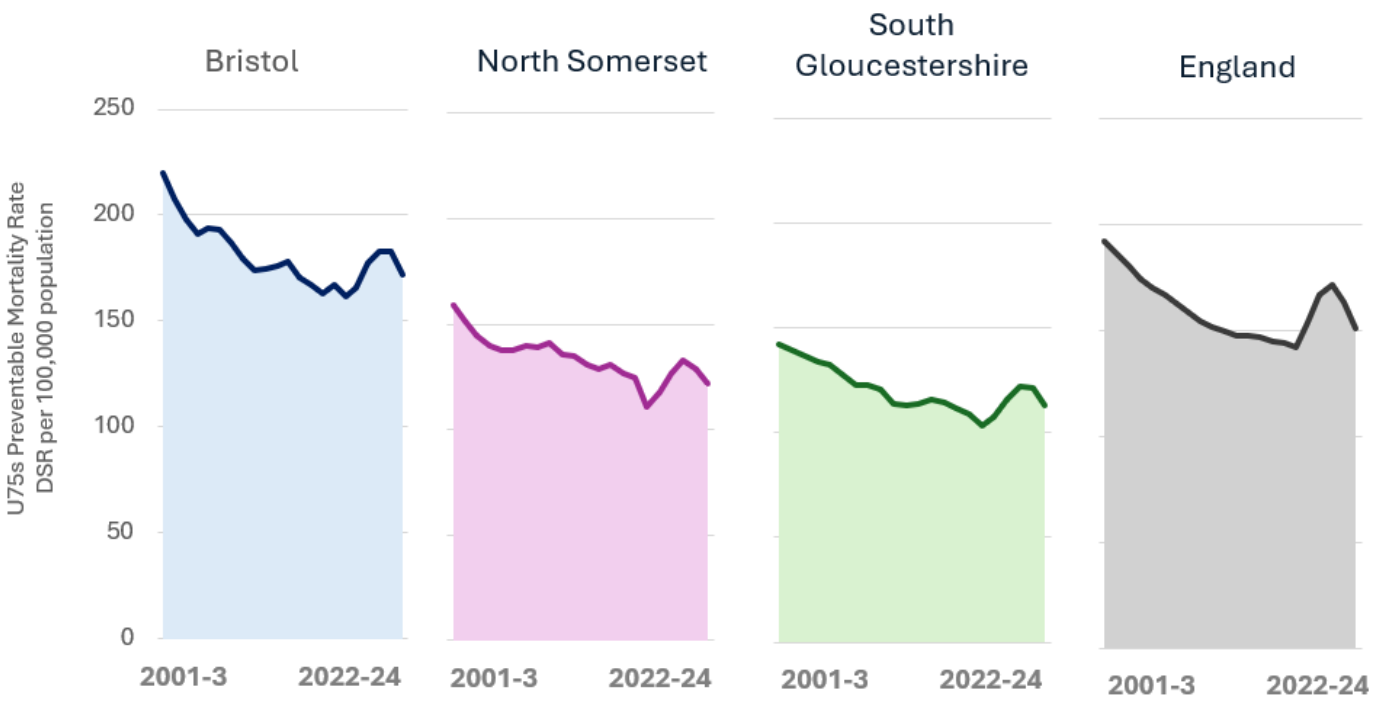


* For further explanation of the CMS score, please see 6.2 Population Segmentation in BNSSG

3.4 Trends in early death rates

Early deaths from preventable causes

Figure 6: After several years of rising early preventable deaths[4], rates are falling again but remain above pre-pandemic levels[5]



Early deaths (Under 75 years) from preventable causes had been declining for some time but increased again at the time of the COVID-19 pandemic. Rates are now coming down again but have not yet returned to pre-pandemic levels.

In BNSSG, circulatory diseases and liver diseases are major contributors to early preventable deaths.

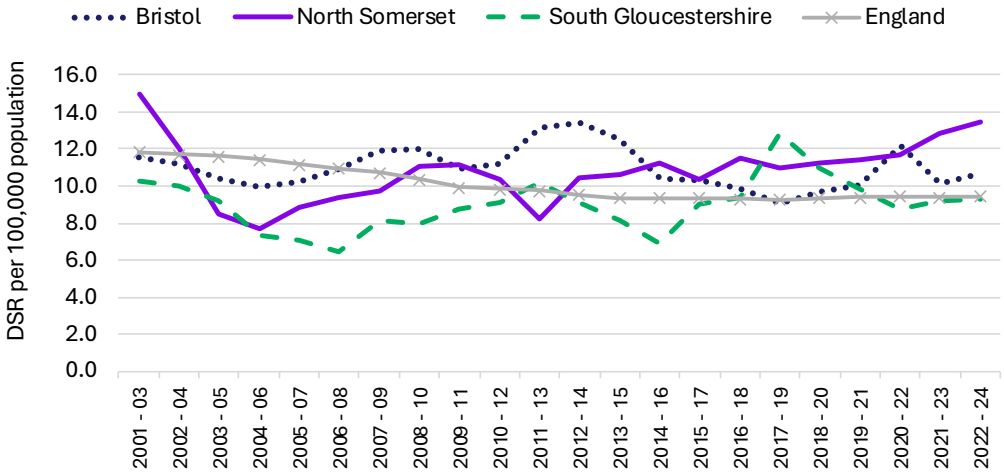
Bristol has the highest rate of preventable early deaths. This is higher in males than females and many of these early deaths are due to cancers and respiratory disease.

Early preventable deaths from liver disease are increasing in South Gloucestershire, particularly for males. Early preventable deaths from respiratory diseases are increasing in Bristol and North Somerset.

Early deaths by major causes

Cancer: In Bristol, early deaths for males show a slight decrease after 3 years of increase. Rates of lung cancer are higher than England for both males and females. In North Somerset, early deaths from colorectal cancer are higher than the England average and are increasing (Figure 7). In South Gloucestershire, early deaths from cancer are increasing for males.

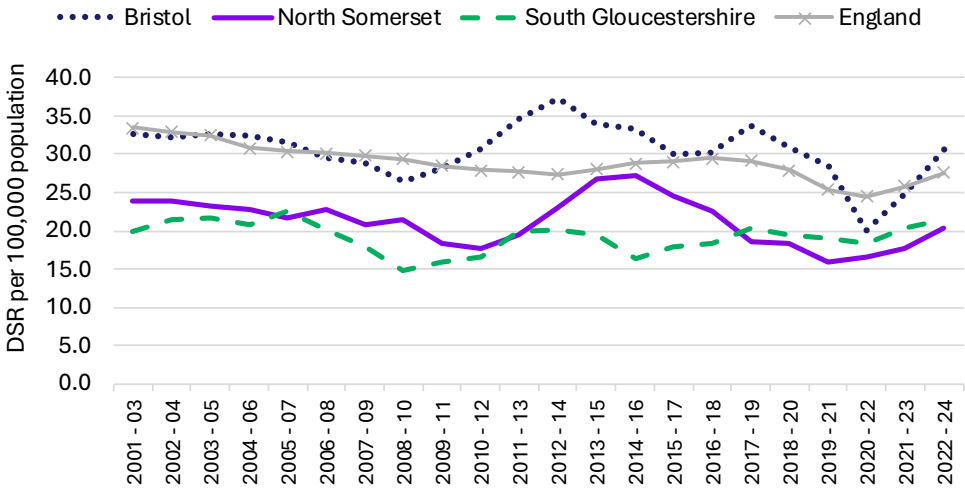
Figure 7 Early deaths from colorectal cancer are increasing for females in North Somerset



CVD: Early deaths from CVD in Bristol are significantly higher than England. Latest data show a slight decrease for Bristol males (2022-24). There have been increases in early deaths from stroke for both males and females. In South Gloucestershire the recent upward trend in early deaths for males has reduced slightly in 2022-24.

Respiratory disease: In Bristol early deaths from respiratory diseases are significantly higher than England, and a sharp upward trend is seen for females (2020-22 to 2022-24, Figure 8)

Figure 8 Early deaths from respiratory disease are increasing for **females** in Bristol

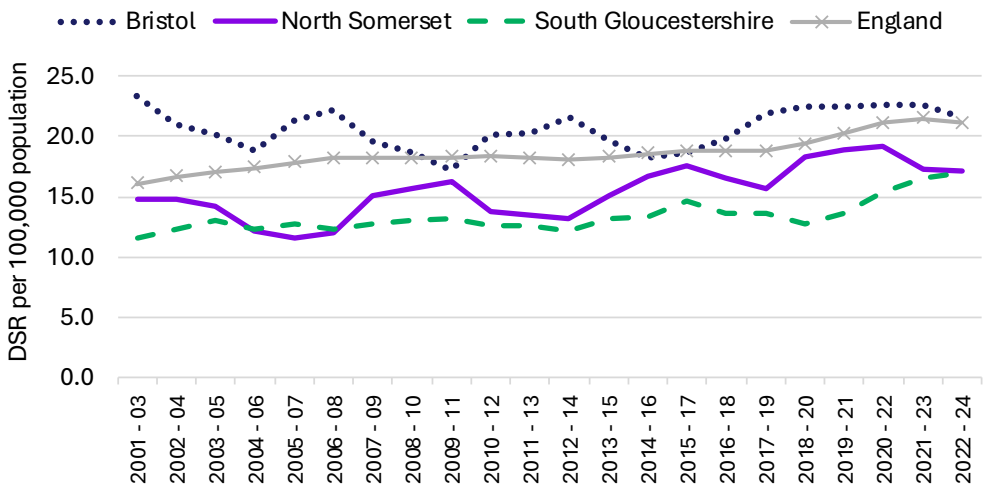


Liver Disease: There has been a recent upward trend in premature deaths from liver disease across all three areas for both males and females, with the latest data showing Bristol and North Somerset rates fairly level but South Gloucestershire continuing to rise (Figure 9).

Liver disease deaths are lower overall than the other major causes. In England, the number of people dying prematurely from liver disease and liver cancer has increased by almost two-thirds (64%) in the last 20 years.

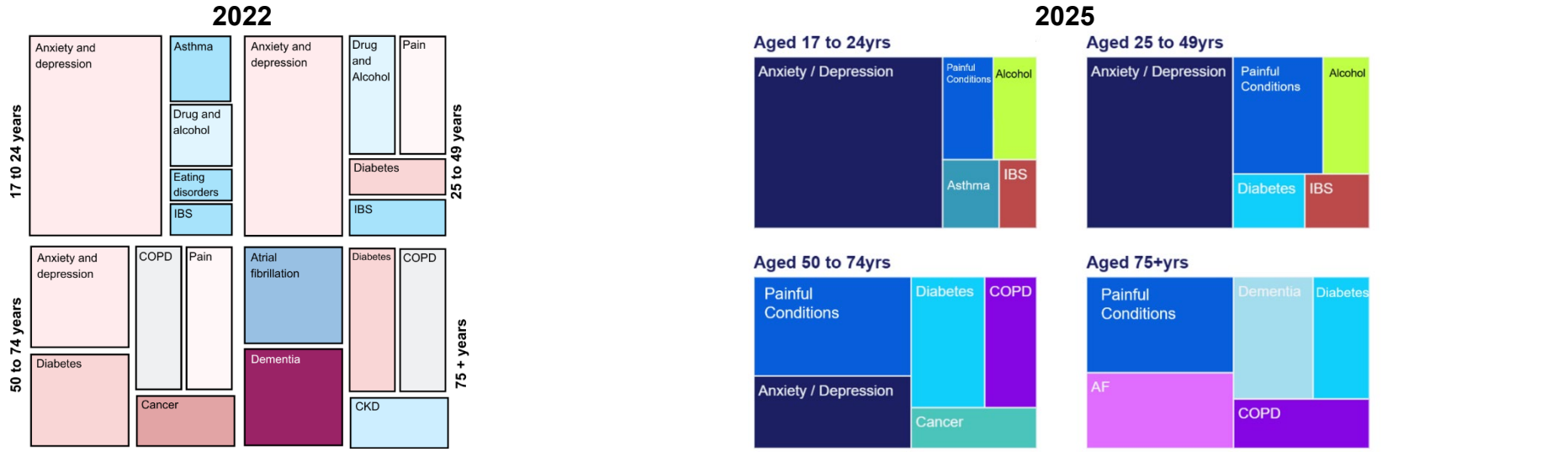
Please note: Figures 7 to 9 have different axis on each chart. This is to be able to visualise trends over time clearly

Figure 9 Early deaths from Liver Disease are increasing in South Gloucestershire



3.5 Biggest Impacts on Health

Figure 10 The impacts on health through the life-course in BNSSG



The 'tree plots' above show the conditions that have the greatest impact on the population, in four different age groups. The bigger the box within each of the four squares, the bigger the impact of that condition.

Health impacts are based on the Cambridge Multimorbidity Index conditions, calculated as the prevalence of a condition multiplied by the 'weighting' for that condition. Weightings take into account risk of death and intensity of service use.

Figure 10 shows the original tree plots from 2022 and new plots for 2025. The 2025 chart is again highlighting the prominence of anxiety and depression impacting on health and use of health services. We continue to see high impact from drugs and alcohol among younger adults, and the impact of diabetes and chronic pain among the adult population.

More accurate data on chronic pain in this update shows it as even more significant than in our previous report. It is one of the biggest impacts across all age groups.

This is consistent with modelling work by the Health Foundation, showing that chronic pain prevalence is projected to increase by around a third by 2040, and is one of the top two conditions for projected increase in prevalence, alongside diabetes[6]. In BNSSG around 1 in 10 people are living with chronic pain and people in the most deprived areas, women and some minority ethnic groups are disproportionately affected by chronic pain[7].

3.6 Differences in Healthcare

Health inequalities are systemic, unfair and avoidable **differences in health** across the population, and between different groups within society. **Healthcare** inequalities relate to inequalities between groups in the population in the **access** they have to health services, and in their **experiences** and **outcomes** from healthcare. Tackling inequalities in health outcomes, experience and access is one of the four core purposes of integrated care systems (ICSs)[8]

The 2025 *Understanding Healthcare Inequalities in BNSSG Annual Report*[9] reported that:

- **Emergency admissions** are higher in areas of high deprivation for children and highest for Asian/Asian British, Black, African, Caribbean or Black British ethnic groups and this gap is increasing.

- Adults living in the most deprived areas (IMD1) are 1.3 times more likely to **attend A&E** compared to the overall BNSSG population and are almost twice as likely to attend A&E compared to the least deprived areas (IMD5). There are more people living in the most deprived areas (IMD1&2) waiting for planned hospital treatment. People in the mixed or multiple ethnic groups or 'other' ethnic groups are more likely to have the longest wait times (over 65+ weeks).

- **Planned admission rates** are significantly lower in Black African, Caribbean or Black British groups and Asian or Asian British than the other groups and lower than BNSSG overall.

- **Talking therapy intervention rates** are significantly lower in BNSSG's most deprived populations compared to other groups. Rates of talking therapies interventions are significantly lower than the BNSSG average for all ethnic groups other than White and Mixed or Multiple ethnic groups.

3.7 Our Future Population

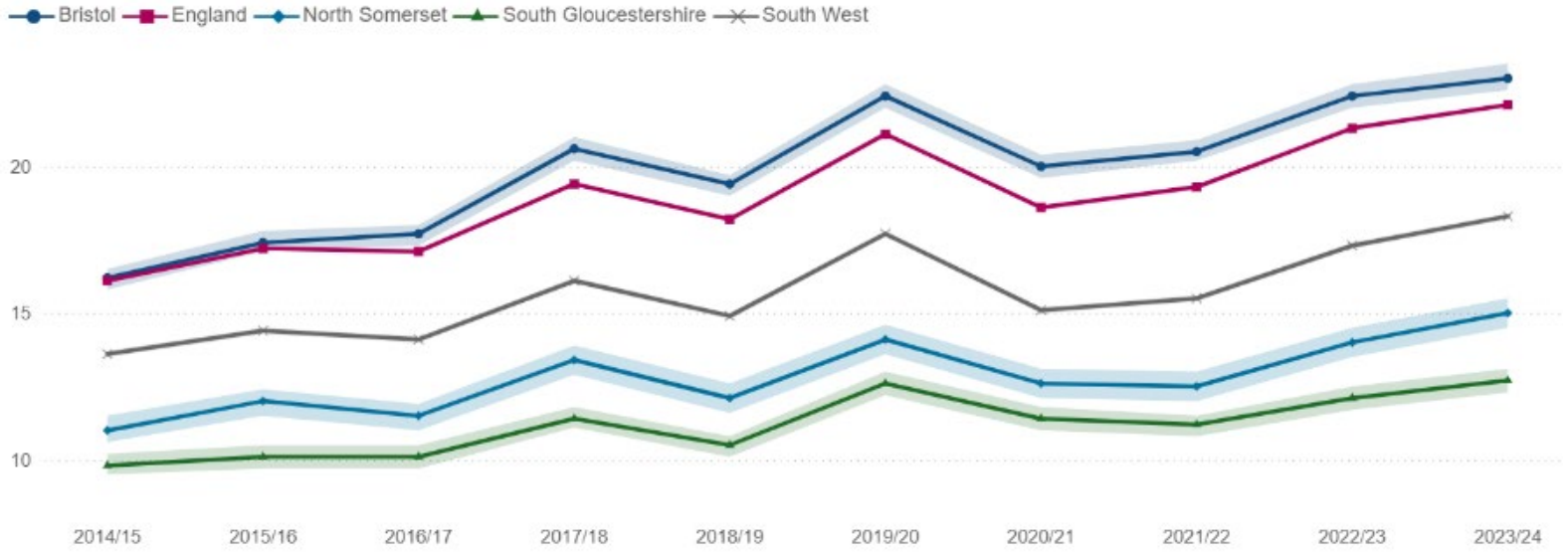
By 2032, the **population of BNSSG is projected to grow by over 100,000 people (10%) from 2022**, with a 10% increase in Bristol, 6.5% increase in North Somerset, and 13% increase in South Gloucestershire. Both South Gloucestershire and North Somerset are expected to see a higher proportion of residents in the over 65 years and a lower proportion aged under 18. Bristol's largest increase will be the younger working age population. As highlighted in *Our Future Health,* ill health rather than age alone is the dominant determinant of demand for non-elective care, strengthening the case for focusing on prevention.

4. Starting Well

4.1 Building blocks for future health

Poverty affecting children is a major driver of future inequality in health. The 31,633 children in BNSSG growing up in poverty are more likely to experience health problems from birth and to accumulate physical and mental ill health throughout life (Figure 11).

Figure 11 The proportion of children living in relative low-income families across BNSSG is increasing[10].



There are almost **4,000 more children living in poverty in 2023-24 compared to 2021-22.** Both North Somerset and South Gloucestershire have rates that are lower than the England average but are following the rising national trend. In Bristol, rates are significantly higher and closely match the national trend.

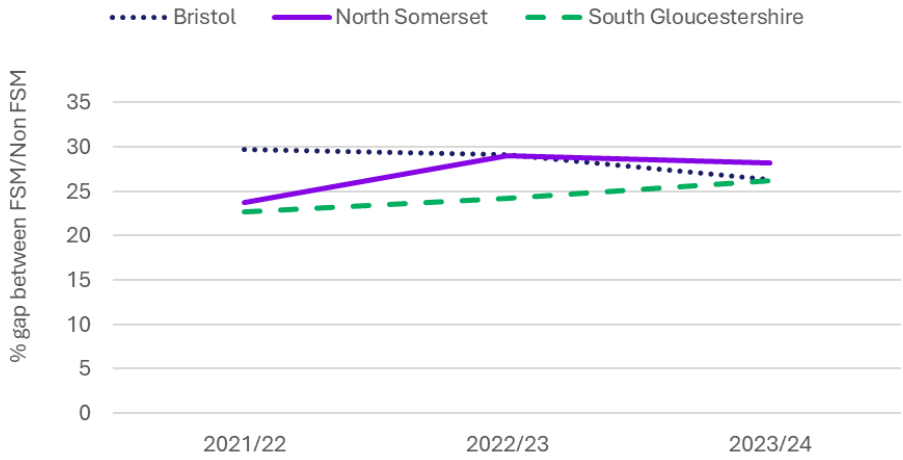
Early development at age 2-2.5 years is a strong predictor of later educational attainment and lifelong health. The Healthy Child Programme review at this stage assesses communication, social skills, and physical development, helping to identify children who may need additional support.

The proportion of children who have achieved a good level of development at 2-2.5 years has improved across BNSSG and is above the England rate. Inequalities remain between those eligible for free school meals (FSM) and those not eligible, and with ethnicity, gender and special educational need[11].

Measures of **school readiness at age five** show a 18-25% gap between the most and least deprived areas (as indicated by Free School Meal (FSM) status) in the percentage of children ready for school in BNSSG (Figure 12).

There is a mixed picture across BNSSG. For Bristol and North Somerset, the gap is closing, while for South Gloucestershire, the gap is increasing.

Figure 12 School readiness: inequality in children not achieving a good level of development in Reception



Across BNSSG, there were 1,438 16-17 year olds **Not in Education, Employment or Training** in 2023-24. There have been significant increases in Bristol and North Somerset, and both areas are significantly higher than the England average

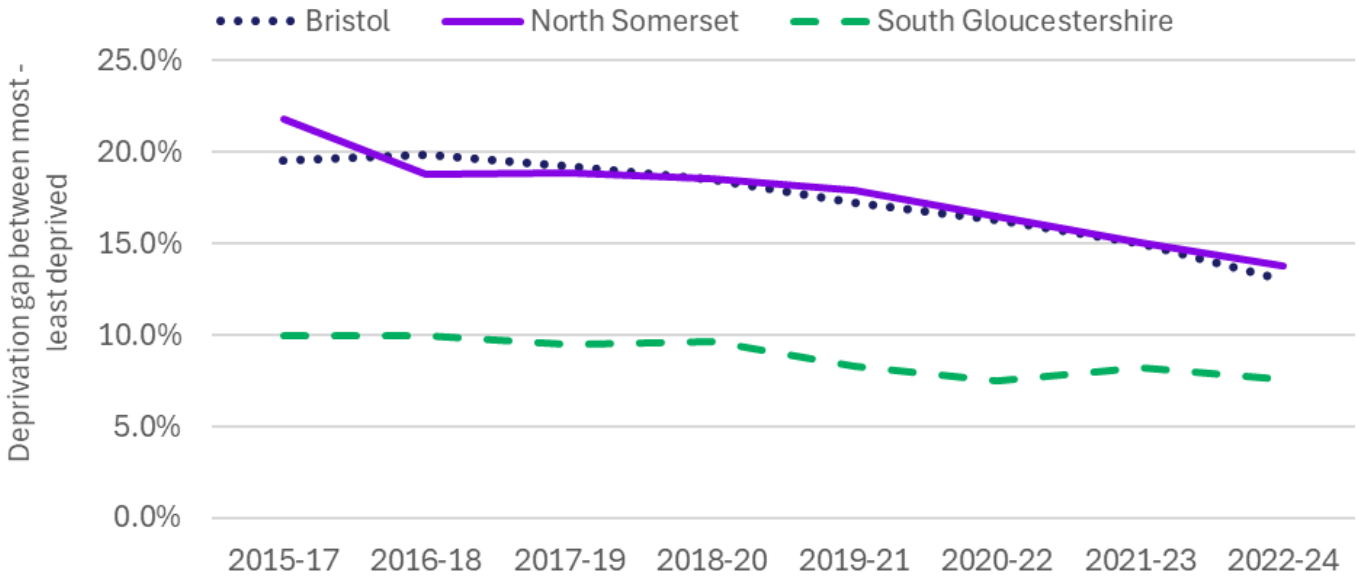
4.2 Healthy habits

Smoking during pregnancy is one of the most significant modifiable risk factors for poor pregnancy outcomes such as stillbirth, low birthweight, and premature birth.

Rates of smoking during pregnancy have **continued to decline** across BNSSG, in line with the England average. Latest local analysis continues to highlight inequality with higher rates amongst mothers living in more deprived areas, mothers of mixed and white ethnicities and younger mothers[12,13].

Figure 13 shows that there has been a **decline in the gap** between the most and least deprived areas for Smoking at the Time of Delivery, showing that while rates are reducing overall, they are reducing more in the most deprived areas.

Figure 13: The inequality in Smoking at the Time of Delivery is reducing[14]



Across BNSSG, around one in five children in reception are overweight or obese. In Year 6, it's around two in five.

Keeping a healthy weight in childhood is important for lifelong health and wellbeing. Excess weight in early years is strongly associated with increased risk of chronic conditions such as type 2 diabetes, cardiovascular disease, and poor mental health.

National Childhood Measurement Programme (NCMP) data show that rates of overweight and obesity remain high and vary by deprivation and ethnicity.

The prevalence of overweight and obesity in **Reception** has been increasing gradually since 2022-3. In **Year 6,** there had been a steady decline across all three Local Authority areas since 2021/22 but in 2024-25 the prevalence has started to increase again.

There are some areas where these rates are much higher for example in Year 6 in Lawrence Weston rates are 46.4%, compared to 35.3% for Bristol overall. In North Somerset, 30% of children in Reception were overweight or obese in Hutton, Locking and Banwell, compared to 22.9% in North Somerset overall.

Figure 14 shows that in **Reception** the inequality gap has reduced for Bristol and North Somerset but has **increased for South Gloucestershire.**

In **Year 6** there has been little change in this gap in Bristol and North Somerset. In **South Gloucestershire, the inequality gap has widened**. In the most deprived quintile, the rate has increased from 21.9% to 25.7% compared to 14.1% to 14.4% in the least deprived quintile over the last 5-year period.

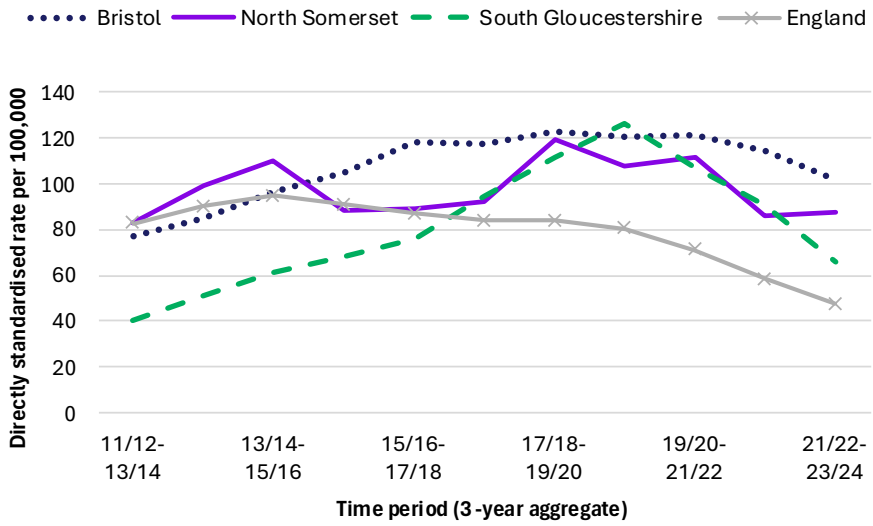
Figure 14 % Gap between most and least deprived for childhood obesity[15]

Drug and alcohol consumption among young people remains a significant public health concern, with far-reaching implications for physical health, mental wellbeing, educational attainment, and long-term life outcomes.

Across BNSSG, there are high rates of hospital admissions linked to **alcohol and to drug misuse**; these are significantly higher than the England average in all three local authority areas.

Admissions due to **substance misuse** in 15–24-year-olds (figure 15) have declined across all three local authority areas, while remaining significantly higher than the national average.

Figure 15 Across BNSSG, we have seen reductions in young people admitted to hospital for substance abuse[16]



Hospital admissions for **alcohol** in under 18's are higher than the England average across all three local authority areas. While there have been some marginal declines in alcohol specific admissions (<18 years) in Bristol and North Somerset, this is not the case in South Gloucestershire, where there has been a marginal increase in keeping with national trends.

4.3 Mental health

Self-harm among young people is a significant public health concern and a strong indicator of underlying mental health needs. Hospital admissions for self-harm in those aged 15 to 24 have remained high in recent years. In North Somerset, the rates were the highest in the South West region and in the top 5 nationally in 2022.

There has been a reduction in emergency admissions for self-harm in those aged 15 to 24 in Bristol. Rates are still significantly higher than England, but these have been declining in Bristol and South Gloucestershire since 2020-21. Admissions for self-harm for all ages are increasing in North Somerset; however, there's a downward trend for young people aged 15-24.

In-depth local work on self-harm among young people[17] has shown that approximately 43% of Emergency Department (ED) attendances for self-harm were repeat attendances. There were increasing attendances and admissions for the 10–14-year-old age group, particularly for females, and increasing presentations at ED for males. Rates of admissions for self-harm by deprivation showed that rates were more than double in the most deprived areas compared to the least deprived areas[17].

4.4 Maternity services

Findings from a recent BNSSG Maternity Equity Audit [18](2024) show:

Premature delivery: There has been a decrease in deliveries before 37 weeks of pregnancy in the last 3 years (4.7 to 4.3%) but an increase in births before 34 weeks (1.8% to 2.3%). Premature births are increasing in 30-34 and 35+ year old age groups. The gap in premature birth rates with deprivation has been decreasing in Bristol and North Somerset, and steady in South Gloucestershire.

Low birth weight at Term (<2500g): this rate has **increased** over the last 3 years, from 2.5% to 2.7% in 2024. Low birth weight at term is commoner in more deprived areas, and the **gap by deprivation has increased** across all three local authority areas.

Breastfeeding initiation: the rate in North Somerset has increased from 74.4% in 2022 to 78.6% in 2024. In Bristol, it has increased from 81.0% to 82.3%. Breastfeeding initiation has declined in South Gloucestershire from 77.8% to 76.5%. **The deprivation gap is decreasing** across all three Local Authority areas.

4.5 Infant and Child Mortality

Child Death Overview Panel (CDOP) Summary[19]:

In BNSSG, 50% of deaths reviewed by the CDOP panel between April 2024 and March 2025 were in the 40% most deprived areas across BNSSG (Deprivation Quintiles 1&2).

Infant mortality rates are highest in Black/Black British groups nationally. National data shows that by ethnicity, over a six-year period, the infant death rate was highest for infants of black Caribbean ethnicity (9.2 per 1,000 infant population), followed by black African (9.1 per 1,000 infant population), and Asian Pakistani (7.4 per 1,000 infant population). This was higher than the rate for white British ethnic background (2.7 per 1,000 infant population)[20]. There are very small numbers by ethnicity at BNSSG level, but 'other' and Black/Black British groups appear highest.

In 25% of deaths modifiable risk factors were identified. In the National Child Mortality Database report high maternal BMI, parent/carer smoked tobacco or e-cigarettes in the household and e-cigarette use during pregnancy, co-sleeping and unsafe sleeping arrangements were reported as the most common modifiable risk factors[20].

5. Living well

5.1 Building blocks

In *Our Future Health*, we highlighted the importance of social, economic and environmental factors in building good health and wellbeing.

Fuel Poverty has decreased in 2023 compared with 2021, across all three local authority areas.

Homelessness: There has been an increase in people owed a duty under the Homelessness Reduction Act in South Gloucestershire and Bristol (with a decline in North Somerset). Bristol has seen a significant increase in people living in temporary accommodation.

Employment: The economic inactivity rate across Bristol and South Gloucestershire has reduced since 2021 but has increased significantly in North Somerset from 13.7% in 2020-21 to 18.9% in 2023-24.

5.2 Healthy habits

Obesity is reported as the biggest risk factor for disability in BNSSG[21]. It is the second leading cause of preventable cancers, and a major risk factor for type 2 diabetes and for cardiovascular diseases. Around 90% of adults with type 2 diabetes are overweight or obese. Obesity prevalence is highest in more deprived areas.

In 2023/24, estimates of **overweight prevalence** among the adult population were lower in Bristol (around 56%) compared to England (63%), while North Somerset and South Gloucestershire were similar to the England and South West average. Overall, rates across all areas have **remained broadly stable**, with some year-to-year fluctuations.

Smoking is the primary driver of the gap in life expectancy between rich and poor. It accounts for more years of life lost than any other modifiable risk factor. Smoking rates have shown a decline over recent years across all three local authority areas, in line with national trends. However, latest available data indicate **this decline has stalled** in Bristol (12.6%) and North Somerset (8.7%). South Gloucestershire is lower at 7.3%.

The reduction in smoking prevalence is not consistent across our population, with rates remaining higher in some groups such as those in routine and manual occupations, individuals with a long-term mental health condition, and those admitted to treatment for substance misuse.

Drug and alcohol impact is increasing. Hospital admissions for drug use amongst 15–24-year-olds remain significantly higher than the national average and are increasing, especially in South Gloucestershire. Alcohol related hospital admissions are increasing across all three areas and are significantly higher than England.

The number of people dying from drug related deaths is high in Bristol and increasing. This represents the tip of the iceberg. Drug and alcohol misuse impacts heavily on families and communities. The updated health impacts tree plots in section 3.3 continue to show drugs and alcohol being among the conditions having highest impact on health among younger adults in BNSSG.

5.3 Health impacts

Painful conditions are in the top five most impactful conditions across BNSSG, across all adult age groups.

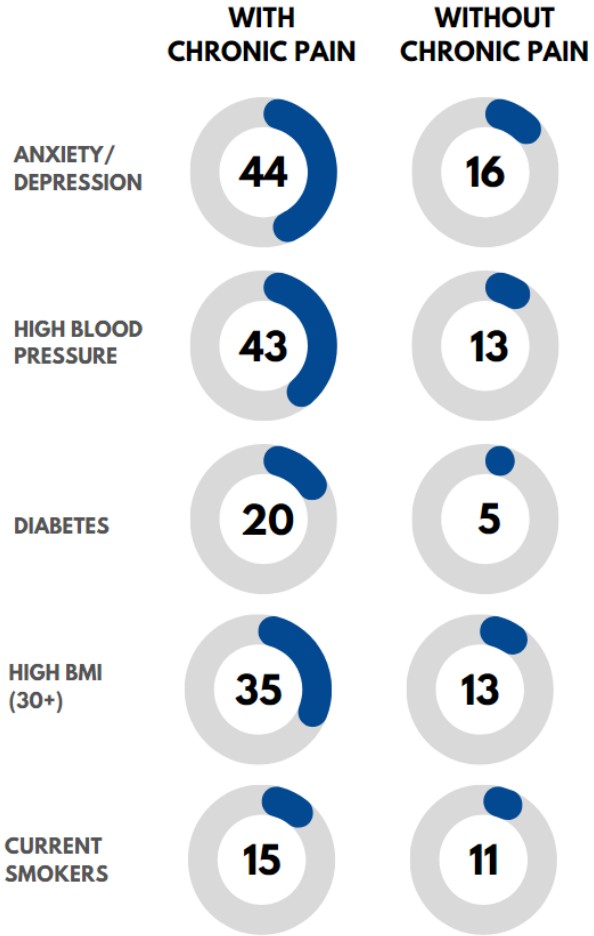


Figure 16 Prevalence of commonly occurring conditions for people with chronic pain and without chronic pain in BNSSG (%, 2022-23)

Recent local analysis shows 1 in 10 people in BNSSG are living with chronic pain[6]

In BNSSG, there is a 20-year inequality gap in the prevalence of chronic pain overall, people in the most deprived areas have the same prevalence of chronic pain in their early 40's as people in the least deprived areas in their late 60's.

Chronic pain is also common among women, and some minority ethnic groups. People who are homeless are 4 times more likely to have chronic pain when compared to the overall population and people who have a Learning Disability are 2.4 times more likely to be living with chronic pain.

Chronic pain clusters with conditions such as anxiety, depression, high body mass index, high blood pressure and diabetes.

Figure 16 shows the prevalence of some health conditions for people living with and those without chronic pain.

For example, high blood pressure and high body mass index (BMI) are around 3 times more common in people with chronic pain than those without chronic pain.

Evidence shows that chronic pain is closely linked to anxiety and depression. Prevalence of anxiety and depression is higher in people with chronic pain. Living with chronic pain can also increase the risk of developing anxiety or depression .

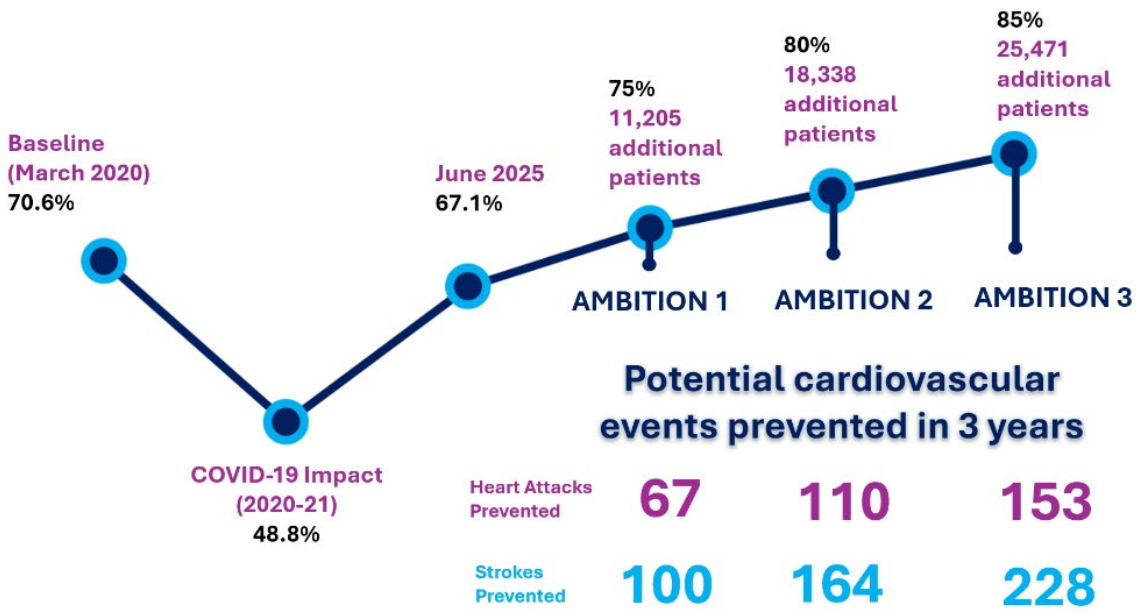
5.4 Cardiovascular disease

Heart disease alone is the top cause of years of lost life in BNSSG.

NHS Health Checks are offered five-yearly to 40-74 year olds, to identify and manage risk of **cardiovascular disease (CVD)** and related conditions, and support management of lifestyle risks (e.g. weight, smoking, high blood pressure and raised cholesterol levels).

Across each of the three local authority areas, there have been **increases in people taking up the offer** of the NHS Health Checks.

Figure 17 The size prize for blood pressure management in BNSSG[22]



The Size of the Prize resource in Figure 17 models' impact of further improvements in blood pressure management on heart attacks and strokes. To reach the target of 80% optimally treated, we need to improve treatment for over 18,000 patients.

This could prevent 110 heart attacks and 164 strokes within a 3-year timescale.[22] Almost 5,000 additional people have been identified with hypertension in BNSSG between 2021-22 and 2024-25[23].

There have been some real successes in improving the care of people living with CVD, including the management of people with high blood pressure where the **numbers of people treated to recommended treatment target has improved.** There have also been increases in people aged 45+ who have had a blood pressure check in the last 5 years.

There are persistent gaps in hypertension management by deprivation and ethnicity. For example, **between the 'black' and 'white' ethnic groups, where this gap is greater than for deprivation and widening** (Figures 18 & 19). The ICB Health Inequalities and Prevention Team is working with local communities to improve the management of hypertension in Black Caribbean communities[24,25].

People who have a high risk of developing CVD that are being treated with lipid lowering therapy has improved. Those living in the most deprived areas are more likely to be treated compared to those in the least deprived areas.

There have been improvements in prescribing rates of blood thinning medication to reduce stroke risk from Atrial Fibrillation. However, this remains below the national ambition. Prescribing is lowest for people living in the most deprived areas (IMD1). By broad ethnic group, rates are fairly similar across all groups. There has been a significant improvement in the 'Other' ethnic group over the last 2 years[9]

Figure 18 % of people with hypertension and treated to target by deprivation quintile in BNSSG (2022-2025)

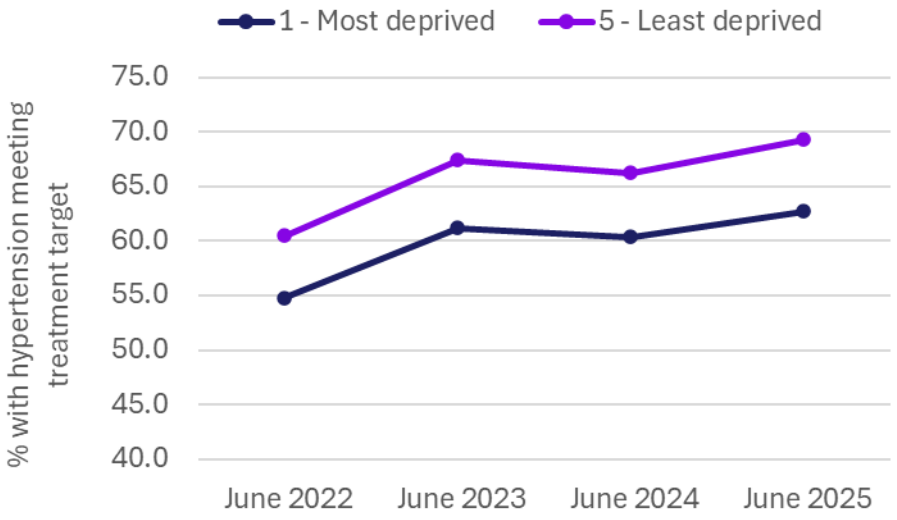
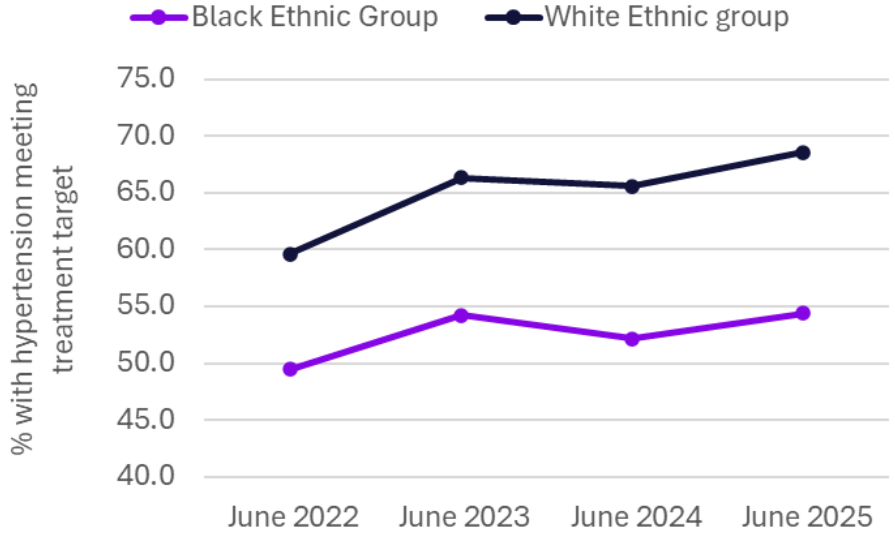


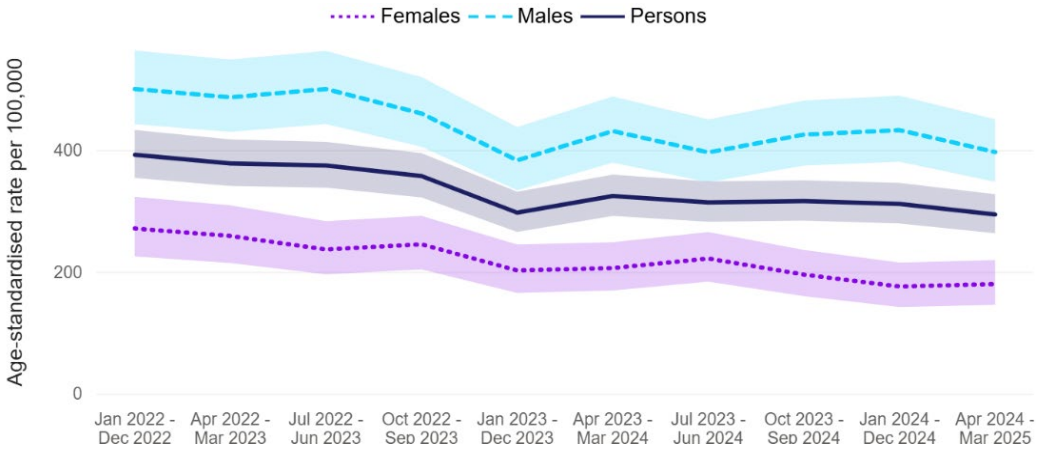
Figure 19 % of people with hypertension and treated to target by ethnic group in BNSSG (2022-2025)



CVD Outcomes: CVD Prevent Audit[26]

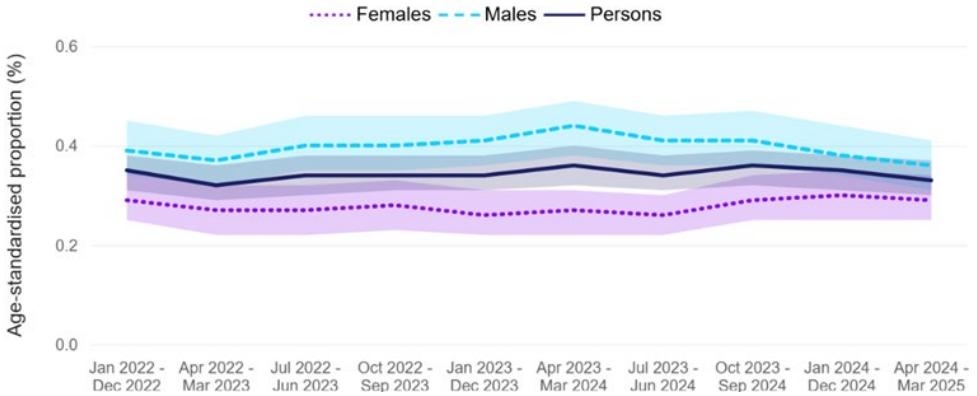
The CVDPREVENT audit data has been linked to hospital and death records to better understand the health outcomes of its patients. These indicators in Figures 20 to 22 are experimental outcome indicators and only include people treated for hypertension.

Figure 20 There has been a reduction in the rate of deaths from CVD in people with GP recorded hypertension.



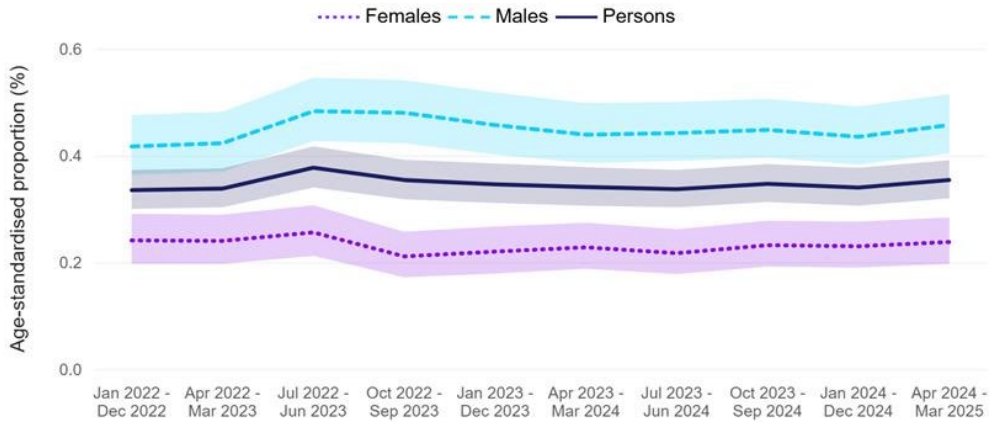
The rate of deaths from CVD for people with GP recorded hypertension are significantly lower than England for females and persons. There has been a recent small decrease in people with GP recorded hypertension who are admitted with stroke as a primary cause.

Figure 21 There has been a decrease in people with GP recorded hypertension admitted with stroke as a primary cause



For people with hypertension admitted with myocardial infarction as a primary cause, there has been little change over time. Nationally and regionally there have been improvements.

Figure 22 Little change in admissions for myocardial infarction among people being treated for high blood pressure



5.5 Cancer Screening

Cancers are the second biggest contributor to the gap in life expectancy across BNSSG. It is estimated that nearly 50% of cancers are preventable through supporting people to live healthier lives. This includes avoiding smoking, maintaining healthy weight, reducing harmful alcohol consumption, eating healthily and staying safe in the sun.

Screening coverage rates for breast and bowel cancer have seen improvements across BNSSG over the last 3 years. However, rates for **Bristol remain significantly lower than the England average.**

Across all three local authorities there has been a **decline in screening coverage for cervical cancer**, following the national trend.

Across all of the main screening programmes for cancer, Bristol has the lowest rates in the South West region.

National Disease Registration Service (NDRS) data shows there has been a decline in the proportion of cancers that are diagnosed at stage 1 and 2 in BNSSG from 56.7% in 2019-21 to 55.5% in 2020-22[27]. More recent provisional data from Rapid Cancer Registration Data shows 62% of all cancers were diagnosed at stage 1 or 2 in BNSSG (compared to 59.5% nationally), indicating an improvement in early diagnosis[28].

5.6 Diabetes

Nationally, the Diabetes Prevention Programme has shown evidence of significant reductions in new cases of type 2 diabetes amongst those at risk. Increased uptake is needed, particularly among deprived and minority ethnic groups.

In BNSSG, there have been increases in people known to have high blood sugars in the 'pre-diabetic' range, who have had a fasting blood glucose test in the last 12 months. However, over the last 2 years rates have been significantly lower than in England overall[29].

There have been significant improvements in the proportion of people with type 2 diabetes who have received all nine recommended annual care processes, from around a quarter in 2021-22 to 57.5% in 2023-24, this is significantly higher than the England average[29]. There has also been a decline in major lower-limb amputations for people with diabetes[29].

People with type 2 diabetes who achieve all three treatment targets for blood sugar management, blood pressure and cholesterol has shown slight improvement since 2021-22 in BNSSG but remains significantly lower than the England average[29].

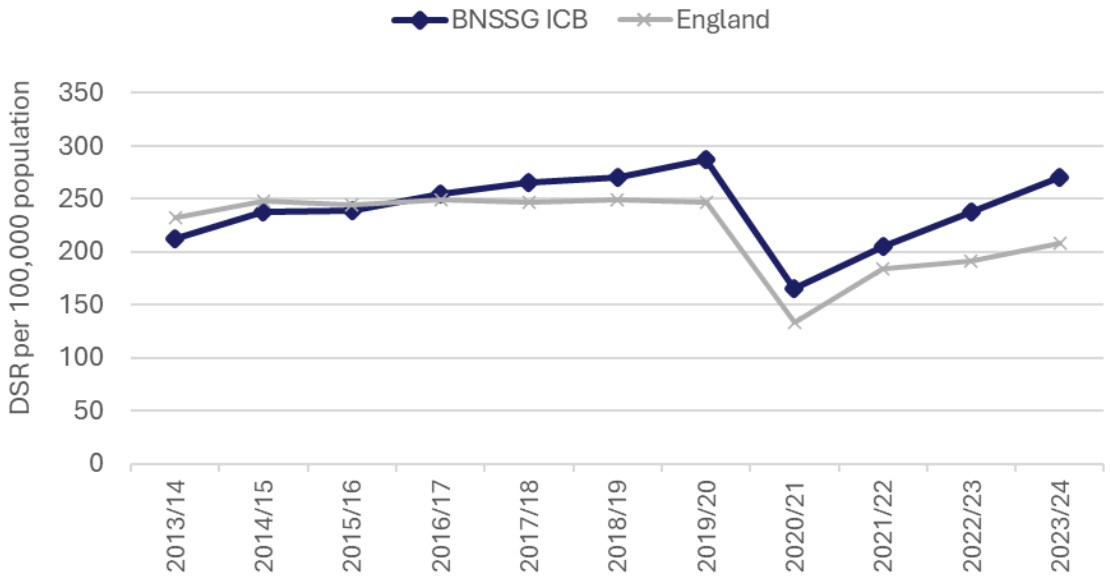
5.7 Respiratory conditions

Respiratory diseases are significant drivers of acute hospital activity and show a strong gradient with deprivation in BNSSG. Chronic obstructive pulmonary disease COPD is a key area of focus to address inequalities in health outcomes, particularly through vaccinations (COVID, pneumococcal and flu) to reduce infective exacerbations of COPD and emergency admissions.

There have been improvements in BNSSG in the proportion of patients with COPD who had an annual review since 2021-22 (59.8%) to 73.1% which is similar to the England average[30].

Emergency admissions for COPD are rising in BNSSG, and more rapidly than in England overall (Figure 23)

Figure 23 Rising Emergency Hospital admissions for Chronic Obstructive Pulmonary Disease (COPD)



6. Ageing Well

6.1 Multimorbidity

By 2040, there is expected to be an increase in many long-term conditions, in some cases these are expected to almost double.

Recently published modelling of future health trends in England by The Health Foundation[6] predicts that numbers of people living with long term conditions are going to increase substantially over the next decade or so. The number of people living with a long-term condition is projected to increase by 37%, from 1 in 6 people in 2019, to 1 in 5 by 2040 as shown in Figure 24.

Increases are particularly notable for diabetes and chronic pain. Many of these long-term conditions can be prevented or delayed. Much type 2 diabetes can be prevented or delayed, especially though maintaining healthy body weight and nutrition[6]

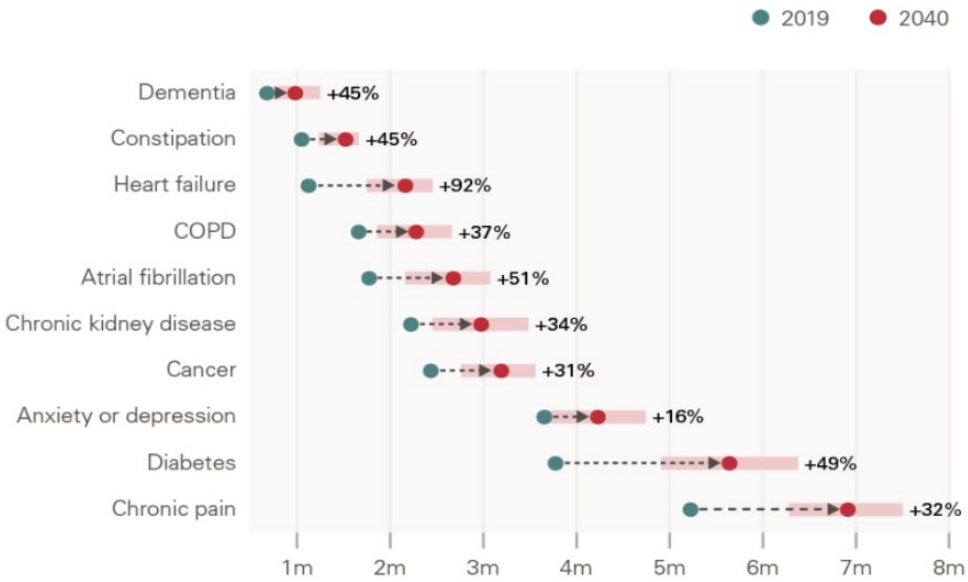


Figure 24 The number of people living with a long-term condition is expected to increase by 37%. Cases of diabetes are estimated to increase by 49%[6]

6.2 Population Segmentation in BNSSG

Using our System Wide Dataset and the Cambridge Multimorbidity Score (CMS)[31] adults aged 17 and over can be grouped into five different segments. This helps us understand people's health needs and plan services that better support each group.

The CMS looks at the long-term health conditions someone has and gives each condition a score.

These scores are added together to give an overall CMS score. A higher score usually means that someone has more complex health needs, more contact with health services and higher use of NHS resources. This overall score places someone into one of the five segments**.**

In Segment 5, this group is small (around 3.4% of the population) but typically includes people with the most complex health needs and the highest use of services and healthcare spend.

6.3 Frailty: Using the segmentation model in BNSSG

Frailty Assessment and Coordination for Emergency and Urgent Care (F-ACE) is an example of using a population segmentation model to deliver better services. F-ACE is a service for older people with multiple medical conditions or those living with frailty, who have urgent or emergency care needs.

The goal of the service is to provide a multi-professional, multi-organisation, person-centred assessment and, where possible, support them to be cared for in their own home with care being delivered by a multidisciplinary team[32].

The intervention is targeted to support people in segment 5 (from the BNSSG core segmentation model) of the population. People in this group are at more at risk of experiencing unnecessarily long stays in hospital and risk of adverse effects. An evaluation of the programme has shown that it was highly effective in sustainably avoiding ambulance conveyances, A&E attendances, non-elective admissions and length of stay for its target population[33].

6.4 The BNSSG Dynamic Population Model (DPM)[34]

The DPM estimates how the size and health of the adult population (aged 17+) may change over time in each Local Authority across BNSSG. The model uses the same health segments described earlier to show how people are likely to move between segments over time. This helps to understand how health needs may increase or change across the population.

The DPM predicts there will be a general shift towards poorer health across BNSSG, although the scale and speed of change vary by Local Authority. The largest growth in Segments 4 and 5 is expected among older people, with more residents living with multiple long-term conditions and more complex health needs.

By 2047, the model predicts that the adult population is projected to increase by around 16%, with a greater proportion of people in poorer health segments. It also estimates that healthcare costs may to rise by 15–22% across BNSSG.

A key priority for the system is to slow this progression into poorer health states, which can be achieved through prevention and early intervention at all stages of life.

6.5 Falls

Fear of falling contributes to social isolation, reducing quality of life and increasing the need for care and support services.

Emergency admissions for falls in people aged 65+ have fallen in both Bristol and South Gloucestershire. In **North Somerset rates of emergency admissions for falls have increased significantly** since 2021[35].

At an ICB level, there has been a reduction in emergency admissions for falls in people aged 65+ since 2019-20. Rates remain high when compared to ICB peers and regional averages. BNSSG ICB has the highest rate in the South West region, significantly higher than the England average, 6th highest in the country and highest among ICB peers.

7. Dying well

There has been a slight reduction in the proportion of people who died at home or in a care home between 2022-23 to 2023-24 from 60% to 59%.

A higher proportion of people who were on the end of life (EOL) register died at home or in a care home (76%) compared to people who were not on the register (49%) in 2023-24[36].

More people have had a ReSPECT form completed, rising from 28% in 2022-23 to 60% in 2023-24 overall. This was highest for people on the EOL register at 80% compared to 48% for those who were not on the register[36].

There have been increases in the proportion of deaths taking place in a hospice, which remains significantly lower than England but there has been an overall improvement over the last three years[37].

In BNSSG, there has been a significant increase in people aged under 75 who have a three or more emergency hospital admissions in the last three months of life. This has increased from 8.2% in 2021 to 10% in 2023[37].

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