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 16 April 2026

Venue: Council Chamber, City Hall, College Green, Bristol BS1 5TR

Agenda

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

2. Minutes of previous meeting held on 12 February 2026
- To approve the minutes of the previous meeting.

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

4. Update from ICB Chair - 1.35 pm
- Jeff Farrar, ICB Chair

5. Health and Wellbeing Board and Locality Partnership updates including local Neighbourhood Health and Wellbeing Plans - 1.50 pm
- Overview of Neighbourhood Health Framework from ICB led by Joanne Medhurst, Chief Population Health Improvement Officer
- Updates from the respective Chairs of the Health and Wellbeing Boards and Locality Partnership on Neighbourhood Health

6. Intelligence Centre Update - 2:20 pm
- Update from the ICB led by Jeff Farrar, ICB Chair, and Joanne Medhurst, Chief Population Health Improvement Officer

BREAK – 2:40 pm

7. Prevention in BNSSG – insights from Directors of Public Health Annual Reports – 2:50
- Updates from respective Directors of Public Health for each local authority.

8. Forward Plan for ICP 2026-27 – 3:35 pm
- To note the forward plan update.

9. AOB – 3:40 pm

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12 February 2026

The Loft @ The Stable, 3-6 Wadham Street, Weston-Super-Mare, BS23 1JY

Minutes

Attendance list

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

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)
Dominic Ellison (WECIL/VCSE Alliance)
Mandy Gardner (Voluntary Action, North Somerset)
Rob France (ACFA advice network/St Pauls Advice Centre)
Mark Coates (CEO, Creative Youth Network)
Aileen Edwards (CEO, Second Step/VCSE Alliance)

Council, Constituent Health and Care Organisations:
Sarah Weld (Director of Public Health, South Gloucestershire Council)
Matt Lenny (Director of Healthy and Sustainable Communities, including Director of Public Health, North Somerset Council)
Ingrid Barker (Group Chair, Bristol NHS Group)
Paula Clarke (Group Formation Officer, Bristol NHS Group)
Dr Rebecca Maxwell (Trust Medical Director, Bristol NHS Group)

Locality Partnerships:
David Moss (Woodspring & Weston Locality Partnership)
Alison Findlay (South Gloucestershire Locality Partnership)
Sharron Norman (North and West Bristol Locality Partnership)

Apologies for absence:
Councillor Stephen Williams (Chair, Bristol Health and Wellbeing Board)
Christina Gray (Director of Public Health, Bristol City Council)
John Martin (CEO South Western Ambulance Service)
Anne Clarke, (Director of Adults and Housing at South Gloucestershire Council)

Ruth Hughes, (CEO, One Care)
Fiona Mackintosh (ACFA advice network/St Pauls Advice Centre)
Raz Akbar (South Western Ambulance Service)
Kristie Corns (South Gloucestershire Locality Director, BNSSG Integrated Care Board)
David Jarrett (BNSSG Integrated Care Board)

1. Welcome & Introductions

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

2. Minutes of previous ICP Board meeting held on 11 September 2025

The minutes of the previous ICP Board meeting on 11th September 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. Update from ICB Chair / CEO on ICB restructure

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

- Shane Devlin and Jeff Farrar provided an update on the organisational structure and governance arrangements for the Integrated Care Board noting the move to a cluster board with Gloucestershire from 1 April 2026.
- It was noted that the ICB plan to reduce the number of board members and Directors and noted that recruitment was ongoing.
- VCSE representatives raised concerns around loss of colleagues and instability in the sector and urged ongoing engagement in the new structure.
- It was noted that the ICB was committed to better partnership working and alignment with the Health & Wellbeing Boards.

5. Health and Wellbeing Board and Locality Partnership updates on Neighbourhood health and care plans

The board received updates from the respective Health and Wellbeing Boards for each local authority on Neighbourhood Health and Care Plans.

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

a. Bristol Neighbourhood Health and Care Plan Update

- Sharron Norman presented the Bristol Neighbourhood Plan update which was a whole-system framework ensuring community cohesion.
- The plan would ensure an evidence-based approach learning from those with lived experience and alignment with children and families strategy and programmes, adult social care strategy and programmes, NHS strategy, GP reforms and community services.
- Concerns were raised about lack on investment in the VCSE sector and the need for strengthened support for community organisations and it was suggested that this be made explicit in the neighbourhood plans.
- There was a discussion around the social determinants of health and the impact on health outcomes which should be considered in the neighbourhood plans.
- It was noted that the plan was a high-level framework and feedback on widening VCSE representation and social determinants of health was welcomed.

b. North Somerset Health and Care Plan Update:

- David Moss presented the North Somerset Neighbourhood Plan, highlighting the "mosaics" concept from static architecture to living system which aims to shift the operating model from transactional silos to relational complexity.
- It was noted that the framework and forward trajectory were being developed to support partner conversations over the coming year and ambitions should be aligned with emerging government policy and funding mechanisms.
- Concerns were raised about engagement gaps in rural or less-resourced areas with the risk of communities being forgotten, and colleagues highlighted the need to align neighbourhood health with mental health initiatives.
- Colleagues expressed support for creative approaches but stressed the need for careful planning to avoid missing vulnerable groups.
- It was noted that the presentation slides on the North Somerset Neighbourhood plan were not included in the reports pack but could be shared with the Board after the meeting.

c. South Gloucestershire Neighbourhood Heath and Care Plans Update.

- Sarah Weld presented the South Gloucestershire Neighbourhood Plan update which focused on place-based approach informed by local neighbourhoods and communities, prioritising prevention and reducing inequalities.
- Highlighted the rural challenges, alignment with primary care network, and community initiatives including leg clubs and fall prevention along with continued engagement with VCSE organisations.
- There was a discussion around challenges relating to population growth and access to hospital services, particularly at Southmead hospital.
- There was a discussion on how local neighbourhood plans interface with West of England Combined Authority (WECA) responsibilities and regional working arrangements, particularly around transport and social care impact. It was noted that

thew Children in Poverty Strategy was an example of existing alignment opportunities.
- Colleagues noted the importance of embedding social value within contracts and ensuring commissioners take responsibility and are held accountable.

6. Update on ICB Population Health and Strategic Commissioning Plan

The Board received an update on the BNSSG Integrated Care Board's Population Health and Strategic Commissioning Plan 2026-2031, with a particular focus on the year 1 commissioning intentions.

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

- It was noted that it was a national requirement for ICBs to develop a five-year plan and the timing of this plan had presented challenges due to a shorter timeframe, pending cluster arrangements with Gloucestershire ICB, and alignment with the HWB's development of Neighbourhood plans.
- It was noted that shared priorities and ambitions included Healthy Lives, Health Equity and Best Value.
- It was noted that the plan highlights the role that the NHS will play with a focus on prevention, moving more care into the community and the use of digital technology.
- A summary was provided on the commissioning intentions for the coming year which included 12 priority areas as outlined in the reports pack.
- It was noted that the Population Health Improvement Directorate led on data analysis and engagement with partners to ensure effective and informed commissioning decisions.
- Colleagues noted the importance of creating conditions for good health and welcomed work around the impact of poverty.
- There was a discussion around the use of AI and the overall approach in commissioning work, which could be progressed with support from partners.
- It was noted that the system was under-resourced and required investment. Colleagues emphasised the need for a strong outcome framework and agreement across local authorities to align sequencing.
- Colleagues asked if the plan document was publicly available and it was confirmed that this had been approved by ICB and would be published in due course.

7. Update on the Joint Clinical strategy, the Bristol NHS Group and the exploration of the merger of the two Trusts (NBT and UHBW)

The Board received an update on the joint clinical strategy and the exploration of the merger of the two trusts, North Bristol Trust and University Hospitals Bristol and Weston, led by the Group Chair.

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

- Ingrid baker, Group Chair, introduced the item and shared presentation slides which provided an update on progress against the Joint Clinical Strategy, which was launched in 2024, and next steps for the merger, which included alignment to the NHS 10-year plan.
- An overview was provided on delivering benefits for the 'four Ps', patients, people population and public purse.
- It was noted that a refresh and reframe of current plans for 2026 to align with 10-year health plan shifts included prevention, hospital to community and digital technology.
- It was noted that the merger aims to align services under a single leadership model across BRI, Southmead, and Weston hospitals.
- It was noted that a series of partnership engagement events and would be held to help shape services and ICP Board members were welcome to join.
- VCSEs urged that that colleagues from the Trust respond to the consultation on migrant settlement delays and access to care, and other similar consultations for the sector.
- Colleagues welcomed the progress against the merger which will overcome barriers and strengthen services.

8. Forward Plan for the BNSSG ICP Board 2026-2027

The Forward Plan for the BNSSG ICP Board for 2026-27 was noted.

9. AOB

There was none.

Meeting close: 4pm

Neighbourhood Health Framework

NHS England has published the Neighbourhood Health Framework, building on the 10 Year Health Plan's vision for **proactive, community-first model of care**, moving activity **out of hospitals and into neighbourhood settings**. This new guidance outlines a range of specific delivery targets, timelines, clear governance structures and introduces three new types of provider organisations.

The Neighbourhood Model of Care

Key goals

- **Improve services and population health outcomes** and reduce health inequalities
- **Improve the cost effectiveness of services**, including a significant reduction in demand for acute services
- **Improve the service user experience**, through faster, accessible and more coordinated care delivery
- **Empower people** to manage their own health and care and stay well closer to home
- **Improve outcomes for high-priority groups** through earlier interventions and reduced hospital admissions

How this is achieved

- Renew the emphasis on primary, secondary and tertiary **preventative care**
- **Expand neighbourhood-based alternatives to hospital care** (MDTs, virtual wards, intermediate care, urgent response, specialist GP support, diagnostics, etc.)
- **Use digital tools and integrated data**, to improve access to care, responsiveness and coordination across services
- **Deliver proactive community-based care** through Integrated Neighbourhood Teams
- **Focus proactively on high-need populations**, reducing acute demand

Health and Wellbeing Boards (HWBs), ICBs, and local authorities will set **local goals** to improve care, reduce inequalities, support home-based care, and align with local reforms and community initiatives.

Some Key Areas of Focus for Neighbourhood Health

Strengthen neighbourhood health and GP services: Enhance GP access (90% urgent patients seen same day by March 2027), cut bureaucracy, expand digital tools, reform out-of-hours services, and use pharmacies as first points of contact to **improve efficiency, patient experience, and outcomes**

Reduce hospital demand: e.g. 25% outpatient diversion through single points of access for 10 specialities by March 2027. Redesign services to prevent deterioration, providing seamless care through locally defined **INTs**. **Deliver better alternatives** e.g. local 24/7 mental health centres.

More granular priority cohorts: the 10YP notes priority cohorts for neighbourhood care, but this guidance raises specific conditions (CVD, diabetes, COPD and dementia) and adds cancer as a distinct INT priority. All children needing access to an INT will have it by 2028/29.

The framework outlines **3 new types of Neighbourhood organisations**:

Single Neighbourhood Provider
Deliver services within a defined area (**pop. ~50k**), working alongside local GPs

Multi-Neighbourhood Provider
Coordinate services across a larger geography (**pop. 250k+**) to deliver population-focused care

Integrated Health Organisation
Manage whole-population budgets for defined areas and lead commissioning decisions

Enablers for Delivering the Vision

- **Estates**: Care will be delivered locally, digitally, or at home, with **Neighbourhood Health Centres** integrating healthcare and community services – targeting 250 NHCs by 2035, of which 120 by 2030
- **Workforce**: **Multidisciplinary teams will work across settings**, supported by new roles, skills, and career pathways – details to be included in 10-Year Workforce Plan.
- **Finances**: ICBs will lead commissioning and funding, shifting resources from acute care and using flexible, outcome-based contracts to support **proactive, population-focused care.** The financial framework will be amended from 2026/27.

Next Steps

- **Next commissioning cycle for 2026/27:** ICBs and HWBs should implement **immediate priorities** – reducing admissions, improving GP access, establishing INTs, and eliminating 52 week waits
- **Longer term neighbourhood health strategies for 2027/28:** Commissioners should align national objectives with local priorities, setting clear geographies, responsibilities, and integrated plans, then incorporating this locally owned plan into their refreshed 5-year Strategic Commissioning plan

*Source: Policy Paper: **Neighbourhood health framework**, published 17 March 2026, www.gov.uk*

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Integrated Care Partnership Board

Agenda item	5a	Meeting date	16 April 2026

UPDATE – BRISTOL HEALTH AND WELLBEING BOARD

1. The most recent Bristol Health and Wellbeing Board meeting was held on Thursday 19th March 2026. Papers can be viewed here: ModernGov - bristol.gov.uk

- 18th February development session: a joint workshop was held with the One City Transport Board. Following rich discussions, actions are being developed to increase health involvement in active travel projects and communications, and other ideas are being taken forward in the One City Active Bristol Strategy.
- 19th March public meeting included:
  -Bristol Suicide Prevention Strategy 2026-2030 was approved
  -Bristol Drugs and Alcohol Strategy 2026-2030 was approved
  -Update provided on the Best Start in Life Plan.

2. Current issues/priorities:

Neighbourhood health

- Following workshops with additional local partners, a vision, essential pillars and critical enablers were set out in the Bristol Neighbourhoods Wellbeing and Health Plan and submitted to the ICB in February. This helped inform shortlisting within the Neighbourhood Health Development Fund. The Plan will be further developed following the publication of the national Neighbourhood Health Framework
- Desk-based work is underway prior to workshops and consultation to determine neighbourhood footprints. The scope includes 'natural neighbourhoods', PCN footprints, health need, community anchor organisations and Family Hubs. To avoid duplication, links are being made to similar work happening elsewhere in the system, for example the Clinical Support Unit and Bristol City Council Children and Education directorate

SOUTH GLOUCESTERSHIRE - HEALTHY NEIGHBOURHOODS PLAN

Version 0.5 DRAFT 28.11.2025

UNIVERSAL OFFER

WHOLE POPULATION

"I am generally fit, well and happy."

"I feel part of my community and have opportunities to contribute."

PREVENTION & EARLY INTERVENTION

WHOLE POPULATION + TARGETED COHORTS

"I can access what I need, when I need it."

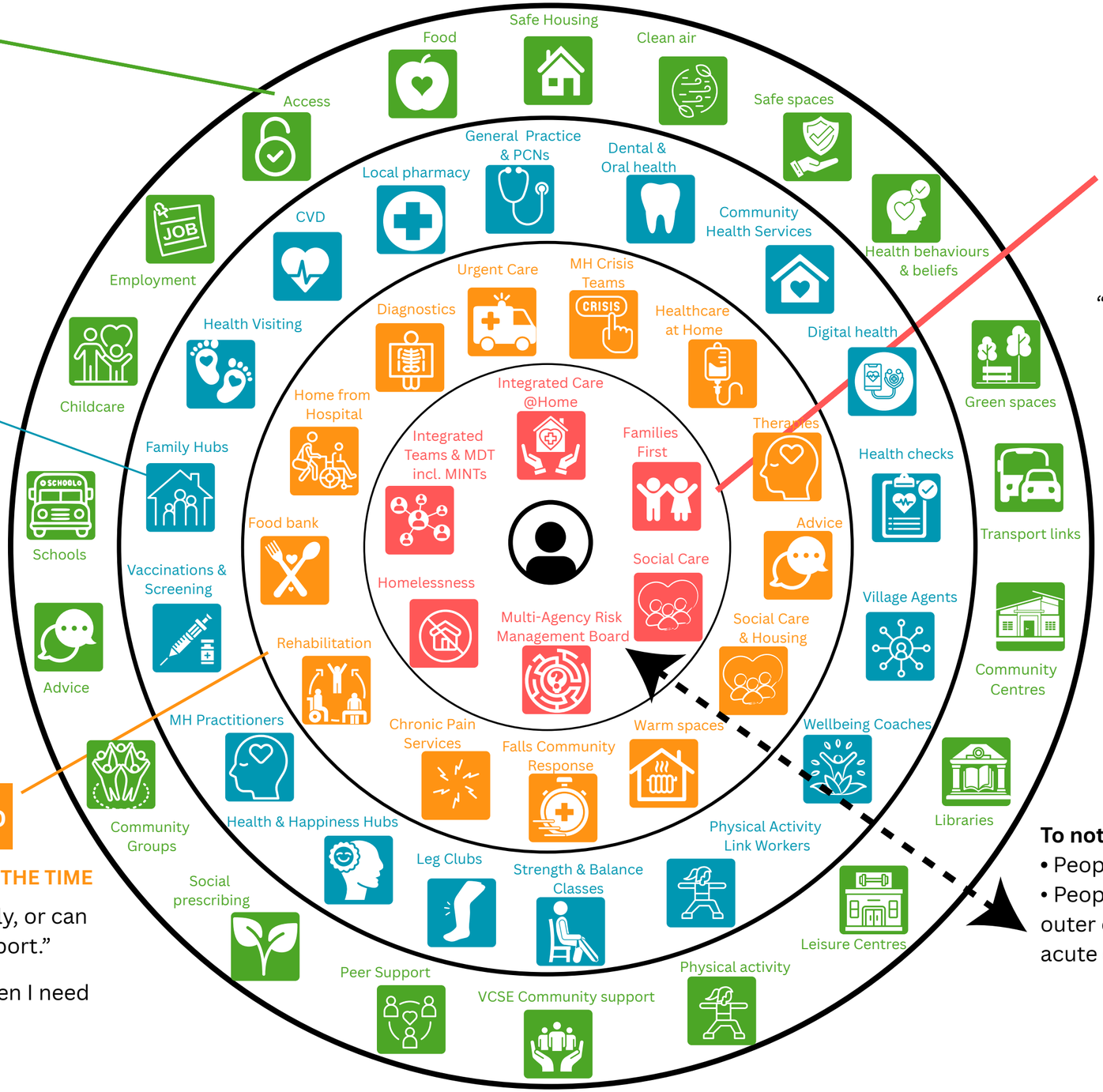
"I am supported to stay well and prevent crisis, not just treated when things go wrong."

ACUTE EPISODE OF NEED

SOME OF THE POPULATION, SOME OF THE TIME

"I can access specialist services locally, or can easily reach them by public transport."

"I know how to contact someone when I need help, and they respond."



LIVING WITH COMPLEXITY

TARGETED COHORTS

"My life is complex."

"I am dealing with multiple challenges daily."

"I need on-going / long-term support to thrive."

"I can get help that looks at all of me - my mental, physical and social needs."

To note:

- People can span multiple circles.
- People can be supported to return towards the outer circles, even when they have experienced an acute episode of need and / or complexity.

Key facts about South Gloucestershire

300,000

people live in South Gloucestershire, projected to reach **350,000** by **2041**. The area is a mix of urban, rural, and market towns, with substantial new development. Diverse with **80% rural** and **20% urban** split in land and 60% population living in urban areas. There are notable **health inequalities** in health, access, and outcomes, especially for **deprived and rural communities**.

Our challenges

Health Inequalities, wider determinants and population change.

Despite generally better health outcomes than the national average, there are **significant disparities** in preventable deaths, mental health, obesity and access to services. Issues include poverty, educational attainment gaps, **rural isolation**, **transport barriers**, and the impact of climate change. An **ageing population** and growing numbers of **children in poverty** present ongoing challenges.

Community insights

Priorities include health, wellbeing, education and tackling poverty.

What matters locally: Residents value community, **access to ameneties**, and a balance of urban / rural life. There is **strong local pride**, especially at the town / village level.
Engagement: People want **genuine involvement in decisions**, not tokenistic consultation.

How we work together

South Gloucestershire has **1 Locality Partnership** which is a principal delivery mechanism for the **Health & Wellbeing Strategy** and is leading the development of our Neighbourhood Health and Care Plan. There are **6 Primary Care Networks**. The LP works closely with the HWBB: there is **shared membership** and **regular meetings** between leaders and delivery groups.

Our approach to Neighbourhood

Our neighbourhood approach will be based around **how residents define their local neighbourhood and communities**. This may include approaches based around where people live, where they go or shared interested and activities.

- Neighbourhood is a **way of working**, a **culture** and an approach to supporting communities.
- Community voice must be included from the start – **community empowerment** is key.
- Communities are **best placed** to know what they need, and we will believe what they tell us.
- People are complex. We will no longer respond to **complexity** by compartmentalising people's lives to simplify service delivery.
- Children, young people and adults cannot be separated by artificial boundaries. People exist in **family units**, and each unit is unique in its make-up and needs.
- **Trusted relationships** are everything – who do we need to be in a relationship with to change outcomes?
- If we choose the wrong **measures**, we choose poor **outcomes**. It all begins with outcomes.
- We will prioritise **prevention** and **reducing inequalities**. We recognise that health is shaped by multiple overlapping factors and reducing inequalities goes hand in hand with prevention and addressing core determinants of health.
- We will remember that our **current approach** to service provision is not resulting in optimum outcomes or experience for our population and communities.
- The role of statutory commissioners and Place is to **convene** and **enable**, not control.
- This new way of working may feel **messy** and uncomfortable and that's ok. We will learn to sit with the discomfort and resist the urge to return to the status quo.

SOUTH GLOUCESTERSHIRE - HEALTHY NEIGHBOURHOODS PLAN

Version 0.8 DRAFT 06.03.2026

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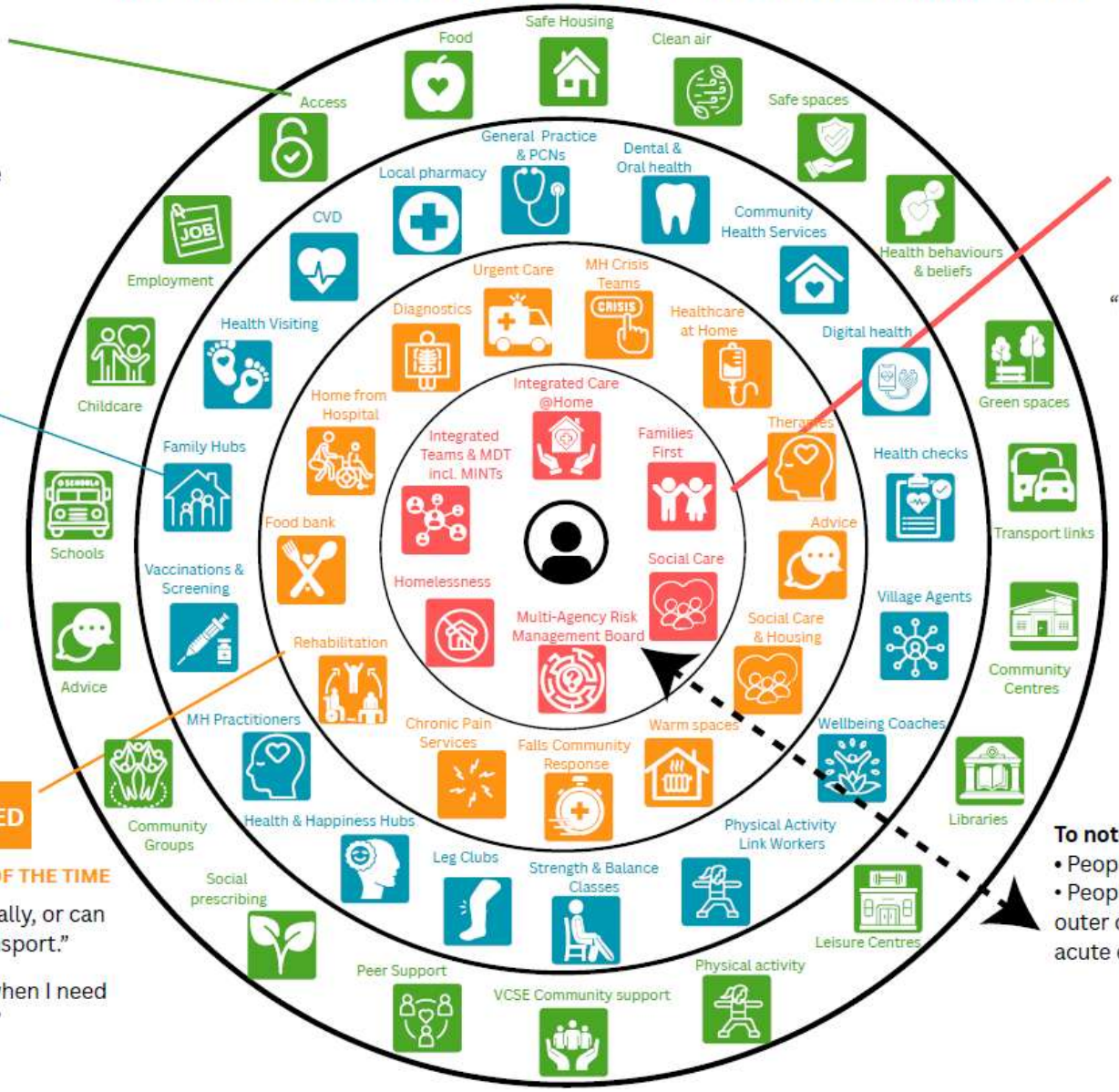

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Universal offer Spotlight: Active Lifestyle Centres

Provided by: Circadian Trust (CT).

Service overview: 5 Active Lifestyle Centres in South Gloucestershire: Bradley Stoke, Kingswood, Longwell Green, Thornbury & Yate. Over 120,000 unique customers and 2.5 million physical activity visits in 2024-5.

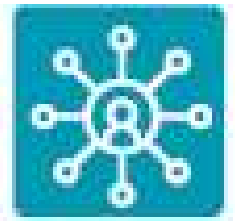
Helping people improve their health and wellbeing via physical activity opportunities. Teaching 12,500 children and adults to learn to swim each week. Providing unique places for people and clubs for training and competing. Being a social hub for recreation, formal and informal meetings and community events. Helping people with diverse requirements achieve their goals. Developing and delivering services in partnerships with other organisations in the health, education or community development sectors to increase participation in healthy physical activity across the population. This includes the Healthy Weight Service and Escape Pain programmes amongst many.

Impact: In a rolling 12-month period between April 2024 and March 2025 CT generated a total of £21.56m social value compared to 2023 - 24 total of £16.09m in all activities across all facilities. This places CT in the top quartile for Annual Social Value Change when benchmarked against other leisure providers on a like for like basis (per facility).

Recognition: All sites rated at least "very good" with Longwell Green Centre rated 'OUTSTANDING' by Sport England's quality scheme (Quest).

Funded by: South Gloucestershire Council.

Prevention & Early Intervention: South Gloucestershire examples



VILLAGE AGENTS: Provided by **WERN** with a presence in Marshfield & District, Pilning & Severn Beach, Cotswold Edge, Severn Vale and Falfield. Village Agents are embedded in rural communities across Cotswold Edge, Boyd valley, Ladden Brook, Severn Vale, Pilning & Severn Beach and connect individuals to services and organisations, enabling them to remain independent in their home for as long as possible. They provide practical support and advice on a 1:1 basis through home visits, as well as liaising closely with voluntary groups, parish and town councils, and health providers locally to join up efforts and make sure the needs of those they are working with are better served.
Impact: Village agents reached 354 people in 2025, many of whom received support that's likely to have negated the need for them to present to primary care.
Funding arrangements: Jointly funded by South Glos Council and SG Locality Partnership (Health Inequalities fund).

4PCN LEG CLUB: Volunteer led, walk-in service for treatment for chronic leg ulcers in a non-medical setting. Partnership of General Practice, VCSE and local Volunteers. Holistic care with equal focus on reducing social isolation and connecting people to their communities. Ongoing support after healing.
Impact: Over 60 members so far.
Funding arrangements: PILOT - Jointly funded by South Glos Council and SG Locality Partnership (Pro-Active Care fund).

PHYSICAL ACTIVTY LINK WORKERS: Provided by **Southern Brooks** and linked with the Feeling Better in South Gloucestershire project (SGC). Uses a person-centred approach to help individuals get more active in a supportive judgement-free way. Using a 'what matters to me' approach increases physical activity, builds confidence and emotional resilience, and connects people to their community.
Impact: 62% reported an increase in their physical activity. 88% reported a positive change to their mental wellbeing (Nov'24).
Funding arrangements: Jointly funded by South Glos Council and SG Locality Partnership (Pro-Active Care fund).

Prevention & Early Intervention Spotlight (1): Health & Happiness Hubs

SOUTHERN BROOKS
connect support thrive

Provided by: Southern Brooks

Service overview: Health & Happiness Hubs offer a 10-week programme of facilitated topics. We explore self-care using practical and positive psychology approaches. We aim to help people value themselves, take responsibility for their wellbeing, and build supportive connections in their community, increasing happiness and resilience. Sessions are interactive and participatory, creating real peer support, and people are encouraged to make small, positive changes. Participants can attend reunions every 11 weeks to stay connected and motivated.

While mainly for people with long-term health conditions, the hubs also support people in social isolation, with low self-esteem and poor self-care.

Impact:. People report feeling safe, having a better understanding of how to care for themselves, feeling valued and valuing self and increased connection to others. Many people have stayed in touch with each other and meet in the community, completely independently.

A total of 265 clients have attended and based on total responses across all 5 hubs, **89% of participants said they felt more motivated and empowered and 100% said they had benefitted** from attending.

Funded by: South Gloucestershire Locality Partnership (Health Inequalities fund).

Prevention & Early Intervention Spotlight (2): Pro-Active Social Prescribing

SOUTHERN BROOKS
connect support thrive

NETWORK4
Green Valleys | Three Shires | Orchard | Downend

Provided by: Network4 PCN and Southern Brooks.

Service overview: Proactive Social Prescribing is a different approach to health and wellbeing. The aim is to find people and reach out, rather than waiting for them to ask for help. We can then connect people to services in their community before things get worse. This is to support physical, mental and social wellbeing.

2025/26 focus on the following groups in the most deprived areas:
- Phone support to parents with children with learning disabilities
- Information to parents with children under four years
- Carer support to carers
- Cold homes support both over phone and via letter to older adults

Impact: 112 carers in deprived areas have been contacted and 32% chose to be referred. 1,157 text or letters to patients with COPD and CVD in the most deprived areas and that may live in a cold home with information on services that can support. All materials written towards the Uk average reading age of 9-11 to promote health literacy.

Recognition: Personal Recognition Award to Sarah Watts, Personalised Care Lead & Southern Brooks Social Prescribing Team. (South-West Integrated Personalised Care Awards 2025).

Funded by: NHS England.

Acute episode of need: South Gloucestershire examples

CHRONIC PAIN SERVICES: Provided by **DHI** to help people manage chronic pain and improve their wellbeing. The service focuses on a person's story and how it has changed them. It is not necessarily about changing drugs or lowering doses – it provides people with alternative approaches to pain management that are integrated into mainstream services, utilising community assets and empowering people to become an agent and expert in their own pain management and wellbeing.

Impact: 300+ people seen since 2022. 97.9% reported a positive experience. 89.1% showed demonstrable improvement in health & wellbeing

Funding arrangements: SG Locality Partnership (Pro-Active Care fund). Funds 2 PCNs out of 6.

SOUTH GLOS RAPID RESPONSE: Partnership provision by **South Glos Council** and **Sirona**. Rapid Response is a dual service that supports adults who are in a social care crisis who are at home + covers Careium pendant calls (provided by SGC) – Falls and non-response. The service has Rapid Responders (Carers) who are on standby and have access to a Raizer (lifting) Chair. There is an Emergency Support Officer who covers the call desk. The service is free for the first 72 hours. People in a social care crisis can be referred by professionals, family members or self referrals. Care and support can be provided in a person's home whilst an ongoing Care Act assessment can assess for the longer-term needs if appropriate. For a falls call a Rapid Responder can attend to complete a risk assessment and determine if it is appropriate to lift someone from the floor. For a non-response call the Rapid Responder will attend to ensure that the person is safe and well and action further support (Ambulance, GP etc) if required.

Impact: Reduction in ambulance conveyances & non-elective admissions. Improved outcomes for people who have fallen at home.

Funding arrangements: Partly funded by South Glos Council Adult Social Care and partly funded by Better Care Fund. Pilot extension funded by BNSSG ICB (winter monies).

HOME FROM HOSPITAL: To support people with discharge and improving health and wellbeing outcomes – supporting P1 to P0 shift to help system pressures – the team is embedded within the TOCH which has improved communication and integration.

The team can then refer onto Welcome Home service for post-discharge support. Welcome Home provides post discharge support for up to 6 weeks support in the community – looking to establish a range of onward connections.

Impact: Improving health and wellbeing outcomes, expediating discharge, reducing rates of readmission.

Funding arrangements: Better Care Fund.

Acute episode of need Spotlight: When Advice Really Matters (WARM)

citizens advice South Gloucestershire

Provided by: Citizens Advice South Gloucestershire

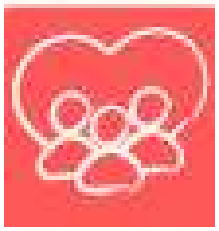
Service overview: The WARM service provides confidential, accredited and independent debt, benefits and welfare advice for those accessing primary care and VCSE health and wellbeing services because socio-economic issues and financial hardship are impacting on their mental health. The service provides extra capacity to support the most vulnerable and those at risk of becoming vulnerable due to the cost-of-living crisis and rise in energy caps.

Impact: The service has supported 221+ clients (101 over 50yrs). Average income gained per client £8.1k.

Recognition: Awarded 1st place in the 'Client Service Innovation' Category and 2nd place in the 'Most Impactful Mission – Take Early Action' category at the 2025 national Citizens Advice Annual Awards.

Funded by: Jointly funded by St Monica Trust and South Gloucestershire Locality Partnership (Health Inequalities fund).

Living with complexity: South Gloucestershire examples



SOCIAL CARE: Dementia Carers Breaks: providing support to carers of people with dementia who are typically unable to be supported at home. Operating as a proof-of-concept model to demonstrate the need and value of the service. There is a working group which has identified the outcomes. Targeting specialist 3rd sector providers who form partnerships with registered care providers to seek innovative ways to deliver respite breaks.

Impact: demonstrates integrated working between SG Adult Social Care teams and VCSE + helping to keep people in their own home

Funding arrangements: Accelerated Reform Fund.

FAMILIES FIRST PARTNERSHIP: Local multi-agency implementation of a national reform of Children's Social Care. Codesign, with families and practitioners across South Gloucestershire, of a new delivery model comprising multi-disciplinary Family Help Lead Practitioners providing assessment, support, interventions and family group decision making for children and families. These new Family Help teams will operate on a neighbourhood basis, supported in delivery of Child Protection activities by a new specialist Multi-Agency Child Protection Team.

Impact: a transformed system where practitioners from social work, police health and education work together to promote the wellbeing of children and keep them safe from harm. More children grow up safely with the right love and support around them. Evaluation framework agreed by FFP Programme Board.

Funding arrangements: mostly funded through re-design of existing services, with some additional funding via the Children, Families and Youth Grant.

Living with complexity Spotlight: Mental Health & Wellbeing Integrated Team (MINT)

Provided by: AWP, Second Step, Southern Brooks, South Gloucestershire Council.

Service overview: Mental Health & Wellbeing Integrated Network Team (MINT) Hub is South Gloucestershire's place-based team bringing together NHS, Social Care and VCSE Partners to provide community mental health support for adults (18+) with complex needs, bridging gaps between primary and secondary care, with a focus on psychological therapies and early intervention.

The team provides integrated, personalised care for people, close to home including specialist services; physical health; young people's transitions; employment and housing.

Impact: 50% increase in the time PCLS are able to spend on interventions (Oct'24). 33% of clients receiving a bespoke pathway across health & social care enabled by the Shared Case Discussion (July'25).

Recognition: BNSSG MINTs were a finalist at the 2025 Health Service Journal Awards within the category 'Integrated Care Initiative of the Year'.

Funded by: BNSSG Integrated Care Board and South Gloucestershire Council.

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

Integrated Care Partnership Board

Agenda item	5b	Meeting date	16 April 2026

UPDATE – SOUTH GLOUCESTERSHIRE HEALTH AND WELLBEING BOARD

1. The next South Gloucestershire Health and Wellbeing Board meeting will be on 23 April and the papers will be available here one week in advance: Agenda for Health & Wellbeing Board on Thursday, 23rd April, 2026, 10.00 am - South Gloucestershire Council.

2. Since the last ICP meeting the Board and Locality Partnership have held two joint development sessions related to the Health and Wellbeing Strategy's year one areas of focus. On 4 February, there was a session on how we shape our approach to Children, Young People and Families' Neighbourhood Health and Wellbeing, which helped to shape our Best Start in Life Plan (published at the end of March and to be shared with the Board on 23 April). On 19 March, there was a session on Housing & Wellbeing at which members discussed proposed principles for ensuring housing is considered in all work; and opportunities to take forward as mandated priorities in 2026-27. A follow up session is taking place on the afternoon of 23 April.

South Gloucestershire Neighbourhood Wellbeing and Health Plan

3. Health and Wellbeing Board senior officers are currently considering DHSC's new Neighbourhood health framework, published in late March. There have been initial discussions with the Board Chair and the Senior Officer Group; and a discussion paper is going to be presented to the Health and Wellbeing Board on 23 April to agree the next steps and a timeline for developing the South Gloucestershire Neighbourhood Wellbeing and Health Plan during 2026-27 so that it is ready to be published at the start of the 2027-28 financial year.

   Work to date

4. In South Gloucestershire we had already started to develop our thinking around place-based working in line with one of our 2025-29 Health and Wellbeing Strategy strategic commitments about 'building a programme of place-based working'. It is also one of the annual focus areas for the first year of the strategy to 'develop a shared vision for place-based working and Neighbourhood Health in South Gloucestershire and support actions to implement this'.

5. The existing partnerships and particularly the close working and aligned priorities of both the Health and Wellbeing Board and Locality Partnership have enabled the collaborative development of a draft plan (Appendix 1) with local partners.

6. Our approach to date has been to build upon work that is already taking place in South Gloucestershire. The slides at Appendix 2, provide examples of neighbourhood working that is already taking place. In addition, we have initiated some enabling work through CVS South Gloucestershire to look at best practice for VCSE Infrastructure organisations and the 'health of the SG VCSE sector'.

7. We have established a Neighbourhood Plan Core Group to continue to develop plans and discussions are taking place regarding arrangements for high level leadership and oversight within the Council.

8. Members of South Gloucestershire Health and Wellbeing Board and Locality Partnership are also working with BNSSG colleagues as part of a Neighbourhood Programme Board to coordinate and support neighbourhood health work at a system level. This includes oversight of an NHS Neighbourhood Development Fund options appraisal and deployment of funds when parameters are agreed.

Issues

9. Within South Gloucestershire, there are different types of boundaries dividing up the area and various ways organisations cluster to deliver services across the patch. Further details are provided here: Views of South Gloucestershire. Through our JSNA, Health and Wellbeing Strategy and other analysis such as the Community Conversations and Healthier Together 2040 work we have a good understanding of our local population at these various footprints, including inequalities and those currently experiencing poor outcomes as well as high users of multiple types of services and opportunities for earlier intervention.

10. Within the Health and Wellbeing Strategy we outline our approach to place-based working as being based around how residents define their local neighbourhood and communities. This may include approaches based around where people live, where they go or shared interests and activities. Within the various strategies, policies and conversations it is clear, that there is no one definition of community, place or neighbourhood and that thoughts on this differ depending on professional background; but more importantly our communities do not see it in the same way.

11. NHS England expects systems to define neighbourhood footprints around natural communities, typically serving populations of around 50,000 people, as the first step in implementing neighbourhood health. Our approach is therefore proposed to be one around Primary Care Network geographies supported by common principles and based on the concept that neighbourhood is a way of working, a culture and an approach to supporting communities. We know that local approaches developed with communities gain deeper understanding of the variety of local assets and challenges; and that there is a strong theme from community insights that residents want more work delivered in this way and a say over things that affect them.

12. Health and Wellbeing Board and Locality Partnership Delivery Group and Board members have been engaged with the development of the South Gloucestershire Neighbourhood approach for some time now. A formal 'place based and neighbourhood working in South Gloucestershire' development session was held on 9 June 2025 and each of the forums have had numerous further focussed sessions on Neighbourhood Health.

13. Partners also came together to collaboratively develop a submission for the first wave of the National Neighbourhood Implementation Programme and whilst South Gloucestershire was not one of the areas selected the submission received positive feedback and provided the opportunity to capture and reflect upon all the existing neighbourhood work being undertaken.

14. BNSSG partners also came together on the 13 November for a Neighbourhood Planning workshop with a view to learn more about the three Health and Wellbeing Board Neighbourhood plans, the similarities, differences and opportunities to develop a BNSSG shared understanding of what we mean when we talk about place, neighbourhood and neighbourhood health.

15. In the absence of the full DHSC Model Neighbourhood Framework the high-level draft South Gloucestershire Neighbourhood Wellbeing and Health Plan was developed as fully as possible and presented to the Health and Wellbeing Board on 15 January 2026. Now guidance has been released the plan will be reviewed.

Next steps

16. During 2026 to 2027 health and care organisations in South Gloucestershire and BNSSG will work with communities and wider partners to develop a full plan that sets out plans to:
    - Tackle unwarranted variation in GP access
    - Improve primary-secondary care interface
    - Establish Integrated Neighbourhood Teams (INTs)
    - Reduce non-elective admissions via urgent, rehabilitation and reablement capacity
    - Start the planning for elective pathways at neighbourhood level
    - Improve outpatient pathways
    - Improve data-sharing arrangements
    - How ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance
    - Outcome measures that cover the whole life course of the individual and reflect both health and social care needs

17. Our immediate next steps include:

    - A detailed review of the Neighbourhood health framework guidance issued in late March.
    - A reset of our approach now that the deadline for the publication of final plan has moved to April 2027.
    - Consideration of how proposed changes to the ICB might impact the plan and future governance and ways of working.

Health and Wellbeing Board Chair: Cllr John O'Neill Cabinet Member for Adults and Homes John.o'neill@southglos.gov.uk	Contact for further info: Kirstie Corns Locality Director for South Gloucestershire Kirstie.corns@nhs.net Sarah Weld Director of Public Health for South Gloucestershire Sarah.weld@southglos.gov.uk

Appendix 1: South Gloucestershire Healthy Neighbourhoods Plan v1

Appendix 2: Examples of neighbourhood working in South Gloucestershire PowerPoint slides

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

Integrated Care Partnership Board

Agenda item	5c	Meeting date	16th April 2026

Title	North Somerset Health and Wellbeing Board approach to Neighbourhood Wellbeing and Health		
Scope: System-wide or Programme?	Whole system	Programme area	Neighbourhood Health and Wellbeing
Author & role	Matt Lenny, Director Public Health David Moss Locality Director		
Sponsor / Director	Jenna Ho Harris, Chair North Somerset Health and Wellbeing Board		
Presenter	Matt Lenny		
Action required:	Discussion and endorsement		
Discussion/ decisions at previous committees	*Please list below all relevant Steering Groups/Boards, along with dates and what decisions/endorsements were made)*		
	3 multi-partner workshops Oct - Jan 2026		

Purpose:

This paper sets out the Health and Wellbeing Board's direction of travel for neighbourhood wellbeing and health in North Somerset. It provides a high-level overview of how partners are working together to shift the centre of gravity towards prevention, community connection, and earlier support through neighbourhood-based working.

The accompanying slides set out the emerging framework that will guide development during 2026/27. The Integrated Care Partnership is asked to recognise this direction of travel, support the Health and Wellbeing Board in its system stewardship role, and enable coherence across neighbourhood approaches locally and across BNSSG.

Summary of relevant background:

North Somerset has a strong and established Health and Wellbeing Strategy, locality partnerships, and a track record of place-based and community-led working. Building on this, the Health and Wellbeing Board is leading the development of a shared neighbourhood wellbeing and health approach that reflects local context, assets and inequalities, while aligning with national NHS neighbourhood health expectations.

The attached framework sets out how neighbourhoods will be understood and supported at different scales, from hyper-local communities through neighbourhood teams and locality partnerships, with the Health and Wellbeing Board providing strategic leadership, outcomes focus and governance. The approach recognises the critical role of voluntary, community and social enterprise partners, lived experience and adaptive ways of working in responding to complexity. Development during 2026/27 will focus on coherence, learning and shared foundations rather than fixed blueprints.

Discussion / decisions required and recommendations:

The Integrated Care Partnership is asked to:

1. **Recognise and endorse** the Health and Wellbeing Board's direction of travel for neighbourhood wellbeing and health in North Somerset, as set out in the attached framework.
2. **Acknowledge the Health and Wellbeing Board's role** in holding the place-based narrative, outcomes and coherence for neighbourhood working across partners.
3. **Support the Health and Wellbeing Board and locality partnerships** to hold themselves together as a system, enabling alignment between neighbourhoods, places and system-level priorities.
4. **Commit to working through the Health and Wellbeing Board** to ensure neighbourhood approaches are coherent individually and collectively, and aligned across all BNSSGG partners, while remaining locally led and community driven.
5. **Note that 2026/27 is a development year**, focused on building shared understanding, governance, evaluation and learning, with further proposals to come forward as the neighbourhood plan matures.

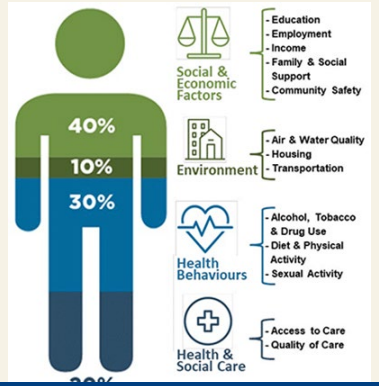
NORTH SOMERSET NEIGHBOURHOOD WELLBEING & HEALTH PLAN 2027–2032

A framework for how we will develop our plan during 2026/27

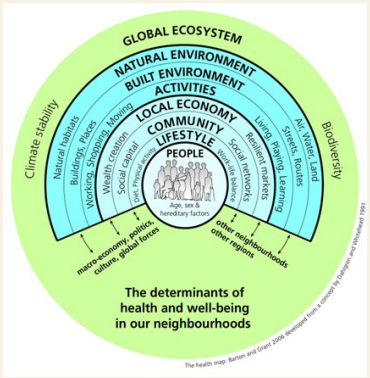
PLAN ON A PAGE

KEY ELEMENTS OF THE NORTH SOMERSET NEIGHBOURHOOD WELLBEING & HEALTH PLAN

Key principles:



We recognise good wellbeing and health is built and developed in everyday life not just health and care services



Thriving neighbourhoods are where people, families and communities are at the centre of how opportunities and support are shaped for different needs.

Neighbourhood health framework - GOV.UK

Vision and Purpose (taken from our Health and Wellbeing Strategy):
Working together to ensure equality of opportunity for everyone in North Somerset to start, grow up, live, work, age and die well and to enjoy good wellbeing and health.

1. What is the ask?

To build a Neighbourhood Health Plan during 2026/27 which puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population.

This includes the services that people rely on close to home, such as GPs and community services and, where appropriate, urgent care, diagnostics and outpatients.

It also includes local authority-commissioned services, such as adult and children's social care and public health services.

2. How will we achieve this?

Leadership from the Health and Wellbeing Board to bring partners together

Building insight from communities and enabling positive change to happen at the most effective place

– hyper-local communities (streets, towns and villages)

- Neighbourhoods/Primary Care Networks (circa 50,000 population

- Locality Partnerships (circa 100,000 population)

- Place (circa 225,000 population)

- With connection to other systems e.g. ICB, Mayoral Combined Authority

3. What can we learn from?

Development and implementation of our Health and Wellbeing Strategy

Leadership and delivery from our two Locality Partnerships

Benefits of nomadic working and system thinking

Creating adaptive spaces for better solutions

National pilot programmes for Neighbourhood Health (including learning from Woodspring and local action in Weston, Worle and Villages)

Emerging national evidence and guidance

4. What does better look like?

Integrated support that meets local population needs effectively

Accessible hubs, peer support, and community spaces to empower residents and simplify access.

A measurable shift from reactive to preventative care and support

Improve services for people who need routine healthcare, so neighbourhood health benefits everyone

Improve proactive care for people with complex needs

Deliver better alternatives to hospital care

Measuring impact: During the 2026 to 2027 financial year, Health and Wellbeing Boards will work with communities, health and care organisations and wider partners to establish outcome measures that cover the whole life course of the individual and reflect wellbeing, health and social care needs.

LONGER VERSION

A REMINDER: OUR HAWB STRATEGY

The strategy is centred around five key approaches to improving health and wellbeing:

1. prevention - ensuring children have the best start in life and preventing health and wellbeing problems throughout life
2. early intervention - intervening as early as possible to address any health and wellbeing needs in people's lives
3. holistic action and support - implementing person-centred action on all factors that influence people's lives
4. healthy and caring communities - empowering people and communities to be connected, healthy and resilient through strengths-based approaches, trauma-informed practice, and engagement and involvement
5. tackling inequalities - prioritising action to ensure equal opportunity access to services, experience, and outcomes, to reduce inequalities between groups.

A REMINDER: OUR HAWB STRATEGY

Across these approaches, we will address the following priority themes:

- mental health and wellbeing
- food, nutrition and oral health
- tobacco, alcohol and drug use
- being active
- core determinants of health
- healthy places and communities.

A REMINDER: OUR HAWB STRATEGY

The strategy also highlights seven guiding principles that will underpin our partnership working across North Somerset:

1. partnership, collaboration, co-design and co-production
2. a focus on tackling inequalities
3. taking a place-based approach
4. using data, intelligence and insight to drive decision-making
5. connecting people and sharing and building power with communities and building on local strengths
6. using trauma-informed and compassionate approaches to improving health and wellbeing
7. being anti-racist and taking a pro-equity approach through all that we do.

VISION AND PURPOSE

This plan is a local delivery vehicle for the ambitions agreed in the Health and Wellbeing Strategy as well as a method for delivering the ambitions in the NHS 10-year plan.

Our Vision

- Everyone in North Somerset can start well, live well, age well and die well.
- Neighbourhoods create the conditions for good wellbeing throughout life.
- People feel connected, safe, supported and able to thrive.

Our Purpose

- Improve wellbeing and health outcomes.
- Reduce inequalities that are persistent across communities.
- Shift the centre of gravity toward prevention, community connection, and earlier support.
- Bring services, systems and communities together around what matters locally.

What this plan does

- Sets a shared North Somerset approach.
- Builds on HWBB strategy and Locality Partnership work.
- Aligns with NHS direction but remains place led and community driven.

WHAT IS THE ASK?

- To build a Neighbourhood Health Plan during 2026/27 which puts the person at the centre of how we deliver their health and care by organising services so they can work together to serve a defined population.
- This includes the services that people rely on close to home, such as GPs and community services and, where appropriate, urgent care, diagnostics and outpatients.
- It also includes local authority-commissioned services, such as adult and children's social care and public health services.
- To ensure Voluntary Community and Social Enterprise (VCSE) are at the heart of Neighbourhoods recognising the trusted spaces they create that services often are not able to achieve.

WHAT IS THE ASK?

Stage 1: immediate changes in the 2026 to 2027 financial year

ICBs will need to ensure the NHS delivers the minimum basic requirements in 2026 to 2027, as well as laying the groundwork for more fundamental reform. As part of this, ICBs and HWBs should start developing and embedding new ways of working with local government and wider partners in 2026 to 2027 to start jointly developing their approach to neighbourhood services in their area. These minimum basic requirements are:

- agree an initial plan to reduce non-elective admissions and bed days by increasing the capacity of urgent, rehabilitation and reablement services at neighbourhood level, based on patient risk register analysis
- agree a plan for tackling unwarranted variation and improving access to general practice, ensuring core hours requirements as defined in the national GMS contract are met, including the newly introduced urgent access requirements
- agree neighbourhood footprints around natural communities for the future development of INTs
- agree plans to establish INTs focused on high priority cohorts, including how devolving care budgets could work in their area
- start to plan for a new neighbourhood approach for elective pathways with detail on how they can contribute to meeting the RTT standard and how they would use a devolved commissioning budget for outpatients for their population
- confirm plans to meet 18-week community waits and eliminate 52-week waits.
- confirm how ICBs and local authorities intend to use pooled funding under the Better Care Fund (BCF) in line with BCF guidance (noting that any funding decisions must also be consistent with the national conditions for the fund, including the required increases in ICBs' minimum contributions to adult social care over the next 3 years)
- continue to improve the primary and secondary care interface in line with the red tape challenge
- confirm organisational ownership of planned deliverables
- confirm plans for having the appropriate data-sharing arrangements in place to do robust patient identification and evaluation

Regional teams will work with ICBs on progress against the essential actions. ICBs are requested to ensure these are completed as soon as possible.

WHAT IS THE ASK?

Stage 2: longer-term reform (April 2027 to March 2029)

In parallel to stage 1 and over the longer term, the NHS and local authorities must work together with partners to deliver the fundamental changes we want to see. For implementation from at least the 2027 to 2028 financial years, ICBs should work with HWBs and their partners to develop a locally owned neighbourhood health plan.

Once agreed with HWB partners, the plan will need to:

- provide a broad overview of how the national NHS objectives will begin to be delivered through the 3 reform agendas outlined above
- set out how neighbourhood health will support wider local goals to improve health outcomes and reduce health inequalities, and deliver on any locally agreed wider public service reform agendas
- set out how local objectives are informed by the JSNA, and any other assessments by ICBs or local authorities, as deemed necessary by them and the HWB
- confirm final geographies that partners will then work within
- confirm which organisations are responsible for different elements of delivery
- confirm the arrangements that will be in place to deliver this, including governance and operational partnership arrangements
- confirm how any other relevant initiatives align with the strategy (such as Best Start Family Hubs, housing, mental health hubs, Pride in Place and employment support)

Once this is agreed, the ICB will incorporate this locally owned plan into their refreshed 5-year strategic commissioning plan, in line with the strategic commissioning framework, which will be the formal NHS commissioning strategy for neighbourhood health. Systems are expected to go beyond the measures outlined in this framework (for example to develop the role of neighbourhood health in prevention) if they choose to do so.

WHY NEIGHBOURHOODS?

National context

- NHS shift: hospital → community; sickness → prevention; analogue → digital.
- Integrated Neighbourhood Teams becoming the delivery platform for much of the NHS 10-year plan.
- Emphasis on population health, personalised care and multi-agency response.

Local reality

Wide inequalities in health and wellbeing outcomes, with some areas ranked among lowest in the country

- North Somerset is ageing faster than much of the South West.
- Frailty levels rising, particularly in Woodspring.

Complex care needs for children and families

- Increasing demand for urgent and hospital services unsustainable long term.
- Rurality and geography create access barriers.

Community voice

- People want earlier help, easier access, stronger belonging, and joined up support.
- Lived experience calls for connection, compassionate spaces, and autonomy.

WHAT ARE NEIGHBOURHOODS?

Neighbourhoods are:

- The smallest meaningful scale where lives, services and relationships intersect.
- Geographies aligned to PCN footprints but connected to communities of identity, interest and experience.
- Places where people naturally gather and define how wellbeing is shaped.

Neighbourhood health brings together:

- General practice, community health, mental health, social care, VCSE.
- Prevention, early help, and non-clinical support.
- Community-led initiatives and creative health.
- Lived experience and local priorities.

Our definition is flexible, responsive to rurality, coastal identity, hidden deprivation and community voice.

STAY ROOTED IN REALITY

As an example, a summary of themes from workshops, lived experience, VCSE partners and locality engagement:

- “I want support before things get bad.”
- “Help should be local, familiar, human and joined-up.”
- “We need better access to mental health and earlier support.”
- “Transport and geography make everything harder.”
- “I want to feel connected, valued and part of something.”
- “Listen to us, don’t design things without us.”
- Strong appetite for:
  - Creative health, social prescribing, peer support.
  - More community spaces.
  - Help around grief, trauma, dementia and ageing.

HAWB LEADERSHIP

HAWB provides strategic leadership through:

- **Prevention**: Best start in life, lifelong wellbeing.
- **Early intervention**: Respond before crisis.
- **Holistic action**: Whole-person and whole-community approaches.
- **Healthy & caring communities**: Strengthening resilience and belonging.
- **Tackling inequalities**: Improving access, experience and outcomes.
- **Place-based approaches**: Local strengths, local identities, local leadership.
- **Trauma-informed, compassionate practice**.

This plan is a local delivery vehicle for the ambitions agreed in the Health and Wellbeing Strategy as well as a method for delivering the ambitions in the NHS 10 year plan.

A CONNECTED SYSTEM

A connected system built from the ground up:

1. Communities (residents, groups, VCSE, lived experience)

Rooted in belonging and agency.

Source of insight, creativity, solutions and trust.

2. Neighbourhoods (PCN footprints 30k–50k)

Integrated health, VCSE and council teams.

Deliver proactive support, prevention, personalised care.

Connect services to local identity, culture and assets.

3. Locality Partnerships (Woodspring & Weston)

Multi-sector leadership groups (“place-based partnerships”).

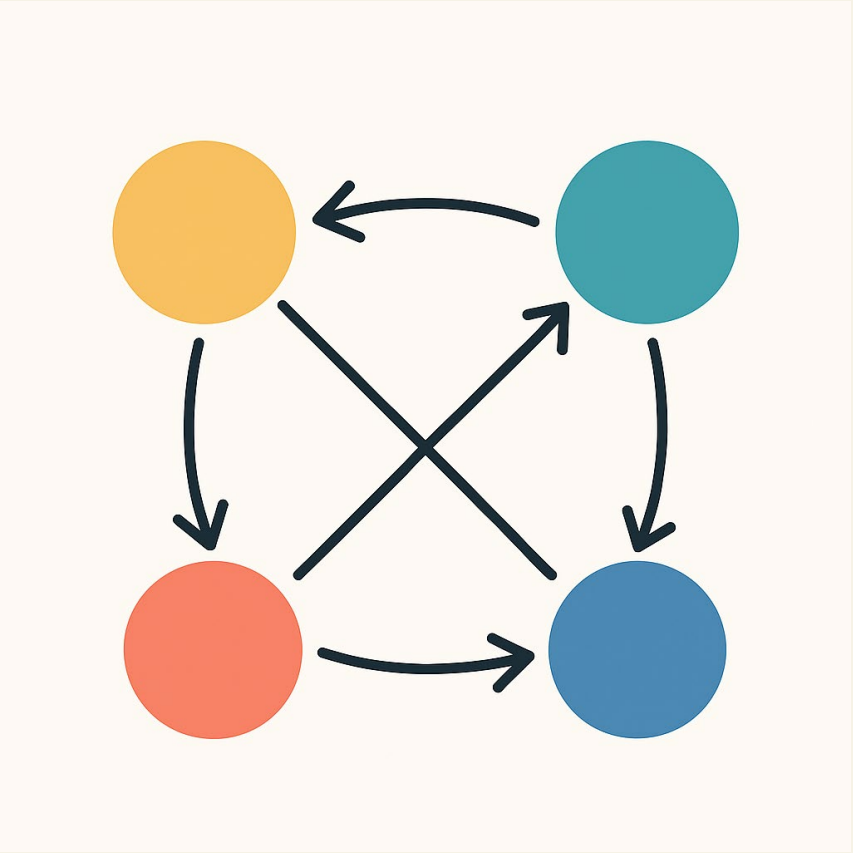
Align resources, share risk, design pathways, convene the system.

Enable innovation, collaboration and local investment.

4. Health & Wellbeing Board

Sets outcomes, priorities, governance, inequalities goals.

Holds accountability for population wellbeing.

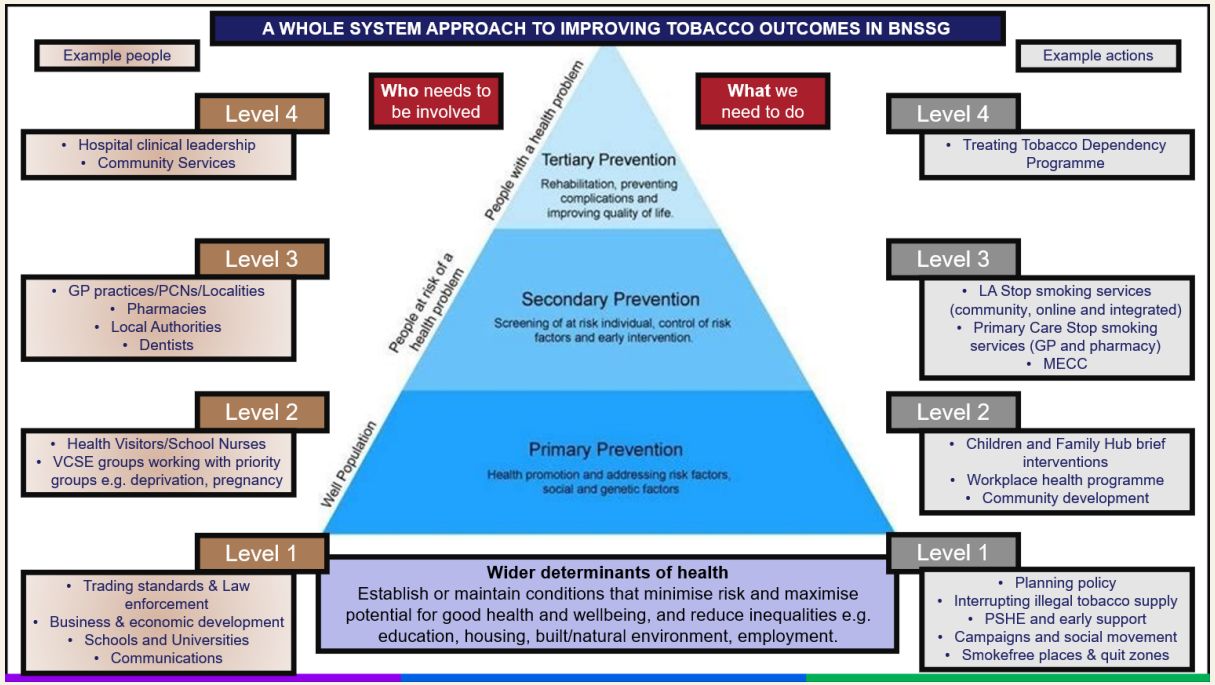


With connection to other systems e.g. ICB Cluster, Mayoral Combined Authority, Local Resilience Forum etc.

PREVENTION AT ALL LEVELS

What we need to consider:

- What builds and maintains everyday good wellbeing and health? – *Also known as the wider determinants of wellbeing and health.*
- How do we intervene more quickly if people are at higher risk and may need help (in a way that is possible and meaningful for them)? – *Also known as primary prevention*
- How do we get good support and treatment to those with enduring needs/long term conditions to protect their health and improve the quality of their life? – *Also known as secondary prevention*
- How do we support people with more acute needs back into a stable state and maximise their health and wellbeing for as long as possible? – *Also known as tertiary prevention*



A recent good example of this system approach, across all elements of wider determinants and prevention is our Smokefree Generation programme. The image below shows how action is required across a wide range of partners, with different roles and actions working together to have greater impact across the population and tackling the inequalities in outcomes between different cohorts at the same time.

WHAT CAN WE LEARN FROM (1/4)

Locality Partnerships have already shown how they can enact change:

- Act as convenors across health, VCSE, council, communities.
- Hold place-level insight about assets and gaps.
- Build shared priorities and coordinate investment.
- Provide governance, accountability and alignment.
- Champion community-led solutions.
-

Their role is to:

- Create cross-sector capacity.
- Enable integrated pathways.
- Support neighbourhood teams to operate effectively.
- Broker relationships and build the conditions for trust.

WHAT CAN WE LEARN FROM? (2/4)

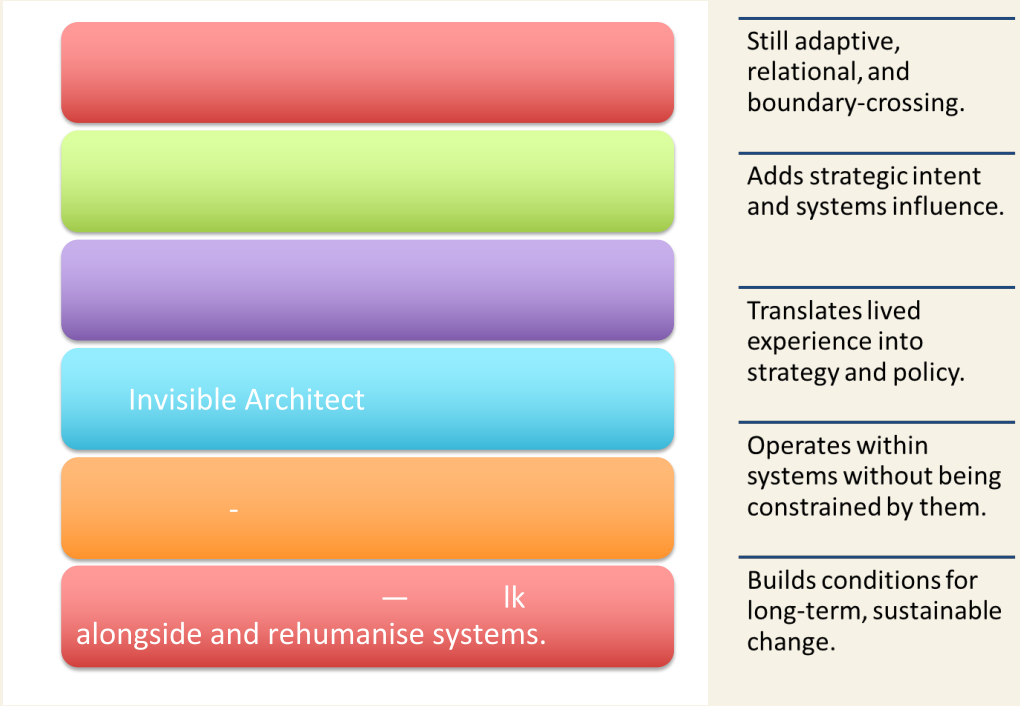
Nomadic Working

The North Somerset way of working across boundaries:

- Moves fluidly across services, organisations and communities.
- Acts as relational glue and connective tissue in complex systems.
- Sees patterns, opportunities and emerging signals.
- Translates community insight into system action.
- Maintains trust and holds shared purpose.

Why it matters for neighbourhoods:

- Complexity cannot be solved by rigid structures alone.
- Nomadic roles broker connection where systems are fragmented.
- Creates belonging and shared ownership.
- Humanises decision-making and brings nuance to strategy.



Traits of strategic nomadic working

WHAT CAN WE LEARN FROM? (3/4)

Adaptive Space is where transformation happens:

- A safe, relational “in-between space” where organisations learn together.
- Supports experimentation, dialogue and testing ideas.
- Cross-sector, cross-professional and community-inclusive.
- Why it matters now:

The system is pressured; adaptive space helps manage tension.

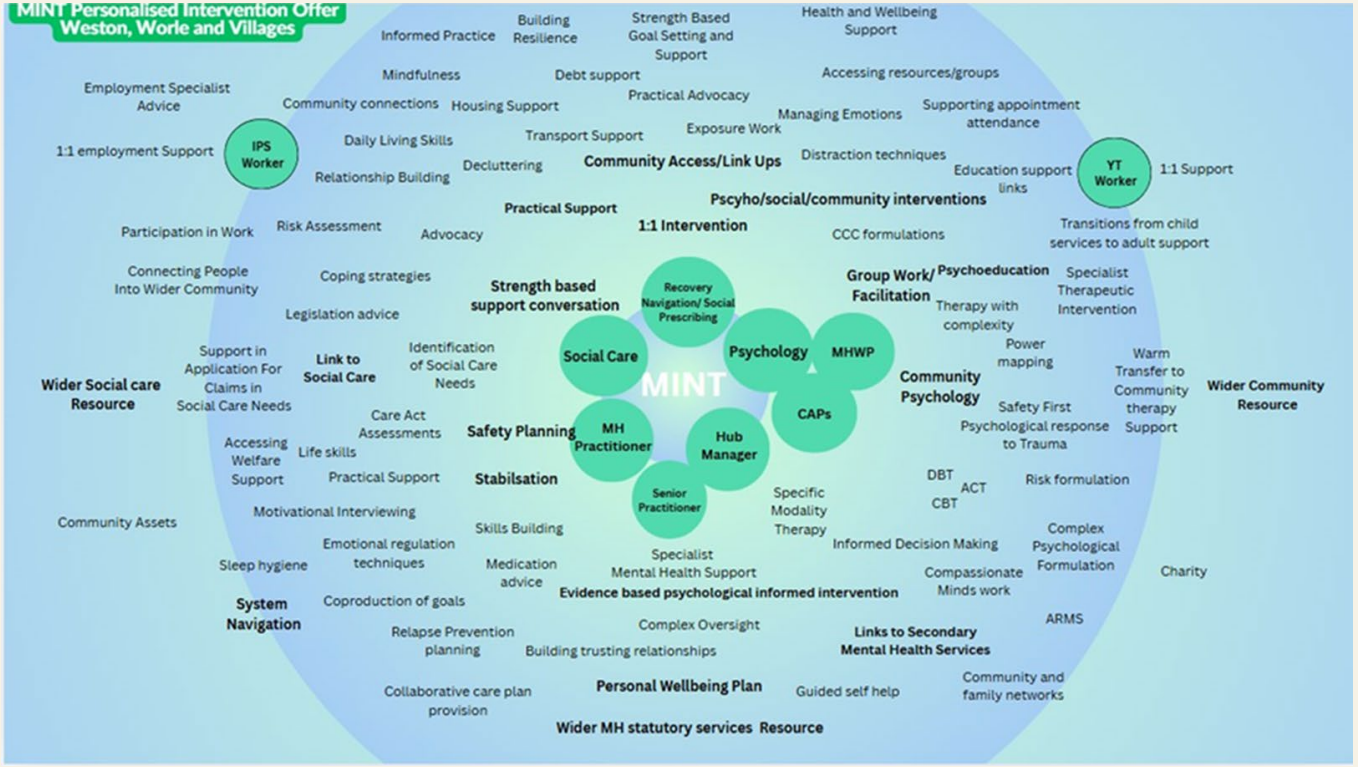
- Enables “test and learn” without waiting for permission.
- Allows complexity to be worked with, not shut down.
- Builds the cultural foundation needed for trust and shared action.

In North Somerset this includes:

- Locality Boards and workshops.
- Neighbourhood huddles.
- Community-led events.
- Shared learning sessions.
- Creative enquiry and lived experience panels.

WHAT CAN WE LEARN FROM?

1. Mental Health Integrated Network team (MINT) – Integrated Neighbourhood Working (Case Study)



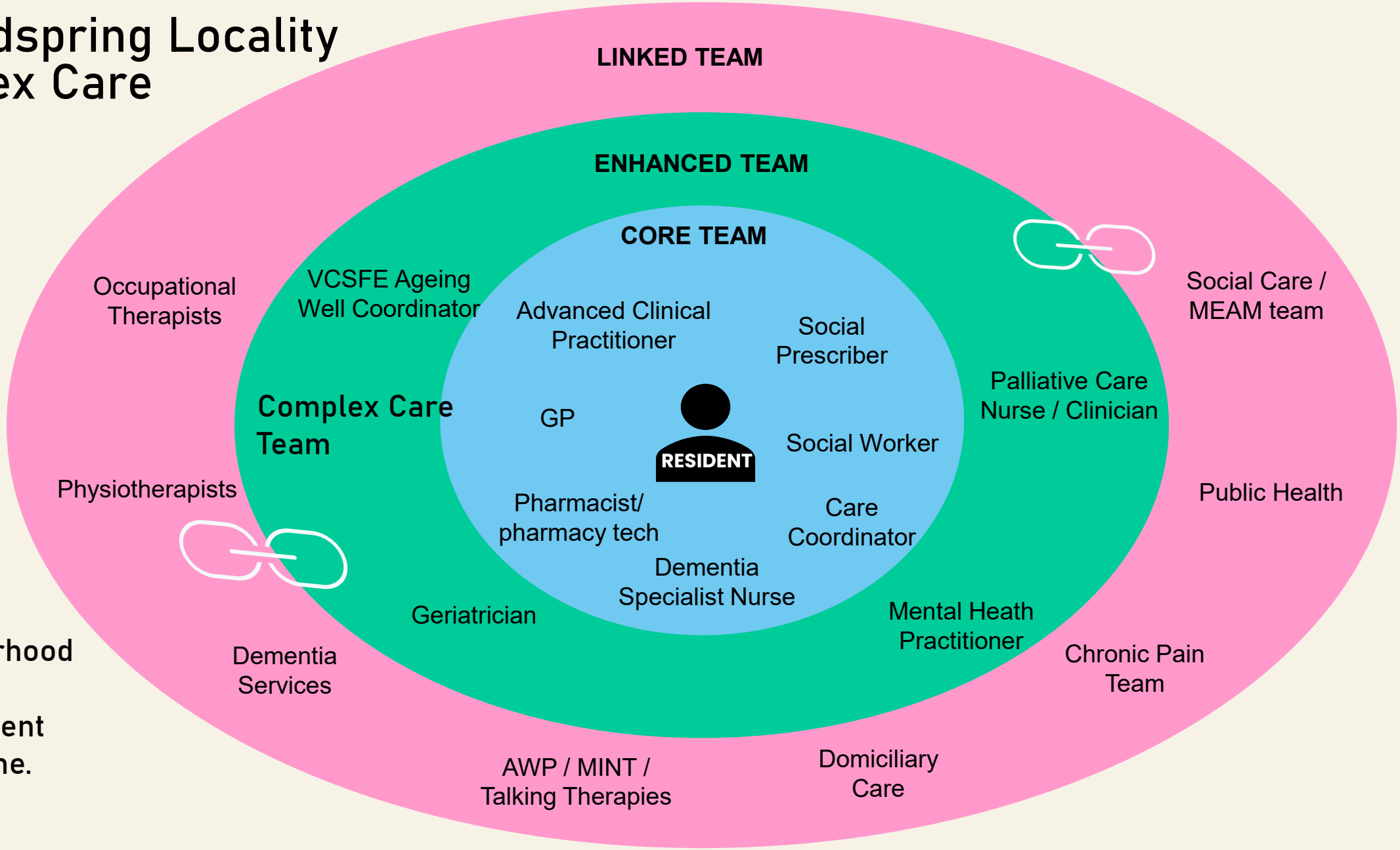
Single integrated team working across sectors - Mental health practitioners work day-to-day with GPs, community services, VCSE and social care as one neighbourhood team, without referral or hand-offs.

Whole-person support at neighbourhood level - Mental health is addressed alongside physical health, social needs and wider determinants, based on what matters to people locally.

Flexible and adaptive, not pathway-driven - The team adapts to local need, testing and shaping responses in real time rather than operating fixed referral pathways or service thresholds.

Builds integration into everyday practice - Shared working, trust and learning across partners become the norm, strengthening neighbourhood delivery beyond mental health alone.

2. Woodspring Locality Complex Care Team



National Neighbourhood Health Improvement Programme.

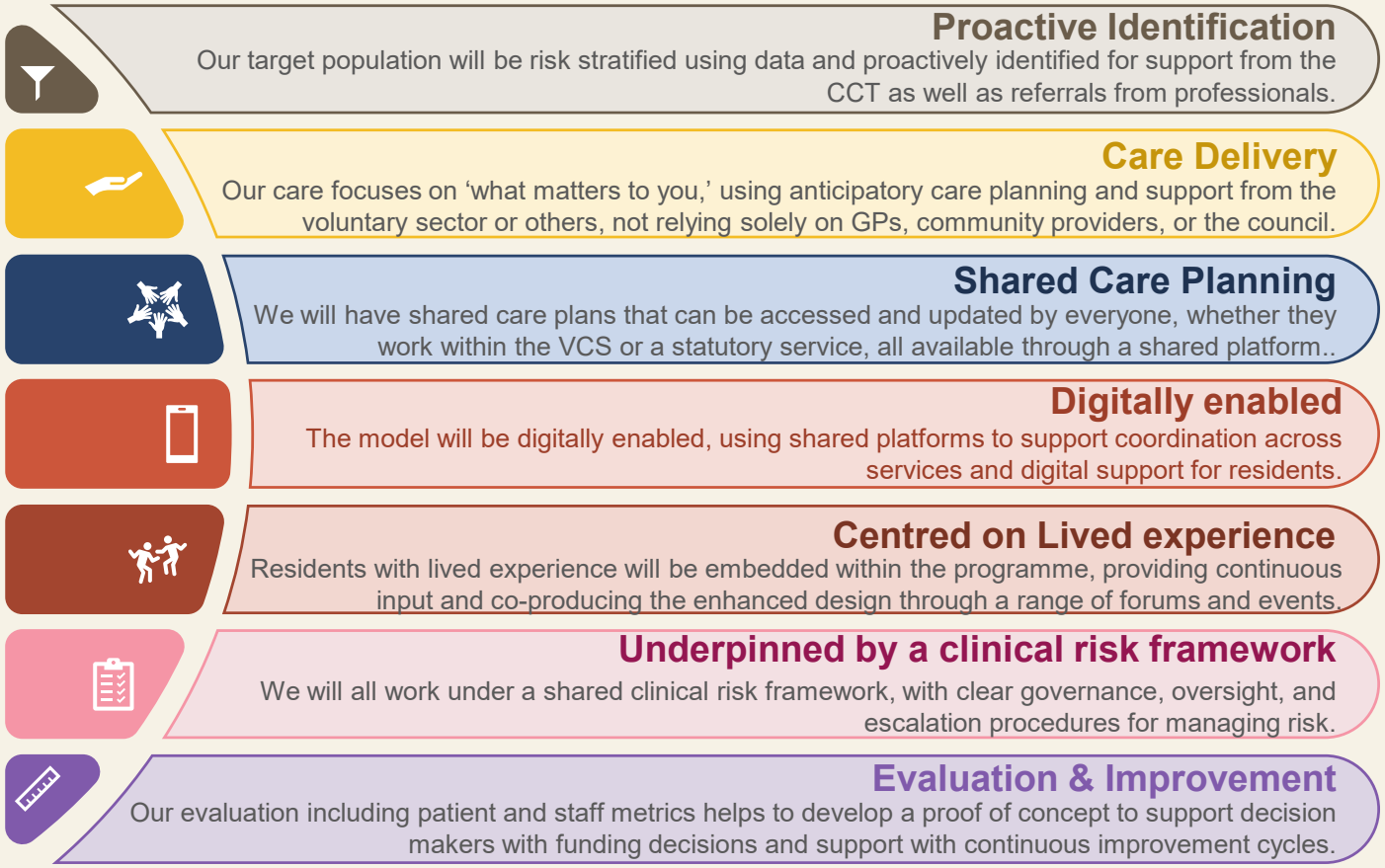
We have an extensive team, with some members forming the core MDT, others providing enhanced support, and others linking in the core team when required.

Complex Care Team continued

The ambition:

A truly **anticipatory** neighbourhood care model for people **aged 65+ in CMS segment 4**, delivering best-practice proactive care planning based on "**what matters to you?**".

A systematised, patient- centred approach, **co-produced with residents**, that anticipates risk, plans early, and ensures consistent follow-up over time.



Woodspring Locality Partnership investing in cross sector test of change under the National Neighbourhood Health Improvement Programme.

3. PROFFS is a Primary Care Osteoporosis, Falls & Frailty Screening programme

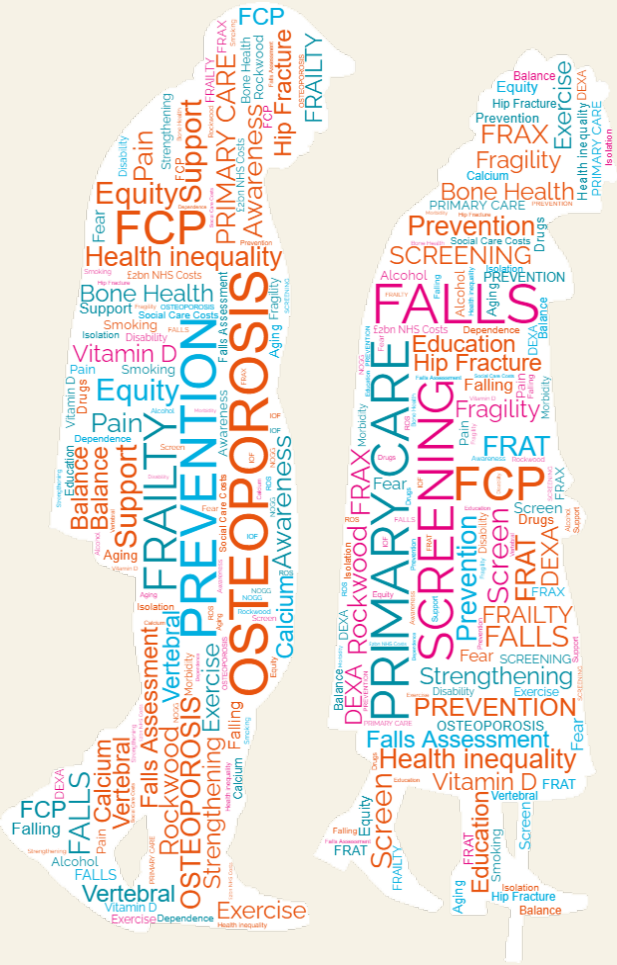
Mary's Story

Mary, a 79 year old wife and carer responded to the PROFFS questionnaire as she had previously fallen and was becoming increasingly worried about her balance and falling over. She did not want to bother her GP about it, her husband was more important, having suffering a life-changing stroke. Prior to his stroke, Mary was fit and active and enjoyed going to the gym with her friend. Her friend, however, sadly passed away during COVID.

Mary has no children and after COVID and her husband's stroke, her friendship circle diminished. Corinne was the first person she had spoken to in over a week. Despite reaching out through the PROFFS questionnaire, she downplayed her falls risks as all she could think about was her husband.

Taking time and with empathy and care, Corinne was able to discuss her needs and arranged for her to have routine blood tests. She put her in touch with the social prescribing service for support as a carer, financial advice and because she was lonely.

Mary could not see any way to get more active especially as she had limited respite time. But by working through her problems with Corinne, Mary was able to come up with solutions herself and through this the PROFFS Balance Exercises and Information Pack was co-developed.



WHAT DOES BETTER LOOK LIKE?

Examples.....

1. More care closer to home

- Integrated Neighbourhood Teams aligned to PCNs.
- Earlier interventions for frailty, long-term conditions, mental health.
- Stronger links between health, VCSE and council services.
- Strengthen community transport

2. Stronger wellbeing and prevention

- Creative health programmes (Good Grief, community arts, storytelling).
- Social prescribing expansion.
- Falls prevention, healthy lifestyles, dementia-friendly initiatives.

3. Easier access & navigation

- Local access points and community anchors.
- Clearer signposting to clinical and non-clinical support.
- Co-located or linked-up multi-agency hubs.

4. Connected, resilient communities

- Peer support groups.
- Community-led microgrants.
- Belonging, safety, connection, identity.

MEASURING OUR IMPACT

National ask:

During the 2026 to 2027 financial year, Health and Wellbeing Boards will work with communities, health and care organisations and wider partners to establish outcome measures that cover the whole life course of the individual and reflect wellbeing, health and social care needs. The listed NHS national goals are listed as below.

Goal 1: improve health outcomes

We aim to improve health outcomes with specific focus on high-priority cohorts

Goal 2: improve access to general practice

We aim to improve access to general practice so people can see their GP in a timely, high-quality way.

Goal 3: improve experience of planned care

We will improve experiences of planned care and cancer care, and support delivery of the referral to treatment (RTT) standard

Goal 4: better urgent and emergency care performance

We aim to improve urgent and emergency care (UEC) performance in line with agreed standards, including improving ambulance response times.

Goal 5: improve patient and staff satisfaction

We want to improve patient and staff satisfaction with NHS services.

MEASURING OUR IMPACT

For all partners in North Somerset, our approach reflects the following key characteristics.

We measure:

- Trust, collaboration and shared purpose across partners.
- Earlier identification, prevention impact and activation of support.
- Access, experience and outcomes across neighbourhood teams and community pathways.
- Community belonging, participation, confidence and resilience.
- Reductions in unwarranted variation between neighbourhoods.
- Outcomes that reflect real change in people's lives.
- The enabling conditions for transformation: participation, connection, psychological safety and shared behaviours.
- Neighbourhood readiness, maturity and strength of multi-agency working.
- Equity of investment and reach into underserved communities.
- Scalability and adaptability of neighbourhood models.

How we evaluate:

- Mixed-methods: quantitative data, stories, lived experience and behavioural insight.
- Regular learning cycles to surface patterns, signals and early wins.
- Shared dashboards and insight products to support transparent, collective decision making.
- Resident voice embedded through panels, enquiry, and co-designed indicators.
- Theory of Change approaches to link investment → activity → enabling conditions → outcomes.
- Real-time learning rather than static KPIs or retrospective judgement.
- Evaluation of partnership behaviours, trust, pace, participation, shared risk and problem-solving as core markers of neighbourhood effectiveness.

Shared evaluation framework created through Locality Partnerships, and more can be read hear: - Eval-framework-LPs-report_guidance-7fa782b15c6390f5.pdf

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

Integrated Care Partnership Board

Agenda item	6	Meeting date	16/04/2026

Title	Intelligence Centre Update			
Scope: System-wide or Programme?	Whole system		Programme area (Please specify)	Intelligence Centre
Author & role	Kerrie Darvill, Intelligence Centre Programme Director			
Sponsor / Director	Jo Medhurst, Chief Population Health Improvement Officer			
Presenter	Kerrie Darvill & Charlie Kenward			
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)* • BNSSG Digital Delivery Board (DDB) • Finance, Estates & Digital (FED) Committee • ICB Board The above all strongly support the Intelligence Centre programme, which resulted in FBC final approval in March 26. Two topics will be carried forward to have oversight at the new redesigned FED committee – these relate to resource alignment with the cluster transition plans and system leadership transformation engagement.			

Purpose:

The purpose of this paper is:

1. To provide an overview of the Intelligence Centre vision
2. To update on programme progress made to date
3. To share key next steps.

Summary of relevant background:

As a transformed ICB, we want to be a world class strategic commissioner. Only by commissioning services strategically will we deliver the 'three shifts' set out by the government – from hospital to community services, from analogue to digital, and from treatment to prevention. Also, only by commissioning services strategically will we improve the health of our population, reduce inequalities, and improve service quality.

To do that, we need joined-up information about the communities we care for. The Intelligence Centre is the engine that enables us to do that. This fundamental shift

will transform how we work, by digitising core business processes to ensure that we truly become insights driven and put intelligence at the heart of our decision making.
Discussion / decisions required and recommendations:
The ICP Partnership Board is asked to consider the updates and provide any suggestions that will support the successful delivery of this change.

Healthier Together Intelligence Centre

Programme Update April 2026

The need for an Intelligence Centre

The way we currently work – both as an ICB and as system partners will not take us together into the future that we all want to create.

We can't continue much further with existing practice, and it will become limiting to try and continue developing what we have without improved infrastructure. We are also facing the reality of significant reductions in ICB headcount, with ambitious savings targets across the rest of the NHS. It is now expected that all ICBs now work towards introducing an Intelligence based approach, which results in this programme facilitating the required change to meet the strategic needs of the ICB.

In BNSSG we are a national leader in population health insights, but:

- the information is not widely available for our partners or patients/public
- we don't have the truly joined up information about the communities we care for that we need to be effective strategic commissioners
- data is stored in different organisations, in different departments, in different formats, and saved in different systems
- we have data sharing agreements and arrangements, but we don't share data well
- we have Connecting Care in order to provide direct care to people, but it is focused on sharing patients' clinical records, not strategic or operational insights
- our processes are manual and often slow, clunky, and prone to delay. We will have all experienced challenges finding the information we need
- we tend to use manual processes for working across organisations and these only use digital tools on a small scale
- lastly, only ICB colleagues can easily see the combined data about the care that people receive, and we want to open that up so that our partners can see it, so that we are transparent about our decisions, and so that we can collaborate on solutions to the challenges we face together.

It will democratise our combined information, analysis, and insights across the ICS. We will be able to tailor health and care services much more responsively, and test new ways of providing care on a population basis over the long term.

We will be able to harness and use information in a way that we simply haven't been able to do before. There are capabilities it provides that we can envision today, and there are opportunities it will create for years into the future that we can't necessarily envision yet.

It gives us the opportunity to embrace that future that we wouldn't otherwise have.

How this will work

The Intelligence Centre will be made up of a series of technologies that are connected together to enable us to take advantage of the benefits that a combination of tools can provide. Both quantitative and qualitative automated data feeds into the Intelligence Centre from partners. Partners will be able to access and extract information, managed by role based controls. Data quality status will be transparent to users alongside data to support informed use.

This sits above all the systems we use - with their different firewalls, different file formats, different operating systems and enables us to share and use information in a consistent, accessible, transparent way across our health and care system. The access to the Intelligence Centre will be via a single web portal to provide a seamless user experience.

It will automate and speed up some of our current clunky, long-winded, administrative processes for getting information. It will enable quicker answers to questions that we need to make better informed decisions.

Digital processes will be developed to facilitate new ways of working, to support a step-by-step approach to include insight consideration. The Intelligence Centre products/tools to be developed will focus on ICB led change. System partners can also utilise the technology for their system working initiatives, but will need to resource this enabling work appropriately.

The right time to do this

It is acknowledged that there is currently a significant amount of change being experienced due to ICB cluster transition, system partner transformation, NHS England changes etc. However, it is considered vital to continue to progress and prioritise this work now as it's a key enabler to future successful operations (both as a commissioner and a mechanism to maintain relationships).

The programme has already started to involve Gloucestershire ICB digital leadership colleagues, with an aim to move towards cluster wide scope in the coming months.

Progress that's been made

Over the last few years, foundations have been put in place to get us ready for this transformational change. These have included:

- IG Committee – system wide Information Governance leads working together to standardise and streamline processes
- Information Sharing Charter – system partners becoming charter members to commit to data sharing safely
- Data Leaders – system wide data leadership working together to implement technology and processes to benefit all
- Robust digital transformation methodology and programme approach
- Federated data platform – gained understanding of this nationally provided technology and introduced required governance processes
- Stakeholder engagement – to ensure that the Intelligence Centre adapts to continue to meet need
- Urgent care tools – work is underway to introduce a new system control centre product
- Business case – Outline Business Case and Full Business approval
- Specialist expertise – selected a partner to work with us to ensure we safely utilise and manage the best technology possible.

What's next

The next stage in our journey is to design and build the Intelligence Centre environment itself. The activities relating to this will involve implementing the technology, transferring existing data, dashboards etc and setting up new data flows.

Also, work has started to redesign and digitise our core processes over the next three years. Priority developments are strategic commissioning (including neighbourhoods), contracting, VCSE brokerage and maternity.

The future reality

We will be able to allocate funding appropriately, see the impacts of change on outcomes quickly, including on inequalities, and amend services if needed, and then check the outcomes position in the future.

This is about shared intelligence, improved decision-making, and better outcomes. It won't just mean we can get better answers when we ask questions of our data – it will mean we can ask better questions.

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

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Intelligence Centre Update

Integrated Care Partnership Board

16 April 2026

Our shared vision…..

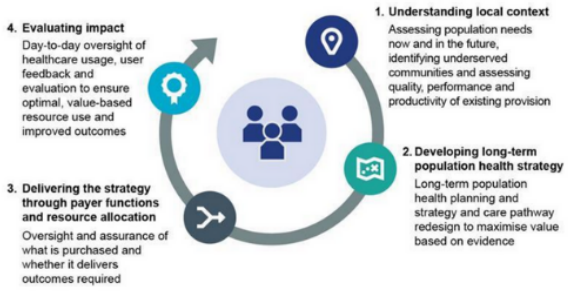
Through data-driven strategic commissioning we will improve health outcomes and reduce inequalities for the population we serve

World class commissioning depends on *shared intelligence*

The Intelligence Centre

The shared insight that powers strategic commissioning

Strategic commissioning cycle to improve population health



Benefits of the Intelligence Centre

Shared understanding and alignment

- A single, shared view of population need and outcomes
- Consistent definitions, baselines and measures
- Decisions aligned across partners and priorities

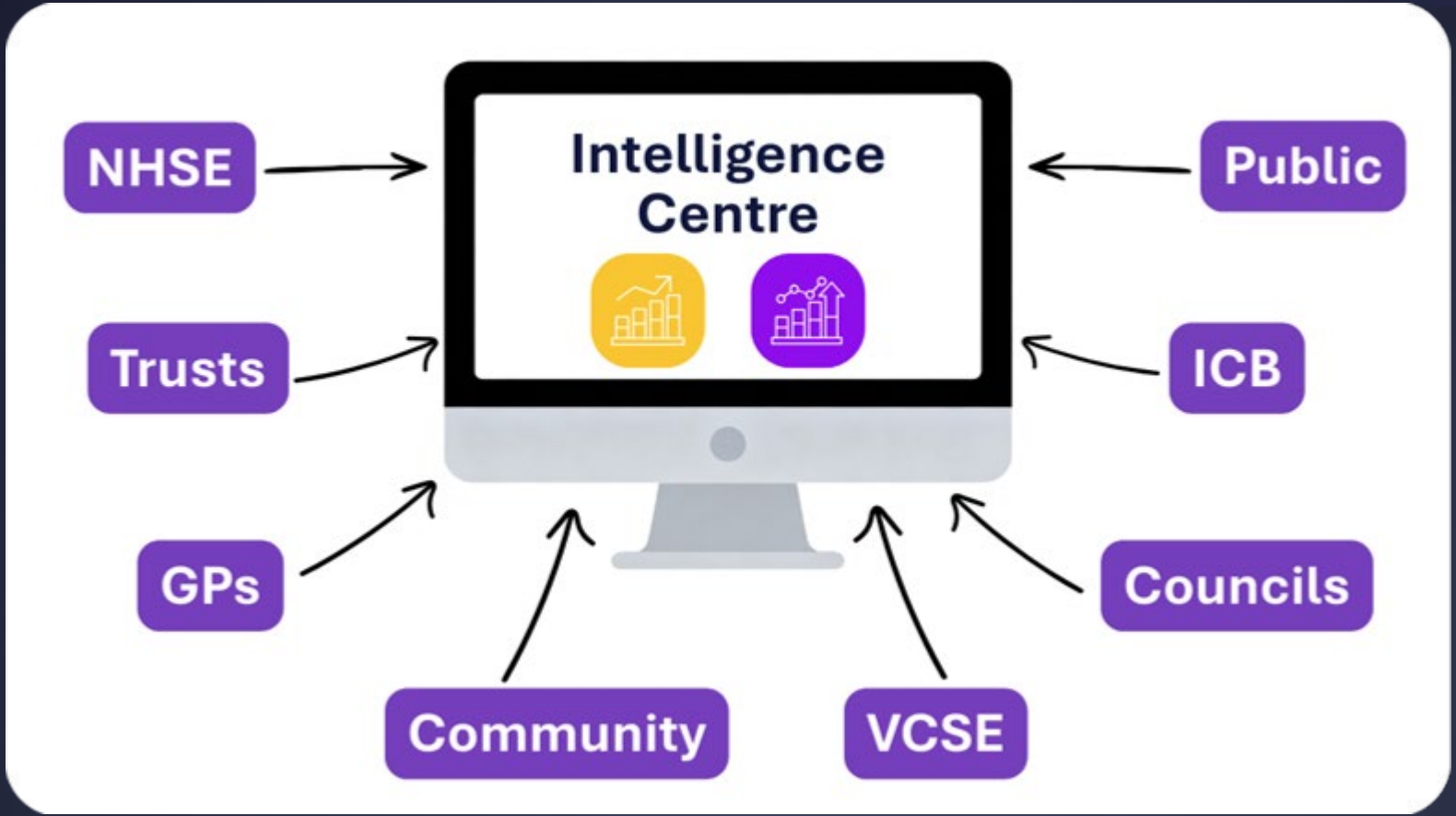
Confident decisions and targeted action

- Resources directed to greatest benefit and reduced variation
- Pathway redesign informed by insight, demand and equity
- Change programmes guided by timely evidence

Continuous learning and improvement

- Impact assessed quickly and credibly
- Variation identified early and acted on
- Feedback loops from delivery to strategy as standard

Simple access



The status quo is no longer an option. The Intelligence Centre is *how* we move beyond the status quo

From data by exception to **data by default.**

From fragmented systems to **joined-up insight.**

From manual effort to **repeatable, scalable intelligence.**

Shared intelligence. Quality decisions. Better outcomes.

World class strategic commissioning – by design.

How this will work

- Technologies that connect together
- Single web user portal
- Automated data feeds from system partners
- Transparent data quality status
- System partners can access and extract data
- ***Digitised core business processes***

Progress so far

- Information Governance
- Data leadership
- Programme & digital transformation
- Stakeholder engagement
- Urgent care tools – System Control Centre
- Business cases
- Specialist expertise

Key next steps

- Intelligence Centre build
- Existing data and outputs (dashboards etc.) transfer
- New data flow mechanism
- Digital process redesign priorities:

➢ Strategic commissioning (including neighbourhoods)
➢ Contract management
➢ VCSE brokerage
➢ Maternity

Shared intelligence.
Quality decisions.
Better outcomes.

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

Integrated Care Partnership Board

Agenda item	7a	Meeting date	16 April 2026

Treating to Prevent: Bristol Director of Public Health Annual Report 2025
Annual Director Public Health Report

1. **Introduction:** This report focusses on the prevention of ill health. It is written at a time when local authorities, the NHS and community and voluntary sector partners are working together to deliver Neighbourhood Health as a core part of the NHS 10-year plan. At the same time Integrated Care Boards are becoming Strategic Commissioning Organisations. The shift from sickness to prevention is necessary for health outcomes but it is also essential for the sustainability of the health service.

   Within this context the report focusses on the inequality of access to and uptake of health interventions which contribute to the differential gap in health outcomes. In particular, the report highlights a menu of well evidenced 'best buys' in relation to disease prevention which are affordable, and doable, within health and care settings, and within our communities.

2. **The prevention challenge:** People are living longer but spending longer in poorer health. Deaths from preventable causes are starting to increase after many years of steady decline. The gap in life expectancy between the most and least deprived areas for females is 4.6 years and 8.3 years for males.

   The gap in life expectancy, and in healthy life expectancy, is caused primarily by three groups of conditions circulatory diseases, cancers and respiratory disease.

   These three groups of conditions share common risk factors which can be prevented or reduced such as smoking, harmful alcohol consumption, unhealthy weight and diet, and being physically active. There are also multiple early intervention points, including medication which can prevent, reduce and delay the progression of disease.

3. **What works?** The report looked at the evidence for preventative interventions to understand how our health and care system can get the best value from prevention. Interventions for early identification and early intervention for major conditions affecting health in Bristol have been assessed across three dimensions:

   - Evidence of impact - What measurable health outcomes does the intervention deliver?
   - Value for money -Is the intervention cost-effective, or does it deliver a strong return on the investment (ROI)?
   - Equity impact: what do we know about the intervention helping reduce health inequalities?

4. **Addressing Inequalities:** Despite the availability of many effective, evidence-based secondary prevention interventions, people living in more deprived circumstances and minority ethnic groups experience significantly lower uptake, delayed diagnosis, and poorer outcomes. Early deaths from cardiovascular, for example, are around 2.7 times higher in the most deprived areas compared to the least deprived areas. People living in the greatest need have the greatest barriers in accessing help, experience differences in their care and may have difficulties in the management of their condition. Barriers include knowledge and trust, structural exclusion and service design.

   Targeting prevention services and treatments more effectively for those groups with the highest need or lower uptake in these programmes will achieve the greatest benefit and best value.

5. **Examples of Best Buys**

   Seasonal Influenza Vaccination: The flu vaccine is offered annually to people at higher risk of complications, including older adults, people with long-term conditions, pregnant women, and frontline health and care workers. Equity impact: Coverage remains uneven in Bristol, with almost half of adults with chronic conditions unvaccinated, and 2 in 10 over 65s at risk going unvaccinated. Uptake is lower in deprived areas and for people in Black and Asian ethnic groups.

   Hospital-Based Smoking Cessation (CURE Model): The CURE model offers comprehensive smoking cessation support to all patients admitted to hospital, regardless of the reason for admission. It combines behavioural advice, pharmacotherapy (such as nicotine replacement therapy), and structured follow-up after discharge. Equity Impact: Smoking rates are higher in deprived communities and among people with mental health conditions. In-hospital pathways reach groups often missed by community services. Evidence shows higher uptake among minority ethnic patients when support is offered on the ward, and outcomes improve with immediate pharmacotherapy, specialist advisers for mental health, and tailored follow-up via community pharmacy or digital options.

   Optimising treatment for CVD risk factors: This involves reviewing and optimising treatment in patients with high blood pressure, atrial fibrillation, high cholesterol, or cardiovascular disease to ensure they are receiving the right medication to reduce their risk of heart attack and stroke. Equity impact: Premature CVD mortality in Bristol's most deprived quintile is 2.7 times higher than that of the least deprived. Improving blood pressure management in the most deprived and among South Asian, Black African and Black Caribbean groups offers a big opportunity to improve population health in Bristol and also reduce inequalities.

   Delivery of Nine Diabetes Care Processes: People with diabetes have an annual check of 9 key health indicators which include blood pressure, cholesterol, HbA1c

(blood sugar measurement), kidney function, foot health check, and smoking status. Equity impact: People from deprived areas and minority ethnic groups are less likely to receive all nine care processes, leading to higher complication rates. Diabetes UK's "No One Left Behind" strategy aims to close gaps by ensuring culturally relevant support, tackling systemic barriers, and working with the NHS to deliver fair access. The strategy sets a goal of 90% uptake of all 9 care processes by 2030, reducing preventable complications and improving outcomes across all groups

As an appendix to this report, we have published a document of local case studies: Treating to Prevent Case Studies V1.5 .

This will be maintained as a live resource. If you would be prepared to share your work please send your case studies and best practice stories to: ph.intelligence@bristol.gov.uk

6. **The report concludes with seven specific recommendations:**

1.**Reduce variation in screening and immunisation programmes** by monitoring uptake and taking focussed action with communities

2.**Invest in best buys** to prevent, reduce or delay the impacts of major diseases and conditions.

3.**Improve uptake of health checks** for underserved and at-risk groups; and provide timely preventative interventions.

4.**Use digital tools** to support prevention, include digital options (like apps or online tools) as part of the mix to help people take care of their health.

5.**Use data** to understand and improve access. Make sure we can see data by things like ethnicity, income, disability, and other factors, so we know if services are reaching people fairly.

6.**Work closely with communities and neighbourhood health providers** to understand barriers and identify solutions.

7.**Use Every Opportunity to Support Prevention**: Whenever health or care staff meet with someone, they should look for chances to check health risks, give advice, start treatment, or refer people for help. Prevention should be part of everyone's job.

Christina Gray
Director of Public Health
Bristol City Council

North Somerset Council

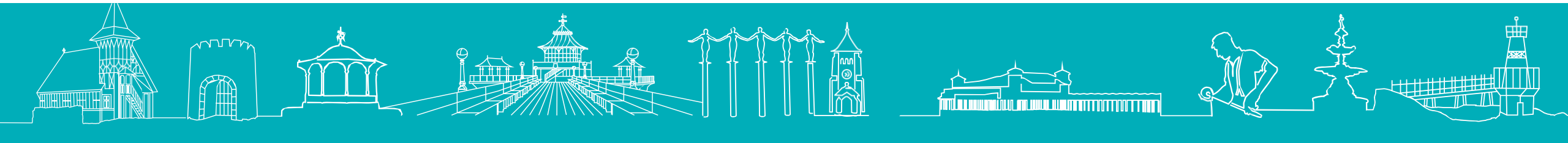
Open, Fairer, Greener

2026 North Somerset DPH Annual Report

Prevention and Healthy Settings

Healthy and Sustainable Communities
Health Improvement Team

Liz Green, Helen Aston, Steve Davis, Jayne Worrall, Naomi Greaves, Georgie MacArthur



Settings Programmes: Background and Rationale

- Grounded in the principles outlined in the WHO Ottawa Charter for Health Promotion (1986): '*health is created and lived by people within the settings of their everyday life'*

- Embed a holistic approach to shaping the environments in which people grow up, learn, and work. Aim to be supportive of good health and wellbeing, promote equity, and integrate action across risk factors.
  - May involve changes to policy, structure or management, staff training, infrastructural changes, culture change, involvement of staff/parents/carers/children, communications, interventions

- Fit with a lifecourse approach that recognises importance of clustering and/or accumulation of risk factors over time and the need for support at critical periods (e.g. transition to school, into employment)

- Scope is broad and includes educational settings and workplaces, as well as care homes, community venues, hospitals, and whole villages, towns or cities

Benefits of settings programmes

Healthy Early Years North Somerset

Healthy Schools Network North Somerset

Healthy Workplaces North Somerset

Environments influence behaviour, stress, opportunities, relationships & health outcomes

Benefits re nutrition, oral health, social and emotional health and wellbeing

Benefits for weight, physical activity, nutrition, tobacco use, bullying

Benefits for productivity, reduced sickness absence, retention, mental wellbeing, workplace reputation

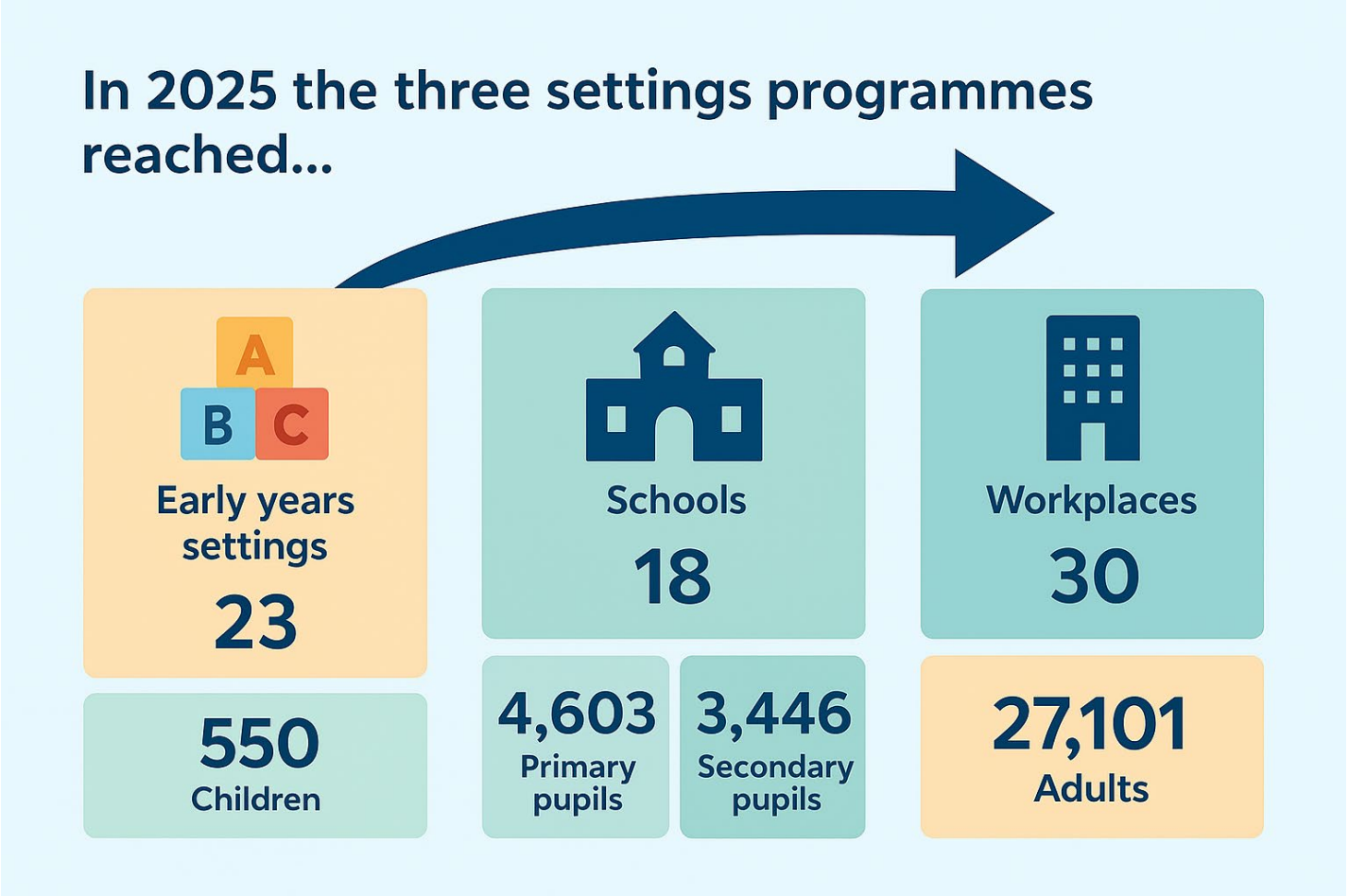
Alignment to policy and strategy

- North Somerset's healthy settings programmes are a growing feature of preventive work

- Aligned to NHS 10-Year Health Plan and Neighbourhood Health models.
- BNSSG ICS Strategy – best start in life, prevention and early intervention
- North Somerset Joint Health and Wellbeing Strategy and Corporate Plan
- Build on national evidence and guidance e.g. NICE, WHO, EYFS, Ofsted

- Tackling inequalities e.g.:
  - Geographical targeting
  - Inclusive settings
  - Access to interventions

Population reach in North Somerset



Proportionate universalism: includes targeting to settings in more deprived areas and workplaces for particular occupations to address inequalities

Impacts

- **Healthy Early Years**
  - Settings: 1 in 5 children experiencing the scheme attending settings in the most deprived area
  - Improved practitioner training, awareness and skills
  - Peer learning, new guidance, policies on staff wellbeing, updated resources to reflect cultural diversity
  - Involvement of parents/ carers to embed change outside of the settings

Year 1 Food & Nutrition and Oral Health
Year 2 Mental Wellbeing and Injury & Illness Prevention
Year 3 Physical Activity and Environmental Sustainability

Participating in the Healthy Early Years Scheme this year has been transformative for both myself and the children and families I support through my childminding setting. Increased awareness of nutrition and oral hygiene has shifted my reflections, values and ultimately the lives of the children in my care (EY practitioner)

Healthy Schools Programme (Primary plus PSHE programme)

- **Most commonly identified themes**: physical activity (n=12), mental health (n=9) and healthy eating (n=9)
- **Changes in primary schools include:**
  - Nurturing routines; changes to language, SEMH interventions; soft start spaces, sensory rooms
  - Training and skills development
  - Increased range of play activities and sports clubs available
  - Increased fruit and veg consumption and cooking opportunities
  - Guidance on lunchboxes

- **Changes in secondary schools include:**
  - Increased PSHE learning time; peer network for sharing of best practice
  - Pupil voice and involvement
  - Changes to assessment, new speakers, new SEND resources

"I love the sensory room, it really helps me to not be so cross. I love the squeezy thing and I love to swing on the bar. When I want to hide, I go under the balls and no one can see me. I like to take a friend with me if I can show them how to do things. Then I go back into class and do my learning." [pupil]

Healthy Workplaces Scheme

- Accreditation scheme (Member → Bronze → Silver → Gold)
- Employers benchmark and improve across six healthy workplace goals and nine health and wellbeing topics

- Membership expanded to 33 workplaces (28,004 employees)
- 2 Gold, 3 Silver, 11 Bronze awards achieved
- 5 events reaching 236 employees from 72 businesses
- Workplace CVD Health Check Pilot: 1,196 health checks delivered in 52 workplaces (leading to 245 GP referrals)
- Increased uptake of healthy lifestyle, smokefree, WorkWell and mental health services
- Some evidence of reduced sickness absence

'"For us, this award isn't just about meeting criteria. It reflects the everyday choices our team makes; supporting one another, prioritising honesty, creating space for wellbeing conversations, and making sure people feel able to bring their whole selves to work"

Vision: creating healthier places to grow, learn and work

Every child, young person and adult in North Somerset should experience a healthy place - whether a nursery, school or workplace - that enables them to thrive.

Healthy places are those where:

- Health and wellbeing are part of everyday culture, not an add-on
- Staff are confident and supported to promote health and wellbeing
- Environments make healthy behaviours easy and enjoyable
- Policies and systems reduce barriers and create fairness
- People feel safe, respected, included and able to participate
- Support is accessible early, without stigma
- Families, communities and employers are partners in prevention

Questions, comments and further information

Further information on the programmes will be shared through our DPH report in May 2026.

With thanks to colleagues leading our settings programmes:

Healthy Early Years

- Nicky Stead: nicky.stead@n-somerset.gov.uk
- Jayne Worrall: jayne.worrall@n-somerset.gov.uk

Healthy Schools

- Helen Aston: helen.aston@n-somerset.gov.uk
- Steve Davis: steve.davis@n-somerset.gov.uk

Healthy Workplaces

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South Gloucestershire Council

Delivering with you

Director of Public Health Report

Prevention in South Gloucestershire

2025

Contents

Foreword

Welcome to the Director of Public Health Annual Report for South Gloucestershire 2025 which focuses on prevention.

Directors of Public Health have a statutory requirement to produce an independent annual report. These reports highlight local health issues and showcase best practice, as well as promoting local action for better health and wellbeing.

I have chosen to focus my 2025 report on prevention to celebrate the excellent partnership work that has taken place over the last few years on prevention through our South Gloucestershire Prevention Programme 2023-25; to share the Making the Case for Prevention Toolkit produced as part of this work; and to set out the opportunities I see for building on this in response to local, regional and national policy including the national 10 Year Health Plan for England: fit for the future.

The intention of the Prevention Programme was to deliver long-term, transformational system change in the way we work in South Gloucestershire. We structured the programme around four themes - start well, live well, age well and community-in-action. South Gloucestershire's Public Health team provided partnership support and technical expertise in the development of projects, organisation of workshops and operational oversight and we partnered with the University of the West of England to design an overarching evaluation of the programme's impact and develop a prevention toolkit to help new projects demonstrate expected prevention gains through return on investment and social value.

In collaboration with the South Gloucestershire Locality Partnership, the programme has brought partners from the council, NHS and voluntary and community sector together in new ways and put prevention at the heart of our work for health and wellbeing. This report is intended to capture our learning, highlight areas of good practice already in place and set out further opportunities for local action to protect and improve the health and wellbeing in South Gloucestershire. I hope that it will provide a useful reference document for years to come.

I would like to acknowledge and thank all those who have been involved in the development and delivery of South Gloucestershire's Prevention Programme. It has been a true partnership approach including colleagues across the Council, NHS, and voluntary sector and in our local communities and University of the West of England.

Sarah Weld, Director of Public Health

Executive Summary

Prevention can be simply defined as the action of stopping something from happening or arising. From a public health perspective prevention means taking action to help people live longer, healthier lives.

Many health and care challenges stem from preventable risks and there is a strong case for the social and economic benefits of prevention across the life course. However, it is widely recognised that prevention has repeatedly been given less attention than more immediate pressures on the NHS and social care. This is because short-term budgetary pressures often require organisations to demonstrate in-year cashable savings whilst prevention initiatives tend to have longer-term horizons in terms of impact on individuals and communities and return on investment.

This Director of Public Health Annual Report for South Gloucestershire 2025 sets out a comprehensive and evidence-based case for putting **prevention at the heart of health, wellbeing, and public services**. It reflects on the achievements of the **South Gloucestershire Prevention Programme**, the results of its independent evaluation and the future opportunities to embed prevention across systems, communities, and policies.

Prevention matters because:

- It improves quality of life and reduces health inequalities
- It saves money, makes better use of limited resources and can reduce demand for services
- It tackles inequalities
- Every £1 invested in prevention can deliver significant social and economic benefits
- Multiple small changes across a whole system can have a big cumulative impact

Demonstrating the impact of local investment in prevention can be complex. The benefits of prevention initiatives often span sectors and unfold over time. Economic Return on Investment (ROI) and Social Return on Investment (SROI) play important roles in understanding the full spectrum of impact investing in prevention can play in population health improvement.

The £2m South Gloucestershire Prevention Programme, established in 2022/23, set out to deliver **long-term, transformational system change** in the way we worked in South Gloucestershire so that **we shifted the balance of our support towards prevention** to improve health and wellbeing outcomes for local people and reduce inequalities.

Evaluation of the programme conservatively estimated social return on investment across all projects was at £4.50 to £7.50 per £1 invested, with even greater returns likely to accrue over time as long-term outcomes matured. This confirmed the Prevention Programme's success not only as an economically effective initiative, but also as a transformative investment in and impact on the health, equity and resilience of the South Gloucestershire population.

Based on the evidence presented in this report including findings from the Prevention Programme, we set out **six actions** that partners across the **council, the NHS and VCSE organisations** should take together to **shift the system towards prevention.**

1. **Align priorities and funding around longer-term shared prevention outcomes**
2. **Embed prevention into frontline services and pathways**
3. **Tackle the building blocks of health together**
4. **Invest in community-led and VCSE-delivered prevention**
5. **Share data and insight to target early action**
6. **Measure what matters and learn together**

The South Gloucestershire Public Health team is committed to ensuring that our learning from the Prevention Programme is taken forward and embedded in ongoing work by the council and its partners. The Making the Case for Prevention Toolkit, produced as part of the programme, leaves a legacy tool for supporting local planners to evaluate the impact of future initiatives.

We set out below some of our key work over the coming year.

In 2026 our Public Health work will include:

- **Promoting this report and the South Gloucestershire Prevention Toolkit** to raise awareness and better enable council teams and partner organisations to build return on investment thinking into project planning.
- **Continuing to lead and promote the** South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29 strategic commitment to shift upstream with a focus on prevention.
- **Reviewing our Public Health core training offer** and sharing learning opportunities about the prevention of ill health, the importance of the building blocks of health, the science of behaviour change and reducing health inequalities. This will involve locally delivered training and signposting to regional and national resources, such as Making Every Contact Count - elearning for healthcare, the Behaviour Change Development Framework - BCDF and Events and webinars - The Health Foundation.
- **Working with partners to develop and implement Neighbourhood Health and Best Start in Life Plans** with a focus on prevention and early intervention; reaching people earlier and empowering them to stay healthy and well, and achieve and thrive.

What do we mean by prevention?

Prevention can be simply defined as **the action of stopping something from happening or arising.** From a public health perspective prevention means taking action to help people live longer, healthier lives.

Prevention encompasses approaches and actions that can be taken to increase the chances of people of all ages being in good mental and physical health; influence local social and economic determinants of health and inequalities (the building blocks of health); reduce the risk of people deteriorating if they are in poor health and support quicker recovery; and support people to be as independent as they want to be.

Types of prevention

There are many ways to classify prevention. Prevention is often described in different 'levels' according to whether an intervention focuses on preventing, reducing, or delaying the progression of disease or need for care and support (1).

- **Primordial prevention:** action to ***prevent*** exposure to risk factors or improve environmental, social and economic conditions.
- **Primary Prevention:** action to ***reduce*** risk and promote health and wellbeing.
- **Secondary prevention:** emphasises early intervention by identifying disease before symptoms have progressed to stop or ***delay*** a condition worsening, if possible, through promotion of independence and self-care.
- **Tertiary prevention:** ***support*** or rehabilitation to help people to maintain independence and manage their condition.

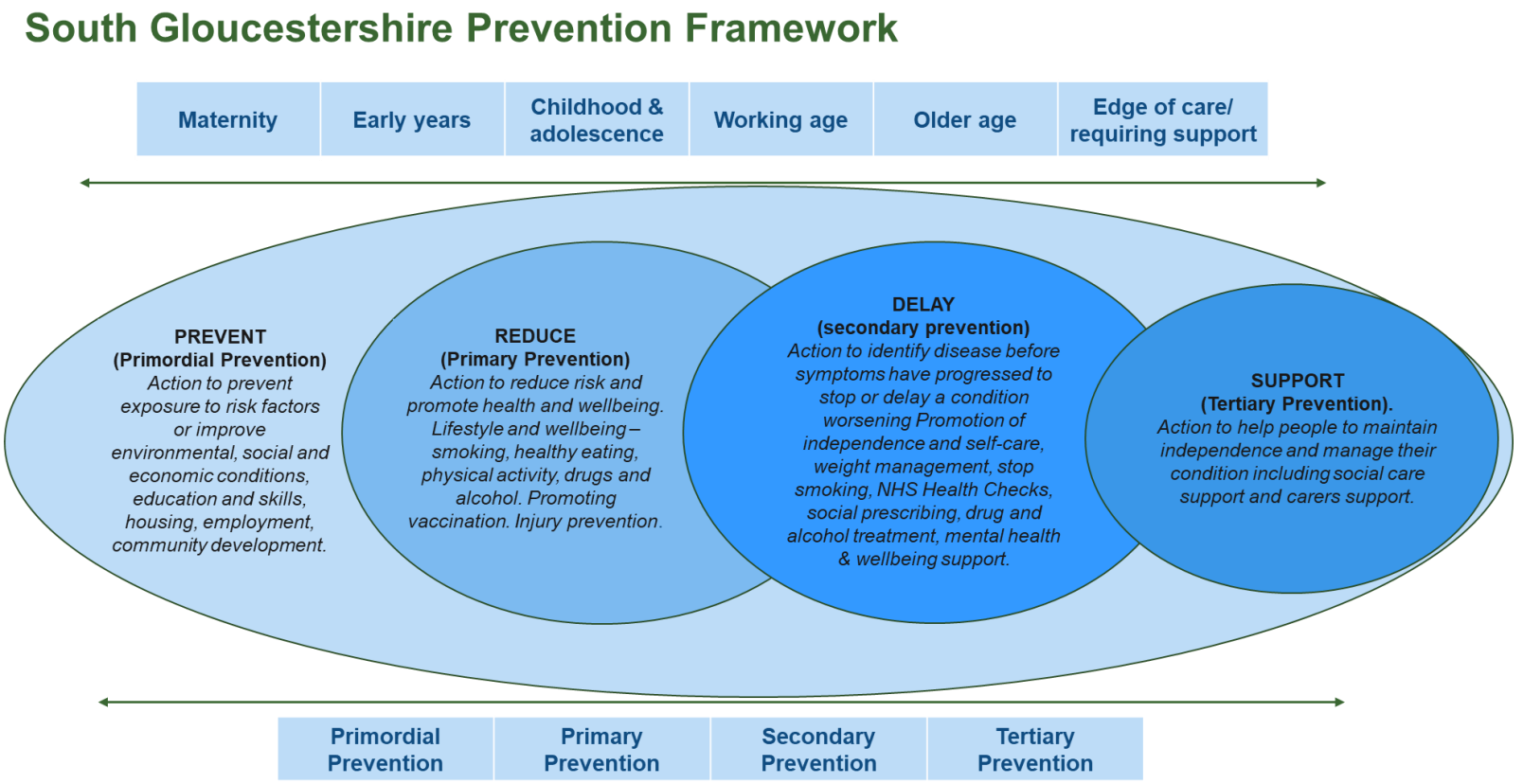
Opportunities for prevention

There are opportunities for prevention:

- **Across the life course** - by giving every child the best start, supporting working-age adults and enabling older people to age well.
- **In our communities** - by strengthening connections, reducing isolation, building on existing assets and tackling local inequalities.
- **In services people use** - embedding prevention into health, education, housing and social care**.**
- **Through joined up strategic work** on the 'Building Blocks of Health' such as education, housing and employment.

South Gloucestershire Prevention Framework

To inform the planning and design of our South Gloucestershire Prevention Programme we created a framework to describe the different levels (types) of prevention, provide some examples of the types of initiatives that could be established and how we must also ensure we take a life course approach from early years through to older age.



Why prevention matters

A healthy population is vital for a strong economy and for communities in which everyone can participate fully. Almost every aspect of our lives impacts our health and ultimately how long we will live – from the quality of our homes and jobs to access to education, public transport, and experiences of poverty or discrimination. These are often described as the "building blocks of health" (2).

Figure 1- Building Blocks of Health, Frameworks UK and Health Foundation, 2022

Over the last century great progress has been made in helping people live longer lives because of developments in health and care and public health. However, many people in South Gloucestershire are living with poor mental and physical health and lives are being cut short.

In South Gloucestershire average life expectancy is 81 years for men and 85 years for women. Healthy life expectancy for both men and women in South Gloucestershire is 63 years, meaning that on average, men born today can expect to live 18 years in poor health and women 22 years (3) (4). As a result, many people are living longer with complex health and care needs, affecting both quality of life and demand for services. There are opportunities to change this through prevention.

It is widely agreed that prevention is important.

- Prevention improves quality of life and reduces health inequalities.
- Prevention saves money, makes better use of limited resources, and can reduce demand for services.

- Prevention tackles inequalities.
- Every £1 invested in prevention can deliver significant social and economic benefits.
- Multiple small changes across a whole system can have a big cumulative impact.

Evidence for and challenges in investing in prevention

Many health and care challenges stem from preventable risks and there is a strong evidence base for the social and economic benefits of prevention across the life course. However, it is widely recognised that prevention has repeatedly been given less attention than more immediate pressures on the NHS and social care. This is because short-term budgetary pressures often require organisations to demonstrate in-year cashable savings whilst prevention initiatives tend to have longer-term horizons in terms of impact on individuals and communities and return on investment (5) (1).

Evidence shows that:

- **The health and care system is unsustainable unless we do something differently.** Without comprehensive action to promote health and wellbeing and prevent the need for intervention, the pressures on health, care and other public services will only increase (5).

- **A system focus on prevention is essential for improving population health and wellbeing.** Early intervention to tackle the risk factors that cause disease enables people to live longer in good health (6). Staying healthy helps individuals to remain independent and active in their community. This in turn supports wellbeing.

- **Prevention and early intervention in childhood** fosters healthy behaviours throughout life, especially for improvements in immunisation take up, healthy weight and oral health. Increased investment in early help and family support reduces statutory intervention in Children's Services and has a positive impact on numbers of Children in Need (7). Return on investment (ROI) from prevention is greater the earlier in life it is invested in.

- **Prevention is an effective way to reduce inequalities.** Preventable diseases are disproportionately experienced by some groups (8). For example, cardiovascular disease is among the largest contributor to health inequalities, accounting for one-fifth

of the life expectancy gap between the most and least deprived communities (9). Action to tackle risk factors for major preventable disease is an important way to reduce health inequalities.

- **Action to tackle the core determinants (building blocks) of health can have the greatest impacts.** Many health inequalities stem from social inequalities such as inadequate housing, limited access to nutritious food and poverty (6). Social and economic factors account for 40% of the modifiable determinants of our health (1). Healthcare contributes only about 20% and yet the bulk of current health spending goes to health services.

The benefits of prevention initiatives often span sectors and unfold over time. Demonstrating an impact on the population is an important element of supporting investment decisions and continuing to create evidence to build the case for prevention is a public health priority locally and nationally. Implementing community prevention interventions requires robust and systematic approaches to measure and value population impact effectively and this is why in South Gloucestershire we have created the Making the Case for Prevention Toolkit described later in this report to guide project managers and leads in planning and evaluating the impact of public health and prevention initiatives.

Prevention policy

Local Authorities and the NHS have statutory responsibilities for undertaking prevention and the wider public sector, the voluntary, community and social enterprise (VCSE) sector and the business sector all have a role to play.

Prevention has long been a priority in South Gloucestershire. Many current local and national policies set out a commitment to prevention (6) (11) (12).

Local Policy

Prevention is a theme within South Gloucestershire's Council Plan 2024-2028 and shifting upstream with a focus on prevention is one of the five strategic commitments in the South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29 (13). The Health & Wellbeing Strategy sets out a new approach for the South Gloucestershire Health and Wellbeing Board to strengthen the delivery of existing prevention commitments, develop how it works together in partnership and more closely with our communities, and strengthen our use of data and insights in planning and decision making. This approach builds on the learning from the South Gloucestershire Prevention Programme described in this report.

National Policy

The key national health policy, Fit for the future: 10 Year Health Plan for England (14), sets out a shift from sickness to prevention for the health service in England as one of the core strategic shifts. This shift is woven throughout the policy and is described as essential to the future sustainability of the NHS.

It commits to:

- shifting resources and services upstream
- reaching people earlier

- using technology to predict risk
- empowering people to stay healthy
- reducing the burden of avoidable disease

This is echoed in Neighbourhood Health policy which places prevention at the core of the shift towards a neighbourhood-based model of care.

Prevention is a core theme in the **Children's Wellbeing and Schools Bill** (15) and supporting policy. Especially the **Giving every child the best start in life - GOV.UK Policy Paper** (16) which sets out actions to ensure every child has the best start in life and the chance to achieve and to thrive.

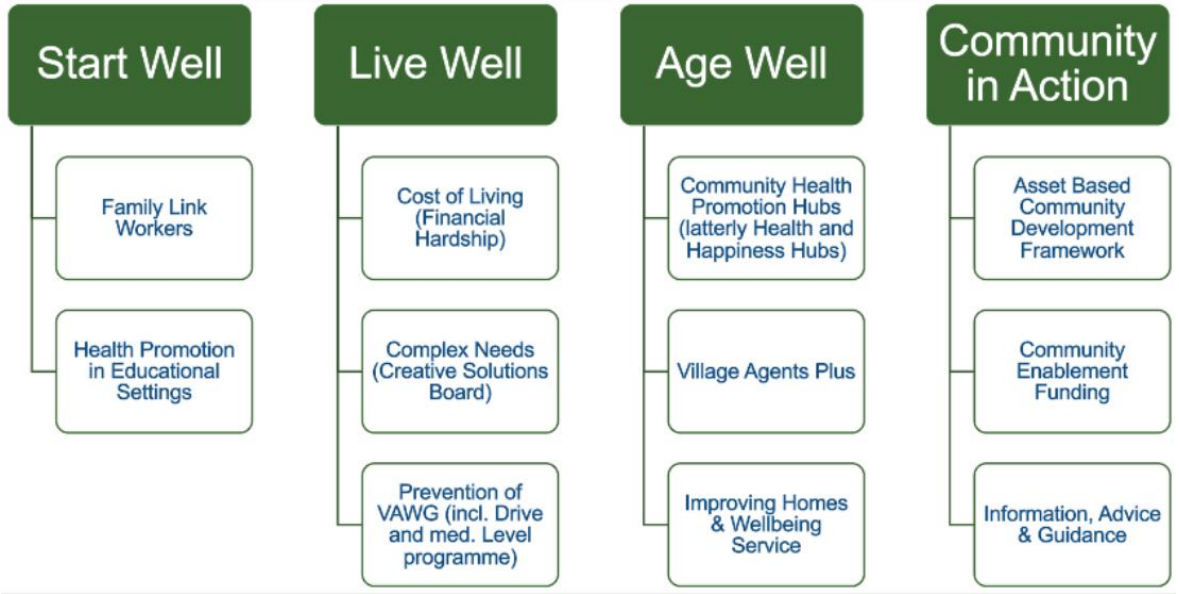
The **English Devolution White Paper: Power and partnership: Foundations for growth** (17) highlights the need for urgent reform to public services to focus on prevention, with programmes built more closely around people and the places they live.

South Gloucestershire Council Prevention Fund Programme

The South Gloucestershire Prevention Programme was a £2million one-off fund established in 2022/23 using £1m from South Gloucestershire Council and £1m from the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB) in match funding.

The intention of the Prevention Programme was to deliver **long-term, transformational system change** in the way we worked in South Gloucestershire so that **we shifted the balance of our support towards prevention** to improve health and wellbeing outcomes for local people and reduce inequalities.

The programme included 11 projects across four themes:



Overall Prevention Programme Evaluation

We commissioned the University of the West of England (UWE) to design an overarching evaluation (18) of the prevention programme's impact on system and culture change. This included capturing the economic and social impacts of the prevention fund projects using measures and techniques to calculate the economic **Return on Investment (ROI)** and the **Social Return on Investment (SROI)**, which are two complementary approaches to evaluate the economics of prevention.

ROI traditionally focuses on how much money is saved or earned for every £1 spent or invested	**SROI** is a broader concept, monetising social, wellbeing, and community outcomes improved mental health, reduced loneliness, enhanced resilience, or better housing security vital to wellbeing and healthy lives

In the field of preventive public health, where benefits often span sectors and unfold over time, both ROI and SROI play important roles in understanding the full spectrum of impact investing in prevention can play in population health improvement.

Key findings from the evaluation are set out below. The full evaluation report can be viewed on the health strategies page of the Council website.

The final section of this Director of Public Health Report sets out a series of case studies of projects included in the Prevention Programme:

- Family Link Workers
- Health Promotion in Education Settings (HPES)
- Cost of Living (Financial Hardship)
- Complex Needs (Creative Solutions Project)
- Prevention of Violence Against Women and Girls (VAWG)
- Health and Happiness Hubs
- Village Agents Plus

- Improving Homes and Wellbeing Service
- Asset-Based Community Development (ABCD) Framework and Community in Action Enablement Grants
- Information Advice and Guidance (South Glos LIFE)

Each case study provides and overview of the project, what was achieved, return on investment estimated from the programme evaluation and a description of impact and future plans.

Prevention Project Minimum and Maximum Ranges for ROI and SROI Estimates

Project	ROI Range (Min–Max)	SROI Range (Min–Max)
Family Link Workers	£2.00 - £4.00	£3.50 - £4.00
Health Promotion in Education	£2.00 – £4.00	£6.00 – £10.00
Cost of Living: Financial hardship	£1.00 – £2.00	£2.00 – £5.00
Creative Solutions Board (CSB)	£4.00 – £10.00	£7.00 – £12.00
VAWG Schools Programme	£3.00 – £6.00	£6.00 – £10.00
Health and Happiness Hubs	£1.50 – £2.50	£3.00 – £5.00
Village Agent Project	£2.50 – £4.00	£3.50 – £5.00
Improving Homes & Wellbeing	£4.50 – £7.50	£7.00 – £10.00
Community in Action (ABCD)	£1.50 – £2.00	£2.00 – £3.00

The blended SROI across all projects was conservatively estimated at £4.50 to £7.50 per £1 invested, with even greater returns likely to accrue over time as long-term outcomes mature. This confirmed the programme's success not only as an economically effective initiative, but also as a transformative investment in and impact on the health, equity, and resilience of the South Gloucestershire population.

Conclusions from UWE's Evaluation

While all projects delivered positive social returns, those addressing complex needs - the **Creative Solutions Board**, **Improving Homes & Wellbeing**, school-based initiatives such as **Health Promotion in Education Settings** and **Violence Against Women and Girls (VAWG)** —offered the greatest long-term impact. Other projects also played a vital role in stabilizing vulnerable populations and supporting access. The **Family Link Worker** project sitting in the middle delivered strong, personalized gains in attendance, wellbeing, and family resilience (12)

- South Gloucestershire Council's Prevention Fund Programme **delivered a strategic, place-based investment in population health**, combining community empowerment with fiscal responsibility.
- By focusing on **early intervention, social connection, and upstream support**, the programme successfully targeted root causes of poor health, reduced inequalities, and shifted the system toward a more proactive, person-centred approach.
- Successful preventative work starts with innovation, identifying the priorities and needs of communities in action, to start well, live well, age well and ensure investment in prevention achieves impact for communities.
- Taken together, the **£2 million investment** by South Gloucestershire Council and the local Integrated Care Board funded targeted prevention projects that collectively delivered **strong economic returns and meaningful social value**. Across health, housing, education, and community wellbeing, the SGC Prevention Fund Programme has demonstrated excellent value for money, particularly through early intervention, system collaboration, and community engagement.

Making the Case for Prevention: A Toolkit

Overview

As well as independently evaluating our prevention programme we wanted to develop a way for project managers to illustrate how further initiatives to improve people's health and wellbeing can lead to wider positive benefits for the economy and society (e.g. returns on investment and increases in social value). We felt this could help get projects over the line because decision-makers would have a fuller picture of the wider impact(s) of a project; and it could also support project evaluation and building an evidence base for public health impact.

We commissioned UWE to investigate this and they created a Making the Case for Prevention Toolkit.

The toolkit is based on the RE-AIM planning and evaluation framework: www.re-aim.org (19), which was developed to make research findings more generalisable through the application of specific and standardised ways of measuring key factors. It also facilitates **translation** of evidence into practice.

RE-AIM stands for:

Reach

Effectiveness

Adoption

Implementation

Maintenance

Who it is for

- Those responsible for planning, implementing, and evaluating health and prevention projects across the Integrated Care System.
- Staff writing business cases so that they can make the case for prevention and what impact it is expected to have economically and socially for the population or community.
- It can be used to think forward to appraise/plan or look back to evaluate interventions.
- Business cases can be presented in both future and past modes to persuade decision makers to invest in prevention where there are competing choices.

How to use the toolkit

- Plan and Document Impact: Use the RE-AIM framework to assess project reach, effectiveness, and sustainability, helping you build a strong case for your work.
- Communicate with Funders and Stakeholders: Present clear, structured insights on your project's value, impact, and long-term potential, ensuring alignment with organisational and funding priorities.

Making the Case for Prevention Toolkit

Conclusion

Embedding prevention in everything we do is essential if we want to improve the health of our population and reduce the demand on health and care services.

The evaluation of the South Gloucestershire Prevention Programme demonstrated the economic and social gains that can be achieved from a preventative approach, with a particular focus on groups with complex needs to improve resilience, equity and reduce inequalities in health and care outcomes.

The South Gloucestershire Public Health team is committed to ensuring that our learning from the Prevention Programme is taken forward and embedded in ongoing work by the council and its partners. The Making the Case for Prevention Toolkit, produced as part of the programme, leaves a legacy tool for supporting local planners to evaluate the impact of future initiatives.

We set out below some of our key work over the coming year and our calls to action for the wider council and partner organisations.

In 2026 our Public Health work will include:

- **Promoting this report and the South Gloucestershire Prevention Toolkit** to raise awareness and better enable council teams and partner organisations to build return on investment thinking into project planning.
- **Continuing to lead and promote the** South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29 strategic commitment to shift upstream with a focus on prevention.
- **Reviewing our Public Health core training offer** and sharing learning opportunities about the prevention of ill health, the importance of the building blocks of health, the science of behaviour change and reducing health inequalities. This will involve locally delivered training and signposting to regional and national resources, such as Making Every Contact Count - elearning for healthcare, the Behaviour Change Development Framework - BCDF and Events and webinars - The Health Foundation.
- **Working with partners to develop and implement Neighbourhood Health and Best Start in Life Plans** with a focus on prevention and early intervention; reaching people earlier and empowering them to stay healthy and well, and achieve and thrive.

Call for Action

Based on the evidence presented in this report including findings from the Prevention Programme we set out below **six actions** that partners across the **council, the NHS and VCSE organisations** should take together to **shift the system towards prevention**, grounded in evidence from local and national place-based practice:

1. **Align priorities and funding around longer-term shared prevention outcomes**
   - Recognise that prevention initiatives tend to have **longer-term horizons** in terms of impact on individuals and communities and return on investment.
   - Agree a **set of shared prevention goals** to work together on across partnerships.
   - Align outcomes and funding so prevention is a **core, jointly owned objective**.
   - Move from short-term pilots to **multi-year investment** that gives delivery partners and communities stability.

2. **Embed prevention into frontline services and pathways**
   - Make prevention "everyone's business" by embedding **brief interventions, social prescribing and early help** into primary care, social care, housing and employment services.
   - **Routinely ask** about issues such as social and lifestyle determinants of health and respond by signposting to information, support and training (see links on Resources page).
   - Support workforce training across sectors so staff understand **prevention, behaviour change and trauma-informed practice**.

3. **Tackle the building blocks of health together**
   - Coordinate action on **housing quality, employment, income, education, transport and green space**, recognising these as prevention interventions.
   - Use council levers (planning, licensing, procurement) alongside NHS influence and VCSE reach to create **health-promoting settings, neighbourhoods and places**.
   - Prioritise prevention efforts in communities experiencing the **greatest health inequalities**.
   - **In our role as employers**: maximise workforce wellbeing, workforce training and development.
   - **In our roles as "anchor institutions":** consider the building blocks for health and how to improve the local economy and provide a healthy environment to support population health outcomes.

4. Invest in community-led and VCSE-delivered prevention

- **Understand what outcomes matter to people.** Be brave in our redistribution of power and agency to communities so that we build on existing assets and strengths.
- Shift resources upstream by working with or commissioning **VCSE organisations** to plan and deliver prevention activity with and in local communities.
- Use asset-based approaches that build on **community strengths**, not deficits.

5. Share data and insight to target early action

- Combine quantitative data with **VCSE insight and lived experience** to understand what's really driving need locally.
- Develop **shared population health intelligence** across partners which enable evidence-based actions to be targeted where they are most needed.

6. Measure what matters and learn together

- Shift performance frameworks away from activity and throughput towards **long-term outcomes, wellbeing and reduced demand**.
- Recognise that whilst it can be difficult to show impact on outcomes short term, with the use of tools, such as the **Prevention Toolkit and the RE-AIM framework** we can identify more interim shifts (for example in mindsets, experiences, structures and support mechanisms) that move us in a more positive direction.
- Build in **learning, evaluation and improvement** from the start, using the Prevention Toolkit to make the case for prevention and the expected economic and social return on investment for the population or community concerned; and build this into decision making and performance monitoring.
- **Share learning openly** across the system to scale what works and stop what doesn't.

Case Studies - South Gloucestershire Council Prevention Fund Programme

The final section of this report sets out a series of case studies of projects included in the Prevention Programme:

- Family Link Workers
- Health Promotion in Education Settings (HPES)
- Cost of Living (Financial Hardship)
- Complex Needs (Creative Solutions Project)
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Each case study provides an overview of the project, what was achieved, return on investment estimated from the programme evaluation and a description of impact and future plans.

Family Link Workers

Overview

This project supported the Council Plan to give children the best start in life by tackling persistent and severe school absence. Launched in December 2023 (with a two-year funding period) the team worked early with families to identify barriers to attendance, improve wellbeing, and reduce the need for statutory intervention.

Schools referred families via termly attendance meetings, with referrals reviewed by a multi-agency panel (Family Link Managers, Education, Compass, Virtual School, EPs).

Support was voluntary and tailored, with each family receiving an assessment and individual plan.

Work included building confidence, managing anxiety, improving routines, travel training, social skills, and signposting to other services.

Close collaboration with schools and professionals ensured coordinated early help and consistent communication.

What was achieved

- Improved attendance and re-engagement in mainstream education.
- Stronger home-school relationships and earlier help pathways.
- Reduction in exclusions, safeguarding referrals, and EHCP requests.
- Families reported better wellbeing, reduced stress, and renewed confidence.
- The team worked with over 100 young people over the two-year period.
- Average increase in attendance was 17%.

Young people said: “It feels really weird to say this, but I actually love school now!”

Parents said: “Your support came just at the right time—it took the pressure off us.”

Family Link Support Plan

Return on Investment

Estimated **ROI** was **£2.00–£4.00 per £1** invested, reflecting the cost avoided through improved attendance, fewer exclusions, and reduced referrals to Child and Adolescent Mental Health Services (CAMHS) or safeguarding services. The **SROI** was estimated at **£3.50–£4.00 per £1**, capturing broader social value such as improved family stability, emotional wellbeing, and community connectedness. These estimates were consistent with evidence from similar early intervention models, including social prescribing and family-focused support schemes (EIF, PHE, HACT), which showed strong returns when working relationally with vulnerable families to prevent crisis escalation.

What next

The project secured continuation funding from other sources and the workers were made permanent members of staff. The team continues to work with children, young people and families to increase attendance and secure better outcomes.

Health Promotion in Education Settings (HPES)

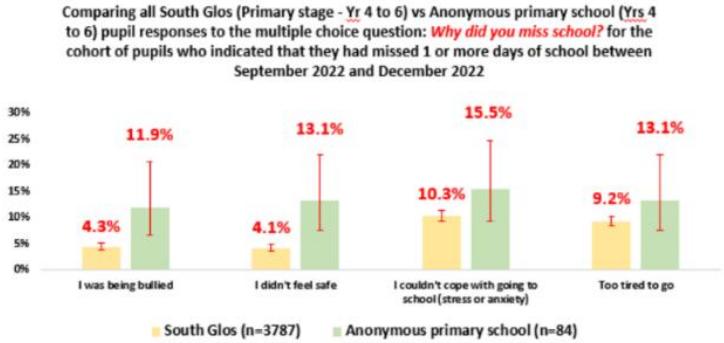
Overview

This project supported schools to design, deliver, and evaluate health and wellbeing interventions that improve attendance, attainment, and reduce health inequalities. The project worked with ten targeted schools, identified through health need data (Free School Meals (FSM) %, Pupil Premium, attendance, and deprivation).

- Schools analysed Online Pupil Survey (OPS) data to define SMART objectives and priorities.
- Support provided through guidance, meetings and access to delivery and teaching resources.
- Focus areas included improving self-esteem, resilience, mental wellbeing, physical activity and healthy lifestyle choices.
- Aims were to build capacity for sustainable health promotion practice using an Assess, Plan, Do, Review framework.

What was achieved

- 100% of targeted schools completed project proposals with SMART objectives.
- 80% delivered and evaluated the intended intervention.
- 100% of targeted schools identified barriers and facilitators to delivering health promotion.
- Strengthened links between educational settings and health improvement teams.
- Schools reported increased confidence in using pupil data to plan wellbeing interventions.



Schools said

"The OPS data helped us see exactly where support was needed - our pupils' confidence and attendance are already improving."
"Having access to shared resources and funding made it possible to run activities we'd only ever talked about before."

Return on Investment

Although no formal cost–benefit model was applied, proxy analysis suggested a strong **ROI of £2.00–£4.00 per £1** invested, derived from reductions in future service demand (e.g. CAMHS referrals, absenteeism and exclusion). The **SROI** was estimated at **£6.00–£10.00 per £1**, reflecting added value from increased confidence, inclusion, physical activity, and staff capability. These estimates were consistent with evidence from WHO and NICE on school-based health promotion interventions. The previously evaluated

Outdoor Learning & Food sub-project reinforced this by demonstrating long-term sustainability through infrastructure and staff development investments. In addition, 86% of the targeted schools who delivered their planned intervention and completed the medium-term outcomes and measures questionnaire reported having planned and delivered a subsequent health and wellbeing-related intervention within six months of completing their project.

Case Study: A priority neighbourhood primary school, with 30% of pupils eligible for FSM, 17% receiving SEN support, and 40% in IDACI ranks 1-3, used art and Lego therapy interventions to bolster their mental health support to build additional resilience and coping strategies in pupils. The aim was to reduce persistent absence in the pupil population, whilst increasing Pupil Premium attendance.

Persistent absence amongst all pupils in the academic year prior to the intervention was 17.7%. By the mid-point of the academic year 2023/24 that had reduced to 14%, with a further reduction to 12% by the end of the project. For Pupil Premium children, attendance improved by 1%.

The school reported being more likely to use OPS data and very likely to use an assess, plan, do, review framework when delivering future interventions. When asked to select descriptions from a list to capture their experience, they highlighted:

- This has been a positive experience for us, and we are appreciative of having had the opportunity to participate.
- This opportunity has allowed us to deliver something of value to our school and pupils, and we have taken positive learning from this experience that we can use in the future.
- Participating in this project has made us more confident and/or more likely to deliver other specific and/or targeted health and wellbeing interventions in the future.

What next

HPES leaders have worked collaboratively to ensure their Core Offer is better aligned with the needs of our schools. In time, we anticipate this resulting in increased uptake of awards and quality marks that enhance whole-school approaches to things like mental health and food and nutrition. Improvements in OPS participation, data collection, and reporting enhances the ability of our schools to better understand pupil health and wellbeing need and plan, deliver, and evaluate interventions accordingly. A new Online Pupil Survey is being undertaken in 2026 which will inform future priorities for HPES.

Cost of Living (Financial Hardship)

Overview

This project supported residents, families, and communities to improve financial security and resilience, helping people stay warm, well fed, and mentally well. Work included developing a Financial Security Framework, supporting the council and partners with inequality analysis and delivering targeted programmes such as holiday clubs and the 'Take the Credit' Pension Credit campaign.

- It provided holistic financial support, including benefit checks and tailored advice.
- Used data and insights to target support and adapt service delivery.
- Worked with community partners (e.g. Mamas Bristol, TPX Ltd, supermarkets, LGBTQ+ group Alphabets).
- Delivered practical help through Community Welcome Spaces, Warm Packs and Cool Packs.

What was achieved

- Developed a Financial Wellbeing Strategy and action plan.
- Shortlisted for LGA Campaign of the Year for Cost-of-Living communications.
- In 23/24 distributed 500 Cool Packs to residents during the summer, then 1,000 Warm Pack and 250 electric blankets during the winter months.
- In 24/25 distributed another 500 cool packs, 100 warm packs and 393 electric blankets.
- Worked in partnership with Age UK, Severn Wye and Lendology to offer more support to our residents through low interest loans, boiler and home checks as well as ensuring they were on the correct tariff and getting everything they were entitled to.
- Increased uptake of Pension Credit through targeted community outreach, including over 60 'pop ups' in our local communities.
- Enhanced partnership working and data-driven decision making across services.

Residents said

“I can’t thank you enough for the free blankets and goodies… I don’t put my heating on as much now - I’m like a little caterpillar all snug in my warm cocoon.”

“Pension Credit has made my life a lot easier - my energy costs are down, and I’m getting the help I didn’t know I was entitled to.”

Return on Investment

Estimated **ROI** was **£1.00–£2.00 per £1** invested, primarily reflecting modest reductions in cold-related GP visits, A&E attendances, and hospitalisations (based on PHE’s cold homes evidence and Age UK fuel poverty models). The **SROI wa**s estimated at **£2.00–£5.00 per £1**, accounting for improved thermal comfort, reduced stress, and enhanced perceived wellbeing. These estimates were in line with broader evaluations of winter warmth programmes across the UK, such as those reported in NICE guideline NG6 and Public Health England's housing and health cost–benefit analysis.

What next

The next steps are to continue to offer support to our residents but move away from a crisis approach and focus more on long-term sustainable help. The Crisis and Resilience Fund starting in April 2026 will support our ability to do this.

Cost of Living support hub: [Cost of living help | BETA - South Gloucestershire Council]

Complex Needs (Creative Solutions Project)

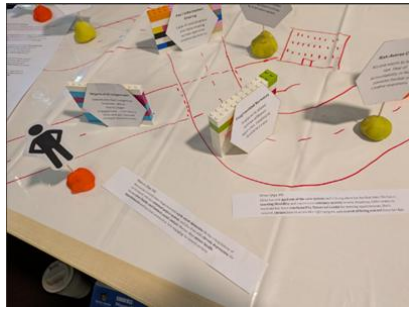
Overview

Individuals and families living with complex situations often require more flexible, creative approaches involving many agencies working together. This project further developed the Creative Solutions Project (CSP) to provide an independent escalation process, ensuring collaborative and person-centred responses for people dealing with significant complexity, including young people aged 16–18.

- We expanded the Creative Solutions Board (CSB) model to promote flexible working across services and build understanding of the “cost of complexity.”
- We developed a resource pack including shared risk assessments and supported lived experience participation infrastructure to inform practice across wider systems.
- We ran regular multi-agency ‘Journey through Complexity's’ sessions with partners such as Drive, Julian House, Nelson Trust, Housing First, AWP, and Unity Sexual Health.
- We strengthened the trauma-informed practitioner network, with around 80 professionals engaging monthly through a combined CSP and trauma-informed newsletter.

What was achieved

- More collaborative, flexible inter-agency working.
- Improved health and wellbeing outcomes for people with complex needs.
- Successful outcomes in several complex cases, including access to specialist rehab and independent support.
- Greater practitioner understanding of complexity and system-wide learning shared across the network.
- Cost savings through more effective, joined-up solutions.



Case Study: Client A, a veteran struggling with alcohol addiction, was referred to the CSB by Help for Heroes after other services had reached their limits. Through joint working, the client related to a specialist veterans' rehabilitation centre and completed 12 weeks of treatment. Adult social care and occupational health adapted his home to meet his needs and ongoing support was coordinated across agencies. He has since shown remarkable progress — a powerful example of how creative, multi-agency collaboration can transform lives.

Return on Investment

Estimated **ROI** was **£4.00–£10.00 per £1** invested, reflecting cost avoidance from reduced A&E visits, homelessness-related spending (~£25,000 per person annually), and criminal justice interventions. The **SROI** was even greater at **£7.00–£12.00 per £1**, considering personal empowerment, housing stability, and improved mental health. These figures aligned with findings from the Golden Key Bristol evaluation, MEAM coalition research, and King's Fund work on integrated care for high-need population.

What next

Multiple agencies, led by the council, are now exploring together how we embed the learning, structures and processes created for the Creative Solutions Project in our business-as-usual work to support people living with complexity.

Prevention of Violence Against Women and Girls (VAWG)

Overview

This project used public health principles - early intervention, health promotion and trauma-informed creative education - to prevent violence against women and girls (VAWG) in South Gloucestershire. By working collaboratively with schools and partners, it aimed to foster safer environments and drive cultural change. Key partners included Unique Voice, which delivered creative school workshops, and co-funding for the Drive perpetrator programme, challenging abusive behaviours at their root.

School Education: Unique Voice delivered creative assemblies and workshops to Year 9–11 pupils in 12 secondary schools (Sept 2024–July 2025), using interactive activities and a film made with Crimestoppers to explore VAWG.

Phase 2 Targeted Interventions: Based on feedback, targeted sessions for Year 10 groups in four schools covered:

- Redefining violence (physical, psychological, systemic, online)
- Power dynamics and healthy relationships
- Safety and vulnerability
- Respect, equality, advocacy and collective action

Boys' Workshops: 32 targeted sessions engaged 120 male students in four schools, providing a safe space to challenge stereotypes, reflect on values, and learn about respectful relationships.

Drive Perpetrator Programme: Collaborative project with police and agencies targeting high-risk perpetrators of domestic abuse. Delivers case management, disruption activities, and behaviour change.

Scan this QR code to view our video: “We Feel Unsafe - Ending Violence Against Women and Girls-VAWG-Safer Streets”. Web Link - [We Feel Unsafe - Ending Violence Against Women and Girls - VAWG - Safer Streets on Vimeo]

What was achieved

- Student Knowledge: After workshops, 94% understood VAWG occurs in multiple forms (up from 78% pre-programme); 83% recognised harm of gender stereotypes (up from 70%); 81% supported gender equality (up from 74%); 76% understood media's role in VAWG (up from 48%).
- Confidence: 45% felt comfortable discussing VAWG; 45% confident challenging stereotypes; 38% confident calling out harmful behaviour.
- Staff Feedback: 100% of school staff would recommend the programme, citing strong pupil engagement and improved understanding.
- Drive Programme results: Worked with 85 perpetrators, 91 victim/survivors, and 175 impacted children/year. 1,044 support/disrupt interventions annually. 87% reduction in physical abuse; 31% improvement in understanding of abusive behaviour.

Return on Investment

Estimated **ROI** was **£3.00–£6.00 per £1** invested, mainly via avoided school exclusions, safeguarding referrals, and early abuse prevention. Estimated **SROI** was **£6.00–£10.00 per £1**, including increased safety, equality, wellbeing, and healthier relationships. These are consistent with Home Office VAWG programmes, Respectful Relationships Education (Australia), and Early Intervention Foundation findings.

What next

- Successful expansion of the Drive Programme - now running across three local authority areas with further Home Office funding secured for 2026/7. Independent evaluation by Workforce Development Trust available.
- Pilot group work for medium-risk perpetrators underway (2025/6); next steps involve reviewing and deciding on future funding.
- Education in Schools: This year's Online Pupil Survey (OPS) will further evaluate pupil understanding. Ongoing work, funded by the Prevention Fund and other sources, will inform future VAWG school initiatives.
- Strategic Alignment: In line with the National VAWG strategy focus on prevention, efforts will continue to fill identified gaps in provision through partner collaboration.

Health and Happiness Hubs

Overview

This project involved the establishment of Health and Happiness Hubs, community-based, non-clinical programmes supporting people with long-term health conditions to improve wellbeing, confidence and quality of life. Managed by the VCSE sector and delivered in partnership with Primary Care Networks (PCNs) and local services, the hubs addressed wider determinants of wellbeing, including social connection, physical activity, mental health, housing, finance, and lifestyle. The hubs empowered people to value themselves and take an active responsibility in managing their health and happiness, helping to reduce demand on health and social care services.

Participants attended a ten-week programme focussing on health and wellbeing education, advice and practical guidance through interactive discussions and tasks. A strong focus on peer support helped reduce isolation, build confidence, and create lasting social connections, with regular reunion sessions offered between programmes.

What was achieved

- Hubs launched in January 2024 in Yate and Cadbury Heath, targeting priority cohorts identified through Population Health Management data.
- Established an open system for professional and self-referrals.
- Regularly reviewed programme content to remain responsive and flexible.
- Participants reported positive lifestyle changes, increased confidence, improved social connections and increased physical activity.
- Participants reported feeling welcome and safe, with positive peer support developing and groups meeting independently outside the hub.
- Hubs expanded to five locations across South Gloucestershire.

Scan this QR code to view our video, “**Health & Happiness Hubs**”.

Web Link - [Health & Happiness Hubs - YouTube]

Residents said:

“I’m definitely feeling more motivated now. I’ve started line dancing and I think much more about what I eat – before, I couldn’t be bothered.”

“I feel a bit more confident and think more about what I want and who I am. This was a great group and the hub is a great place. The discussions and chats are wonderful.”

Return on Investment

ROI is estimated between **£1.50–£2.50 per £1** invested, primarily reflecting reduced use of primary care and lower demand for long-term services, consistent with NHS England evaluations of self-management and health coaching. The **SROI** is higher, between **£3.00–£5.00 per £1**, factoring in enhanced confidence, social networks, and emotional wellbeing. These estimates are supported by NICE guidance (PH49) on behaviour change and findings from social prescribing models, including evaluations from the University of Westminster and NHS England’s universal personalized care framework.

What next

Secured additional funding to continue the hubs, including the recruitment of a second group facilitator to enable increased outreach work into rural and minority communities while still providing 1:1 support for those who cannot attend the hubs.

Village Agents Plus

Overview

This project helped isolated and vulnerable residents access high-quality local information, support, and services, enabling them to remain independent in their homes and reduce reliance on health and social care services. The Village Agents worked in partnership with communities to build resilience and empower residents to support each other.

- Provided personalised support, advice and signposting across health, wellbeing, mobility, financial and social needs.
- Engaged communities to identify gaps, devise solutions and maintain local facilities.
- Supported the creation of peer networks and local initiatives such as warm hubs, seated yoga and outreach foodbanks.
- Worked closely with Parish Councils, local organisations and service providers to coordinate support.

What was achieved

- Established strong links with communities and Parish Councils, with Village Agents held in high regard.
- Approximately 80 residents supported by February 2025, including complex cases.
- Assisted residents with a wide variety of issues, including social isolation, mental and physical health, access to services and financial support.
- Facilitated new local initiatives, e.g. warm hubs in Marshfield, seated yoga in Hawkesbury, outreach foodbank in Severn Beach.
- Roadshows and steering group meetings strengthened community engagement and collaboration across four local areas.

Residents said:

“It was such a relief to find someone I could talk to face to face, someone who took time to understand the issues and had the contacts to find out what was happening.”

Return on Investment

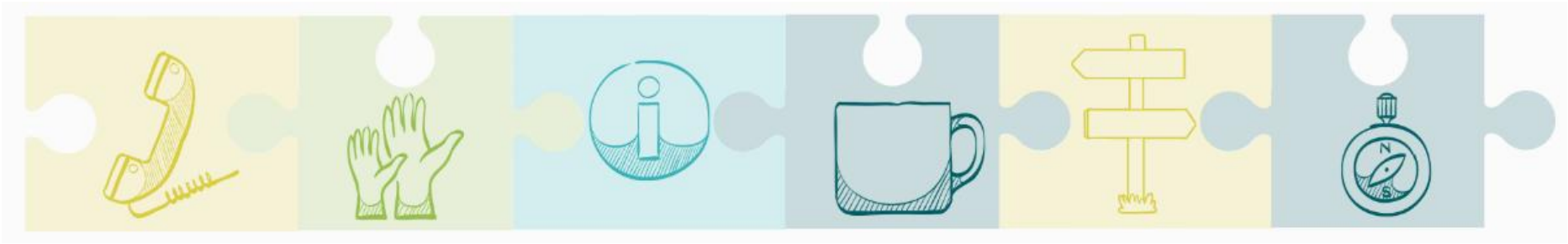
ROI was estimated between **£2.50–£4.00 per £1** invested, driven by reduced GP visits, delayed entry into formal care and avoided crises. **SROI** was estimated at **£3.50–£5.00 per £1**, reflecting improved wellbeing, reduced loneliness and strengthened community support networks. These estimates aligned with national evaluations of Age UK's Personalised Integrated Care programme and the Rotherham social prescribing pilot.

Case Study:

82-year-old lady received support with Blue Badge application, stairlift installation, Attendance Allowance and benefits, improving mobility, financial wellbeing and reducing isolation.

What next

Secured additional funding for the West of England Rural Network to continue to provide a Village Agent service in South Gloucestershire. Further information, including how to refer to the service, can be found here: https://www.wern.org.uk/southglos-village-agents



Improving Homes and Wellbeing Service

Overview

This project saw the establishment of the Improving Homes and Wellbeing Service (IHWS), designed to tackle poorly maintained homes and the underlying causes, primarily supporting older homeowners (aged 50+). By offering free, personalised interventions, the programme aimed to improve living conditions, promote independence, and reduce health and wellbeing risks. The service educated residents on home maintenance and wellbeing, connected them with financial and health support, and involved communities to build neighbourly resilience and reduce crime risk. Professionals benefited from an alternative referral pathway and collaborative working with Village Agents.

What was achieved

Year One

- 51 referrals received; 33 residents fully supported; 10 given advice only.
- Issues addressed included hoarding (14 cases), clutter (20), overgrown gardens (18), broken windows/house repairs (11) and fire/CO_2 risks (21).
- Distribution of essential items: 19 oil-filled radiators, 56 heated blankets, 40 cold weather packs, 10 boiler services, 40 door draught excluders, 15 extension leads.
- Financial benefits: Estimated £45,000 saved through avoided enforcement; NHS savings from damp, cold, and fall prevention may reach £313,500.
- £14,000 additional client support funding from St. Monica's Trust.

Year Two

- 43 referrals received; 85 more residents supported via practical items (heated blankets, well packages, energy bulbs, extension leads, boiler services).

Outcome	Number of People Helped
Improved living conditions	6
Home/garden improvements	21
Prosecutions/enforcement prevented	9
Fewer GP/hospital visits	15
Health and wellbeing improvements	21
Slips, trips, and falls prevented	17
Support networks improved	24
Positive service outcomes	22
Safeguarding concerns resolved	8

- 96 residents assisted with: 23 oil radiators, 76 heated blankets, 40 cold weather packs, 25 extension leads, 40 draught excluders, 150 energy bulbs, 21 boiler services.
- Critical interventions: two boilers and one gas cooker condemned and replaced via grant support.
- Wales and West provided £35,000 funding for 121 boiler repairs, ensuring safe winter heating for vulnerable residents.

Partnership Impact

The involvement of Age UK South Gloucestershire proved invaluable, leveraging trusted connections with the 50+ community and enhancing holistic wellbeing through additional projects like walking clubs and financial clinics. This partnership supported residents to remain safely and independently at home.

Case Study: J's Story

J's home fell into disrepair, and he was hospitalised due to mental health issues and diagnosed with dementia. IHWS coordinated entry to his home, installed a key safe, addressed heating and safety concerns, and provided essential household repairs and cleaning. These interventions enabled J's safe return home and avoided a potential weekly care cost of £1,000. The social worker praised the service's efficiency and impact, highlighting its role in multidisciplinary hospital discharge and ongoing support.

Return on Investment

Estimated **ROI was £4.50–£7.50 per £1** invested, driven by reductions in health and social care costs (falls, winter deaths). Estimated **SROI was £7.00–£10.00 per £1** invested, reflecting improvements in comfort, independence, and mental wellbeing. Evidence base: BRE's cost-benefit analysis, PHE toolkit, Welsh RRAP programme.

Consistently high referral and uptake rates demonstrated trust in the service and its team. The IHWS significantly improved residents' health, wellbeing, and safety, enabling them to remain in their homes for longer. Rapid consideration for continuation and potential scaling was recommended to sustain its preventative impact on statutory services such as Adult Social Care and the NHS.

What next

Secured additional funding for Age UK South Gloucestershire to continue the service in 2026/27 subject to putting in place a longer-term plan for commissioning the service from 2027. Age UK South Gloucestershire | Improving Homes & Wellbeing

Asset-Based Community Development (ABCD) Framework and Community in Action Enablement Grants

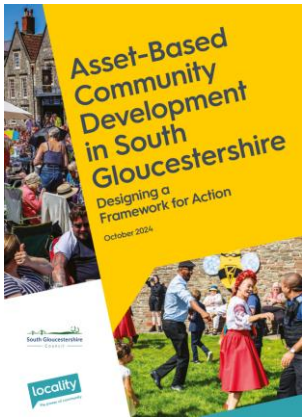
Overview

This programme strengthened communities by focusing on their existing strengths, assets, and capacities, rather than deficits. The ABCD approach identified individual skills, experience, enthusiasm, networks, and physical spaces such as parks or buildings, enabling community-led development. The Community in Action Enablement Grants put this into practice by providing flexible funding to support locally driven plans, helping communities address inequalities, improve wellbeing, and reduce demand on public services.

- Developed a consistent ABCD Framework for South Gloucestershire to guide strategic partnership working.
- Supported VCSE, local communities, and Town/Parish Councils to identify and harness local assets.
- Enabled transformational change in how the Council and partners engage with communities.
- Provided grants through Community in Action Enablement to fund locally tailored community initiatives aligned with ABCD principles.
- Integrated with the Information, Advice, and Guidance project to promote preventative working across the wider prevention programme.

What was achieved

- In September 2023, national organisation ‘Locality’ was commissioned to help develop and deliver the ABCD Framework for South Gloucestershire, in partnership with local stakeholders.
- Extensive cross-sector engagement (pop-ups, meetings and co-production workshops) took place to assess awareness, opportunities and training needs.
- Creation of an ABCD Framework with core principles, actions, and indicators and an ABCD training plan to build stakeholder capacity.
- Strengthened relationships across sectors, facilitated a growing awareness and support for ABCD and early grant activity enabling communities to act on local priorities, fostering empowerment, resilience and preventative outcomes.



[Stronger Together - Asset-Based Community Development for South Gloucestershire - Leaflet]

[Asset-Based Community Development in South Gloucestershire - Report]

Return on Investment

Estimated **ROI** was **£1.50–£2.00 per £1**, based on more efficient use of local resources and reductions in service duplication. **SROI** was estimated at **£2.00–£3.00 per £1**, reflecting increased social capital, civic participation and resilience. These values were supported by Locality and NEF research on ABCD models, as well as the IMPACT Age well project in Northern Ireland, which demonstrated strong social returns from community-led health improvement.

What next

Continued use and embedding of the ABCD Framework in business-as-usual and remaining funds for community grants to be allocated during 2026-27.

Information Advice and Guidance (IAG)

Overview

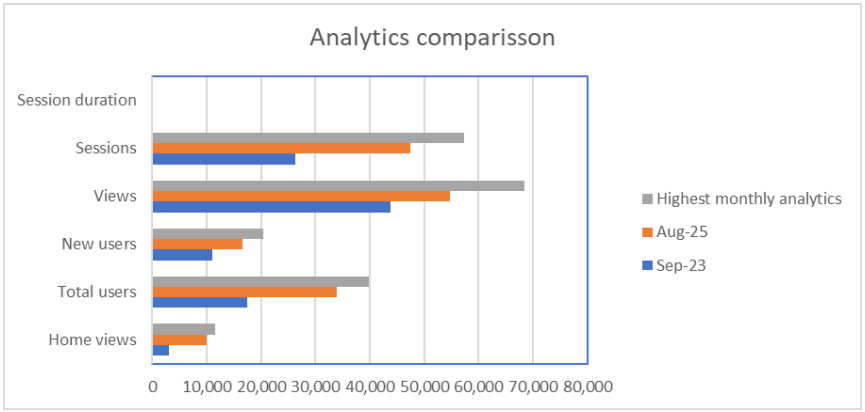
This project strengthened preventative working by enhancing South Gloucestershire Council's South Glos LIFE website and asset-mapping tools (directory of services). A clear, well-promoted IAG offer to help residents make informed decisions about their wellbeing, supports frontline staff and reduces digital exclusion - particularly in rural communities. The project delivered targeted communication, partner outreach and training to increase awareness, usage, and confidence in navigating available support.

What was achieved

- Promoted South Glos LIFE through presentations, digital/print materials, social media, and partner newsletters to increase awareness and uptake across internal teams, partners, rural forums, and VCSE groups.
- South Glos LIFE became the recommended 'directory of services' so it was better populated and used by stakeholders.
- Stakeholder insights informed redevelopment of the website to improve accessibility and relevance.
- Improved and positive feedback received about the look, feel and content of the website.
- Delivered the 'Tea and Tech – You Said, We Did' pilot with Village Agents (WERN) and Age UK South Glos to support digitally excluded rural residents in navigating the site.
- Age UK South Glos now uses the website as the homepage for tablet-loan schemes and as a teaching tool in 1:1 and group digital inclusion sessions.

Website Growth (Average Monthly, Sept 2023 – August 2025)

+3,121 Home views
+5,511 total users
+3,184new users
+7,948 sessions
+6,369 page views



Return on Investment

Improved digital access strengthens independence, connects residents to services and enhances preventative support. Increased awareness and use of IAG reduces isolation, supports wellbeing and builds capacity for frontline staff. Estimated **ROI** was **£1.50–£2.00 per £1**, based on more efficient use of local resources and reductions in service duplication. **SROI** was estimated at **£2.00–£3.00 per £1**, reflecting increased social capital, civic participation and resilience. These values are supported by Locality and NEF research on ABCD models, as well as the IMPACT Age well project in Northern Ireland, which demonstrated strong social returns from community-led health improvement.

What next

Integrate the promotion of South Glos LIFE and the directory of services into everyday operations, with all officers taking an active role in engaging residents and partners. In line with stakeholder support, there are plans to further amplify the South Glos LIFE website across social media and other council platforms, ensuring wider community awareness and access to resources for the future.

Resources

UWE Evaluation Report

Prevention Toolkit

Locally delivered training courses

Behaviour Change Development Framework - BCDF – sets out what sort of behaviour change training and planning is needed to effectively support people to make positive changes in their lives.

Making Every Contact Count - elearning for healthcare – national MECC online training.

Population Health Intelligence Portal | BETA - South Gloucestershire Council (home of the South Gloucestershire Joint Strategic Needs Assessment (JSNA)).

South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29

Home | One You South Gloucestershire – South Gloucestershire healthy lifestyles information.

Events and webinars - The Health Foundation – national events and webinars.

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Acknowledgements

Prevention is everyone's business. This DPH report is evidence of that and represents whole team effort in the Public Health and Wellbeing Division at South Gloucestershire Council and colleagues across the Council, NHS, and voluntary sector and in our local communities and University of the West of England. Thanks go to everyone who contributed to this report.

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We also appreciate all other colleagues and partners who have continued to invest efforts in prevention and tackling health and wellbeing inequalities in South Gloucestershire

South Gloucestershire Council

Delivering for you

Prevention in South Gloucestershire

Director of Public Health Annual Report – 2025

Sarah Weld

Director of Public Health

Introduction

South Gloucestershire Council

Delivering for you

The 2025 Annual Director of Public Health Report focuses on Prevention in South Gloucestershire.

The Annual Director of Public Health Report is an opportunity to:

- Showcase the health of the local population and highlight health issues.
- Contribute to improving the health and well-being of local populations and reducing health inequalities.
- Promote action for better health and assist with the planning and monitoring of local programmes and services that impact on health over time.

Purpose of this report

- Celebrate the excellent partnership work that has taken place over the last few years on prevention through our South Gloucestershire Prevention Programme 2023-25 and share evaluation findings.

- Share the Making the Case for Prevention Toolkit produced as part of this work

- Make the case for ongoing investment in prevention in South Gloucestershire and to set out the opportunities I see for building on this in response to local, regional and national policy including the national 10 Year Health Plan for England: fit for the future.

What do we mean by prevention?

South Gloucestershire Council

Delivering with you

Prevention can be simply defined as *the action of stopping something from happening or arising.*

From a public health perspective prevention means taking action to help people live longer, healthier lives.

There are opportunities for prevention:

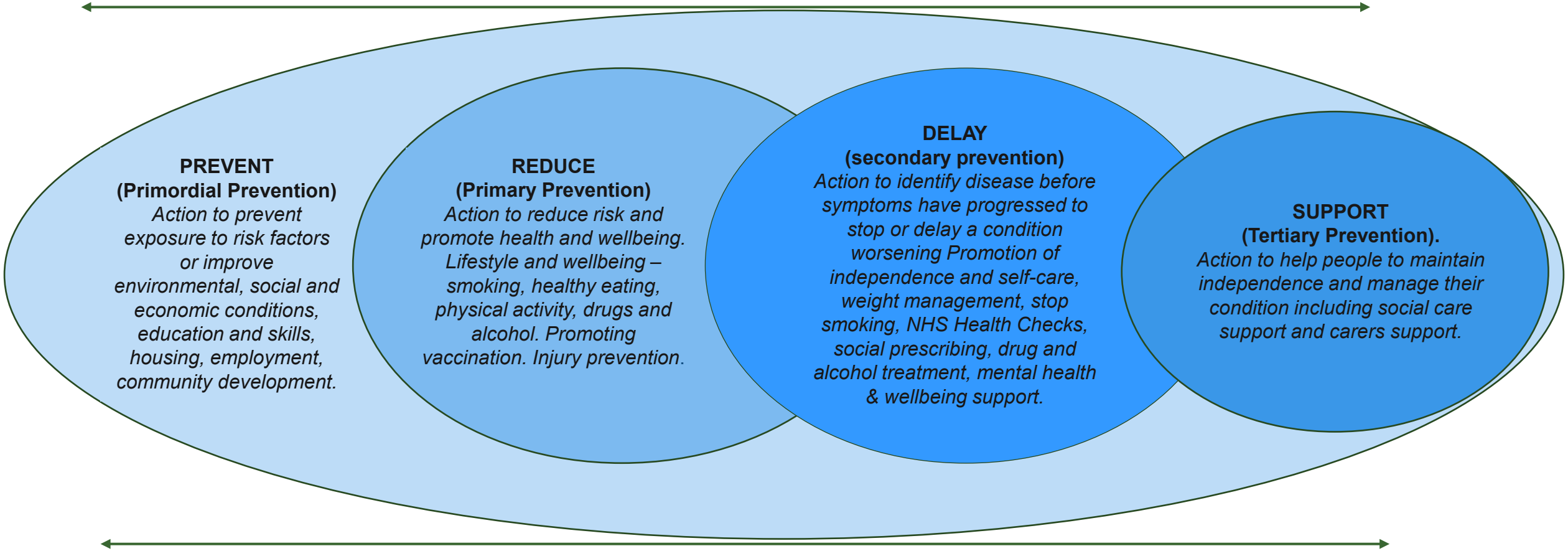
- **Across the life course** - by giving every child the best start, supporting working-age adults, and enabling older people to age well.
- **In our communities** - by strengthening connections, reducing isolation, building on existing assets, and tackling local inequalities.
- **In services people use** - embedding prevention into health, education, housing, and social care
- **Through joined up strategic work** on the 'Building Blocks of Health' such as education, housing and employment.

South Gloucestershire Prevention Framework

South Gloucestershire Council

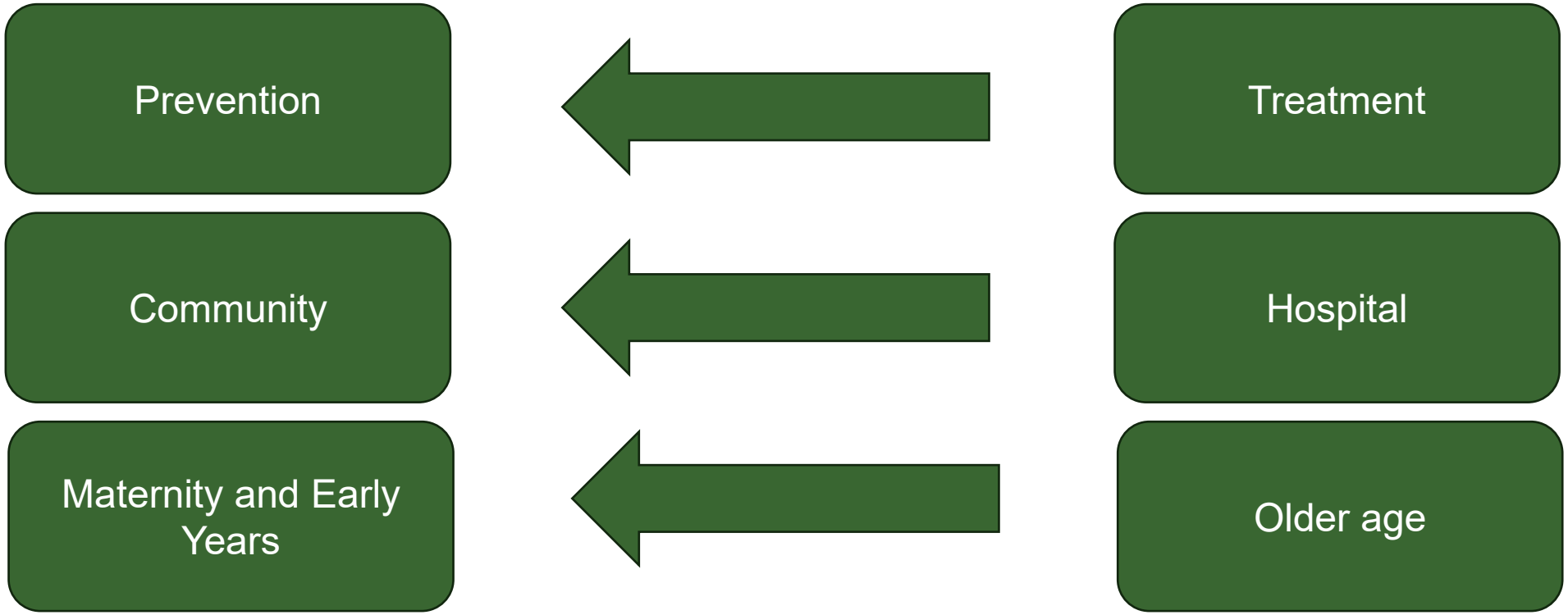
Delivering for you

Maternity	Early years	Childhood & adolescence	Working age	Older age	Edge of care/ requiring support



Primordial Prevention	Primary Prevention	Secondary Prevention	Tertiary Prevention

The “left shift”



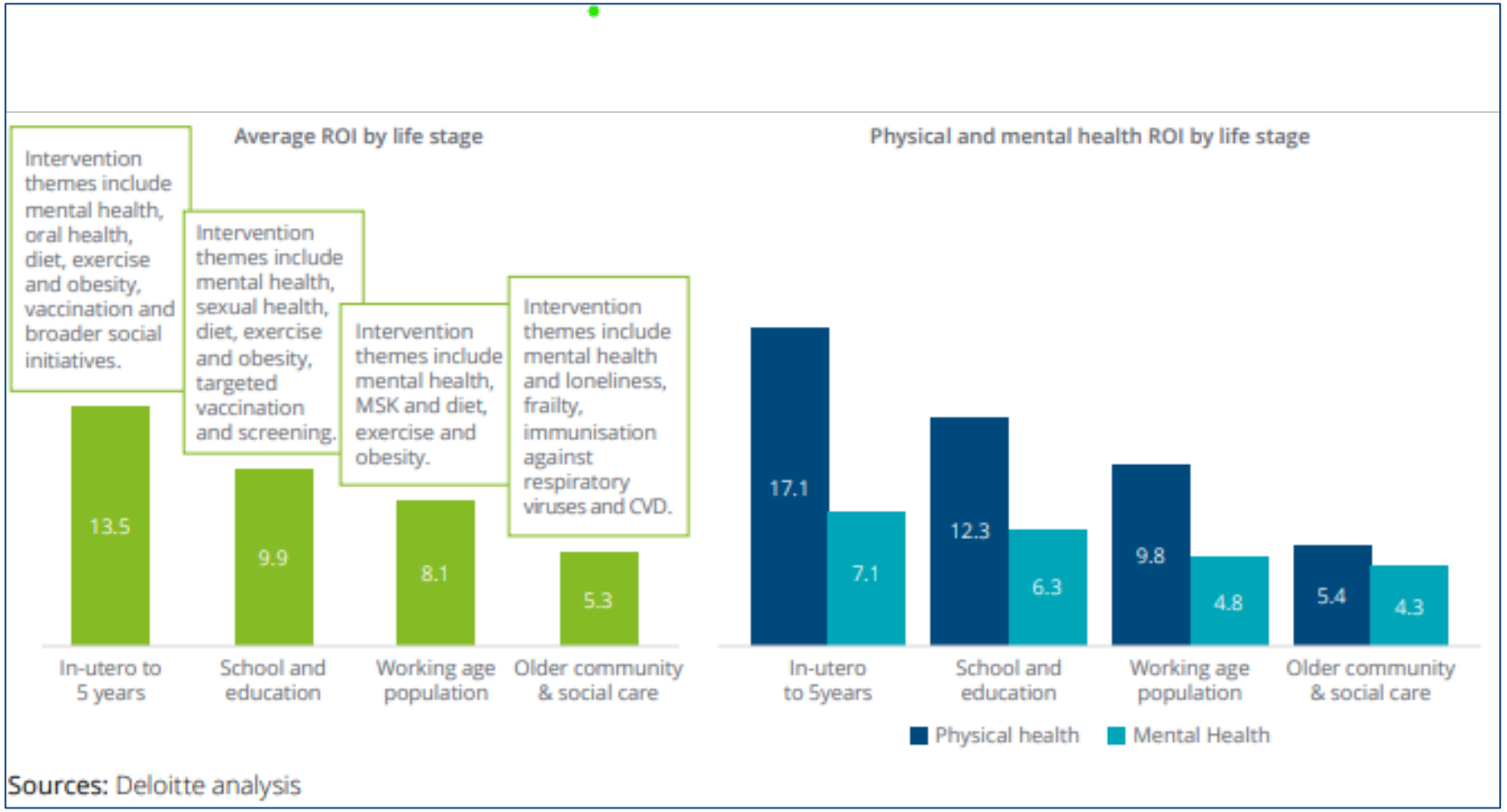
Why prevention matters

Many health and care challenges stem from preventable risks and there is a strong case for the social and economic benefits of prevention across the life course.

Prevention matters because:

- It improves quality of life and reduces health inequalities.
- It saves money, makes better use of limited resources, and can reduce demand for services.
- It tackles inequalities.
- Every £1 invested in prevention can deliver significant social and economic benefits.
- Multiple small changes across a whole system can have a big cumulative impact.

Prevention – Return on Investment



ROI traditionally focuses on how much money is saved or earned for every £1 spent or invested

SROI is a broader concept, monetising social, wellbeing, and community outcomes improved mental health, reduced loneliness, enhanced resilience, or better housing security vital to wellbeing and healthy lives

South Gloucestershire Prevention Programme Evaluation
ROI and SROI Estimates (Min–Max Ranges)

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Project	ROI Range (Min–Max)	SROI Range (Min–Max)
1. Cost of Living: Warm Pack & Household Support Fund	£1.00 – £2.00	£2.00 – £5.00
2. Health and Happiness Hubs	£1.50 – £2.50	£3.00 – £5.00
3. Creative Solutions Board (CSB)	£4.00 – £10.00	£7.00 – £12.00
4. Community in Action (ABCD)	£1.50 – £2.00	£2.00 – £3.00
5. Village Agent Project	£2.50 – £4.00	£3.50 – £5.00
6. VAWG Schools Programme	£3.00 – £6.00	£6.00 – £10.00
7. Improving Homes & Wellbeing Service	£4.50 – £7.50	£7.00 – £10.00
8. Health Promotion in Education Setting	£2.00 – £4.00	£6.00 – £10.00

Challenges of investing in prevention

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	Payers	Beneficiaries	Why this matters
Early years and school age interventions	• Local authorities • Education budgets • Schools • NHS	• The NHS (through reduced chronic disease later in life) • Employers (through a healthier, more productive workforce) • Society (through higher earnings and reduced welfare dependency)	The education sector pays for interventions, but the bulk of the financial and health returns are realised decades later, outside its budget
Working age population interventions	• NHS • Employers (via workplace wellbeing and occupational health programmes) • Local authorities	• Employers (reduced absenteeism and presenteeism) • The wider economy (higher productivity and tax receipts) • Families (better household stability) • NHS (reduced healthcare costs)	Employers fund interventions but often only capture short-term productivity gains, while the NHS and Treasury realise longer-term cost savings and fiscal benefits
Older population interventions	• NHS • Local authorities (social care budgets)	• The NHS (through avoided admissions) • Local authorities (delayed residential care) • Carers and families (reduced burden)	The costs are highly visible in NHS and local authority budgets, while the wider value – reduced carer burden, avoided welfare dependency, improved wellbeing – is rarely monetised or modelled

Sources: Deloitte analysis

It is widely recognised that prevention has repeatedly been given less attention than more immediate pressures on the NHS and social care.

This is because short-term budgetary pressures often require organisations to demonstrate in-year cashable savings, whilst prevention initiatives tend to have longer-term horizons in terms of impact on individuals and communities and return on investment

Prevention as a national and local priority

Local Authorities and the NHS have statutory responsibilities for undertaking prevention and the wider public sector, the voluntary, community and social enterprise (VCSE) sector and the business sector all have a role to play.

Prevention has long been a priority in South Gloucestershire. Many current local and national policies set out a commitment to prevention.

Implementing community prevention interventions requires robust and systematic approaches to measure and value population impact effectively and this is why in South Gloucestershire we have created the Making the Case for Prevention Toolkit

Next steps

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In 2026 our Public Health work will include:

- **Promoting this report and the South Gloucestershire Prevention Toolkit** to raise awareness and better enable council teams and partner organisations to build return on investment thinking into project planning.
- **Continuing to lead and promote the** South Gloucestershire Joint Local Health and Wellbeing Strategy 2025-29 strategic commitment to shift upstream with a focus on prevention.
- **Reviewing our Public Health core training offer** and sharing learning opportunities about the prevention of ill health, the importance of the building blocks of health, the science of behaviour change and reducing health inequalities. This will involve locally delivered training and signposting to regional and national resources, such as Making Every Contact Count - elearning for healthcare, the Behaviour Change Development Framework - BCDF and Events and webinars - The Health Foundation.
- **Working with partners to develop and implement Neighbourhood Health and Best Start in Life Plans** with a focus on prevention and early intervention; reaching people earlier and empowering them to stay healthy and well and achieve and thrive.

Call for Action

Based on the evidence presented in this report including findings from the Prevention Programme we set out below **six actions** that partners across the **council, the NHS and VCSE organisations** should take together to **shift the system towards prevention**, grounded in evidence from local and national place-based practice

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Action	What this would look like
1. Align priorities and funding around longer-term shared prevention outcomes	• Recognise that prevention initiatives tend to have **longer-term horizons** in terms of impact on individuals and communities and return on investment • Agree a **set of shared prevention goals** to work together on across partnerships • Align outcomes and funding so prevention is a **core, jointly owned objective**. • Move from short-term pilots to **multi-year investment** that gives delivery partners and communities stability.
2. Embed prevention into frontline services and pathways	• Make prevention "everyone's business" by embedding **brief interventions, social prescribing and early help** into primary care, social care, housing and employment services. • **Routinely ask** about issues such as social and lifestyle determinants of health and respond by signposting to information, support and training (see links on Resources page). • Support workforce training across sectors so staff understand **prevention, behaviour change and trauma-informed practice**.
3. Tackle the building blocks of health together	• Coordinate action on **housing quality, employment, income, education, transport and green space**, recognising these as prevention interventions. • Use council levers (planning, licensing, procurement) alongside NHS influence and VCSE reach to create **health-promoting settings, neighbourhoods and places**. • Prioritise prevention efforts in communities experiencing the **greatest health inequalities**. • **In our role as employers**: maximise workforce wellbeing, workforce training and development. • **In our roles as "anchor institutions":** consider the building blocks for health and how to improve the local economy and provide a healthy environment to support population health outcomes.
4. Invest in community-led and VCSE-delivered prevention	• **Understand what outcomes matter to people.** Be brave in our redistribution of power and agency to communities so that we build on existing assets and strengths. • Shift resources upstream by working with or commissioning **VCSE organisations** to plan and deliver prevention activity with and in local communities. • Use asset-based approaches that build on **community strengths**, not deficits.
5. Share data and insight to target early action	• Combine quantitative data with **VCSE insight and lived experience** to understand what's really driving need locally. • Develop **shared population health intelligence** across partners which enable evidence-based actions to be targeted where they are most needed.
6. Measure what matters and learn together	• Shift performance frameworks away from activity and throughput towards **long-term outcomes, wellbeing and reduced demand**. • Recognise that whilst it can be difficult to show impact on outcomes short term, with the use of tools, such as the **Prevention Toolkit and the RE-AIM framework** we can identify more interim shifts (for example in mindsets, experiences, structures and support mechanisms) that move us in a more positive direction. • Build in **learning, evaluation and improvement** from the start, using the Prevention Toolkit to make the case for prevention and the expected economic and social return on investment for the population or community concerned; and build this into decision making and performance monitoring. • **Share learning openly** across the system to scale what works and stop what doesn't.

Image generated with Copilot

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Thank you

Any questions?

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BNSSG INTEGRATED CARE PARTNERSHIP BOARD
FORWARD AGENDA PLAN

1.30 pm – 4.00 pm, 16 April 2026 (Council Chamber, City Hall, College Green, Bristol, BS1 5TR)
- Update from Integrated Care Board Chair
- Health and Wellbeing Board and Locality Partnership updates including local Neighbourhood Health and Wellbeing Plans
- Intelligence centre update
- Prevention in BNSSG – insights from Directors of Public Health Annual Reports

Meeting dates for 2026-27 Municipal Year:

1:30-4:00pm, Thursday 16th July 2026 (S. Gloucestershire, venue TBC)
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
-Neighbourhood Health and Care Plans update
- Workshop on the role of ICP

1:30-4:00pm, Thursday 10th September 2026 (Vision North Somerset, Bradbury Room, 3 Neva Road, Weston-super-Mare, BS23 1YD)
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships
- Potential workshop around collaborative approach to corporate parenting and its relationship with health (further to the 11 Sept 25 presentation/discussion on corporate parenting)

1:30-4:00pm, Thursday 12th November 2026 (Beira Room, City Hall College Green, Bristol BS1 5TR)
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships

1:30-4:00pm, Thursday 18th February 2027 (S. Gloucestershire, venue TBC)
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships

1:30-4:00pm, Thursday 15th April 2027 (Vision North Somerset, Bradbury Room, 3 Neva Road, Weston-super-Mare, BS23 1YD)
- Update from Integrated Care Board Chair
- Update from Health and Wellbeing Board Chairs x3
- Update from Locality Partnerships

Items to be scheduled:
- Voice of lived expertise (with representatives from disability and race equality networks)
- Local Healthwatch update