NHS
Gloucestershire, Bristol, North Somerset and South Gloucestershire
Integrated Care Boards

Understanding Gloucestershire and BNSSG: an Integrated Needs Assessment

Gloucestershire, Bristol, North Somerset, and South Gloucestershire ICBs

November 2026



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Background and context

Fit For the Future, the 10 Year Health Plan for England, provides a clear vision for the Gloucestershire, and Bristol, North Somerset, and South Gloucestershire (BNSSG) ICBs. It outlines three shifts intended to transform the NHS into a system that is fairer, more coordinated and patient-oriented, more fully maximising the benefits of technology, with a renewed focus on prevention.

Underneath the 10 Year Health Plan, the Medium Term Planning Framework outlines the new operating model to deliver these changes, including a new neighbourhood health approach. Alongside this, we have described what good, evidence-based care looks like in six priority areas through the new and planned Modern Service Frameworks, to ensure greater consistency in service delivery across England.

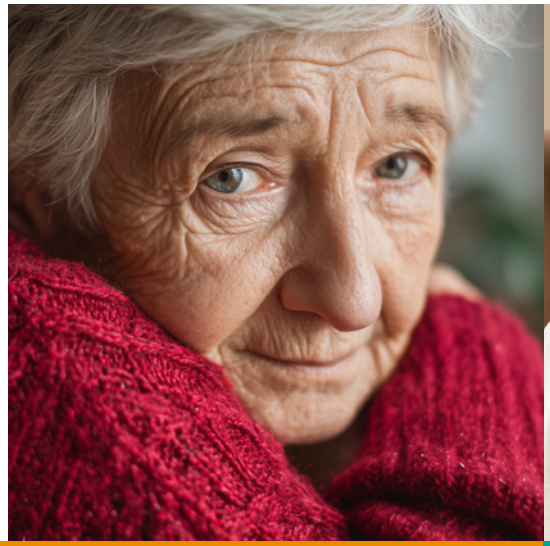
Taken together with the updated commissioning cycle outlined in the Strategic Commissioning Framework, Integrated Care Boards have renewed purpose in responding to population need, aligning with the ambitions outlined in our Population Health and Strategic Commissioning Plans. The Integrated Needs Assessment (INA) is one of the ways in which evidence feeds into strategic planning.

This INA does not start with a blank page.

We know that our health is affected by having the right building blocks in place, such as strong family and community relationships, safe quality housing, meaningful work, good education and freedom from discrimination. For many, these building blocks are missing, which worsens people's social or job opportunities, habits and ultimately their health. We also know that ill health and risk factors don't exist in isolation; they cluster within individuals, families and communities[1]. More information on our population can be found in **Gloucestershire's previous Integrated Needs Assessment**, and BNSSG's **Our Future Health: Three Years** on report, which this INA builds on.

The priority areas included here therefore largely represent priorities identified through our business plan and existing commitments across the Cluster. They include areas that are currently moving at pace, such as supporting **people living with frailty** through a neighbourhood approach, as well as **maternity** where there is already an established Case for Change in Gloucestershire. However, it also identifies areas where we don't know enough yet about our priorities, where more data and insight is needed to ensure effective strategic commissioning.

This INA has also been developed during a period of significant organisational transition and the development of new intelligence arrangements across Gloucestershire and BNSSG since the two ICBs Clustered in April 2026. It therefore takes a deliberately pragmatic approach: drawing together the strongest available evidence across the footprint, alongside deeper analysis of four areas of particular strategic importance. It does not seek to provide an exhaustive assessment of every aspect of population need, but provides an important evidence input to the current planning cycle and a foundation from which future INAs can build. Further details on the method used to produce the INA can be found in Appendix A.





There are five key areas on which this INA looks to deliver key insight and information to inform commissioning plans, in line with national guidance:

	Approach in this INA	Future ambition
Person-level data, segmentation, and risk	This INA references the varied approaches to segmentation and risk stratification used historically across Gloucestershire and BNSSG, as well as including insights from analysis using person-level data.	While taking a pragmatic approach to the data and approaches already available across Gloucestershire & BNSSG, work will continue to bring together a single person-level data for the new ICB footprint. This will require significant time and resource given the technical complexities.
Quantitative analysis, plus research and lived experience	This INA includes quantitative analysis, research and lived experience, broken down by Place and other population characteristics where possible.	Future iterations will more clearly be able to disaggregate this analysis and insight consistently by Place and other population groups across the new ICB footprint such as 'Core20' and locally identified 'PLUS' groups.
Drivers of demand, wider determinants, activity, and cost	This INA considers both drivers of demand and wider determinants across the four chosen	Work on activity and cost is already ongoing as part of the ICB planning process and will be considered alongside future INAs.
Inequalities in access, experience, and outcomes	This INA clearly highlights inequalities in access experience, and outcomes.	Future iterations of the INA will seek to build on the data available currently, including in the ways outlined in each chapter here. The ICB is already developing new approaches to disaggregating data as standard where possible across all outputs to better inform strategic commissioning decision.
Clear opportunity for prevention or redesign	This INA identifies areas of opportunity throughout for the four chosen areas. It also provides examples of where previous successful prevention or redesign activity can inform future changes.	This will continue in future Gloucestershire and BNSSG INAs.

In line with the Strategic Commissioning Framework, the Gloucestershire and BNSSG Cluster is currently also well-advanced in actively developing its intelligence function. As part of the development, this INA identifies areas for future development in terms of data availability and in particular where data to inform our understanding of health inequalities needs further development. These areas will continue to be a focus for the intelligence function, and future refreshes of the INA will report on progress in this area.

Please note, the evidence presented in this Integrated Needs Assessment draws on existing analyses undertaken using different methodologies, datasets and reporting periods across Gloucestershire and BNSSG. Direct comparison of rates and indicators is not always possible. However, similar themes and patterns have been identified across both systems and inform the Cluster-level insights wherever possible.

In addition, throughout this report, we use different terms to refer to people's ethnicities. Where we draw on another report we use the language of the original to accurately reflect the insights, approach, and intentions there. Where we report inequalities observed in local or national outcomes data without existing reporting, we use the language of the NHS Race and Health Observatory in that where "context is not decisive, we will use collective terms such as 'Black and minority ethnic', 'ethnic minority', 'Black, Asian and minority ethnic' interchangeably"[2].

Executive summary

NHS Gloucestershire ICB and NHS Bristol North Somerset and South Gloucestershire ICB clustered in April 2026. The ICB Cluster serves a population of around 1.7 million.

This Integrated Needs Assessment establishes a shared evidence base for strategic commissioning across Gloucestershire, Bristol, North Somerset and South Gloucestershire.

Existing data and insights present a clear picture of our Cluster:

- A growing, but ageing population where some people experience the earlier onset of multiple conditions than average.
- Persistent inequalities associated with deprivation, ethnicity and geography.
- Despite varying needs between Place and neighbourhood, there is a consistent preference from people that their care be organised around them as a person, not siloed by service or pathway.
- A clear need for strengthened prevention and early intervention, particularly for those communities and populations experiencing the poorest outcomes.

This INA first outlines these demographic trends and differences in experience of access and care. These then continue throughout four priority areas explored in more depth. Across the chosen areas of focus, key findings highlight clear opportunities, and the importance of prevention for Gloucestershire and BNSSG:

Maternity and neonatal care:

1. Inequalities in outcomes, access and experience remain the most significant challenge across our ICB footprint. Reducing these inequalities must be a priority, and will require a coordinated approach to maternity intelligence and improvement.
2. Our maternity services are supporting increasingly complex populations, with uncertainty about the impact of population growth in this area due to (internal and international) migration in particular. Strengthening quality of care, including prevention and pre-pregnancy, is therefore crucial.
3. Prevention and early intervention offer the strongest opportunity for improvement across Gloucestershire and BNSSG.

People living with Severe Mental Illness (SMI)

1. Premature mortality and health inequalities remain our most significant challenge.
2. The quality and experience of care is inconsistent across Gloucestershire and BNSSG, and can contribute to poorer outcomes. Person-centred and joined-up care may offer a way to a more equitable experience.
3. Within this, prevention, physical health support, including physical health checks and follow-ups, and integrated care offer our clearest opportunity for improvement.

Preventing and treating cardiovascular disease

1. Most cardiovascular disease is preventable, making prevention our highest-impact intervention opportunity.
2. Significant opportunities exist across the Gloucestershire and BNSSG area to improve identification and management of cardiovascular risk, including hypertension control, treatment optimisation, and earlier identification of risk.
3. Effective prevention requires community-based, person-centred approaches, not clinical care alone. This includes specifically reducing inequalities for our deprived communities, Black and minority ethnic populations.

Supporting people living with Frailty

1. Growing rates of frailty and clinical complexity will place increasing pressure on our health and care services – with expected growth of this population between 30-40% across the Cluster. The potential impact is substantial, with frailty-related activity accounting for almost 45% of potentially mitigable hospital admissions across Gloucestershire and BNSSG.
2. Earlier intervention can prevent avoidable decline, maintain independence and reduce hospital use.
3. Successful neighbourhood approaches in Gloucestershire and BNSSG, providing coordinated multidisciplinary support closer to home, must support both individuals and their carers.

These key findings will be built on by further analysis as required to support our work and strategic commissioning in each area.

Throughout this document there are also several consistent considerations that are applicable to each chosen priority area:

- The connections between the building blocks of good health (for example, our environment, education, exercise, and relationships) and their effects on opportunities and healthy habits mean that poor health clusters within individual people, families and communities. For example, early analysis by BNSSG ICB suggests that almost 10% of variance in nonelective healthcare use is accounted for by differences in household and area.
- Past and current experiences of racism, trauma and multiple disadvantage can have a significant and wide-reaching impact on how people access and experience health and care. This impact is present throughout all the priority areas covered in detail in this report, with some evidenced through lived experience and some visible directly in outcomes data. We recognise that anti-racist and trauma-informed approaches are important and necessary to reduce the harm caused by these experiences.[3]
- People are more than a collection of their conditions. As highlighted in BNSSG's **work to understand working age adults affected by multiple long-term conditions**, being treated as an individual is paramount for people.
- People can fit into more than one 'category'. Different parts of a person's identity can overlap and shape their experiences. This can mean they face multiple barriers to getting healthcare at the same time, making it even harder to get the care they need.

Opportunities for strategic commissioning

As noted above, through local and national insight, we know that people want to be treated holistically by the individuals and services that provide them with care, and not as a collection of conditions through parallel pathways that never meet.[4] So, while this report looks at the current picture of need predominantly by Place and relatively large population groups, in using this evidence to inform strategic commissioning, we need to consider people as a whole in our solutions.

In that context, opportunities include:

- Developing a shared commissioning model across the Cluster with aligned outcomes, trajectories and accountability, using the INA as a regularly refreshed Cluster-level document supported by Place-level detail.
- Accelerating person-centred, trauma-informed, integrated neighbourhood models of care that combine physical health, mental health, social care, VCSE and wider community support, with particular attention to frailty, severe mental illness and people with multiple health needs.
- Prioritising prevention, including cardiovascular risk identification and treatment optimisation, smoking cessation, preconception care, falls prevention, and action to delay frailty and multimorbidity.

Measuring progress against outcomes

At a local level, we recognise we have work to do to identify the outcomes and interim measures that will allow us to ensure our work is having the intended impact, working towards the three key shifts under the 10 Year Health Plan, while improving delivery in the ways that are most important to our population. For example, we are committed to more consistent reporting of all metrics disaggregated by key priority population groups, including Core20PLUS5, as well as a better understanding of patient experience.

The priority areas covered in this INA are at different stages not only of planning and delivery but, in part reflecting those differences, also in terms of data maturity:

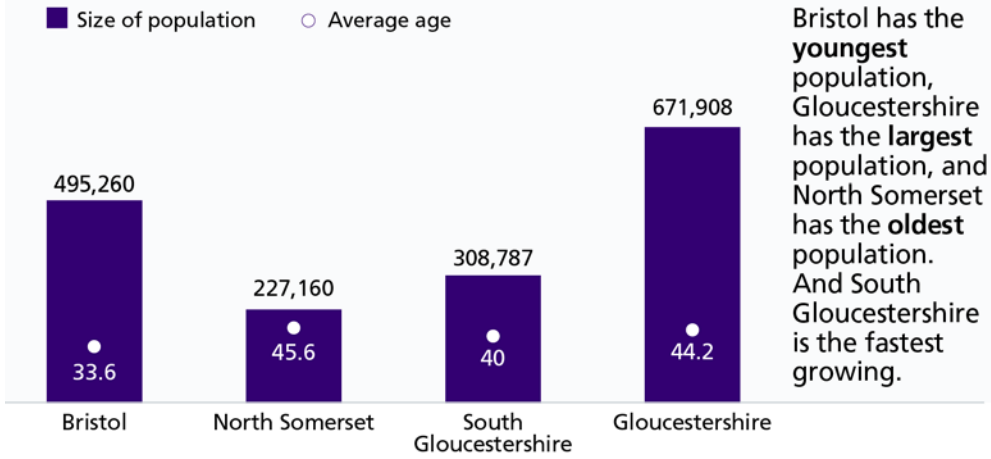
- Maternity data is largely very good across both ICBs. There is a clear overarching case for change in Gloucestershire, and a planned update to the BNSSG Maternity Needs Assessment. The focus for data and monitoring should be on providing a full picture of the intersectional inequalities in this area.
- Data about the outcomes and experiences of those living with Severe Mental Illness is less consistent across the Cluster, and further development is needed.
- CVD is supported by a significant amount of data from local and national sources, with clear and immediate high-impact opportunities for interventions. Data requirements will be focused on ensuring we are able to measure the impact on population health of treatment optimisation.
- The data available to support understanding of the outcomes and experiences of those living with frailty is developing at pace, alongside our approach to neighbourhood health. New ways of working are still being established, and outcomes and experience data will therefore need to align to these, including on cohort definitions to ensure robust evaluation.

This will naturally affect next steps in developing outcomes measures, reflecting how advanced each area is in its development. In addition, we anticipate all stated outcomes and outcomes measures should be developed through a process of co-production. This is essential to ensure that we are measuring the things that matter to people, and that we are able to monitor the changes we want to see from our activity.

Part 1

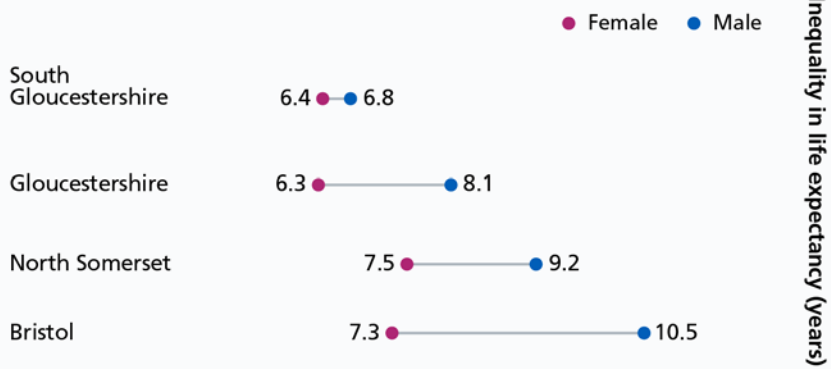
Summary of Places[a]

Around 1.7 million people live in G-BNSSG...



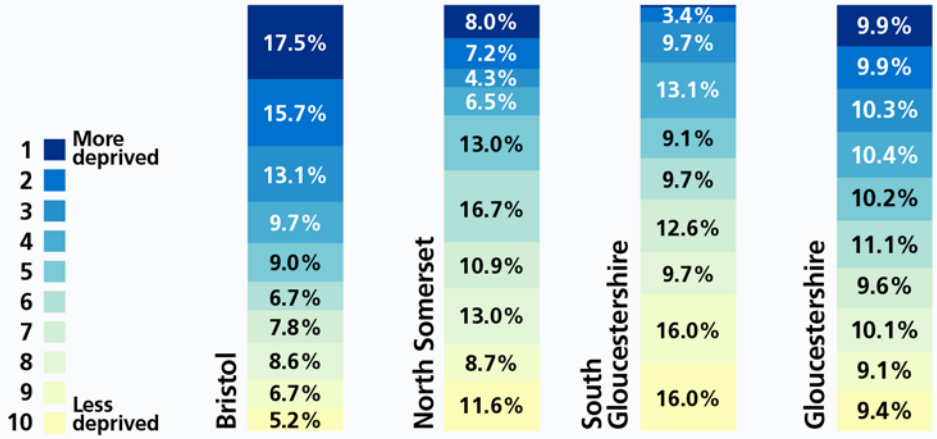
Bristol has the **youngest** population, Gloucestershire has the **largest** population, and North Somerset has the **oldest** population. And South Gloucestershire is the fastest growing.

Men living in the most deprived areas in Bristol live on average **10.5 years less** than a man living in the least deprived areas...

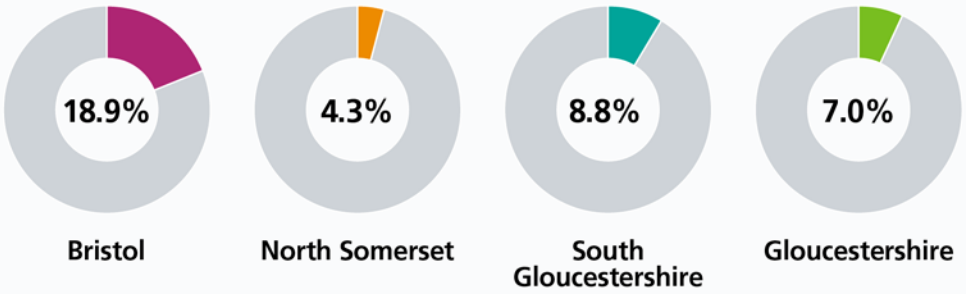


...Women living in North Somerset in the most deprived areas live **7.5 years less** than women living in the least deprived areas.

There are wide variations in deprivation



Black and minority ethnic groups



[a] 1. ONS Mid Year Population Estimates (2025), 2. Inequality in Life Expectancy at birth (2022-4) OHID, Index of Multiple Deprivation (2025) Local Deciles/County Deciles (Gloucestershire), Ethnicity (Census 2021)

Overall

Cluster, Place, and Neighbourhood

A **cluster** is a group of Integrated Care Boards (ICBs) that work together across a larger geography to share leadership, resources and strategic functions while maintaining a focus on local populations through places and neighbourhoods.

A **place** is a large local area where organisations work together to improve the health and wellbeing of a population, usually aligned to one Local Authority area and typically serving around 250,000 to 500,000 people. It brings together the NHS, local authorities, voluntary sector organisations and communities to plan and coordinate services.

A **neighbourhood** is a smaller community within a place, usually serving around **30,000 to 50,000 people**, where services are delivered as closely as possible to residents. Neighbourhood teams bring together GPs, community services, social care, voluntary organisations and other partners to provide joined-up, proactive support tailored to local needs

Within Gloucestershire and BNSSG we have four Places, and neighbourhoods as a delivery mechanism for healthcare services are currently under development.

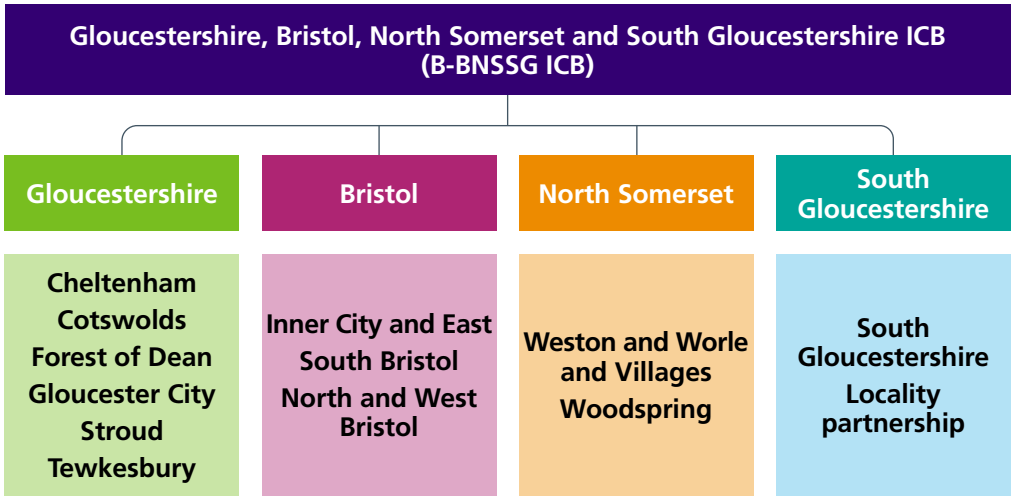
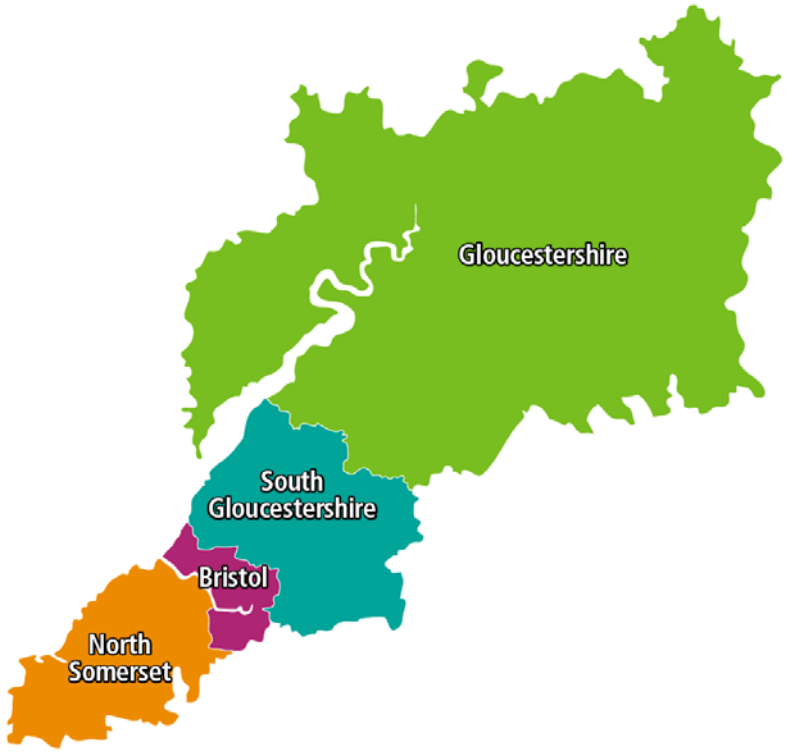


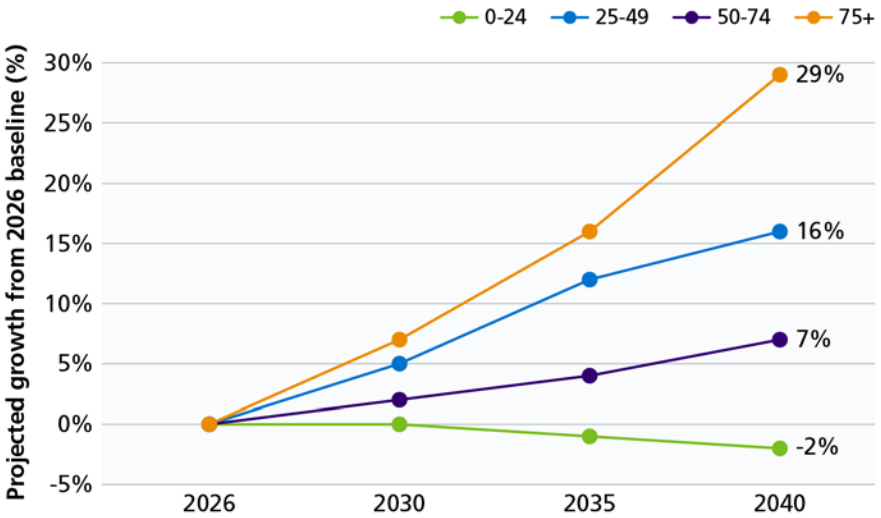
Figure 1. **Map showing Gloucestershire, Bristol, North Somerset and South Gloucestershire (G-BNSSG ICB)**



Across Gloucestershire and BNSSG population health needs are shaped by deprivation, early onset of multiple long-term conditions (multimorbidity), and increasing demand for health services. In Bristol, deprived neighbourhoods face lower healthy life expectancy, higher risk behaviours, and earlier long-term conditions. In Gloucestershire, overall health outcomes are good, but an ageing population, challenges around rurality, widening periods spent in poor health and persistent inequalities between the most and least deprived communities are creating growing pressures on health and care services. North Somerset reveals hidden deprivation, especially in coastal and rural communities, leading to poor service access, social isolation, and rising chronic illness. South Gloucestershire shows generally better health, but growing inequalities and an ageing population.

A growing population across all areas will compound these trends, as shown in Figure 2. The largest population growth is expected to be seen in the 75+ age group (29%) and is highest in Gloucestershire, where this is estimated to grow by 35%. The next highest growth in population will be in the 25-49 year old age group (16%) and will be highest in South Gloucestershire (22.6%). Increases in the 50-75 year old age group will be highest in South Gloucestershire (8.8%). In all areas across Gloucestershire and BNSSG, the population aged 0-24 is estimated to decline (-2%), with the exception of South Gloucestershire, where this is estimated to grow by 4.3%. Individual breakdowns by local authority area are available in Appendix 2.

Figure 2. **Population projected growth for Gloucestershire and BNSSG by age group from 2026 to 2040 (2022-based ONS population estimates – migration category)**[5]



Bristol[6]

Bristol's population is changing rapidly. An estimated **494,400 people** lived in Bristol in mid-2024, with the city growing by **11.4% over the last decade**, faster than England as a whole (7.6%). Population growth has accelerated since the pandemic, driven largely by international migration, particularly from India, China, Nigeria, Pakistan and Ukraine. Bristol is projected to exceed **half a million residents** in 2025 and reach **548,000 people by 2040**, making it one of the fastest-growing Core Cities in England.

Despite this growth, Bristol's population profile is shifting. Birth rates have fallen by **30% since 2012**, while the city continues to attract young adults, contributing to a relatively young population with a median age of **33.6 years** compared with **40.2 years nationally**. Over the next decade, the largest increases are expected among working-age adults and older people, while the number of children is projected to decline.

Bristol is also becoming increasingly diverse. More than **one in four residents (28.4%)** identified with a minority ethnic group in the 2021 Census, rising to over half of residents in some inner-city communities. The city is home to people from **more than 185 countries**, representing **287 ethnic groups**, **45 religions** and **over 90 languages**. This diversity is a major strength but also highlights the importance of culturally responsive services and reducing inequalities experienced by different communities.

Gloucestershire[7]

Gloucestershire's population generally experiences good health and long lives. Life expectancy at birth remains above the national average at **80.0 years for males and 83.8 years for females (2021-23)**, and most residents are currently living with relatively low health needs. Population health modelling indicates that around **73% of registered patients have low health needs**, while **24% have moderate needs** and **3% have high or complex needs**, including people living with multiple long-term conditions and older people with frailty.

Despite these positive overall outcomes, there are differences across the county. Life expectancy in Gloucester is significantly below the national average, and there is almost **eight years difference in life expectancy for men and seven years for women** between the most and least deprived communities in the county.

In 2021, 87.7% of Gloucestershire's population identified as "White British"[8], compared to the national average of 81.0%. Parts of the county are more diverse than others; Barton and Tredworth in Gloucester is the most ethnically diverse area of the county, with more than 30% of the population identifying as an ethnic minority group.

Gloucestershire is also growing and ageing rapidly. The county's population is projected to increase by **17.5% between 2022 and 2047**, adding almost **114,000 residents**, which is substantially faster than projected growth nationally. Growth will be driven largely by people moving into the county, offsetting a projected natural decrease where deaths exceed births. Planned housing developments will support this growth, with local authorities targeting **85,500 additional homes by 2043**, equivalent to adding two new towns to the county's housing stock.

The most significant demographic change will be among older age groups. The number of residents aged **65 and over is expected to increase by 43% by 2047**, while the population aged **85 and over is projected to more than double (111% increase)**. As a result, the county has proportionately fewer children and working-age adults than the national average, and the balance between working-age and retired residents will continue to shift, increasing demand for health, care, housing and community support services. These changes will be felt across the county but are **expected to be greatest in the Cotswolds and Forest of Dean**, where populations are already older and more rural.

This combination of population growth, rapid ageing and widening periods of ill health presents both opportunities and challenges for Gloucestershire. Supporting people to remain healthy and independent for longer, while reducing inequalities and planning for increased demand on services, will be critical to improving outcomes over the coming decades.

North Somerset[9,10]

North Somerset's population is growing, but the drivers of growth are changing. Unlike many growing areas, population increase is not being driven by births. The number of deaths now exceeds births, and fertility rates continue to decline. Instead, growth is largely the result of migration, particularly people moving into North Somerset from elsewhere in the UK, alongside international migration.

The population is ageing and this trend is expected to continue. North Somerset already has a significantly higher proportion of residents aged 65 and over than the national average, with a comparatively smaller working-age population. Population projections indicate that the proportion of older residents will continue to rise while the proportion of younger residents decreases, creating additional demand for health, care, housing, transport and community support services.

Population growth is also unevenly distributed across the area, reflecting patterns of housing development and planned growth set out through the Local Plan. Alongside demographic change, North Somerset's population is expected to become increasingly culturally and linguistically diverse, although the area remains less ethnically diverse than England as a whole.

Despite generally favourable health and socioeconomic outcomes, significant inequalities persist. Some communities, particularly in parts of **Weston-Super-Mare**, experience higher levels of deprivation, poorer health outcomes and greater barriers to opportunity. Around **14% of children live in relative low-income families**, and inequalities are evident between communities across the area.

There are also important differences between urban and rural communities. While some neighbourhoods experience concentrated deprivation and poorer health outcomes, rural areas face challenges associated with an ageing population, social isolation, access to services and limited public transport. These variations highlight the need for targeted, Place-based approaches that respond to the distinct needs of North Somerset's diverse communities.

As North Somerset continues to grow and age, reducing inequalities and supporting healthy, independent lives will be key priorities. Understanding how demographic change, deprivation and geography interact will be essential to planning services and ensuring that future growth benefits all communities.



South Gloucestershire[11]

An estimated **306,300** people lived in South Gloucestershire in 2024. **Population growth and change is one of the defining features of South Gloucestershire.** The population is expected to increase to 345,934 by 2036. New housing and changes in the age and characteristics of the population are reshaping demand for health and care services, transport, community facilities and employment.

South Gloucestershire combines densely populated urban areas with more rural communities, creating varied health and wellbeing needs. The area is becoming increasingly diverse, although it remains less ethnically diverse than England as a whole. People from minority ethnic groups make up around **9% of the population**, reflecting changing communities and highlighting the need for inclusive and culturally appropriate services.

Many residents experience better health outcomes than the national average. Life expectancy is higher than both the South West and England averages, and overall levels of deprivation and poverty are comparatively low but this is not the case for everybody; the South Gloucestershire population experiences higher than average levels of depression and **significant inequalities** in preventable deaths, obesity and alcohol related illness. The number of children eligible for free school meals is growing and the educational attainment gap between those with and without free school meals is widening. This highlights the importance of looking beyond county-level averages to understand and address local inequalities. Whilst some inequalities are linked to deprivation, others are shaped by factors such as access to services, transport, housing affordability, health outcomes and community infrastructure

The population structure presents both opportunities and challenges. South Gloucestershire has a relatively large proportion of children and young people, while also experiencing growth in older age groups. This creates demand across the life course, from education and employment opportunities to health, care and support services for an ageing population. Ensuring that all residents can benefit from the area's generally favourable social and economic conditions and future growth will be important for reducing inequalities and improving health outcomes over time.

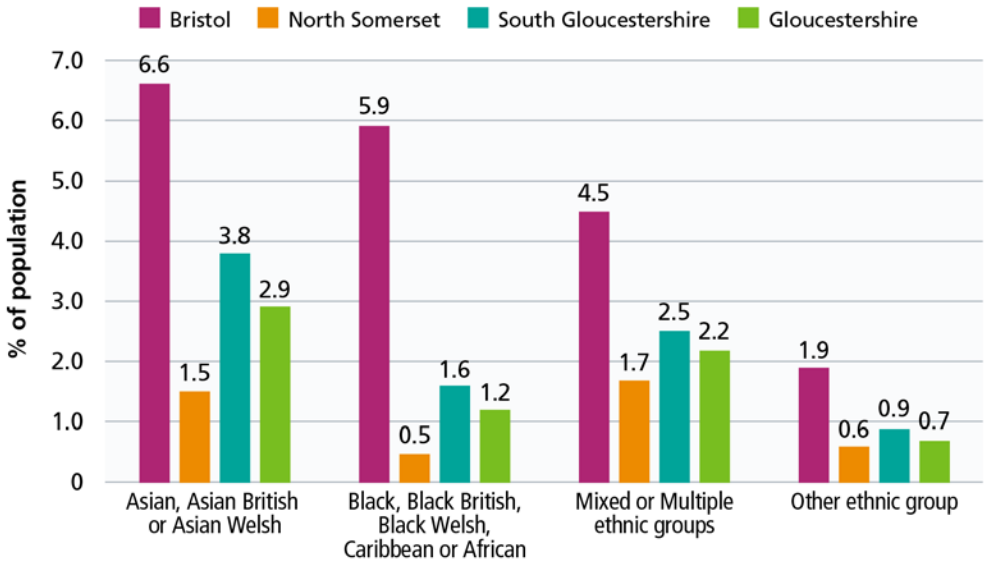
Race and ethnicity

Issues such as discrimination because of race, gender, disability or sexuality can make life even harder for some groups. The pattern of health disparities in Gloucestershire and BNSSG is complicated and the reasons for this are multiple and complex, involving discrimination, trauma, distrust of services, deprivation and language challenges Figure 3 shows variation in ethnicity across Gloucestershire and BNSSG.

Bristol is the most ethnically diverse area with the highest proportions of Asian, Black, Mixed and other ethnic groups including larger Pakistani and African populations (Appendix Table 5). South Gloucestershire is also relatively diverse and has an Indian population (1.7%) similar to Bristol (1.8%) (Appendix Table 5). Gloucestershire is predominantly white but is more diverse than North Somerset, which has the lowest proportions of most ethnic minority groups.

Figure 3 **Ethnicity breakdown by broad ethnic group in Gloucestershire and BNSSG (2021 Census)**

A more detailed breakdown of ethnicity by Place is available in Appendix Table 5.



Building blocks of health and health equity

Ethnic health inequalities are closely linked to the core determinants of health, such as employment, education and deprivation. We know that many ethnic minority groups have poorer health outcomes and that ethnic minority groups are overrepresented in more deprived communities.[12]

In ethnic minority groups, structural racism can reinforce inequalities, for example, in housing, employment and the criminal justice system, which in turn can have a negative impact on health. This is also true for healthcare providers and commissioners who may also contribute to systemic racism through policies, structures and processes. Racism and discrimination can be traumatising and can also have a negative impact on the physical and mental health of people from ethnic minority groups[13]. Experiences of trauma can influence how we interact with others, how we interpret our surroundings and the world around us and how we access, engage with and experience services. While trauma can affect anyone in our population, people living in areas of deprivation, or who already experience health and social inequalities, multiple disadvantage, or who are within inclusion health groups, are more likely to experience trauma in their lives.

We know that inequalities are shaped by social and economic disadvantage. People from ethnic minority groups in Bristol, particularly in Black African communities experience greater disadvantage in education and employment than the national average.

Ethnic inequalities in health are complex and cannot be understood through mortality alone. While some ethnic minority groups experience lower all-cause mortality, many also experience poorer outcomes for specific conditions and barriers to accessing care[14].

The risk of developing and living with multiple long-term conditions is strongly influenced by deprivation[15]. For some conditions, including type 2 diabetes, this risk is further shaped by the interaction between ethnicity and deprivation[16]. Tackling these inequalities requires policy and services designed in a way that recognise this combined impact.

Addressing health equity requires challenging the social structures that perpetuate disadvantage and ensuring that everyone has the opportunity to achieve their full health potential. This involves tackling issues such as poverty, racism, and discrimination, and promoting policies that advance social justice.

It's not a case of just giving everyone the same thing (equality); some people will need more support or need a service to be delivered in a different way (equity).

Figure 4: **Visualising Health Equity: One Size Does Not Fit All**[17]



Experience of health and care

Experience of healthcare is not equal. Poor experience of healthcare is more likely to be reported by people from ethnic minority groups, this can contribute to lower trust and engagement with services and can lead to poorer outcomes.

In BNSSG, people in our Bangladeshi, Caribbean and Pakistani communities have especially poor health diagnosed in their middle to later years[18], whilst those identifying as 'White Gypsy or Irish Traveller' were the most likely ethnic group to report that their health was bad or very bad in the 2021 Census[19]. Similar patterns are seen in Gloucestershire. The NHS Gloucestershire Health Inequalities Information Review (2024-25)[20] found that people from ethnic minority groups experience poorer access, experience and outcomes in relation to healthcare services. While Gloucestershire is less ethnically diverse than BNSSG and England overall, its population is becoming increasingly diverse and understanding the experiences and needs of ethnic minority communities remains essential for reducing health inequalities.

Nationally, evidence indicates significantly higher rates of suicide among those identifying as White Gypsy or Irish Traveller, and a life expectancy 10-12 years lower than the population average[21].

These inequalities start early. In BNSSG, pregnant women from Black, Asian and other ethnic minority groups, as well as those in more deprived areas, are most likely to experience poor birth outcomes, and Black and South Asian communities experience higher rates of infant and maternal mortality[22]. Gloucestershire data shows that people from ethnic minority groups have higher rates of late bookings compared to women from White British groups. This can be one of a number of contributors to poor maternity outcomes[23]. We also know that deaths from CVD and diabetes are higher among Black and South Asian groups nationally[24].

Mental health inequalities are significant. In BNSSG, we know that people from ethnic minority groups are less likely to have access to 'Improving Access To Psychological Therapies' and cognitive behavioural therapy, and have higher rates of compulsory admission to psychiatric wards, particularly for Black (including Mixed) and South Asian groups[25]. In Gloucestershire similar inequalities in mental health services are reported; people from various diverse ethnic groups have significantly lower completion rates of Talking Therapies treatment compared to people from White and Mixed ethnic groups.

We also know that there are high rates of emergency hospital admissions in areas of high deprivation and also for Asian or Asian British, Black, African, Caribbean or Black British ethnic groups, and this gap is increasing[26]. The rate of planned hospital admissions is significantly lower in Black African, Caribbean or Black British, and Asian or Asian British groups, than the other groups and lower than BNSSG overall[27]. In Gloucestershire, differences in how services are used can be seen across different ethnic minority groups; people from Asian or Asian British ethnic groups are least likely to attend an elective appointment or virtual outpatient appointments than other groups. Whilst emergency attendances are significantly higher in Black or Black British and Mixed ethnic groups, possibly due to higher proportions of people from ethnic minority groups living in Gloucester, a more deprived area of Gloucestershire[28]. We know that in BNSSG, uptake of preventative interventions such as vaccination for COVID-19 and flu are much lower in our more ethnic and linguistically diverse communities, even after accounting for deprivation[29]. Similar inequalities have been observed in Gloucestershire, where uptake of Covid-19 and flu vaccines is lower for people from ethnic minority communities[30]. We also know that people of Black African ethnicity, particularly women, are also disproportionately affected by HIV and are the least likely to access preventative treatment (PrEP)[31].

There are also differences in participation in cancer screening in BNSSG, where uptake among ethnic minority groups is low. We also know that Black and Asian women are more likely than White British women to be diagnosed at a late stage for several cancers, including breast, ovarian, uterine and colorectal cancers. However, Black men have lower rates of late-stage diagnosis for prostate cancer, a lack of trust in, and experience of services plays a big part in this[32].

What have people told us?

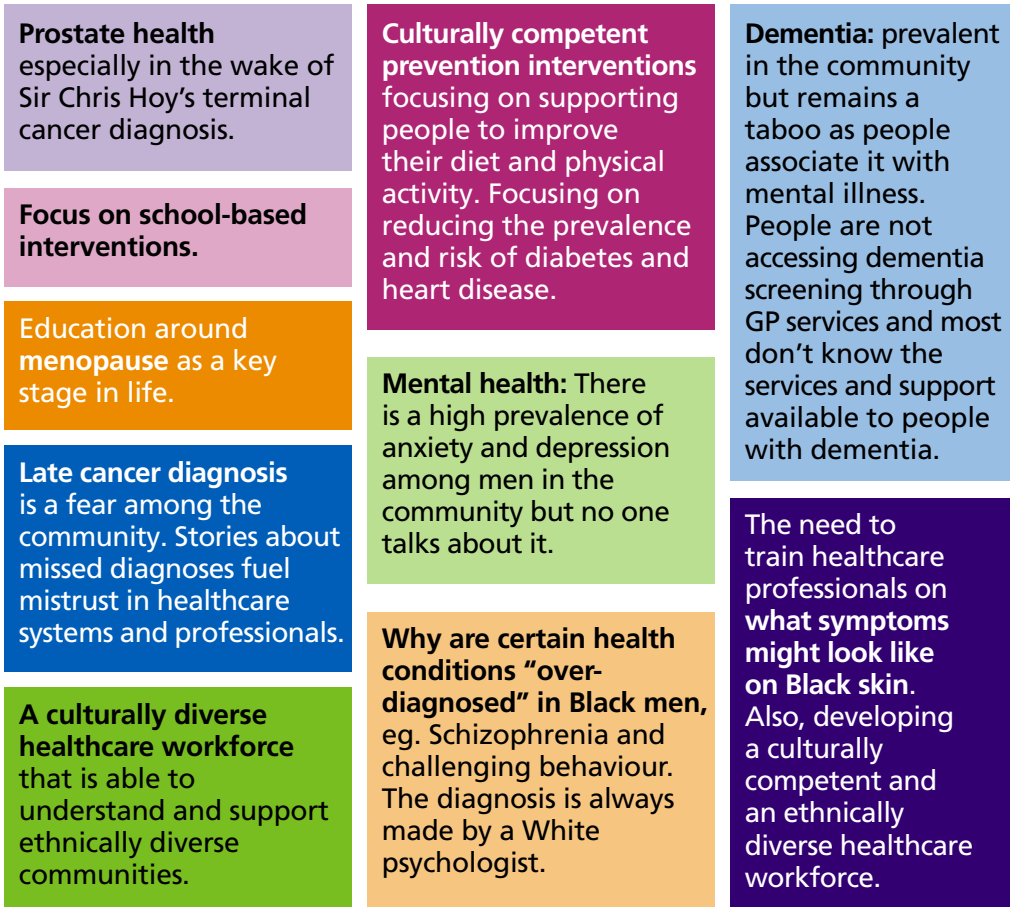
Our communities across Gloucestershire and BNSSG have told us that ethnic inequalities are not just experienced through poorer health outcomes but also through reported barriers to access, navigating through complex systems and their experiences of services.

People have told us, through engagement, that there are many barriers to access, such as the availability of services and lack of culturally responsive care, experiences of discrimination and lack of trust in services, which are regularly highlighted as important issues for our communities.

A 2023 report by the Black South West Network (BSWN) in Gloucestershire highlighted that in a survey among representatives from the Black and Minoritised VCS Sector, racially minoritised health and care services users, and racially minoritised health and care professionals, 76% (of 42 respondents) did not think that their communities' health needs were being met[33].

The BNSSG Diverse Research Engagement Network (REND) Health Ambassadors ran coffee mornings and had informal chats with communities about their health and care issues[34]. Figure 5 below shows some of the themes discussed including culturally competent interventions, lack of awareness of services, training for healthcare professionals, and community health education programmes to address stigma around topics such as cancer, dementia and mental health.

Figure 5 **Themes from Coffee Mornings held by BNSSG REND**



Access to services/system barriers/health literacy

At an engagement event with 14 parent carers from Global Majority communities, as well as professionals who support families navigating SEND and health services, families described major barriers impacting daily life, including navigating health systems alone, stigma around seeking help, lack of culturally sensitive communication, and emotional burnout Parents report that without allies, health appointments feel adversarial. They struggle to challenge decisions and lack accessible, trusted sources of health information[35].

A study into the barriers and facilitators to HIV testing among African and Caribbean heritage communities in Bristol highlighted barriers around trust, confidentiality and poor experiences of healthcare services. Effective facilitators were culturally specific services, community-driven outreach programmes and increased healthcare representation[36].

The BSWN report mentioned previously also highlighted the issue of translation services that do not always have interpreters with sufficient understanding of medical terminology, particularly where there are no direct translations between languages.

> **"And the other issue is people who do translation/ interpretation services not having appropriate training and awareness of medical terminology. Especially when working within mental health services, where commonly heard and understood conditions in English have no equivalent words/phrases in languages such as Gujrati and Hindi. For example, there is no word for depression in Gujrati and Hindi, therefore, if you are working with a person from one of these communities how do you get the message across to the person and provide treatment going forward?"[37]**

Discrimination and stigma

Communities reporting experiences of stigma, racism and cultural stereotyping when accessing services is a recurrent theme. In 2023, young people involved in a co-production workshop for a children and young people's mental health strategy expressed their frustration that health professionals often attributed their concerns to their culture rather than addressing them as individuals[38,39].

> **"Even when people do understand your culture sometimes they then pin everything on that…oh it's because you are Somali when actually it might be about who I am as a person not everything is always about my culture."[40]**

In 2022, the VCSE Mental Health Alliance inequalities report reported that some Black and Asian clients felt that the inadequate care they received was due to racism and microaggression[41]. Experiences like this can create barriers in interacting and engaging with health services and negatively impact people's experience of care.

Case study

Refugee Women's Health Hub (received an inclusion health grant as part of BNSSG Women's Health Programme 2025)

The Women's Health Hub provided a trusted, community-based setting where refugee women could engage with healthcare professionals, supported by community workers and interpreters with established relationships within the community. The programme improved health literacy, confidence and understanding of preventative healthcare, while helping women to navigate services and advocate for their health needs. Feedback from participants and clinicians highlighted the value of trusted relationships in reducing barriers to access and improving engagement with healthcare.

Opportunities/Insight

Ethnic inequalities in BNSSG are shaped by the interaction of deprivation, discrimination, structural barriers and unequal experiences of health services. Tackling these inequalities requires more than equal access. It will require equitable, trauma-informed approaches that recognise different levels of need and work to build trust with communities and address both the social determinants of health, the way services are commissioned and barriers within services themselves.

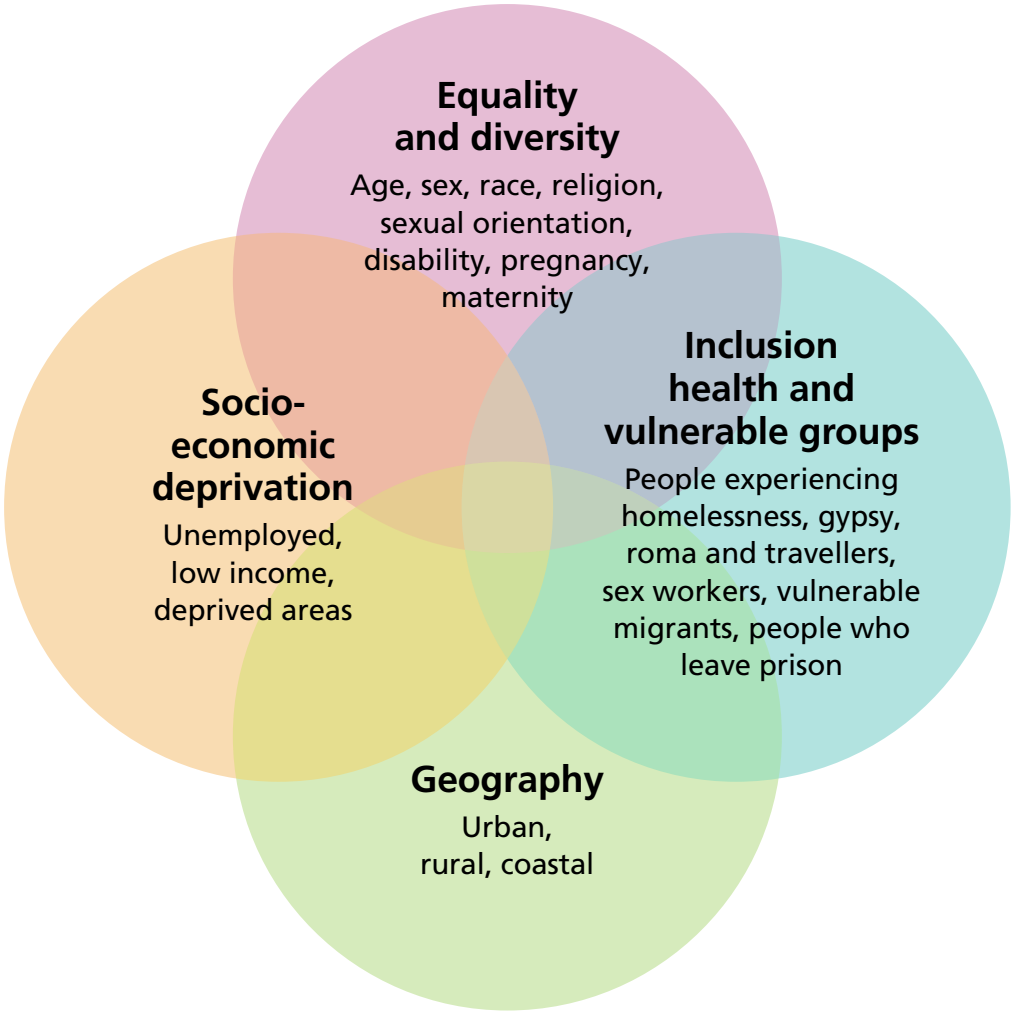
While this chapter brings together evidence on ethnic health inequalities and the experiences of ethnic minority groups in Gloucestershire and BNSSG, these issues do not sit in isolation. Our health and wellbeing is shaped by the interaction of multiple and overlapping dimensions of inequality, including ethnicity, age, sex, disability, socioeconomic circumstances, geography, and experiences of exclusion or discrimination.

An intersectional perspective recognises that these factors do not operate independently and they can often layer on top of each other; these influence people's opportunities, experiences of healthcare, exposure to risk factors, and health outcomes in many different ways.

Figure 6, shows that individuals may experience multiple, intersecting forms of disadvantage that can compound inequities across the life course. For this reason, race and ethnicity will be a recurring theme throughout the remaining chapters of this Integrated Needs Assessment, helping to identify where inequalities persist, how they overlap with other dimensions of inequality, and where targeted action may be needed to improve equity and outcomes.



Figure 6 **Dimensions of Inequality in Health**[42]



Part 2

Maternity and neonatal care

Maternity and neonatal services have a significant influence on the health and wellbeing of mothers, babies, and families and can shape outcomes across the life course.

Nationally, maternity and neonatal services continue to face scrutiny regarding safety, quality, inequalities and experience of care, following a series of national reviews and investigations. National policy continues to emphasise improving maternity safety, reducing inequalities, delivering personalised care and strengthening prevention and early intervention[43,44].

Locally, evidence from Gloucestershire and BNSSG demonstrates persistent inequalities associated with deprivation and ethnicity, alongside increasing complexity of need. Improving maternity and neonatal outcomes requires both high-quality clinical care and a continued focus on prevention, equitable access and addressing the wider factors that contribute to poorer outcomes for some women and babies. GHT maternity services have also been on an improvement journey over the last few years, overseen and supported by Gloucestershire Hospitals NHS Foundation Trust's (GHT) Board, the ICB, and NHS England's Maternity and Neonatal Improvement Programme, following inadequate CQC rating since 2022[45,46,47].

What existing evidence tells us

Persistent inequalities in outcomes and access

Significant inequalities in maternity outcomes, risk factors, and access to care and experience associated with ethnicity and deprivation can be seen across Gloucestershire and BNSSG. Mothers living in more deprived communities experience higher rates of smoking, obesity, later access to antenatal care, and poorer birth outcomes including preterm birth and babies with low birth weight. Inequalities in maternity outcomes for mothers from ethnic minority groups are also evident across both areas, with variations observed in outcomes such as preterm birth, low birth weight and c-section rates. Together, these findings suggest that reducing inequalities in maternity outcomes and experiences should remain a key priority across the Cluster[48,49,50].



For example:

- In Gloucestershire, 23% of births in 2024/25 were to women from ethnic minority communities and 11.8% were to women whose primary language was not English[51], reflecting Gloucestershire's more diverse younger population.
- In BNSSG, around a quarter (25.5%) of all births were to women living in the most deprived communities[52].
- Mothers living in the most deprived communities in Gloucestershire and BNSSG experience higher rates of smoking, obesity, emergency c-sections, and poorer birth outcomes[53,54].
- Mothers of Black ethnicity in BNSSG had the highest rates of emergency c-section and obesity, whilst mothers of mixed ethnicity had the highest rates for preterm birth and low birth weight babies[55].
- Across BNSSG, maternal risk factors such as late booking, smoking and drinking were highest in Bristol and lowest in South Gloucestershire[56].
- In Gloucestershire, statistically significant inequalities were evident by deprivation and some Mixed/Multiple ethnic minority groups for preterm birth (2019/20-2023/24), particularly among babies born in the most deprived decile[57].

Increasing complexity of need

Evidence from both Gloucestershire and BNSSG suggests that maternity services are supporting increasingly complex populations. Inclusion health groups were specifically identified as a priority within Gloucestershire's Maternity Needs Assessment Case for Change.

Whilst both Gloucestershire and BNSSG have experienced declines in livebirths (babies being born alive) and overall fertility rates over the past decade, maternal age has increased across both areas contributing to greater clinical complexity. This is not expected to translate into a proportional reduction in service demand, given increasing complexity of need and changing population characteristics. Obesity remains a significant risk factor and is associated with poorer outcomes including preterm birth, emergency c-section and lower rates of breastfeeding[58,59,60].

Gloucestershire is seeing growing numbers of women entering pregnancy with multiple long-term conditions, while both systems identify increasing demand for perinatal mental health support and rising intervention rates such as c-sections. Together, these findings indicate increasing complexity of clinical and social need, with implications for future service demand and delivery across the cluster[61,62].

Key examples:

- In Gloucestershire, the proportion of women with a BMI ≥30 at booking increased from 21.0% in 2020/21 to 27.2% in 2024/25[63].
- Demand for perinatal mental health support across BNSSG increased from 17% to 20% between 2019/20 and 2020/21[64].
- More women are entering pregnancy with multiple long-term conditions, increasing demand for obstetric and specialist input[65].
- Access to equitable preconception care was identified as an important opportunity to improve outcomes, particularly for women with existing health conditions and those experiencing health inequalities[66].

Modifiable risk factors and opportunities for prevention and early intervention

Evidence from both Gloucestershire and BNSSG demonstrates the ongoing influence of modifiable risk factors on maternity and neonatal outcomes. Smoking, alcohol use in pregnancy, and delayed access to maternity care are associated with poorer outcomes for mothers and babies. These risk factors are not evenly distributed across the populations, with evidence from both systems demonstrating variation associated with deprivation and ethnicity[67,68,69].

Both systems also identify opportunities to improve outcomes through prevention, preconception care and post-birth contraception, early identification of risk, smoking cessation support, and equitable access to maternity services. Early engagement with care can support timely assessment, screening, and intervention, while targeted approaches to prevention may help reduce inequalities and improve maternal and neonatal outcomes across the cluster[70,71,72,73].

Key examples:

- In BNSSG, mothers of White ethnicity had the highest smoking rates at booking and delivery and the highest reported alcohol consumption in pregnancy[74].
- Smoking in pregnancy is more common among mothers living in deprived communities in Gloucestershire BNSSG and remains an important contributor to inequalities in outcomes[75,76].
- Evidence from both Gloucestershire and BNSSG identified lower levels of timely booking among some deprived and ethnic minority communities[77,78]. For example, Black mothers in BNSSG were most likely to book late for antenatal care (29.9% in 2023-5)[79].
- Mothers in BNSSG who smoked were 1.45 times more likely to have a preterm birth, 1.8 times more likely to have a low-birth-weight baby, and 2.2 times more likely not to breastfeed at first feed[80].
- Across BNSSG, mothers who were aged <20yrs, of Mixed ethnicity or in the 20% most deprived areas were more likely to have positive Whooley scores, an indicator of depression risk[81].



What have people told us?

Experience of care and access to support vary between groups

Evidence from engagement work undertaken across both systems, including maternity experience surveys, community insight programmes, Maternity and Neonatal Voice Partnerships (MNVPs) and targeted projects with underserved communities, highlights important differences in how maternity care is experienced and accessed.

Gloucestershire's community insight work has identified issues relating to communication, information, access, mental health support and service experience. In BNSSG, engagement has highlighted barriers to accessing care such as communication challenges, cultural barriers, concerns about stigma, experiences of discrimination and difficulties accessing perinatal mental health support. Together, these findings suggest that improving equitable access, communication, cultural responsiveness and the experience of care remain important priorities across the Cluster[82,83].

For example, across different engagement activity:

- Participants reported communication difficulties and concerns that mental health terminology and screening questions were not always understood or culturally appropriate[84].
- Women described experiences of stereotyping, discrimination and not feeling listened to by healthcare professionals, and some mothers reported concerns about seeking support because of stigma or fear of social services involvement[85].

> **"I feel I can't speak up here because I am Black."[86]**

- An insight programme of almost 900 service users, families, staff and community groups in Gloucestershire highlighted the need for improved communication, more reliable postnatal care, continuity of midwifery care, cultural sensitivity and equitable access as priorities for service improvement[87].
- Focus group discussion regarding pain relief with women who identify as Black and Asian highlighted significant variation in information about pain relief, barriers to accessible information and translation, feelings of being dismissed, and insufficient focus on maternal need[88].

In BNSSG, responding to nationally and locally identified inequity in pain management, the Bristol NHS Foundation Trust have formed an Equity in Pain Management MDT group. Following data analysis and focus groups with women racialised as Black and Asian, the group plans a podcast for anaesthetists based on the feedback, the development of a self-assessment tool for women, and improved communication and materials about pain relief options.

> **"During my pregnancy, I was aware of the issues and inequalities affecting Black and Brown women in maternity care, which made me feel anxious. I spoke to my midwife about my concerns, and they were very understanding and supportive. They listened to me and were helpful throughout my pregnancy and during the delivery, which gave me reassurance and confidence in my care."[89]**



Following a successful pilot, maternity-based Post Birth Contraception (PBC) was commissioned across BNSSG through Yuno Sexual Health in April 2025. PBC is an evidence-based intervention[90,91,92,93], that supports **safer pregnancy** spacing, **prevents** unplanned pregnancies, and **improves equity** by increasing access to effective contraception, particularly for vulnerable and underserved women. Women receive contraceptive counselling during pregnancy and provision of their chosen method immediately after birth if appropriate. Evaluation has demonstrated the service's effectiveness, acceptability and feasibility, with findings now informing national publications[94,95].

A rapid evaluation of the pilot in 2023 highlighted that PBC was well received by women and birthing people, reporting that the service was supportive and friendly, optimises time in hospital and reduced need for primary care interventions, and they felt informed about the different options for contraception.

> **"This service gives the opportunity to get contraception while you have the time – when you get home there is often other things that take priority and GPs aren't as thorough and just put you on something that may not be best suited to you – this should be a compulsory tick box service to a medical discharge from hospital."[96]**

Cluster-level insights summary

The evidence presented in this chapter draws on analyses undertaken using different methodologies, datasets and reporting periods across Gloucestershire and BNSSG. Direct comparison of rates and indicators is not always possible. However, similar themes and patterns have been identified across both systems and inform the Cluster-level insights below.

- Significant inequalities associated with deprivation and ethnicity are evident across both systems and affect outcomes, risk factors, access and experience.
- Maternity services are supporting increasingly complex populations, including older mothers, women with obesity, women with multiple long-term conditions and those requiring mental health support.
- Prevention and early intervention remain important opportunities to improve outcomes, particularly through smoking cessation, preconception care and improving timely access to maternity services.
- Engagement work across both systems suggests that communication, continuity of care, cultural awareness and responsiveness, and trust are among some of the important influences on how maternity services are accessed and experienced.

Opportunities for strategic commissioning

In March 2026, One Gloucestershire released the Case for Change: Making Gloucestershire's NHS Maternity Services Fit for the Future[97], which provides a strategic assessment of local maternity services, highlighting key challenges, inequalities and opportunities to improve outcomes, experience and sustainability of care.

Across the BNSSG footprint, plans are in place to conduct a new Health Needs Assessment, building on a 2021 Health Equity Audit, as well as a BNSSG Infant Feeding Strategy that is currently in development. Alongside the existing Gloucestershire Case for Change, these will provide a clear direction on the priorities for strategic commissioning in maternity across the Cluster. This includes prevention opportunities such as breastfeeding, known to be a key population health intervention of lifelong outcomes, and immediate post-birth contraception which can prevent unintended pregnancies and closely spaced births, which are both associated with poor maternal and infant outcomes[98]. However, it is already evident that significant work is needed to reduce inequity both of outcomes and experiences.

The top three outcome areas to focus on in this area:

1. **Prevention and pre-pregnancy care:**
   Strengthen prevention and early intervention through improved preconception care and immediate post-birth contraception, smoking cessation support, and earlier access to maternity services, particularly for pregnant people at greater risk of poorer outcomes.

2. **Reducing health inequalities:**
   More focused action to reduce inequalities associated with deprivation, ethnicity, and within inclusion health groups, with a focus on improving health outcomes, access, experience and continuity of care for underserved communities.

3. **Shared Cluster approach to maternity intelligence and improvement:**
   Develop a coordinated Cluster approach to maternity intelligence and quality improvement to identify variation, monitor inequalities, understand experiences, and improve equitable access, continuity and experience of care for all.

Data improvements required

Work is already underway to identify key metrics to monitor maternity outcomes, including inequalities in this area, across Gloucestershire and BNSSG. These will be included as part of a new maternity dashboard being produced as part of the Intelligence Centre transformation project. Through this any data quality or measurement issues will be identified for future improvement.

People living with Severe Mental Illness (SMI)

As part of the 10 Year Health Plan for England, the Government has committed to a new approach to mental health[99], and in particular the 2026-27 to 2028-29 Medium Term Planning Framework (October 2025) has a delivery commitment to reduce inappropriate out-of-area placements by the end of March 2027[100].

As part of these commitments, the Government is making available capital funding over the next four years to invest in new models, including community-based mental health centres, mental health emergency departments and eliminating out-of-area placements[101]. Furthermore, a Modern Service Framework for SMI is expected by the end of 2026[102].

In Gloucestershire and BNSSG, ensuring patients are treated and supported as close to their home and family as possible is already a key focus. However, more work remains to be done, particularly with regards to reducing inequity. It is also important to note that that many of the stressors and support for those with SMI are found beyond healthcare and NHS services. A system response will be needed to address these, with prevention and early intervention key.



What existing evidence tells us

Prevalence and variation

Severe Mental Illness (SMI) commonly refers to conditions such as schizophrenia, schizoaffective disorder, bipolar disorder and other psychotic illnesses that are associated with substantial functional impairment and need for ongoing specialist support.

Model-based estimated prevalence of severe mental illness across our footprint are slightly below the national average (1.16%) in both Gloucestershire (1.04%) and BNSSG (1.11%), equating to approximately 19,000 people across the Cluster[103]. However, this overall level likely hides variation locally, with national research suggesting that although bipolar disorder is fairly evenly distributed across areas, schizophrenia and other psychoses are more common in deprived and urban areas[104].

Excess early deaths (under-75) for people with SMI are almost four times more likely than the overall population[105]. Analysis of national data by OHID also highlights negative trends in premature mortality rate in adults with SMI in England. In 2018-20 the premature mortality rate was 104 deaths per 100,000, up from 91 per 100,000 in 2015-17[106]. This represents a 14.5% increase, equivalent to approximately 6,600 additional deaths per year. Later SMI profile updates also indicate that premature mortality and excess premature mortality nationally continued to worsen beyond that reporting period.

Across the new Gloucestershire and BNSSG Cluster, this varies by Place. OHID analysis identifies North Somerset, South Gloucestershire, and Gloucestershire, as areas with high excess premature mortality in adults living with SMI but not high absolute premature mortality in adults with SMI. However, Bristol has both high premature mortality in adults living with SMI and high excess premature mortality

in adults living with SMI, suggesting both concentrated and acute need in this area[107]. All four BNSSG Places are in the worst-performing quintile nationally for excess premature mortality amongst people with living SMI, and two thirds of deaths arise as a result of physical health causes rather than directly due to mental health[108,109].

People living with an SMI are three times more likely to smoke than the general population[110], have higher rates of cardiovascular disease, diabetes, obesity and lung conditions like COPD and asthma. They are also more likely to have multiple physical health conditions compared to the general population and at a younger age[111].

Around a third of people living with a SMI also have co-existing drug or alcohol conditions[112]. In BNSSG, local intelligence shows that there are approximately 1480 people living with an SMI have co-occurring substance use. The majority of live in Bristol (930, 63%), just over one in five live in North Somerset (310, 21%) and around 16% (240) in South Gloucestershire[113].

The **reasons for poorer health among people with severe mental illness** are complex and not fully understood, but mental and physical health conditions are often connected. For example, the side effects of medication used to treat severe mental illness (antipsychotics) can include increases in weight, blood sugar levels, and blood pressure. These in turn increase the risk of diabetes and cardiovascular disease. Higher rates of smoking, poor diet and physical inactivity, as well as social factors such as poverty, lack of employment, stigma and discrimination, also play their part[114].

Even data at Place level may fail to highlight important patterns that can be hidden at a micro level within particular communities and locations. As with all data included in this INA, this high-level summary should therefore be supplemented by local intelligence and data sources.

This chapter focuses on data associated with this formal definition of SMI outlined above. However, it is important to acknowledge that ongoing work suggests there is a notable cohort of people with complex emotional needs who experience multiple crises and receive significant support often through urgent and emergency services. Without an SMI diagnosis, they have no equivalent register or systemic physical health offer, and we may be at risk of understating the full scale and nature of the challenges our system faces with regards to Severe mental illness.

Experience of care

Inappropriate "Out of area placements" (OAPs), are where patients are admitted to a unit outside their local network or services for acute mental health inpatient care due to lack of available beds locally. This complicates contact with families, carers, friends, and care coordinators[115].

As a recent Neurodiverse Connection report for AWP highlighted, from the experience of people who have had out of area placements, and their families, OAPs are seen to reflect wider system pressures "limited beds, inconsistent community teams, poor discharge planning and heavy reliance on police during crises"[116].

Reducing OAPs has been a significant focus across both Gloucester and BNSSG in recent years, in line with national targets.

- In BNSSG, AWP-led initiatives have included strengthened flow governance, more assertive stewardship of out-of-area placements, and improved discharge coordination through the Transfer of Care Hub. In addition, the short-term 'Flow Fortnight' approach was used successfully in summer 2025 to address a period of sustained inappropriate out-of-area placements and increased out-of-area bed days. Learning from this work is now informing the 'Project Zero' approach, a programme of key improvement actions, including greater clinical oversight, the removal of barriers to discharge, rapid escalation and increased multi-agency working[117].
- The Gloucestershire system also has a strong and consistent track record in minimising OAPs, and there have been sustained periods with zero OAPs for adult acute and PICU placements. However, during 2025/26, periods of sustained system pressure have been observed, resulting in higher-than-usual OAPs. These increases were particularly evident around bank holiday periods, with additional peaks in November and January associated with workforce capacity pressures[118].

This demonstrates both systems' ability to reduce inappropriate OAPs to zero through operational focus. However, performance has worsened in 2026, with evidence to date in BNSSG suggesting underlying structure causes affecting flow through the system in particular, not simply insufficient beds. In Gloucestershire there have been similar issues of prolonged inpatient stays and delays in securing discharge support, alongside a planned temporary reduction in adult acute capacity in one location.

Opportunities

The ICB should learn from recent years, noting the importance of a whole-system and whole-person approach to achieving sustainable improvements in inappropriate OAPs to return inappropriate out of area placements to the previous low levels in Gloucestershire and BNSSG.

While OAPs as a national priority have been a focussed on here, broader outcomes to consider for people living with SMI should be considered alongside prevention, recovery, physical health, housing and social inclusion.

Other variation in experience of care for patients living with SMI in our area include:

- **Restrictive interventions** – Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and to staff. Patients from the least deprived areas of Gloucestershire and BNSSG experience significantly lower rates of restrictive interventions than those from the most deprived areas."[119] In Gloucestershire, this gap between the most and least deprived deciles has increased in recent years[120].
- **Physical health checks** – people living with SMI die on average 15-20 years earlier than the general population, often as a result of preventable physical illnesses. Although in BNSSG and Gloucestershire 75.8%[121] and 73.2%[122] of people with SMI respectively received these health checks in 2024-25, this deteriorated to just 64% in BNSSG in 2025-26 and 62.6% in Gloucestershire.

The 2025 Annual Report of the Bristol Director of Public Health notes that for Bristol "increasing uptake to 90% [from 75.8%] would mean around 750 additional people receiving a check", highlighting the potential to improve outcomes[123]. From current baselines, the increase in number of people receiving a health check would be even more significant. In addition to reducing the risk of preventable premature mortality, there is also evidence that people with SMI who receive a physical health check have 20% fewer A&E visits on average, 25% fewer mental health admissions, and 24% fewer emergency physical health admissions per year[124].

Opportunities

Increasing uptake of physical health checks, plus follow-ups, has the potential to impact both long-term risk of premature mortality for people with SMI, as well as more immediate healthcare usage. This will require a focus not only on the annual checks, but also on ensuring appropriate interventions after the risks have been identified.

What have people told us?

This variation in the experience of care is also evident in the direct feedback received from people living with SMI receiving care and treatment. A recent report by Neurodiverse Connection explored the lived experiences of people from racialised, neurodivergent, disabled and seldom-asked communities across the AWP footprint, as well as the experiences of people placed in out of area inpatient settings. It highlighted key difficulties people living with SMI feel when accessing, or trying to access, support[125]. These included:

- Fragmented, confusing and exhausting processes with repeated signposting and unclear pathways meant people felt they were often only taken seriously at crisis point.
- Care that felt rigid, medicalised and standardised, rather than the relational, trauma-informed support that people sought.

- Services causing active harm through poor communication, dismissive interactions and non-trauma-informed approaches.
- An absence of preventative outreach and early intervention, with support instead arriving too late.
- Having to fight constantly to access even basic support leads to self-advocacy fatigue, with the burden feeling particularly difficult for those already in distress and those least equipped to carry it.
- The importance of lived experience, peer support, and community groups, where representation and shared understanding fostered trust.

This reflects feedback received by Healthwatch in 2024 from people receiving inpatient care on wards managed by AWP, which noted differences in:

Availability of care plans

"They give you an illusion of choice when you talk about your care plan."

"I have a care plan that staff try to explain in detail and my input was included."

Communication and respect

"I thought I was going to be discharged last week, but the day passed, and no one mentioned anything"

"I feel both heard and respected by the staff especially by the nurses and healthcare assistants."

"Many of the staff are preoccupied with paperwork and the administrative demands of the job and don't have time to talk."

Perceptions of safety

"The ward can be a scary place at times, especially when new service users arrive as they were often loud and shouting"

"Another individual picked on me, and I was scared but the fast response from the staff was really good."

In 2023, Inclusion Gloucestershire released a report about their Community Mental Health Transformation Lived Experience Survey, which also highlights variation in support, communication, care and access[126].

"Now that I am seeing a Consultant Psychiatrist, I feel like I am getting the support I probably need".

"Young Gloucestershire have supported me a lot. They've helped with so many little pieces which has made my overall mental health much better. They listen and care about what I'm saying."

"NHS never supported me. No person-centred care. Made my mental health much worse due to stigma and staff not listening to me."

"Very difficult to access psychiatrist assessment and follow up support. Very difficult to get support from mental health nurse."

Opportunities

The experience of care is lacking for many people living with SMI. There are significant opportunities to improve this, particularly by strengthening an holistic, trauma-informed and person-centred approach, and further recognising and supporting the value of peer and community support.

Additional Cluster-level insight

South West benchmarking from 2022-23 highlighted key trends for the region and the Gloucestershire and BNSSG areas. However, this needs updating before it can be confidently used as a baseline for future activity. Similarly, availability of data is inconsistent across the Cluster footprint for SMI beyond what is included in this INA, and this will need addressing before additional Cluster-level insight can be reported (for further details see the outcomes section below).

Race and ethnicity

National estimated prevalence of SMI, suggest that the Black ethnic group experience the highest prevalence of schizophrenia and other psychosis, while bipolar disorder has the highest prevalence in the White ethnic group[127].

While it is not possible to directly compare existing analysis across the Cluster[128], the 2025 Health Inequalities Statements for both ICBs similarly highlight a significantly higher rate of restrictive interventions for people in the Black African, Caribbean or Black British ethnic group, than in the White and Asian or Asian British groups[129].

Lived experience highlights numerous areas where experience varies for people from ethnic minority groups:

- A VCSE Mental Health Alliance inequalities report noted that Black and Asian clients felt that the inadequate care they received was due to racism and microaggression[130].
- The same report also detailed that people felt there was a "bias of clinicians in the sense that an English speaking, articulate, white British person would be more likely to be referred to a talking therapy service whilst someone from a minoritised community without those traits i.e., a Somali woman would not"[131].
- The 2026 Neurodiverse Connection report mentioned previously also highlighted:
  - People felt cultural barriers, language differences and a lack of representation shaped how they experienced and accessed mental health support.
  - Inconsistent access to interpretation support, and subsequent reliance on family members or friends affecting both patients' ability to communicate and prompting feelings of shame and discomfort discussing mental health challenges.
  - The absence of services that recognise people as whole individuals and that maintain connection to their local networks, cultures, and identities. It was felt that moving from community to inpatient care can result in people losing the relationships, trust, and understanding that actually promote recovery.



Strategic commissioning implications

Poor outcomes for people living with SMI are not inevitable and efforts to improve physical health will help to reduce many early and avoidable deaths and reduce inequalities.

Physical health checks for people living with SMI represent a clear opportunity to reduce the premature mortality gap. In particular, improving lipid measurement screening and referral for blood pressure treatment in response to elevated CVD risk through physical health checks was a key recommendation of the 2024 HQIP Audit of Early Intervention in Psychosis Provision in England and Wales[132]. Furthermore, an evidence review from the University of Bristol has highlighted case management as showing the most promise in helping more people with SMI access routine physical health reviews, and that having a dedicated professional to support patients through their health checks led to better uptake"[133].

In addition, the lived experience of people living with and receiving treatment for SMI aligns closely with feedback from other priority groups in prioritising holistic care that treats people as whole individuals, not a collection of conditions. As the recent Neurodiverse Connection report for AWP highlighted the current siloed approaches can miss "warning signs that potentially could have been noticed by a team, or by teams being linked up[134]. For example, supported housing letting mental health teams know that there has been an increase in mental ill health, pharmacies who are aware that medication has not been ordered or collected, benefits services being aware that people are having financial issues or police services responding to calls about a person seeming publicly unwell."

Early learnings from Neighbourhoods commissioning could therefore feed in here, and explore what combination of interventions would deliver safer, trauma-informed, more local and least-restrictive care, including whether earlier neighbourhood support could reduce escalation into admission, detention or OAPs.

A focus on outcomes through strategic commissioning also represents an opportunity to strengthen some of the data gaps outlined above in this chapter.



Data improvements required

We anticipate the SMI Modern Service Framework (MSF) will be published later in 2026. The SMI MSF will seek to address the "significant mortality and morbidity gap between people with SMI and those without, significant racial disparities around the use of compulsion, and poor-quality mental health care"[135].

Outcome goal / Moonshot: "By 2035, people with severe mental illness will live longer, healthier and more fulfilling lives through high-quality, integrated and equitable care"		
Pillar 1: Health and wellbeing Improved physical and emotional wellness, stability and function • Reduce premature mortality • Reduce preventable illness • Improve or stabilise symptoms (physical and mental health), reduce risk of reaching crisis, and improve health and support outcomes • Improved health-related quality of life and achievement of personalised care goals	**Pillar 2: High-quality care** Care that is safe, evidence-based, coordinated and responsive • Increase access to timely and appropriate clinical care • Reduce harm, compulsion and restrictive practices • Smooth transitions and continuity of care • Integrated working across agencies • Person-centred care planning and decision making	**Pillar 3: Opportunities, independence and inclusion** Individuals empowered to pursue their goals, maintain independence and access social and economic opportunities • Employment, education, volunteering • Stable and appropriate housing • Financial security • Social connectedness • Autonomy, choice and self-determination
• Gains in health that are achieved equitably between groups	• Accessible care that meets the needs of all groups	• Opportunities and gains are shared fairly between groups

We will seek to align all targets and objectives for our work to improve the experience and outcomes of our population living with severe mental illness.

There are also a number of areas where we will work to identify metrics where we do not currently have visibility. For example, the BNSSG Annual Inequalities statement notes that we have been unable to access information on the following measures, and we will continue to work to address this gap:

- Overall number of SMI physical health checks by ethnicity
- Rates of Mental Health Act detentions by deprivation and by ethnicity

Development of a PHM product to understand the population living with SMI, for example, co-occurring substance use, drugs, alcohol and smoking, which is useful for commissioners. Similarly, across the Cluster, there is currently no standardised OAP reporting for four of the types of bed days in scope for the reduction targets. This system intelligence reporting should be developed to provide greater oversight and assurance of the progress required[136].

We also plan to explore broader outcomes measures that speak to interim trajectories of change – for example, after conducting a physical health check there are a raft of activities and interventions required to ultimately affect premature mortality rates. We must explore how to measure these to better understand our progress in this area.

Further, the wider determinants of health, including deprivation, housing insecurity, employment and social isolation, also play a significant role as both contributors and outcomes for SMI. The potential to include these as outcomes for strategic commissioning should also be explored further, recognising that solutions to achieve change in these areas will require cross-system working with local authority and other partners.

Sources: Mental Health Act Statistics, Annual Figures - NHS England Digital; Mental Health Services Monthly Statistics, Performance February 2026 - NHS England Digital; Premature mortality in adults with severe mental illness (SMI) - GOV.UK; Premature mortality in adults with severe mental illness (SMI) - GOV.UK; Mental Health Act Statistics, Annual Figures – NHS England Digital

Preventing and treating Cardiovascular Disease

The NHS has placed cardiovascular disease (CVD) at the heart of its prevention agenda, recognising it as a major contributor to premature mortality, health inequalities and NHS demand.

The **NHS 10 Year Health Plan** commits to reducing premature deaths from heart disease and stroke by 25% and includes the development of a **CVD Modern Service Framework** to drive improvement. The Framework adopts a cardiovascular-kidney-metabolic (CVKM) approach, focusing on earlier prevention, detection and treatment, finding the "missing millions" with undiagnosed risk factors, and shifting care closer to home.

Through operational delivery within neighbourhoods, the CVD MSF anticipates the following changes nationally over three years:

- 60,00 events avoided
- Productivity gains of £1.3 billion
- Health and Social Care savings of £1.2 billion

The **UCLPartners Size of the Prize** analysis highlights the scale of opportunity, demonstrating that improving identification and management of hypertension, cholesterol and atrial fibrillation could prevent thousands of heart attacks and strokes, reduce inequalities and deliver substantial NHS savings.

Across Gloucestershire and BNSSG, circulatory diseases are major contributors to early preventable deaths. Cancers, CVD, respiratory and liver diseases are the most common causes of early deaths; these same largely preventable conditions also drive most of the gap in life expectancy between the most and least deprived areas.

Many of the leading causes of ill health and early death are linked to behaviours that can be changed. Smoking, obesity, and alcohol misuse are major contributors to cardiovascular disease, cancer, respiratory conditions, and liver disease. Interventions that target these risk factors are among the most effective and cost-efficient ways to improve health outcomes and reduce pressure on the NHS[137].

Risk factors

It is estimated that up to 70% of CVD is preventable driven by hypertension, lipids, smoking, obesity and physical inactivity[138].

Our health is affected by having the right building blocks in place, such as strong family and community relationships, safe quality housing, meaningful work, good education and freedom from discrimination. NHS care accounts for only 20% of a person's overall health outcomes, while the remaining 80% is driven by these wider social and economic determinants of health. For many, these building blocks are missing, which worsens people's social or job opportunities, habits and ultimately their health. We also know that ill health and risk factors don't exist in isolation; they cluster within individuals, families and communities[139].

For example, people living in the most deprived areas are more likely to have CVD, and also have higher rates of diabetes, obesity, smoking and alcohol consumption, which are all key risk factors for CVD.

Prevalence

There are 266,092 people living with hypertension across Gloucestershire and BNSSG. Prevalence ranges from 11.2% in Bristol and is highest at 17.6% in North Somerset (2024/25).

CVD Prevent Audit: Variation in management[140]

As of December 2025, **BNSSG's** performance across the ABC CVD prevention metrics is broadly in line with England, with notable strengths in cardiovascular risk management. There is a slightly higher proportion of people with elevated QRISK scores that are receiving lipid-lowering therapies and offers for smoking cessation support among people with CVD risk factors is above the national average.

The greatest opportunity for improvement lies in hypertension management, with achievement of BP targets (HYP007) which remains below the 80% ambition. Recording of smoking status among people with CVD or CVD risk factors is also below both the 90% ambition and the England average. In addition, BMI recording is lower than nationally, suggesting opportunities to strengthen routine risk factor assessment and prevention activity within primary care.

Opportunities

Optimise hypertension control, improve completeness of risk factor recording, and maintain strong performance in lipid management and smoking cessation support.

As of December 2025, **Gloucestershire** ICB demonstrates strong performance in case finding and monitoring, with a higher proportion of patients with hypertension having a recent blood pressure measurement compared with England. The ICB also performs slightly better than England for BMI recording and provision of smoking cessation support to patients with CVD risk factors.

However, conversion from monitoring to optimal treatment appears to be a challenge. BP control among patients with diagnosed hypertension (HYP007) remains below both the 80% ambition and the England average. Lipid management indicators also suggest scope for improvement, with lower rates of lipid-lowering therapy prescribing among patients at increased cardiovascular risk and those with established CVD.

Opportunities

Strengthen optimisation of hypertension treatment and cholesterol management, increase known at-risk groups for treatment with lipid-lowering therapy while building on existing strengths in patient monitoring, risk-factor recording and smoking cessation support.

For both Gloucestershire and BNSSG, similar trends were observed by inequality in hypertension management (HYP007): rates were lowest in the most deprived areas, lowest in the black ethnic group, higher for females, lower for people living with a learning disability and higher for people living with SMI.

For cholesterol management (P009CHOL), similar patterns were observed. Rates were lowest in the most deprived areas, and highest in Asian ethnic group, lowest for black ethnic group (Gloucestershire) and other ethnic group (BNSSG), lower for females, higher for people with a Learning Disability, higher for people living with SMI (Gloucestershire) and lower for people living with an SMI in BNSSG.

Opportunities for prevention: Post Heart Attack care in a PCN in South Bristol – Using Population Health Management approaches[141]: Population health analysis identified a substantial gap in post-heart attack care at a Bristol PCN. Between 2018 and 2023, 1,967 people experienced an adverse cardiac event, yet 625 (32%) had no recorded statin prescription afterwards. Nearly half of these patients were under 70 years old, a group likely to benefit significantly from lipid-lowering treatment.

The PCN had the highest number of patients across BNSSG not receiving this evidence-based therapy. Those without treatment were more likely to be White, live in more deprived areas and have fewer co-morbidities, suggesting opportunities for intervention may be missed among people perceived to be at lower risk despite having experienced a serious cardiovascular event.

What have people told us?

A consistent picture emerged from patient, community and service engagement work. While many people valued the care they received, several common barriers limited their ability to access services, manage their conditions and reduce their cardiovascular disease risk.

Prevention works best when it meets people where they are

Community based initiatives demonstrated the value of taking prevention into local neighbourhoods. Outreach programmes, community champions and initiatives such as **Know Your Numbers Week**[142] in Gloucestershire helped identify previously undiagnosed risk factors, improve awareness of blood pressure and cardiovascular health, and engage people who may not otherwise access health services.

A quarter of participants receiving a community blood pressure check and who responded to a follow-up survey had never had their blood pressure measured before, while 93% reported the intervention had increased their understanding of high blood pressure.

Knowledge and confidence are as important as clinical care

People living with hypertension and cardiovascular disease frequently reported limited understanding of their condition, treatment and personal risk[143]. Around one-third of people surveyed during as part of a BNSGS ICB survey of patients with hypertension did not know their latest blood pressure reading or target level[144]. A consistent theme throughout engagement with our communities was that many people were unclear about the importance of taking medication consistently[145]. People also said that they wanted more information, clearer explanations following diagnosis, and greater support to make lifestyle changes and manage their own health[146].

Access barriers contribute to inequalities

Across several projects, people described practical barriers to accessing care, including long waits for routine appointments, difficulties navigating services, transport costs, work and caring responsibilities, and digital exclusion.

Missed cardiology appointments were often linked to communication, logistics and appointment accessibility rather than lack of engagement. Patients preferred face-to-face daytime appointments, clear written information and appointment reminders by text or post[147].

Engagement with GP practices highlighted the use of proactive recall systems home blood pressure monitoring, opportunistic checks, community outreach, staff training and continuity of care as examples of how blood pressure control could be improved[148].

Continuity and joined-up care matter

People consistently valued continuity of care, friendly staff and clear communication. However, many reported challenges when moving between primary and secondary care, feeling that information was not always shared effectively and that routine reviews sometimes felt transactional rather than personalised[149]. People want services to take a more holistic approach, using routine reviews as an opportunity to discuss wider wellbeing needs and connect people to community support[150].

Wider factors influence cardiovascular health

Engagement work highlighted the close relationship between physical health, mental wellbeing and ability to engage with long-term condition management. Social connections, physical activity and community support were seen as important contributors to health and wellbeing[151].

Local data has also highlighted the links between cardiovascular risk and multimorbidity. People living with chronic pain were substantially more likely to have high blood pressure, obesity and diabetes than the wider BNSSG population[152].

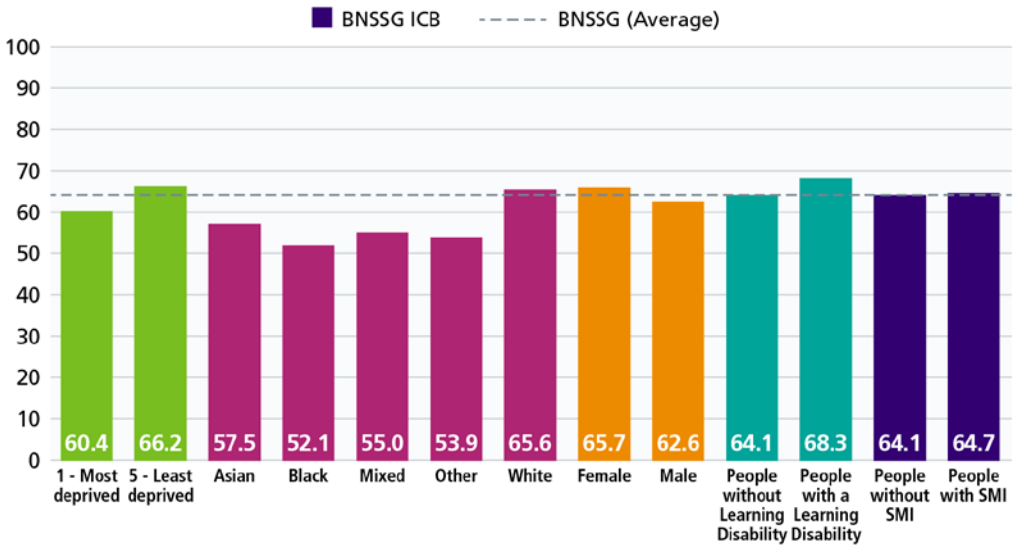
Key insight

Improving cardiovascular outcomes requires more than clinical treatment alone. The evidence suggests the greatest gains will come from combining effective clinical pathways with proactive community outreach, improved health literacy, personalised support and services that are easier for people to access and navigate.

Race and ethnicity

ICB equality objective – Improving hypertension management in Black African and Caribbean communities[153]: In 2024-25 ICB and public health colleagues reviewed national CVD PREVENT data, local BNSSG system wide data, evidence and local insights on inequalities in hypertension treatment.

Figure 7 **Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months by domain of inequality (CVD Prevent, June 2024)**



The information identified clear inequalities in hypertension treatment for Black African and Caribbean populations in BNSSG, who were significantly less likely to be managed to an appropriate treatment target for high blood pressure. A CVD Working Group has been established to work in collaboration with Voluntary Community and Social Enterprise (VCSE) alliance ambassadors and public contributors with lived or learnt experience of cardiovascular disease and ethnic health inequalities, commissioners, primary care colleagues and a secondary care hypertension specialist colleague.

The group has met six times in person to discuss factors and barriers impacting Black African and Caribbean people's poorer CVD health outcomes, higher risk of hypertension, and poorer treatment. They have identified the top barriers to hypertension treatment adherence as a lack of trust and health literacy, with sub-themes relating to each of these areas, including lack of cultural competency, clinical communication, understanding and awareness of high blood pressure, skills, knowledge and understanding of management of CVD and motivational barriers. They have also started to identify recommended solutions and models that will overcome these barriers.

CVD Prevention: Taking Health Checks into the Community

This programme brought cardiovascular disease (CVD) prevention directly into communities, using targeted outreach and trained volunteer community champions to engage people who may not otherwise access traditional services. Community-based screenings for blood pressure, cholesterol, diabetes and atrial fibrillation helped identify people at risk earlier and connect them to support.

By delivering checks in trusted local settings, the programme helped overcome barriers such as access, language, culture and mistrust, while strengthening relationships with underserved communities. As well as identifying cardiovascular risk, it increased health awareness, empowered residents to take action and demonstrated a scalable, cost-effective model for reducing CVD inequalities.

Strategic commissioning implications

Cardiovascular disease is one of the greatest opportunities to improve population health, reduce inequalities and ease pressure on health and care services. The evidence throughout this chapter shows that prevention works, but its impact is greatest when delivered through a coordinated system approach with strong leadership across health, care, local government, communities and employers.

Many of the interventions outlined will be delivered through the Neighbourhood Health Programme. By March 2029 the aim is to see an improvement of at least 10% in evidence-based outcomes, measured through the quality and outcomes framework, for CVD.

From targeted NHS Health Checks and workplace health initiatives to community outreach programmes and smoking cessation services, there are clear examples across Gloucestershire and BNSSG of successfully reaching people earlier, identifying hidden risk and supporting healthier lives. However, prevention cannot stop at identification. Effective follow-up, treatment optimisation and ongoing support are critical to achieving meaningful health gains and reducing inequalities.

The case for investment is compelling. NHS Health Checks deliver a positive return on investment, while improving hypertension control is one of the most cost-effective interventions available. If 85% of people with hypertension were treated to target, an estimated **281 heart attacks, 419 strokes and 224 deaths could be prevented across Gloucestershire and BNSSG**, alongside **over £10 million in NHS savings**.

The message is clear: investment in CVD prevention is not a cost, it is an opportunity to save lives, reduce inequalities and create a more sustainable health and care system.

Data improvements required

Given the national and regional focus on CVD, the data we have available is better than for other areas discussed in this report. Greater use of **CVDPREVENT Audit** data could further improve our understanding of cardiovascular disease across G-BNSSG. Selecting key CVDPREVENT indicators and including within system reporting through the use of automated data feeds or APIs in dashboards would improve the timeliness, consistency and accessibility of performance data.

This would support a more comprehensive understanding of progress against system priorities, facilitate the identification of unwarranted variation, and strengthen oversight of initiatives aimed at improving cardiovascular outcomes.

This could form part of future developments around monitoring outcomes.

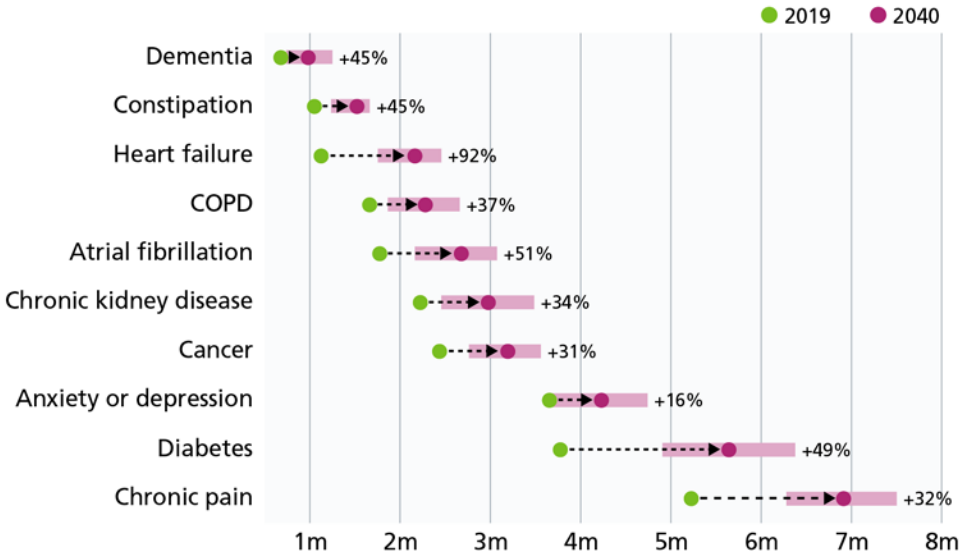


Supporting people living with Frailty

We are living longer, but not always in the best health. Nationally, Healthy Life Expectancy (HLE) is declining, particularly for males. In our area, HLE for females has stabilised in Bristol and Gloucestershire, and a small increase has been observed in South Gloucestershire. For North Somerset, however, HLE continues to decline. In BNSSG, people in the most deprived areas have the same level of ill health in their early 50s as people in the least deprived areas do in their late 60s.[154]

The Health Foundation's modelling of future health trends in England predicts the number of people living with a long-term condition is projected to increase by 37%, from 1 in 6 people in 2019, to 1 in 5 by 2040. Many of these conditions can be prevented or delayed[155].

Figure 8 **Projected total number of diagnosed cases for the 10 conditions with the highest impact on health care use and mortality among those aged 30 years and older, including demographic changes, England, 2019 and projected for 2040[156]**



Nevertheless, frailty is not an inevitable consequence of ageing. People living with frailty are therefore a priority cohort within the 10 Year Health Plan for England, the Medium Term Planning Framework and the Neighbourhood Health Framework[157]. Early detection and reducing decline are also two of the three pillars of shifting from treatment to prevention in the South West. Highlighting the importance of identifying need at the earliest opportunities, targeting at-risk populations, and ensuring people feel empowered with their self-care and receive the right treatment[158].

What existing evidence tells us

Understanding frailty

Frailty is generally agreed to be a syndrome: a distinctive health state in which multiple body systems gradually lose their in-built reserves and resilience to adverse events from a range of triggers. Around 10% of people aged over 65 years are living with frailty, rising to between a quarter and a half of those aged over 85[159].

Frailty is complex and typically associated with older adults, however, it can be experienced at any age. Whilst it is strongly correlated with deprivation, the strongest risk factor is age, and prevalence rises as age increases[160]. It is also impacted by other factors such as social deprivation and living circumstances for example, housing, income, and physical factors such as decline in nutritional status[161].

Research shows that some vulnerable groups with chronic conditions may be at risk of becoming frail earlier in life, while the onset of illness and disability occurs at younger ages for people living in areas of greater deprivation[162].

However, frailty is not an inevitable consequence of ageing; it is reversible in the early stages, and the progression of frailty can be reduced through lifestyle factors including diet and exercise[163]. It can be slowed by adopting a biopsychosocial approach to intervention, implementing personalised and preventative measures that address a person's range of needs in a timely way, enabling them to live independently and healthier for longer[164].

Opportunities/Insight

A key priority for the system is to slow this progression into poorer health states, which can be achieved through prevention and early intervention at all stages of life. This could include initiatives to age well, maintaining independence, or delaying the onset of preventable long-term conditions, which can reduce the amount of time people are spending in poorer health and find ways to help them to live healthier for longer.

Experience of frailty across our Places[b]

BNSSG

In BNSSG, there are around 34,000 registered patients who are in the frailty cohort. This has previously been defined as being aged 75 or over, and in Segment 4 or 5 of the locally established segmentation using the Cambridge Multimorbidity Score. 16,000 of this group are in the most complex segment (5), while 14% are in the most 20% deprived of the population nationally.

People living with frailty are largely concentrated in North Somerset and South Bristol, with the highest concentrations near MIUs in Clevedon, Weston and South Bristol.[165] 70% have hypertension, 50% have painful conditions, and around 30% have AF, hearing loss, diabetes and ~28% have anxiety and depression or Chronic Kidney Disease.

To consider likely changes for these groups in the future, in BNSSG Dynamic Population Modelling (DPM) has estimated how the size and health of the adult population (aged 17+) may change over time in each local authority across BNSSG. The model uses the local CMS-derived segmentation to show how people are likely to change in complexity over time. This helps to understand how health needs may increase or change across the population.

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

Case study

Frailty-ACE (F-ACE) was developed to address growing urgent and emergency care pressures across BNSSG, recognising that people living with severe frailty experience a disproportionate level of hospital use while often being safely supported at home. Population Health Management analysis found that although Segment 5 represents just 3.4% of the population, it accounts for 27% of ambulance conveyances and 49% of ambulatory care sensitive condition admissions.

F-ACE provides multidisciplinary assessment, coordination and tailored urgent care at home, helping people receive care that aligns with their needs and preferences. The service has significantly reduced Emergency Department attendances and non-elective admissions, with analysis suggesting that the 1,223 patients supported avoided around 1,000 ED attendances and 300 hospital admissions[166].

[b] Across the Gloucestershire and BNSSG Cluster, varying definitions of frailty have been used previously and for neighbourhood health programme development. Work is ongoing to harmonise these, and therefore data is presented separately here. Further information on current definitions and plans can be found later in the chapter.

Gloucestershire

In Gloucestershire there are currently 23,757 individuals living with moderate frailty, as identified by the Electronic Frality Index (eFI) of whom 11.6% also have two or more of the Johns Hopkins ACG frailty concepts, and 11,420 individuals living with severe frailty (eFI), 34.0% of whom have two or more concepts.

However, frailty is not evenly distributed across Gloucestershire. Across different measures, including eFI and the Johns Hopkins PNG11 Frailty cohort, areas of particular concentration are in urban areas including Gloucester and Cheltenham in particular, plus Tewkesbury and Cinderford. Analysis by Primary Care Network (PCN) shows even greater variation than at locality level, reaching 6.9% compared with 2.8% for localities.

Beyond geography, in Gloucestershire there is a statistically higher rate of most QOF long term conditions in both (eFI Moderate/Severe and PNG 11 - Frailty) frail cohorts. This can be expected when viewing the frailest individuals within a population who are likely to have a high comorbidity burden.

However, exploring variation by ethnicity, there is a different picture whether cohorts are defined by either eFI or the Johns Hopkins Frailty group (PNG11). Those from an Asian, Black or White ethnic groups are more likely to be living with eFI Moderate/Severe frailty than the ICB average. This may reflect higher levels of frailty or could equally reflect better coding of comorbidities in these groups.

The picture is quite different, however, for Frailty PNG 11 patients (July 2026), whereby all groups (except those in the Mixed or not known groups) are broadly in line with the ICB average. The lower levels of recorded frailty for the mixed and not known groups may reflect experiences, or could equally reflect poorer coding of frailty concepts in these groups.

Case study

Gloucestershire introduced the PCN Frailty and Dementia Proactive Model of Care in 2025/26 to strengthen proactive, neighbourhood-based care for people living with moderate and severe frailty and those with clear and evident symptoms of dementia. The programme aimed to reduce variation in frailty provision across PCNs, improve access to timely dementia diagnosis, and support people to remain independent at home for longer. The model combines an evidence-based frailty pathway with an innovative primary care-led dementia co-diagnosis pathway delivered through integrated neighbourhood teams. Evidence of early outcomes include:

- Faster access to dementia diagnosis
- Reduced unplanned acute hospital attendances and admissions for people receiving a Comprehensive Geriatric Assessment/frailty assessment
- Stronger integrated neighbourhood working
- Positive patient and carer experience

Developing a common cluster approach for neighbourhood health

Reflecting the separate approaches supporting people living with Frailty, Gloucestershire and BNSSG currently have somewhat different definitions of frailty in use as part of their developing neighbourhood health models.

In Gloucestershire, the initial frailty cohort identified by the PCN Proactive Frailty and Dementia Care Service includes people within a given PCN area:

- Of any age at risk of, or living with, moderate or severe frailty, identified through pro-active digital case identification using eFI and the case finding function within the Personalised Proactive Whiteboard;
- Aged 75 years + who have "clear and evident signs" of a dementia, living in the wider community or living in a care home

After which a holistic assessment is conducted to ensure clinical validation of their inclusion in the cohort.

In BNSSG, the cohort of people living with frailty has been identified using a similar combination of demographics, conditions, and clinical expertise. It includes people aged over 45 who meet one of the following criteria:

- An eFI2 score of moderate or severe frailty, where available from primary care records;
- A recorded Rockwood Clinical Frailty Scale score of 5 or above, where clinically assessed;
- Professional or MDT judgement identifying people aged 45-64 who are complex or on a trajectory towards frailty (who should then also record a CFS score).

Initial estimates suggest that this definition will yield a cohort of around 34,000 people in BNSSG (a similar size to the original cohort), however the first phase of activity is also intended to test this assumption, and to explore the impact in particular of the space for clinical expertise in the definition. This will then be refined for future commissioning.

These definitions represent the first step in identifying frailty cohorts for neighbourhood health approaches. From these we will continue to work to produce a shared cohort profile across the Cluster in time. Local evaluation of the neighbourhoods' programme will include the practicalities of identifying the cohort through this definition, whether greater consistency of data collection in this area has been achieved, and whether sufficient flexibility for clinical judgment has been built in.

What people have told us

Impact on individuals living with frailty

Frailty can lead to a loss of independence, increase social isolation, reduce quality of life and have significant impact on an individual's health and wellbeing. Many people living with frailty will also be managing long-term conditions, engaging with and coordinating across multiple health and care services. The combination of some or all of these factors can in turn affect people's mental health.

A report by Healthwatch Bristol about people's experiences of living with LTCs and the impact this has on mental health[167] highlighted this as an important consideration. 80% of people who had received mental health support found it beneficial. People reported that their mental health is impacted by their physical health.

> **"Managing type 1 diabetes, as well as having constant background pain, is wearying. I also sleep very poorly and am always fatigued. Consequently, I do not have the energy to do all the things I want to do. I am always making plans to do activities which I then regret because I feel too tired to enjoy them. It makes me feel dispirited and anxious, and I have the sense that I am not living life to the full."**

The BSWN report referenced in earlier chapters also highlights areas in which the needs of African Caribbean, Chinese and South Asian older people are not being met through their health and care experiences. This included a lack of culturally appropriate food (for example, halal meals), and the lack of specific training for carers to support personal hygiene routines (such as knowing ow to correctly use product to wash a Black person's hair)[168]. These issues in turn placed additional pressure and strain on friends and family members who worked hard to fill in these gaps in care provision.



Further insight into people's experience of living with frailty in Gloucestershire and BNSSG is expected to be available shortly for us to draw on. In August 2026, the national Neighbourhood Health Survey launched to explore the experiences of people at highest risk of hospitalisation, long lengths of stay and disproportionate healthcare utilisation. Using the Hospital Frailty Risk Score (HFRS) to identify those at intermediate and high risk of frailty, the survey will be shared with around two million people, equating to approximately 13,000 per Place. The patient questionnaire will cover topics including patient activation, health-related quality of life, wider determinants of health, patient experience, QALY and WELLBY measures, alongside an equivalent survey for unpaid carers.

The first data from this survey is expected to be available from September 2026. This is also the first national survey where patient survey responses will be linked to healthcare utilisation measures. This will allow analysis including exploration of outcomes across different demographic and socioeconomic groups, and how carer experience and burden influences patient outcomes.

The role and experience of Carers

Frailty rarely affects individuals in isolation. The ability of many people living with frailty to remain independent, avoid hospital admission, and maintain quality of life is closely linked to the availability and wellbeing of unpaid carers. Carers therefore represent both a population with their own health needs and an important consideration within the system supporting people living with frailty.

However, we are not easily able to identify carers at scale to be able to understand their needs. 2023 Health Foundation analysis suggested that data held by GPs and local authorities, at best, identifies between 11-26% of unpaid carers compared to the census[169].

The 2026 GP Patient Survey helps to highlight carers' needs distinct from the people they care for[170], and why identification is crucial. Carers were more likely to report a long-term health condition (70% vs 61% BNSSG, 68% vs 62% Glos) more likely to report feeling isolated or lonely (11% vs 9% BNSSG 9% vs 6% Glos), more likely to report a mental health condition (17% vs 14% BNSSG, 16% vs 11% Glos). Only 63% in BNSSG agreed that they had received enough support from local services or organisations to help them manage their own conditions or illnesses over the last year, and 20% reported problems with their physical mobility (71% and 14% respectively in Glos).

A small scale piece by Healthwatch North Somerset in 2022 explored the needs of carers "unheard from minority groups"[171]. Shared experiences included not identifying as carers, an absence of support from health and social care professionals regarding their role as a carer, barriers presented by language and cultural differences, and a need for emotional support.

Key insight

Improving outcomes for those living with frailty will mean addressing more than the needs of those individuals. Unpaid carers play a vital role which needs greater support, but many also have their own health needs that must be considered.

Strategic commissioning implications

The combination of an ageing population, and an increase in the proportion of people living in poorer health, means effective support for those living with frailty and those at risk of becoming frail, alongside prevention of future deterioration, is essential.

Without continued commitment to person-centred care that supports people in these ways, too many patients will experience care that does not meet their needs, and the pressure of non-elective admissions and other activity will continue to grow across the system.

The Local Government Association High Impact Change Model for reducing preventable admissions highlights the importance of understanding local populations and identifying those most at risk using PHM approaches and risk stratification (High Impact Change A). It includes the key messages of maximising independence and preventing future crises, such as admission avoidance and support following discharge (High Impact Change F). This will require close partnership working and coordination with local authority teams in Public Health and Adult Social Care[172].

Similarly, using the Strategy Unit's analysis of potentially mitigable hospital activity, frailty is also one of the most significant opportunities to support the shift of care from hospital to community across Gloucestershire and BNSSG[173]. Local analysis of this data shows that potentially mitigatable hospital admissions across Gloucestershire and BNSSG for falls, intermediate frailty risk and high frailty risk account for 44.7% of all potentially mitigatable hospital activity. This could prevent up to 45,032 admissions and save 501,404 bed-days. Importantly, these figures should not be interpreted as savings that can automatically be realised at this scale, this provides an evidence-based indication of where the greatest opportunities could be as a starting point for local planning, prioritisation and further clinical and operational assessment.

Data improvements required

Once definitions of frailty have been aligned, Gloucestershire and BNNSG ICB will need to establish a clear approach to measuring and monitoring this priority cohort. Without this, it will not be possible to effectively evaluate our impact in changing models of support for this group. Alongside this, improvements in data quality around recording unpaid carers so that their experiences and outcomes can be considered alongside the main cohort will also be important.



Appendix 1

Methodology

This Integrated Needs Assessment was produced from July - September 2026.

It was produced by a multi-organisation, multidisciplinary team, including from the ICB Cluster and our four local authority public health teams. It was review by a combination of ICB population health colleagues, subject matter experts, and strategy leads, in addition to a senior review by the system Directors of Public Health, ICB CMO, CNO, and Chief of Population Health Improvement.

The INA draws on more than 200 documents and data sources including, but not limited to, local JSNAs, national outcomes data, lived experience, and academic research. As outlined in the report, the priority areas included here largely represent priorities identified through our business plan and existing commitments across the Cluster. They include areas that are currently moving at pace, such as supporting people living with frailty through a neighbourhood approach, as well as maternity where there is already an established Case for Change in Gloucestershire. However, it also identifies areas where we don't know enough yet about our priorities, where more data and insight is needed to ensure effective strategic commissioning.

The document is intended primarily to inform the planning process for the ICB, as well as acting as an 'anchor point' for the development of our Population Health Strategy. It has been developed during a period of significant organisational transition and the development of new intelligence arrangements across Gloucestershire and BNSSG since the two ICBs Clustered in April 2026. It therefore takes a deliberately pragmatic approach: drawing together the strongest available evidence across the footprint, alongside deeper analysis of four areas of particular strategic importance. It does not seek to provide an exhaustive assessment of every aspect of population need, but provides an important evidence input to the current planning cycle and a foundation from which future INAs can build.

In addition to the above, the INA process has also highlighted areas where data needs to be collected or reported differently, and this will be addressed as part of the Population Health Improvement directorates plans for the next year.



Appendix 2

Acronyms and Glossary

Acronyms

Acronym	Definition / meaning based on this document
A&E	Accident and Emergency
ACG	Adjusted Clinical Groups
ACSC	Ambulatory care sensitive condition
AF	Atrial fibrillation
API	Application Programming Interface
AWP	Avon and Wiltshire Mental Health Partnership
BMI	Body mass index
BNSSG	Bristol, North Somerset and South Gloucestershire
BP	Blood pressure
BPG	Best practice guidance; used in reference to NHS frailty pathways guidance
BSWN	Black South West Network
CFS	Clinical Frailty Scale
CGA	Comprehensive Geriatric Assessment
CKD	Chronic kidney disease
CMO	Chief Medical Officer
CMS	Cambridge Multimorbidity Score

Acronym	Definition / meaning based on this document
CNO	Chief Nursing Officer
COPD	Chronic obstructive pulmonary disease
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CVD	Cardiovascular disease
CVKM	Cardiovascular-kidney-metabolic
CYP	Children and young people
DPM	Dynamic population modelling
DSR	Directly age-standardised rate
ED	Emergency Department
eFI	Electronic Frailty Index
eFI2	Electronic Frailty Index 2
EOL	End of life
F-ACE	Frailty-ACE
G-BNSSG	Gloucestershire, Bristol, North Somerset & South Gloucestershire
GHT	Gloucestershire Hospitals NHS Foundation Trust

Acronym	Definition / meaning based on this document
GP	General practice / general practitioner
HEA	Health Equity Audit
HFRS	Hospital Frailty Risk Score
HI	Health inequalities
HIV	Human immunodeficiency virus
HLE	Healthy life expectancy
HNA	Health Needs Assessment
HQIP	Healthcare Quality Improvement Partnership
ICB	Integrated Care Board
IMD	Index of Multiple Deprivation
INA	Integrated Needs Assessment
JSNA	Joint Strategic Needs Assessment
KPI	Key performance indicator
LGA	Local Government Association
LMNS	Local Maternity and Neonatal System
LTC	Long-term condition
MDT	Multidisciplinary team

Acronym	Definition / meaning based on this document
MH	Mental health
MIU	Minor Injuries Unit
MNVP	Maternity and Neonatal Voice Partnership
MSF	Modern Service Framework
NHS	National Health Service
NOMIS	Official labour market statistics service / NOMIS
NOF	National Outcomes Framework
OAP	Out of area placement
OFH	Our Future Health
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OOA	Out of area
PBC	Post Birth Contraception

Acronym	Definition / meaning based on this document
PCN	Primary Care Network
PHM	Population Health Management
PICU	Psychiatric Intensive Care Unit
PNG	Patient Needs Group
PREMS	Patient-reported experience measures
PrEP	Pre-exposure prophylaxis
PROMS	Patient-reported outcome measures
QALY	Quality-Adjusted Life Year
QOF	Quality and Outcomes Framework
REND	Diverse Research Engagement Network
ROI	Return on investment
RWoB	Refugee Women of Bristol
S117	Section 117 aftercare funding / eligibility

Acronym	Definition / meaning based on this document
SEND	Special educational needs and disabilities
SMI	Serious / severe mental illness
UCL	University College London
UEC	Urgent and emergency care
VCS	Voluntary and community sector
VCSE	Voluntary, Community and Social Enterprise
WELLBY	Wellbeing-Adjusted Life Year

Glossary of key terms

Ambulatory Care Sensitive Conditions (ACSCs)

Activities and services designed to prevent unnecessary hospital admissions by providing timely assessment, treatment and support in community or home settings.

Admission Avoidance

Conditions for which effective prevention, early intervention, or ongoing management in community settings can reduce the need for hospital admission.

Cardiovascular Disease (CVD)

A group of conditions affecting the heart and blood vessels, including coronary heart disease, stroke and peripheral arterial disease.

Cardiovascular-Kidney-Metabolic (CVKM) Approach

An integrated approach recognising the relationship between cardiovascular disease, kidney disease, diabetes, obesity and metabolic health.

Cluster

A larger NHS geography where multiple Integrated Care Boards work together to provide strategic leadership, share resources and deliver functions more efficiently across a wider population

Community-Based Prevention

Actions delivered within communities to improve health, prevent illness and reduce inequalities.

Comprehensive Geriatric Assessment (CGA)

A multidimensional assessment of an older person's medical, functional, psychological and social needs used to develop a coordinated care plan.

Continuity of Care

The extent to which people experience coordinated and consistent care over time.

Core20PLUS5

The NHS approach to reducing healthcare inequalities focused on the most deprived communities, additional priority populations and five clinical areas.

Deprivation

A measure of disadvantage relating to income, employment, education, housing, crime, health and the environment.

Frailty

A health state in which multiple body systems lose resilience and ability to recover from stressors.

eFI (Electronic Frailty Index)

A primary care tool that uses routine GP record data to identify and categorise frailty in people aged 65 and over, helping target proactive care.

Health Equity

The principle that everyone should have a fair and just opportunity to achieve their best possible health.

Health Inequalities

Differences in health outcomes, access or experience that are unfair, avoidable and socially determined.

Hospital Frailty Risk Score (HFRS)

A hospital-based risk stratification tool that uses diagnostic coding from previous admissions to identify older people at risk of frailty-related adverse outcomes.

Inclusion Health Groups

People who experience social exclusion, poor health outcomes and barriers to accessing services.

Integrated Care Board (ICB)

The NHS organisation responsible for planning and commissioning services across a geographic area.

Integrated Needs Assessment (INA)

A strategic assessment combining population data, research and lived experience to inform commissioning decisions.

Intersectionality

The way different characteristics and experiences interact to influence opportunities, experiences and health outcomes.

Long-Term Conditions (LTCs)

Health conditions that generally cannot be cured but can be managed through treatment and support.

Maternity Health Equity Audit

A structured assessment of inequalities in maternity outcomes, access and experience.

Multimorbidity

The presence of two or more long-term health conditions in the same individual.

Neighbourhood

A smaller local community within a place where multidisciplinary teams work together with residents to provide joined-up, person-centred care and support close to home.

Neighbourhood Health

A model of care integrating primary care, mental health, social care and community support around local populations.

Neighbourhood Health Teams

Multidisciplinary teams working at a local population level to coordinate integrated health, care and voluntary sector services around the needs of residents.

Out of Area Placement (OAP)

A situation where a patient, usually requiring inpatient mental health care, is admitted to a service outside their local area because suitable local beds or services are unavailable.

Person-Centred Care

An approach that focuses on what matters to individuals rather than treating conditions in isolation.

Physical Health Checks (SMI)

Annual assessments offered to people with Severe Mental Illness (SMI) to identify and manage physical health conditions such as cardiovascular disease, diabetes and obesity.

Place

A partnership area, usually aligned to a Local Authority boundary, where the NHS, local government, voluntary sector and communities work together to improve population health and coordinate services for a larger population.

Population Health

An approach that aims to improve health outcomes and reduce inequalities across an entire population.

Population Health Management (PHM)

The use of linked data and analytics to understand population need and target interventions.

Prevention

Action taken to prevent disease, delay ill health or reduce complications from existing conditions.

Protective Factors

Conditions that help people maintain health, wellbeing and resilience.

QALY (Quality-Adjusted Life Year)

A measure used in health economics that combines quantity and quality of life to assess the value and cost-effectiveness of healthcare interventions.

Risk Stratification

The process of identifying people or groups at higher risk of poor outcomes.

Restrictive Interventions

Practices such as physical restraint, seclusion, or rapid tranquillisation that limit a person's freedom of movement and are used only when necessary to prevent harm.

Segmentation

Grouping people with similar health characteristics or needs to support planning and intervention.

Severe Mental Illness (SMI)

A group of severe and enduring mental health conditions associated with significant functional impairment.

Social Determinants of Health

The wider social, economic and environmental conditions that shape health and wellbeing.

Strategic Commissioning

The process of assessing need, setting priorities and allocating resources to improve outcomes.

Structural Racism

The way policies, institutions and systems can create or perpetuate inequalities between ethnic groups.

Trauma-Informed Approach

An approach that recognises the impact of trauma and seeks to avoid retraumatisation.

WELLBY (Wellbeing-Adjusted Life Year)

A measure that quantifies changes in people's overall wellbeing and life satisfaction, allowing comparison of benefits across different health and social interventions.

Wider Determinants of Health

The social, economic and environmental conditions that influence health beyond healthcare services.

Appendix 3

Data summary

Table 2 **2025 Mid -year population estimates by Local Authority (Males, Females) – ONS**

	Bristol		North Somerset		South Gloucestershire		Gloucestershire	
Age Groups	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**
Aged under 1 year	2,517	2,417	900	914	1,466	1,361	2,985	2,866
Aged 1 - 4 years	9,747	9,316	4,391	4,092	6,666	6,136	13,141	12,422
Aged 5 - 9 years	12,281	11,786	6,283	6,014	9,160	8,459	18,696	17,757
Aged 10 - 14 years	13,063	12,637	6,893	6,526	9,267	8,836	20,030	19,476
Aged 15 - 19 years	15,930	15,531	6,478	5,928	9,315	8,790	19,124	19,111
Aged 20 - 24 years	29,235	30,283	4,681	4,664	10,848	9,173	16,323	15,467
Aged 25 - 29 years	26,166	24,691	5,698	5,932	9,834	9,768	18,152	18,099
Aged 30 - 34 years	22,355	21,732	6,252	6,769	10,987	11,680	20,159	21,172
Aged 35 - 39 years	19,985	19,820	6,873	7,521	11,128	11,689	21,348	23,282
Aged 40 - 44 years	16,697	16,767	7,300	7,663	10,352	10,522	21,066	21,974
Aged 45 - 49 years	14,058	14,005	6,874	7,289	9,100	9,297	19,636	20,198
Aged 50 - 54 years	12,493	12,629	7,425	7,449	9,118	9,188	20,746	21,998
Aged 55 - 59 years	12,126	11,867	7,790	7,983	9,622	10,086	23,216	24,289
Aged 60 - 64 years	10,872	11,198	7,570	7,799	9,186	9,338	23,166	24,270
Aged 65 - 69 years	8,662	9,068	6,314	6,944	7,276	7,609	19,330	20,297
Aged 70 - 74 years	7,106	7,587	5,677	6,487	6,109	6,671	16,289	18,062
Aged 75 - 79 years	6,307	7,110	5,997	6,889	5,926	6,945	15,932	18,048
Aged 80 - 84 years	3,764	4,858	3,979	4,846	4,126	5,139	10,316	12,435
Aged 85 and over	3,295	5,299	3,175	4,901	3,387	5,227	8,269	12,761
	246,659	**248601**	**110550**	**116,610**	**152873**	**155,914**	**327924**	**343,984**
Total	495,260		227,160		308,787		671,908	

Figure 9 **Population in Gloucestershire and BNSSG, 5 year age bands (Males, Females) – ONS Mid-year population estimates (2025)**

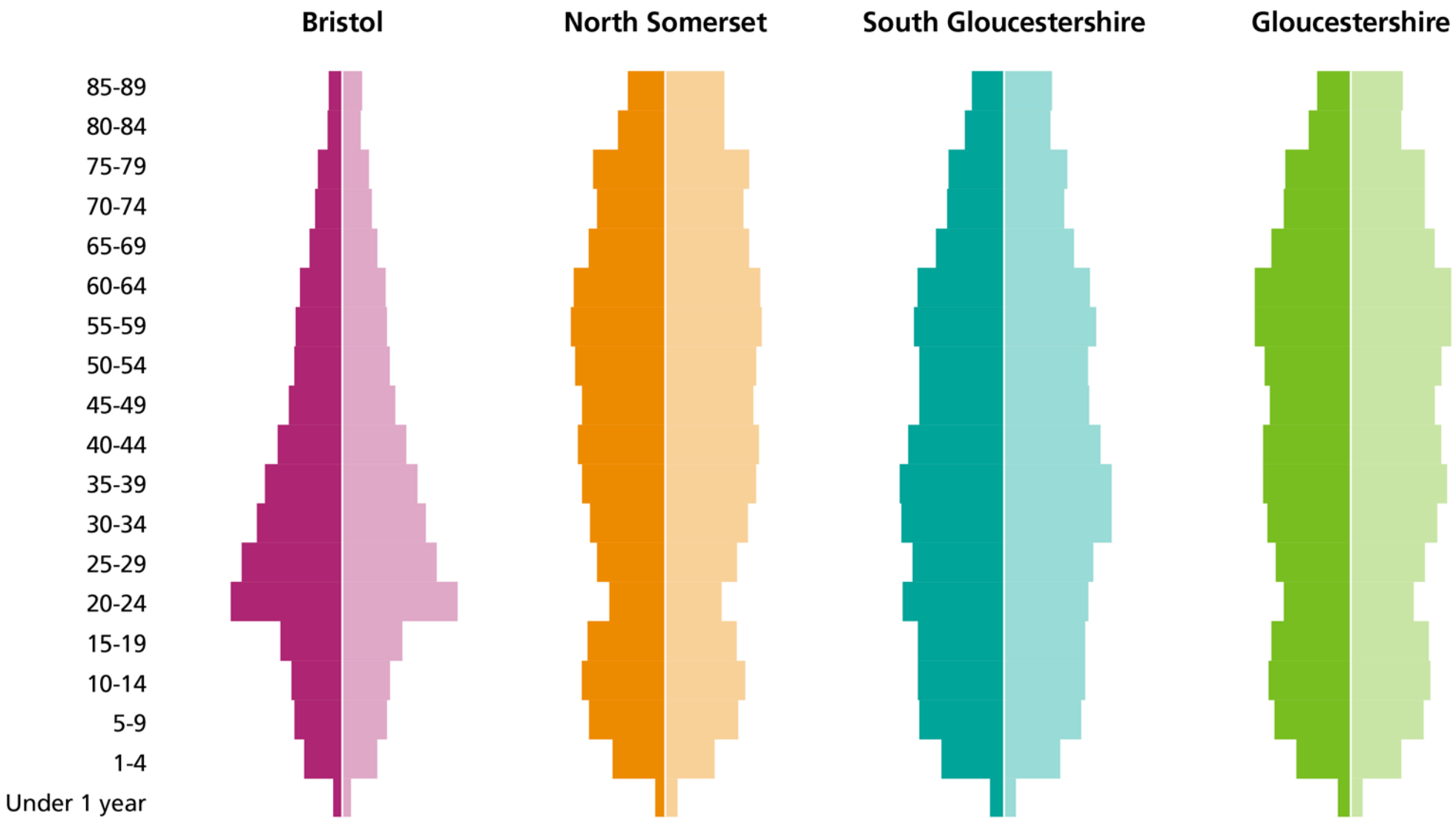


Table 3 **Breakdown by Ethnic Groups in Gloucestershire and BNSSG (2021 Census, NOMIS)**

Ethnic group	Bristol, City of		Gloucestershire		North Somerset		South Gloucestershire	
	No.	%	No.	%	No.	%	No.	%
Total: All usual residents	472,467	100.0	645,079	100.0	216,729	100.0	290,424	100.0
Asian, Asian British or Asian Welsh	31,269	6.6	18,464	2.9	3,322	1.5	11,094	3.8
Black, Black British, Black Welsh, Caribbean or African	27,890	5.9	7,777	1.2	1,139	0.5	4,534	1.6
Mixed or Multiple ethnic groups	21,116	4.5	14,149	2.2	3,635	1.7	7,289	2.5
White	383,142	81.1	600,314	93.1	207,429	95.7	264,856	91.2
Other ethnic group	9,050	1.9	4,375	0.7	1,204	0.6	2,651	0.9

Table 4 **Breakdown by Index of Multiple Deprivation in Gloucestershire and BNSSG (2025, ONS)**

% of population in each decile	IMD Deprivation by Decile (Local/*County)									
Locality	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Bristol, City of	17.5%	15.7%	13.1%	9.7%	9.0%	6.7%	7.8%	8.6%	6.7%	5.2%
North Somerset	8.0%	7.2%	4.3%	6.5%	13.0%	16.7%	10.9%	13.0%	8.7%	11.6%
South Gloucestershire	0.6%	3.4%	9.7%	13.1%	9.1%	9.7%	12.6%	9.7%	16.0%	16.0%
Gloucestershire*	9.9%	9.9%	10.3%	10.4%	10.2%	11.1%	9.6%	10.1%	9.1%	9.4%

Figure 10 **Population Projections – Gloucestershire, Bristol, North Somerset and South Gloucestershire (2026 to 2040, ONS 2022 based mid-year population estimates[3])**

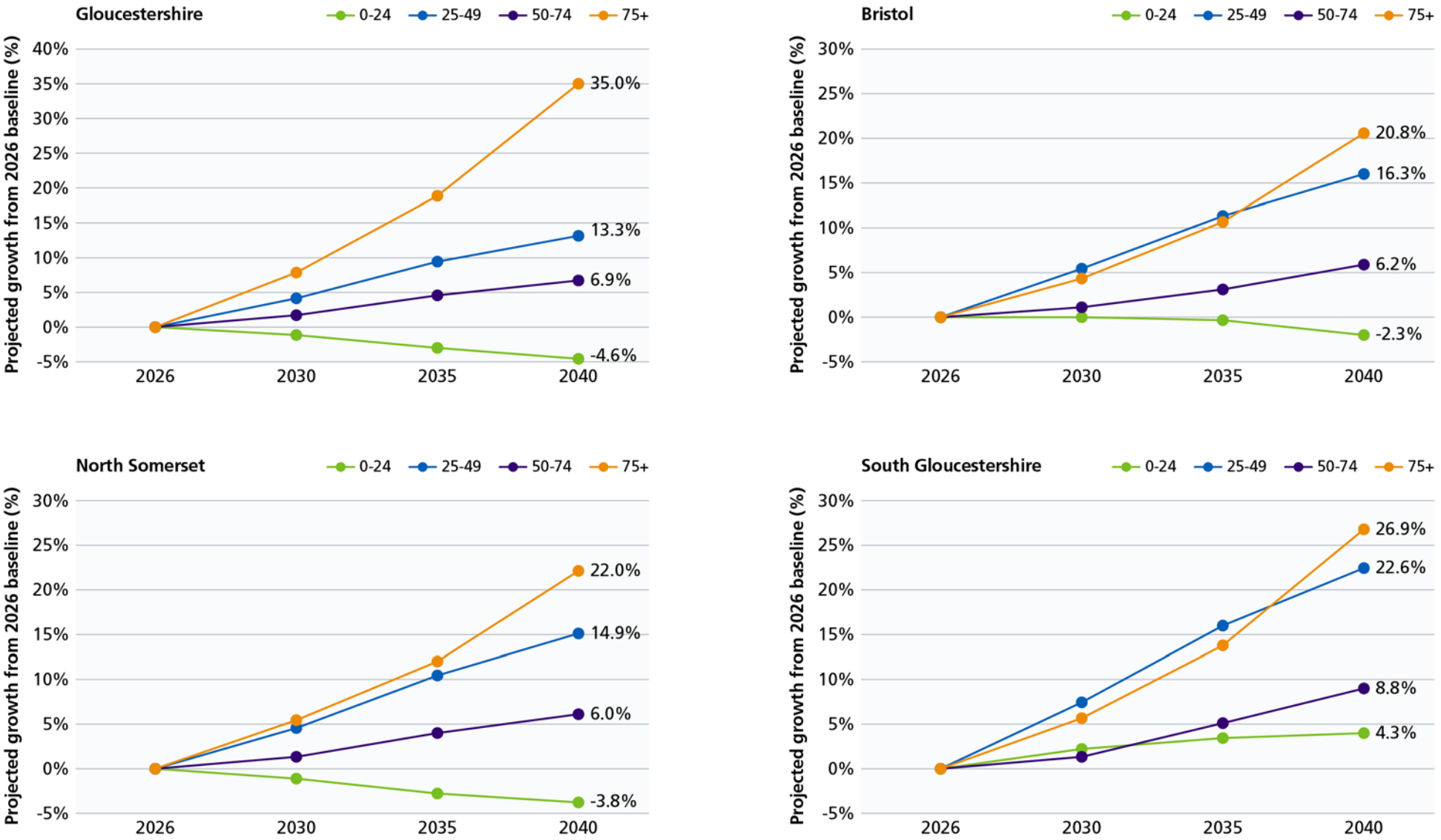


Table 5 **Ethnic group breakdown by place across BNSSG (2021 Census)**

Ethnic group	Bristol, City of		Gloucestershire		North Somerset		South Gloucestershire	
	No.	%	No.	%	No.	%	No.	%
Total: All usual residents	472,467	100.0	645,079	100.0	216,729	100.0	290,424	100.0
Asian, Asian British or Asian Welsh	31,269	6.6	18,464	2.9	3,322	1.5	11,094	3.8
Asian, Asian British or Asian Welsh: Bangladeshi	2,616	0.6	1,563	0.2	433	0.2	581	0.2
Asian, Asian British or Asian Welsh: Chinese	5,466	1.2	2,212	0.3	725	0.3	2,113	0.7
Asian, Asian British or Asian Welsh: Indian	8,302	1.8	8,250	1.3	1,067	0.5	4,867	1.7
Asian, Asian British or Asian Welsh: Pakistani	9,064	1.9	1,716	0.3	148	0.1	1,352	0.5
Asian, Asian British or Asian Welsh: Other Asian	5,821	1.2	4,723	0.7	949	0.4	2,181	0.8
Black, Black British, Black Welsh, Caribbean or African	27,890	5.9	7,777	1.2	1,139	0.5	4,534	1.6
Black, Black British, Black Welsh, Caribbean or African: African	18,149	3.8	3,938	0.6	733	0.3	2,787	1.0
Black, Black British, Black Welsh, Caribbean or African: Caribbean	6,803	1.4	2,627	0.4	251	0.1	1,219	0.4
Black, Black British, Black Welsh, Caribbean or African: Other Black	2,938	0.6	1,212	0.2	155	0.1	528	0.2
Mixed or Multiple ethnic groups	21,116	4.5	14,149	2.2	3,635	1.7	7,289	2.5
Mixed or Multiple ethnic groups: White and Asian	5,556	1.2	4,121	0.6	1,191	0.5	1,953	0.7
Mixed or Multiple ethnic groups: White and Black African	2,621	0.6	1,714	0.3	497	0.2	905	0.3
Mixed or Multiple ethnic groups: White and Black Caribbean	7,714	1.6	5,050	0.8	1,007	0.5	2,711	0.9
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	5,225	1.1	3,264	0.5	940	0.4	1,720	0.6
White	383,142	81.1	600,314	93.1	207,429	95.7	264,856	91.2
White: English, Welsh, Scottish, Northern Irish or British	338,452	71.6	565,811	87.7	195,915	90.4	249,160	85.8
White: Irish	4,288	0.9	4,034	0.6	1,210	0.6	1,327	0.5
White: Gypsy or Irish Traveller	273	0.1	965	0.1	187	0.1	443	0.2
White: Roma	966	0.2	714	0.1	169	0.1	373	0.1
White: Other White	39,163	8.3	28,790	4.5	9,948	4.6	13,553	4.7
Other ethnic group	9,050	1.9	4,375	0.7	1,204	0.6	2,651	0.9
Other ethnic group: Arab	2,540	0.5	865	0.1	247	0.1	751	0.3
Other ethnic group: Any other ethnic group	6,510	1.4	3,510	0.5	957	0.4	1,900	0.7

Table 6 **CVD Prevent: Prevalence Indicators (December 2025, data.cvdprevent.nhs.uk)**

GP Recorded Prevalence	Current performance (Dec'25)		
	BNSSG ICB	Gloucestershire ICB	England
CVDP001CVD: Prevalence of GP recorded cardiovascular disease (wide definition)	6.33	7.26	6.6
CVDP001AF: Prevalence of GP recorded atrial fibrillation	2.71	3.29	2.66
CVDP001HYP: Prevalence of GP recorded hypertension	16.65	19.85	18.38
CVDP002FH: Prevalence of GP recorded possible, probable or genetically confirmed familial hypercholesterolaemia, in patients all ages, calculated as a crude rate per 10,000 patients	21	13.43	23.19
CVDP001CKD: Prevalence of GP recorded CKD (G3a to G5)	4.34	5.96	4.55
CVDP001HF: Prevalence of GP recorded heart failure	1.44	1.41	1.46

Table 7 **CVD Prevent: Regional and ICS Insights for ABC, Smoking and BMI Indicators (December 2025, data.cvdprevent.nhs.uk)**

	Current performance (Dec'25)			To reach ambition (patients)		
CVD Prevent Indicator	**BNSSG**	**Gloucestershire**	**England**	**Target/ Ambition**	**BNSSG**	**Gloucestershire**
CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.	69.05	67.09	69.49	80%	15,854	14,493
CVDP006CHOL: Patients with no GP recorded CVD and a GP recorded QRISK score of 10% or more, who are currently treated with lipid lowering therapy	57.48	54.2	56.75			
CVDP003CHOL: Patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy	64.91	60.61	64.26	65%	40	1856
CVDP009CHOL: Patients with GP recorded CVD (narrow definition), who are currently treated with lipid lowering therapy.	85.73	83.31	85.38	95%	4336	4183
CVDP002AF: Patients with GP recorded atrial fibrillation and with a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant.	91.53	91.93	91.76	95%	687	477
CVDP012CHOL: Patients with GP recorded CVD (narrow definition), whose most recent blood cholesterol level is LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l, in the preceding 12 months	55.3	52.92	50.63			
CVDP008CHOL: Patients with no GP recorded CVD and either a GP recorded QRISK score of 10% or more, or CKD or high risk diabetes, who are currently treated with lipid lowering therapy.	57.41	54.81	57.58			
CVDP001SMOK: Patients with GP recorded CVD or CVD risk factors who are GP recorded current smokers or have no smoking status recorded, whose notes record smoking status in the preceding 12 months.	72.23	71.74	75.09	90%	4397	3468
CVDP002SMOK: Patients with GP recorded CVD or CVD risk factors who are GP recorded current smokers, who have a record of an offer of support or treatment within the preceding 12 months.	77.12	76.88	76.83			
CVDP001BMI: Patients with GP recorded CVD or CVD risk factors, with GP recorded body mass index status in the preceding 12 months.	60.03	64.31	64.1			

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