B&NES Health Inequalities Funding

Health and Wellbeing Board 3/7/25

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Improving People's Lives

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BEMS

Introduction

This report summarises how the health inequalities funding has been allocated in B&NES with outcomes and impact to date. The investment in B&NES supported system and place-based strategic objectives including implementing:

- The BSW Together Integrated Care Strategy
- The three phases of the BSW Inequalities Strategy and
- The B&NES Joint Health and Wellbeing Strategy

The report structure

1. Overview of the Health Inequalities Profile and funding allocation in B&NES
2. B&NES Health Inequalities Fund Projects
3. The B&NES Health Inequalities Network
4. Consideration of the role of the Health and Wellbeing Board in sustaining progress on Health Inequalities in B&NES

1. Overview of the Health Inequalities Profile in B&NES

Data shows that our health and wellbeing in B&NES is generally good in comparison to England. However, two areas (Twerton West and Whiteway) are within the 10% (IMD) most deprived nationally, with some other areas in B&NES among the 20% most deprived. Mirroring the national picture premature mortality is closely associated with deprivation across B&NES. It is encouraging that recent data shows a slight narrowing this life expectancy gap:

- Female life expectancy gap narrowed between 2010-12 to 2018-20. Mainly due to improvements for females in most deprived decile
- Male life expectancy gap narrowed between 2010-12 to 2018-20 With a fall in the least 2 deprived deciles and rise in more deprived deciles, particularly in the most recent 2018-20 period

There are particular areas where B&NES has significant inequalities. This includes the highest excess under 75yrs mortality rate in adults living with severe mental illness (SMI) in England. Adults with SMI are one of our locally defined 'PLUS' groups as are those who experience homelessness. B&NES has a higher number of rough sleepers relative to its population size compared to Swindon and Wiltshire, with much lower life expectancy than general population for people sleeping rough. Another area where we see particular local inequality is in relation to the education attainment gap between children eligible for free school meal (FSM) and non-FSM pupils at key stage 2.

Core determinants of health

Wider determinants impact on our health and wellbeing. For example in B&NES:

- Demand for social housing outstrips supply, quality and affordability and continues to be a challenge
- Increasing numbers of children and young people receiving support for social, emotional and mental health needs. (similar to national trends).
- Pressures on health and social care system have caused challenges with access to services.

The ratio of house prices to earnings (residence-based) in B&NES continues to be higher than national, CIPFA and West of England levels

Refer to B&NES Strategic Evidence Base https://beta.bathnes.gov.uk/strategic-evidence/document-library/strategic-evidence-base-summary-and-full-report

1. Overview of the B&NES Health Inequalities Funding Allocation

Establishing the Health Inequalities Network

The Health Inequalities (HI) network team was established in May 2023 with NHSE inequalities funding which BSW ICB allocated to 'Place'. The posts formed a 'network' to link with local partners and work across the system:

- One post hosted by the public health team at B&NES Council
- One post based at the RUH
- 2x Health Inequalities and Population Health Management (PHM) Facilitator** based within Banes Enhanced Medical Services (BEMS)

A portion of the B&NES Health inequalities funding was allocated to Community Wellbeing Hub Outreach Coordination and improved data infrastructure. Part of the funding originally allocated to support data analysis was redirected to support Core20PLUS5 projects in primary care.

Health Inequalities Projects

2024/25

B&NES received an additional allocation of NHSE health inequalities funding (HIF) from BSW ICB in 2023/24 to further action on addressing healthcare inequalities. A multi-agency task and finish group formed to develop criteria, application, scoring and moderation process.

Twelve projects were selected reflecting a range across adult and children and young people healthcare inequality priority areas. The projects mobilised January-April 2024.

2025/26

Seven of the above projects are continuing in 2025/26 and a further three projects will commence soon. The remaining allocation has been used to extend the RUH and Local Authority HI posts for a further year

**The posts were 0.8wte fixed term to April 2025.The HI manager hosted by B&NES Council and the RUH HI Lead posts have been extended to April 2026 ** One PHM Facilitator left Dec 2023, funds were redeployed by BEMS to secure wider primary care expertise from GP, and programme support*

2. Overview and Evaluation of the B&NES Health Inequalities Fund (BHIF) Projects 2024/25 and BHIF 2025/26 project overview

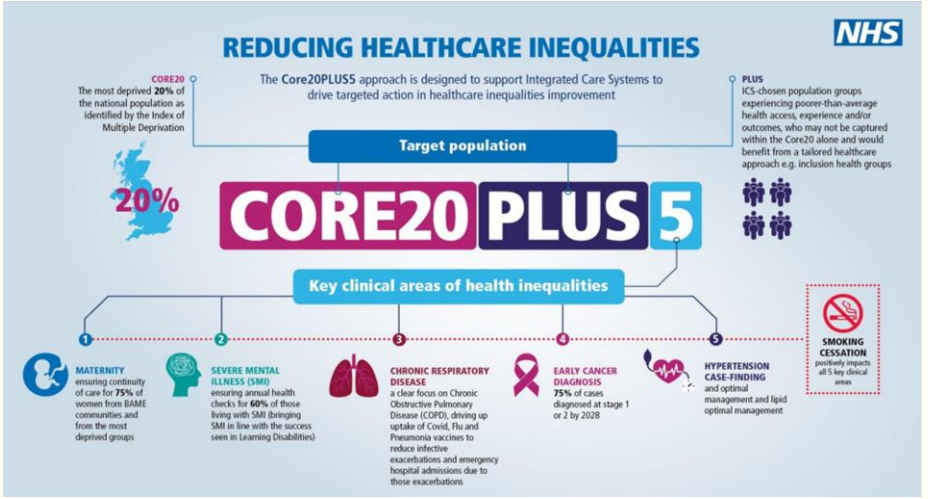
2. BHIF 2024/25: Addressing Healthcare Inequality

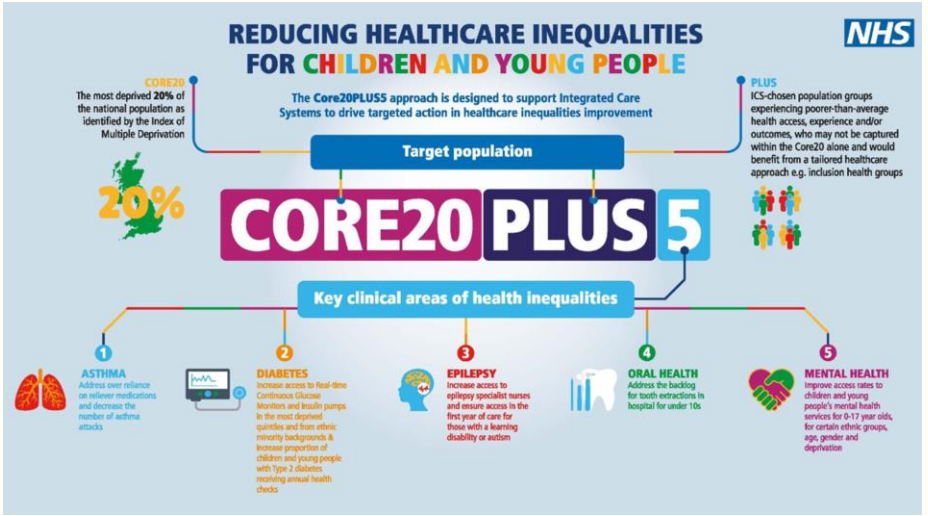
The B&NES Health Inequalities Fund (BHIF) Projects have addressed inequalities through the Core20PLUS5 approach.

Based on the NHS Health Inequalities priorities, BSW ICB Population Health Board agreed the 5 priorities for the funding (Prevention, Restore Services inclusively, Data and intelligence, Core 20 Plus 5 for adults and Core 20 Plus 5 for Children and Young People).

Core20PLUS5 is NHS England approach to support the reduction of healthcare inequalities. The approach defines a population cohort and identifies '5' focus clinical areas requiring accelerated improvement.
Core20 cohort refers to the most deprived 20% of the national population as identified by the Index of Multiple Deprivation (IMD)
PLUS Groups cohort are identified at Place and include inclusion health population and protected characteristic groups

B&NES PLUS groups
Adults: ethnic minority backgrounds, homelessness, SMI
Children BSW: SEND, excess weight/obesity, Children Looked After & care experienced, Early Years, Adverse Childhood Experiences. Additionally for B&NES: CYP PLUS groups are children eligible for free school meals





BHIF Projects (2023/24) – Selection Process

Criteria

Following the 2022/23 HI infrastructure funding to address health inequalities, NHSE allocated £2.057m to the B&NES, Swindon and Wiltshire (BSW) Integrated Care System (ICS) in 2023/24. The funding was aligned to the three localities and B&NES ICA was allocated **£357,896** by BSW ICB to address health inequalities.

In addition to the NHS priorities of: **Prevention; Restoring Services Inclusively** and **Data and Intelligence** BSW ICB Population Health Board identified the following priority areas for this 2023/24 health inequalities funding:

Core20PLUS 5 for adults

- Smoking cessation
- Cardiovascular disease
- Serious mental illness

Core20PLUS5 for children and young people (focus on early years)

- Mental health and wellbeing
- Asthma
- Oral Health

Oversight, Monitoring and Evaluation

The ICA delegated a task and finish group comprising representation from primary and secondary care, BSW ICB, Local Authority and Third Sector to develop a robust and transparent application, scoring and decision-making process for allocation of the funding.

Twelve successful BHIF projects mobilised between January and March 2024. At System level a BSW group has had oversight of performance and quarterly monitoring. At locality level, regular reports have been shared with the B&NES Health Inequalities Group (BHIG).

The following pages provide a high-level overview of some of the outputs, outcomes and impact of the 12 BHIF projects. A more in-depth evaluation to include interviews with BHIF Project leads is underway to inform future learning. This report can be shared later in the year.

BHIF 2024/25 Project Summary (7 projects* continuing 25/26)

Organisation	Project	Who benefits
Bath City FC Foundation*	***Off the Pitch*** **Health and lifestyles interventions workshops and 1-1 support**	**20% most deprived** **Severe mental illness**
Bath Rugby Foundation*	**Hi5!** **Inclusive after school clubs for children with SEND**	**Children with special educational needs** **20% most deprived**
BEMSCA*	**Community Connector at Community Wellbeing Hub** **Support BAME community after hospital discharge**	**BAME**
Bright Start Children's Centres*	**Perinatal mental health support for families facing MH challenges**	**Mothers/babies**
Developing Health & Independence	Homeless Hospital Discharge Service at RUH Providing MH support for those leaving hospital	Homeless
Dorothy House*	**Palliative and EoL care for people experiencing homelessness**	**Homeless**
HCRG Care Group	LD nursing Oral Health Support for CYP with disability/autism	Children & young people Special educational needs
Mental Health Motorbike	Providing community base MH support for motorcyclists	Males
Off The Record	1:1 MH/listening support for CYP in Twerton and Whiteway	20% most deprived
Southside Family Project*	**Targeted family support worker for vulnerable families in Twerton**	**20% most deprived**
Soundwell Music Therapy	Music therapy / art therapy for people with psychosis or schizophrenia	Severe mental illness
Voices *	**Trauma informed recovery for domestic abuse survivors**	**Domestic abuse survivors**

BHIF Projects 2024/25 – Metrics

The tables below and overleaf capture high level summary activity and outcomes as individual projects have specific indicators. There are issues in capturing impact due to the wide scope of the projects, and variation in evaluation tools and scales and what was reported. Projects covered localities across B&NES including rural communities.

Core20/ PLUS GROUP	No of Projects
Core20	5
SEND	2
Homeless	2
BME	1
SMI	2
FSME	1
Young Carers	1
ACE's	2

Activity	No of participants
Engaged mental health promotion events	200
Engaged in CYP lifestyle activities	25
Engaged in family support	133
Engaged in domestic abuse support	21
Engaged in homeless healthcare and homeless support services	188
Referral to further support for families (Core 20)	63

Theme	No of projects
Adult mental wellbeing	3
Adult lifestyle interventions	1
CYP mental health	2
CYP lifestyle interventions	1
Oral Health	1
Family support	2
Homeless healthcare	2
Domestic abuse survivor support	1

Outcome	Individuals reporting improved outcomes
Improved mental wellbeing adult	44
Improved mental wellbeing CYP	142
Improved outcomes relating to family life	30
Improved scores on one or more measures regarding safety and resilience (DA)	21
Homelessness prevented	34
Improved toothbrushing	44
Improved dental health outcomes after referral to specialist dental healthcare	13

BHIF Projects 2024/25 – Metrics

Organisation	Project	Engagement & Impact
Bath City FC Foundation	*Off The Pitch*, Health and lifestyle interventions	Warwick Edinburgh scale - 66% of participants with better wellbeing. 2 safeguarding referrals, 29 hrs of out of session support, 47 sessions. Average attendance of 54 people (target groups) per week
Bath Rugby Foundation	Inclusive clubs for children with SEND	241 attendances from 25 participants (across 25 sessions totalling 361.5 hours). Legacy increased engagement in sports
BEMSCA	Community Connector at the Community Wellbeing Hub to support ethnic minority groups at hospital discharge (RUH)	Supported 148 people, 62 referrals made and received 19 referrals. Legacy: training and engagement with RUH staff to ensure more equitable service
Bright Start Children's Centres	Perinatal Mental Health Support	Referrals: 92; 1:1 support: 44 Referral to other services: 83 (e.g. Trauma Counselling Service); Light touch: 138 Sessions for dads: 2 Increased support for fathers. Positive reduction in mental health score in 1:1 support, parents reported lower levels of anxiety and increased confidence around accessing peer support, domestic abuse disclosure
DHI	Homeless Hospital Discharge (HHD) Service RUH	As a result of funding from Health Inequalities a total of 76 individuals who were homeless at point of admission had their homelessness situation relieved. Many of these would have been rough sleeping and relief would have been to emergency night shelter accommodation, bed and breakfast or on occasions to stay with family or friends. 152 individuals who were at risk of homelessness because of being in hospital were prevented from becoming homelessthe team completed a total of 175 duty to refer to housing options teams. The majority of these would have been to B&NES and Wiltshire but would also have included other local authorities throughout the country. BHIF funding provided an opportunity to identify more sustained funding for the project going forward.
Dorothy House	Creation of pathway for people experiencing homelessness to access palliative and EoL care	Outreach across communities - received 14 referrals/enquiries. people with a palliative diagnosis -Stakeholder engagement 17 new stakeholders contacted & met, 7 service users or family/friends supported, 12 total referrals into HLW service.
HCRG Care Group	Community LD nursing capacity to support children's oral health	56 children had Oral Health Assessments completed, 46 children enrolled and completed support (44 with improved outcomes in toothbrushing). Equipment to help children with techniques and access to dental care (13 children referred to Special Care Dentist) - 98% with improved outcomes for oral health. Legacy of project includes equipment purchased and nurses trained and skilled to continue supporting oral health of CYP with SEND
Mental Health Motorbike	Community based mental health support for motorcyclists (MHFA training and support)	Engaged with over 200 individuals at 16 events; provided information on mental health support and resources. Conducted 12 outreach activities, including attending events like the Kingswood Bike. Legacy: 4 bikers trained in MHFA, Increased links with social prescribers and primary care providing gateway to is group. Awareness raising of men's health issues
Off the Record	1-2-1 mental health/listening service for CYP in Twerton and Whiteway	Improvements in the MH and wellbeing for 125 CYP who engaged aged 10-25 years 90% of whom are living in T&W. Using Core 10 measurement scores the average reduction was from 22.4 (moderate to severe psychological distress) before the support, to 16.1 (mild/moderate level distress) at the end of the support. 100% young people who fed back would rate the service very good or excellent 98% of young people who fed back would recommend the service to a friend
Southside Family Project	Targeted family support worker for vulnerable families in Twerton	37referrals for Family Support for families in Twerton with needs including mental ill-health, special educational needs and disabilities, experience of racism and discrimination, trauma and experience of domestic abuse, attachment disorders, learning disabilities, physical health challenges and disability, issues with school attendance and risk of exclusion, food and energy poverty, social isolation and a child at risk of exploitation. Supported through targeted whole family support case work, home visits, mentoring, coaching, practical food and other support and engagement e.g. Community Hub Group at Bath City Farm. Good progress made on 'distance travelled' outcomes assessment
Soundwell Music Therapy	Music/art therapy for people with psychosis and/or schizophrenia	Overall, 14 attendees to group session and 14 to open group support. 100% with positive personal change, 92% with improved social connections, 92% increased resilience and 100% proactive engagement for 20 week engagement with 92% meeting goals in open group sessions
VOICES	Trauma informed recovery service for domestic abuse survivors	two group work courses, three times per year. Promotion of domestic abuse resources and health education. Running the Freedom Course with 21 participants and Recovery Toolkit sessions. 21 women started the Freedom course and 31 in one-to-one support.

Children and Young People (CYP)
Adults
Adults and CYP

Case studies

Soundwell Music Therapy

Music therapy gave me a sense of being heard and seen without having to always verbalise or intellectualise my feelings into thoughts and language. I saw my confidence grow, felt myself connect with a freedom to allow myself to be playful and explorative without being an expert. It made me think differently about myself in ways in which I can express feelings and traumas.

Off the Record

SS said “he found sessions really useful and to have a safe space to come to check in each week” in sessions he felt “comfortable talking about his challenges without worrying or burdening his already stretched family” and know “he could be completely open”

Brightstart

I feel that it helped to make me a better parent, feeling calmer, lighter and more productive. It was a great point during my week to be able to reset and calm any anxiety I was feeling. Practically, I was really supported in getting organised at home which in turn helped my mental health state to improve.

BEMSCA

Mr J was referred via the CWH to the MDT and have had support from other partners. He came by the CWH hub as he knew I worked there, he had had a message from his GP on his phone and was unable to respond in making the appointment.

A member of the digital inclusion team was then able to come and support him to make the appointment and set it on his diary reminder on his phone. She offered him the training could attend in the atrium. He accepted and will bring his laptop to the appointment. He stayed on to have a chat, 40 minutes, he shared as an old person and not understanding technology he felt left out.

Hi5

L faces significant challenges, including learning disabilities, autism, anxiety, hypermobility, auditory hypersensitivity, and visual perception difficulties. She also navigates a complex family dynamic, with her father managing significant physical disabilities and her brother living with a rare disorder.

In the face of these hurdles, Hi5! Clubs and the additional sporting opportunities have provided L with a lifeline, empowering her to manage her anxiety, build confidence, and foster a sense of belonging. Now L continues to thrive, playing for the Bath Ladies Trojans.

Southside

D continues to engage with weekly support and there has been a noticeable improvement in his confidence and ability to support the children. We hope this will enable D to encourage J to engage with support, and again, model to J that change is possible

BHIF Projects 2024/25 - Legacy and Learning

Opportunities
The application process raised awareness around health inequalities, and the 12 successful project have formed a community of practice as projects have made cross-referrals and promotion of services and a wider public health agenda.

The funding has supported development of an evidence base of 'what works' as well as a chance to innovate, pilot and develop a service e.g. *Bright Start children's centres & development of a PIMH network; Oral health project; Dorothy House co-creation of EoL pathway*

Sustainability
Seven of the projects have had funding agreed for two or three years and will be continuing into 25/26. Some projects with no additional legacy are BAU services and will be seeking funding elsewhere to allow for continuation of the service. One project has secured sustained alternative funding. Some projects are ending but will be leaving a legacy Including: Training tools, Health information literature and equipment (e.g. the CYP oral health project); Increased visibility of services in communities; Research to inform future ways of working/engaging; networks and collaborative working arrangements

Challenges
- Delays in process of grant agreements and getting funds out impacted project delivery and stakeholder relationships
- Short term funding presents difficulties in having time to demonstrate impact; mobilisation & building trust takes time.
- Risk of losing staff if additional funding not secured as fixed term contracts nearing end dates

Learning
- Other funding streams have impacted on financial viability and stability of other services
- Unanticipated factors led to change in delivery models in some cases so that less individuals supported, but those supported are supported for longer while other services had high demand and needed to adapt including signposting to other organisations where possible
- Signposting and follow on services are a challenge as the landscape of services 'shrinks' in response to less resource in the system

Primary Care Based Projects 2024-25 (Total value £36k)

In addition to the BHIF projects the following **primary care focused** projects have been funded from the initial 2022/23 health inequalities funding allocation for B&NES. It was deemed appropriate to fund these projects as there were very few BHIF applications from primary care – these were the highest scoring from the sector.

Autism Spectrum Disorder (ASD) Friendly GP Project (underway) Development of a Toolkit to include resources and a Training and awareness Programme for primary care teams to support them provide a more inclusive service

Primary Care Outreach at Pennard Court in Twerton & Whiteway (core20) (Completed) Partnership approach to increasing access and taking services to people in a manner that is acceptable to them. The residential setting is located within the most deprived (core 20% IMD) locality within B&NES. This project arose from engagement with the local GP Practice to understand what support they needed and the challenges they faced when providing services for their LD population. Learning is informing further targeted outreach with other underserved communities.

Targeted Smoking Cessation Project (underway) Identifying cohorts within target practices to run searches and explore innovative ways to engage patients to consider a quit journey, utilising the Swap to Stop programme The targeted smoking cessation project aimed at promoting the swap to stop initiative for patients of 6 GP Practices in B&NES within a defined cohort focusing on areas of higher deprivation by IMD. The project involves liaison with Practices, local voluntary, community and faith groups to provide smoking cessation, and other healthy lifestyle, advice, and to offer smokers a free vaping kit as a first step towards stopping smoking.

B&NES Health Inequalities Fund Projects 25/26

2025/26 Health Inequalities Grant Funding Programme

B&NES stakeholders were invited to submit bids to address prioritised health inequalities in Core20 areas and PLUS groups in B&NES.

The areas of inequality were chosen following a workshop with Core BHIG members to prioritise across the10 clinical areas using a template which captured public health intelligence, service data, wider determinants and community voice. The priorities selected were:

Adults

- Low uptake of annual physical health checks for those with severe mental illness (SMI)

Children and Young People

- Improving mental health in children and young people who are more at risk of developing poor mental health
- Address over reliance in children and young people on asthma reliever medications and decrease the number of asthma attacks.

Projects (approx. £92K)

The three projects selected are

- PCN/AWP: Outreach to promote physical health checks among people living with SMI
- B&NES YJS/Forensic CAMHS: Enhanced Case Management service
- Bath Mind: CYP Early Connections

3. The B&NES Health Inequalities Network

The B&NES network team have worked as ‘connectors’ working with existing partnerships across B&NES. Following the steer from BSW ICB the main focus has been on addressing Healthcare Inequalities’. The headline progress of the Council’s HI Manager are set out below. The work of the leads in Primary Care and the RUH is covered in the subsequent slides.

Oversight of B&NES allocation of Health Inequalities Funding (BHIF)

- The B&NES HI Manager led the 2024/25 funding process, developing supporting guidance, communicating with local stakeholders and facilitating the scoring and decisions process. The HI Manager also supported mobilisation and effective delivery of the 12 BHIF and primary care projects funded for 2024/25
- By linking with HI leads across the system, the HI Manager was able to learn from and collaborate with Health Inequalities partners within B&NES and across BSW
- Liaising with local funded projects and the ICB to ensure monitoring was in place and there was good reporting on delivery/impact against spend for the ICB

The B&NES HI Manager established the B&NES Health Inequalities Group (BHIG) and Dynamic Core20PLUS5 Delivery Plan, gaining good engagement. This built on local engagement at community events, relationship building and mapping of positive assets in local communities. They supported development of the Whole Systems Health Improvement Framework ensuring HI are prioritised and were involved in the commissioning process for the Healthwatch Tender and for B&NES Community Services ensuring that addressing health inequalities is a ‘golden thread’ in service specifications and throughout the commissioning cycle. They also presented, networked and linked with Third Sector colleagues through the 3SG Integrated Care network providing updates and engagement.
They ensured the HWB is focused on inequalities by contributing to the outcomes framework and implementation plan

3. Network: Addressing HI at the RUH - Highlights

Strategic Focus on Inequalities

An interdepartmental Steering Group has been established to oversee the Health Inequalities Programme. HI metrics have been integrated into all service evaluation frameworks. There have been awareness raising campaigns and training for staff. Work is in progress to improve ethnicity data capture.

Treating Tobacco Dependency

The service is delivered by Health Coaches who work holistically tackling the core determinants of health, adopting Personalised Care principles to support inpatients to quit smoking. Since September 2024:

354 patients have been offered the service with 100% ward coverage. Approx 35% patients who engaged with the service remained smoke-free at 28 days

53 community referrals made (addressing wider wellbeing) including OT, alcohol dependency, weight management, older adults support, mental health, digital support and social prescribing

Digital Inclusion Project

The service is delivered by Digital Navigators who work holistically tackling the core determinants of health Since October 2024:

203 patients have accessed the service, 29% of whom needed help to use the NHS app. 77% of service users felt more confident and motivated to use technology or doing things online after accessing the service

38% patients were signposted to community services and organisations e.g. Age Concern, libraries, One Stop centres

Barriers to attendance (DNAs)

Between December 24 and April 25, 300+ pts who missed their appt were contacted to understand and help overcome barriers to attending. The University of Bath and RUH are working together to analyse the data and a report will be available in Autumn 2025

3. Network: Supporting Primary Care (BEMS) - highlights

Engaging with Primary Care

- Aligning health inequalities work with the Primary Care Network (PCN) contract and finding 'common ground' – there is now a regular standing agenda item on HI at PCN managers meetings.
- Representing and providing an interface to primary care and HI outreach e.g. childhood immunisations in Twerton; Care Home Vaccination Project
- BEMs have supported negotiation of activity-based payment structure for Practices to encourage increased engagement in smoking cessation work in primary care.
- Intelligence support for funding bids to address HI

Population Health Management

HI Data Packs for all 6 PCNS across Core20PLUS5 topic areas (adults) have supported identification of key priorities

High Intensity Users Project responding to PCN manager concerns about freeing up appointments to address inequalities involved undertaking analysis and strengthening links with social prescribing

Outreach Projects

Example: Cancer care for boaters and travellers – increasing GP registration through working with practices to make the process easier. Enhancing data capture so that this population can be identified and targeted e.g. for screening. An extension of the project has been social media campaigns and resources to engage target groups.

Learning Disability Care Home outreach event in Core20 area

Cancer Screening BEMS secured £25k SWAG funding to support early diagnosis through HI targeted social media campaigns

Linking with Hope House Surgery to support the Pain Café (self management and peer support to free up appointment time and support those managing pain)

Community and stakeholder engagement

- Community Asset mapping in Twerton and supporting Bath City Farm linking with primary care
- Supporting digital inclusion and increased use of the NHS app in primary care.

3. Reflections on the B&NES Health Inequalities Network Approach

Opportunities

The creation of posts in different parts of our local system has supported creation and development of relationships across organisations and sectors. Momentum needs to continue to ensure that relationships with our PCNs, practices, secondary care, community partners, 3rd sector organisations are maintained and strengthened.

BEMS has been effective in facilitating connections with primary care (it was noted that other HI teams across BSW struggled significantly more with engagement). Specialist understanding of the PCN contract created opportunities to find 'common ground

The HI Lead at the RUH has created a sustained approach through establishing a steering group and strategic leadership ensuring that HI is embedded into the culture of the Trust.

Challenges

Challenges in engaging front line primary and secondary care due to competing pressures – difficult to truly 'left shift'

Primary Care – took time to effectively engage PCNs and practices in HI work initially. HI work is often targeted and requires a lot more initial resources from the practice. It is a challenging time for primary care in terms of workload and staff retention

Pressure on services, Loss of QOF indicators relating to health inequalities

Focus on healthcare inequality has meant reduced focus on the core determinants (wider socio-economic and environmental factors) in line with Marmot principles for health equity

Risks

Vulnerability of inequalities workstream in context of system pressures and organisational change

Continuity and consistency could be affected by current climate of uncertainty in BSW and nationally.

A long term view and focus is required to create a more equitable B&NES – it will take a generation to address the root causes of health inequalities

There is a need for continued focus on Population Health Management and HI intelligence

4. The role of the Health and Wellbeing Board in sustaining progress on Health Inequalities

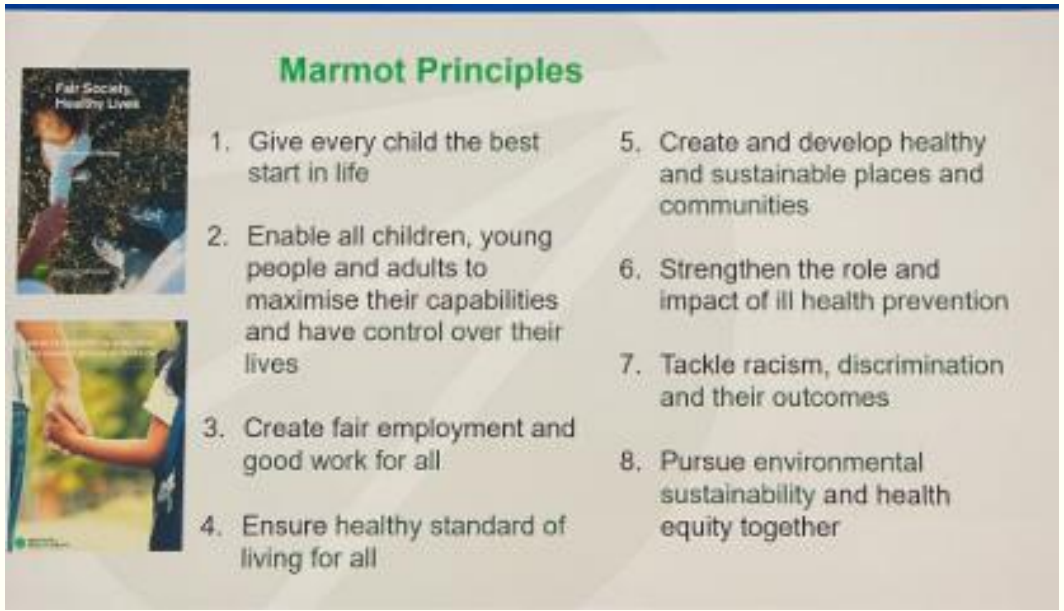
The Health and Wellbeing Board is asked to consider how it can advocate for the need for continued prioritisation and governance arrangements (or at least assurance on alignment) for work on health equity going forward.

Place-Based Approach

The Health and Wellbeing Board is uniquely placed to champion a **'Place Based Approaches for Reducing Health Inequalities'** through its role in oversight of collaborative action across a number of important elements to reduce inequalities at civic and community level and through service-based interventions

A 'Marmot Place'

To date the steer for the HI work programme has been predominantly focused on reducing healthcare inequalities which are important, but this does not address the root causes of ill health and inequality. Through its role the Health and Wellbeing Board could advocate for a broader approach focusing more explicitly on the Marmot Principles for Health Equity



https://www.instituteofhealthequity.org/taking-action/marmot-places

The Health and Wellbeing Board are invited to consider the following questions

1. What is the role of the Health and Wellbeing Board in sustaining progress on Health Inequalities in B&NES? Is there a way of keeping the HI Delivery Plan and BHIG/Network going with reduced coordination capacity?

2. Consider what can be built on in the JHWS strategy objectives as we refresh the actions for 2025/26 as part of the implementation plan refresh? Are the B&NES Core20 + PLUS groups widely known and considered across the 4 priority theme areas of the JHWS?

3. The JHWS provides a vehicle for addressing wider social, economic and environmental determinants of inequality. In line with Marmot Principles for Health Equity can the Board make the contribution more explicit e.g. transport and housing impact on childhood asthma? More explicit focus on addressing Child Poverty (which has increased)**?**