Initial Equality Impact Assessment and Analysis (EqIAA)

Joint Local Health and Wellbeing Strategy 2025-29

Section 1 - Introduction

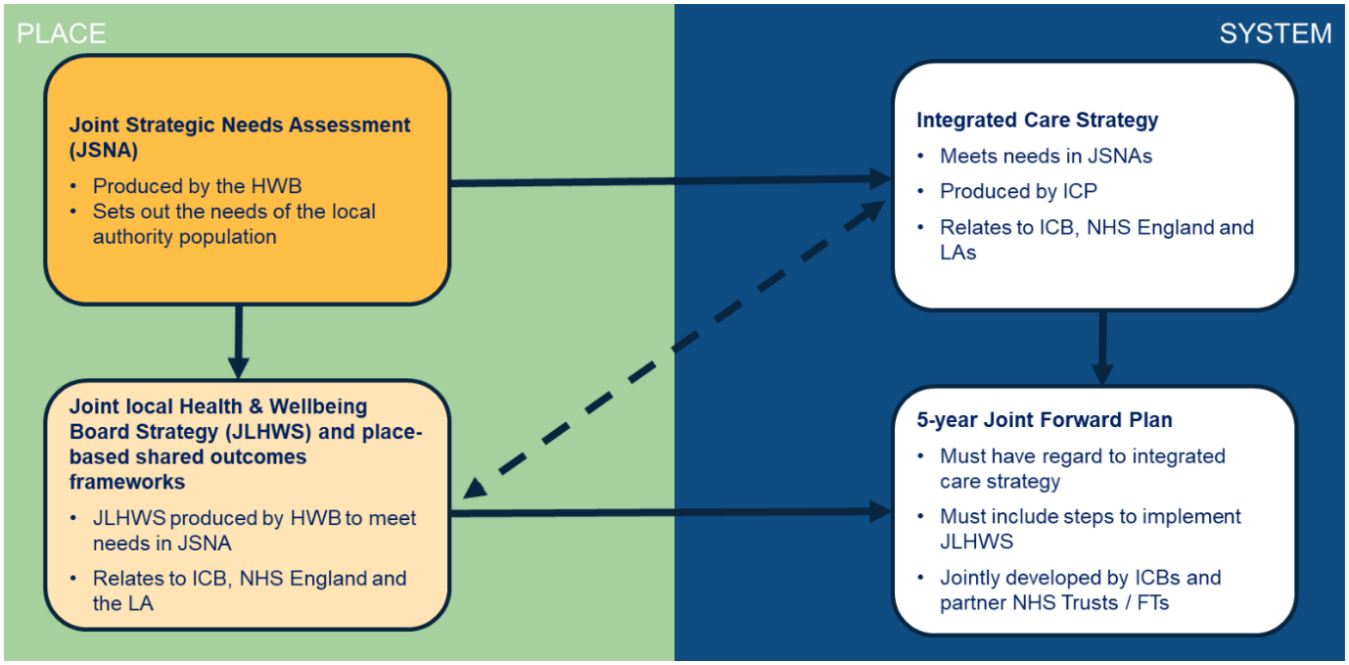
This Equality Impact Assessment and Analysis (EqIAA) relates to the 2025-29 Joint Local Health and Wellbeing Strategy. The Health and Wellbeing Board is a statutory committee of South Gloucestershire Council. It brings together senior political, clinical, professional and community leaders from across South Gloucestershire. The Board aims to reduce inequalities and improve the health and wellbeing of our residents. It works with local partnerships to align strategies, integrate services, and address health priorities through a coordinated, multi-agency approach.

The Health and Wellbeing Board has statutory responsibilities to:

- Develop a Joint Local Health and Wellbeing Strategy (JLHWS)
- Encourage and enable integrated working between health and social care
- Produce a Joint Strategic Needs Assessment (JSNA) and Pharmaceutical Needs Assessment

This strategy is a refresh of the previous Joint Local Health and Wellbeing Strategy which ran from 2021-25. The production of the strategy is the joint responsibility of the Local Authority and the Integrated Care Board (ICB). It is also important to recognise where the Joint Strategic Needs Assessment and Joint Local Health and Wellbeing Strategy fit within the wider Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System (ICS) and how it relates to wider system strategies and plans. This is best illustrated via Diagram 1.

Diagram 1



The 2025-29 Joint Local Health and Wellbeing Strategy sets out:

- A shared vision for the Health and Wellbeing Board over the next four years
- How the Health and Wellbeing Board can use its unique role and membership to lead and advocate for health and wellbeing locally.
- A shared commitment to developing how we work together to deliver that vision.

Section 2 – Research, Engagement and Consultation

How we have developed the strategy:

- We have developed this strategy in collaboration with system partners. For over a year, we have consulted with colleagues from across the health, care and wider system.

- We have reflected on the strengths and challenges of the last strategy, our work as a Board, the Joint Strategic Needs Assessment process and local priorities.

- We have used the Joint Strategic Needs Assessment to understand local needs and inequalities. This strategy is rooted in an understanding of local data and insights.

- We have listened to our communities. This strategy is a response to insights gathered by the Council, Healthwatch and voluntary sector partners.

The following sets out health and wellbeing information for South Gloucestershire residents, focusing on health inequalities linked to Protected Characteristics. It is important to note that health and wellbeing is influenced by many overlapping factors (called intersectionality). For example, a young person's health may be shaped by a combination of factors such as their age, gender, ethnicity, their family or carer's social and economic situation, and sexuality. Any of the Protected Characteristics will play a part in determining a person's health and wellbeing.

In addition to the below, the South Gloucestershire Population Portal forms part of the South Gloucestershire Health and Wellbeing Board's Joint Strategic Needs Assessment (JSNA) (1). The purpose of this tool is to use data and intelligence to provide a current and comprehensive overview of the health and wellbeing of the South Gloucestershire population, framed in the context of health inequalities and local strategies.

Age

The 2023 Office for National Statistics (ONS) mid-year population estimates for South Gloucestershire are as follows (1):

- Young people (0-19 years) 22.8% of the population
- Working age adults (20-64 years) 58.5% of the population
- Older people (65+) 18.7% of the population

South Gloucestershire's population is ageing. Since 2011 there has been a 22% increase in the number of people aged 65 years and over, an 8% decrease in those 15 to 19 years and an 8% decrease in those aged 40 to 44 years.

Young people (2)

- South Gloucestershire is not ranked high in terms of relative deprivation, but inequalities exist and between 10% and 20% of children live in poverty with rates increasing.
- There is a greater proportion of children in South Gloucestershire in low-income groups

than older adults or the population as a whole.
- There are disparities in the prevalence of special educational needs and education health and care plans by deprivation.
- Inequalities in educational attainment exist at all stages of compulsory education from reception through to the end of key stage 4. Children with an education health and care plan, special educational need, children on pupil premium, children in care, boys, and pupils from a Gypsy Roma Traveller background are less likely to meet expected standards.
- There have been increases in the number and rate of vulnerable children being referred to and needing help from social services.
- Around a third of children measured as part of the National Child Measurement Programme (NCMP) are classified as overweight or obese.
- There are high rates of tooth extraction due to decay in under 10s which contribute a large proportion of planned hospital admissions, and rates are disproportionately high in more deprived areas.
- Intentional self-harm constitutes a growing and significant proportion of admissions to hospital in teens, drives high injury admission rates and disproportionally effects girls and those living in more deprived areas.
- According to the Warwick-Edinburgh Mental Wellbeing Scale, pupils who identified as female (54%), other gender (81.1%), lesbian (89.7%) or bisexual (69.8%) were more likely to report their wellbeing score as 'low' (3)
- There are high hospital admission rates for alcohol specific conditions in under 18-year-olds (40.9 per 100,000) compared to national figures (22.6 per 100,000), and high and increasing rates of substance misuse admissions amongst young people in South Gloucestershire(4).

Adults (including working age and older people) (1,5):

- 83% of people are in employment, this is higher than the South West average.
- 59% of adults are overweight
- 12% of adults smoke
- Admission episodes for alcohol-related conditions is 1,933 per 100,000, higher than the England average of 1,705 per 100,000.
- There is variation in preventable mortality from cancer in people under 75 years of age by deprivation.
- There is inequality in life and healthy life expectancy which is impacted by deprivation. Someone who identifies as female will live 67.1 years on average in good health and 17.2 years in poor health. Someone who identifies as male will live on average 63.5 years in good health and 16.3 years in poor health (1). Females in the least deprived areas live on average 5.7 years longer than those in the most deprived areas, for males the difference is 4.3 years (1)

Older people (1,6):

- Important issues for older adults identified locally are caring responsibilities, social isolation, falls, alcohol dependency and oral health.

Disability

- The 2021 census identified that (7):
    - 83.5% of residents considered themselves not disabled
    - 10.2% of residents considered themselves to be disabled and limited 'a little'.
    - 6.3% of residents considered themselves to be disabled and limited 'a lot'.
    - 16.5% of residents considered themselves to be disabled under the Equality Act.

- People who are living with a disability (8):
    - Have a lower life expectancy than people who are not.
    - Are at higher risk of poor sexual health outcomes, in addition to alcohol or drugs related harms.
    - Are over-represented in applying to the Household Support Fund.
- Latest data from the charity Scope has found that extra costs for disabled households continued to rise in the 2022 to 2023 financial year (disabled people will often incur significant expense not incurred by non-disabled people, for example, using medical equipment, having heating on and costs of medications) (9). Analysis shows:
    - On average, disabled households need an additional £1,010 a month to have the same standard of living as non-disabled households.
    - On average, the extra cost of disability is equivalent to 67% of household income after housing costs.
    - The Disability Price Tag is based on the most recently available data at the time of analysis (which was from 2022 to 2023). If we adjust the figure to understand what it might look like in 2024, these extra costs go up to £1,067 a month.
- In 2022 research conducted by the council found that people with disabilities felt worse off than they did a year ago (8). This was 33% compared to 21% of residents who were not living with a disability.
- The proportion of people living with a disability with no qualifications is nearly three times that of people not living with a disability. In addition, people with a disability are nearly 2 times less likely to be economically active than those who are not (8).

Gender reassignment

- The 2021 census identified that (7):
    - 94.6% of residents identified with the same sex registered at birth
    - 0.1% of residents did not identify with the same sex registered at birth, but no specific identity given
    - 0.1% of residents identified as a trans woman
    - 0.1% of residents identified as a trans man
    - 0.1% of residents identified as non-binary
    - 5% of residents did not answer the question.
- A Trans mental health and emotional wellbeing study in the UK and Ireland in found that (10):
    - 88% of the (self-selected sample) said they were either currently depressed or had experienced depression previously
    - 53% of participants had self-harmed at some point, and 11% were currently self-harming.
- There has been a significant rise in transphobic hate crime in South Gloucesterhsire over recent years, which has impacted mental health and wellbeing (8)

Marriage & Civil Partnership

- Data from the ONS found that males and females of all ages who were married or in a civil partnership consistently had the lowest age-standardised mortality rates (11).
- Nationally, in 2019, across males aged 20 years and over, divorcees had the highest age-standardised mortality rates (11).
- Nationally, in 2019, of all females aged 20 years and over, those who were single had the highest age-standardised mortality rates (11).
- The 2021 census identified that for residents over 16 years (7):
    - 47.9% were married or in a registered civil partnership.

Pregnancy and Maternity

- The 2021 census identified that there were approximately 3,000 live births a year (7).
- Inequalities exist in risk factors including late booking, smoking and maternal obesity by maternal age, ethnicity, area deprivation and geography (2,12).
- There are inequalities in birth outcomes (premature birth, Low Birth Weight, still birth, low APGAR score) by maternal age, ethnicity and area deprivation (2).
- National data suggests there is a growing need for maternal mental health support (2).
- There are inequalities in breastfeeding along deprivation, age and ethnicity lines and declining rates from initiation to 6-8 week check (2). Young women from a white background who live in more deprived areas are least likely to breastfeed.

Race and Ethnicity

- The population of South Gloucestershire is predominately white, with non-white minorities representing 8.8% of the population.
- The 2021 census identified that(7):
    - 91.2% of the population were white
    - 3.8% of the population were asian
    - 2.5% of the population were mixed race
    - 1.6% of the population were black
    - 0.9% of the population were 'other'
- People from the 'White British' ethnic group have a higher risk of alcohol or drugs harms (8)
- Council led research in 2022 found that 20% of people from a minority ethnic group reported to be experiencing 'difficulty' or 'great difficulty' compared to 13% of the population overall (8)
- People from the Black/ Black British ethnic group and people stating 'other ethnicities' are overrepresented in applying to the Household Support Fund (8).
- Depending on ethnicity, people from minority ethnic groups are between 1.5 times and 3.5 times more likely than average to be unemployed.
- People from ethnic minority groups are over-represented in lower paid work(8).

Religion or belief

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- The 2021 census identified that(7):
    - 46.1% of the population reported having 'no religion'
    - 44.1% of the population described themselves as Christian
    - 0.4% of the population reported to be Buddhist
    - 1.0% Hindu
    - 0.1% Jewish
    - 1.6% Muslim
    - 0.3% Sikh
    - 0.5% other
    - 5% no answer
- Nationally there has been an increase in hate crimes, some of which relate to religion (8).
- Nationally (13):
    - Those who identified with no religion were significantly less likely to be satisfied with their health than those who identified as Christian, Hindu or Jewish
    - Smoking prevalence was significantly higher among those who identified with no religion than several other religious groups

- Those who identified as Jewish, Christian or with no religion reported a greater mean level of physical functioning than those who identified as Muslim according to the 12-item Short-Form Health Survey (SF-12)

Sex

- The 2021 census (7) identified that in South Gloucestershire the gender ratio was 0.98 males to females
- There is a higher smoking prevalence in men (8)
- For children, boys are more likely to be above healthy weight (8)
- Men are at higher risk of alcohol or drug related harms (8).
- Women and girls are more likely to experience domestic abuse.

Sexual Orientation

- The 2021 census identified that (7):
  - 90.6% of the population identified as straight or heterosexual
  - 1.3% of the population identified as gay or lesbian
  - 1.2% of the population identified as bisexual
  - 0.2% of the population identified as pansexual
  - 0.1% of the population identified as asexual
  - 6.5% of the population identified did not answer the question
- Men who have sex with men have higher risk of poor sexual health outcomes (8).
- There is a higher smoking prevalence for LGBTQ+ people (especially for people who identify as bisexual) (8).
- People identifying as LGBTQ+ at higher risk of alcohol or drug related harms (8).

Socio-economic Groups

- Our data shows that the following ‘groups’ in South Gloucestershire are more likely than average to be living on lower incomes and be experiencing financial insecurity:
  - Families with children
  - Younger adults
  - Women
  - People from many Black, Asian and Minority Ethnic groups
  - People who are renting (disproportionately more likely to be people from many Black, Asian and Minority Ethnic groups)
  - People who have been unemployed, or experienced long-term sickness
  - Disabled people
- People from more disadvantaged socio-economic groups are less likely to attend their NHS health checks (8)
- A higher prevalence of smoking is associated with many indictors of deprivation and marginalisation (8).
- People in lower socio-economic groups are more likely to be above a healthy weight (8)
- People in more disadvantaged socio-economic groups are less able to undertake the housing adaptions required to mitigate the impacts of a changing climate (8).

Care experience

- 2020 data reported that there were 35 per 10,000 looked after children in South Gloucestershire (2)
- Those with care-experience are significantly more likely than the general population to face

significant challenges in their life, such as mental health issues, barriers to education, prison sentences and early mortality(14).

- Children in care are around three times more likely to have a Special Educational Need (SEN) and nearly nine times more likely to have a statement or Education Health and Care Plan (EHCP) (2)
- For children leaving care, children from minority ethnic groups are more likely to be 'Not in Education Employment or Training (NEET)' (8)

Armed Forces Community

- The 2021 ONS survey identified that in South Gloucestershire, the number of veterans stood at 9,498, which represents 4% of the total population aged 16 years and over. 73.4% of veterans (6,970) had previously served in the regular forces, 22.4% (2,124) in the reserve forces, and 4.3% (404) in both (7).
    - The wards in South Gloucestershire with the most veterans in relation to their total population are Chipping Sodbury & Cotswold Edge (5.1% of the total population aged 16+ are veterans), Yate Central (5.1%), and Boyd Valley (4.9%).
    - Veterans are more likely to be older and male in comparison to non-veterans, with 55% (5,187 people) being aged 65 years and over.
    - 97% (9,188) of veterans identify as White British, with only 2% (189) from an ethnic minority background.
    - 64.5% (6,126) of veterans state a religion or belief, with 63% (6,001) reporting being Christian.
    - 57.5% (5,461) of veterans are economically inactive, although 88.5% (4,833) of economically inactive veterans are aged 65 years and over.
    - 83.1% (3,583) of working aged veterans (16-64) are in employment.
    - 54.0% (1,934) of working aged veterans are in managerial, professional, or technical occupations. 24.2% (867) are in skilled trades or process, plant and machine operative occupations.
    - 81.1% (7,703) of veterans have at least one qualification, and 28.8% (2,733) hold a level 4 qualification of above
    - 30.6% (2,903) of veterans are disabled under the Equality Act and 34.2% (3,250) self-reported as being in 'not good health'.
    - 82.1% (5,805) of veterans own a house outright or with a mortgage, although 56% (5,180) of all households with one or more veteran is deprived in at least one dimension (the Census measures deprivation in four dimensions: education, health and disability, and household overcrowding).
    - 28.4% (2,629) of veteran households are single family households where all residents are aged 66 years or older.
- The South Gloucestershire Veterans Support Service has been operational for three years, health and housing were the two most common areas veterans are seeking support for. The support service is seeing high numbers of disabled veterans seeking support, with mental health conditions being the most prevalent impairment type(15).

Geography

- South Gloucestershire has five areas designated as Priority Neighbourhoods (PNs) which are Patchway, Staple Hill, Kingswood, Cadbury Heath and Yate & Dodington.
- Index of Multiple Deprivation
    - Staple Hill PN contains the most deprived LSOA in South Glos. and is the only PN containing an LSOA within the most deprived 20% of LSOAs in England in terms of the IMD
    - All LSOAs within the Cadbury Heath and Patchway PNs are within National Quintile 2
- Income deprivation:
    - Highest levels of deprivation within South Gloucestershire are Staple Hill and

Kingswood, each with 1 LSOA in the most deprived 20% nationally
    - The majority of Priority Neighbourhoods LSOAs fall within the second national quintile for this domain
- Employment:
    - Highest levels of deprivation within Staple Hill (2 LSOAs in NQ1)
    - Patchway and Kingswood PNs both have 1 LSOA in NQ1
- Crime deprivation:
    - Kingswood is the most deprived in this domain (4 LSOAs in NQ1, 4 in NQ2)
- Barriers to housing and services deprivation:
    - Patchway is the most deprived PN for this domain with 1 LSOA in NQ1

Section 3 – Identification of Disparities, Impacts and Issues

To improve the health and wellbeing of South Gloucestershire residents and reduce inequalities the 2025-29 JLHWS sets out five evidence-based commitments to our ways of working.

The below are the five commitments of the JLHWS to our ways of working:

Commitment area 1: Strengthening community involvement
Commitment area 2: Building a programme of place-based working
Commitment area 3: Doing more to reduce inequalities
Commitment area 4: Shifting upstream with a focus on prevention
Commitment area 5: Holding ourselves to account with data and insights

In addition to the five commitment areas there will also be up to four areas of focus, these will be decided annually and will be informed by the Joint Strategic Needs Assessment.

Commitment area 1: Strengthening community involvement

Through the Council's Community Conversations, we have heard that our community wants more say over things that affect them and more meaningful engagement (16).

Evidence shows that involving communities has a measurable impact on health and reducing inequalities (17). However, as highlighted in the table below barriers to community involvement are present. Will need to consider this when involving our community to ensure that our population is represented.

Characteristic	Identification of barriers to community involvement
Age	Young people(18) • Perception that community involvement may feel like school. • Not knowing about opportunities to get involved. • Fear of not fitting in with others. • Information on involvement not being accessible. Working age adults (19) • Involvement events held during the day conflicting with work schedules. • Requiring childcare support. • Depending on the venue there can also be safety concerns if events are held in the evening. Older adults (19). Reduced involvement due to:

	• Being too tired to attend evening involvement events • Feeling unsafe if attending evening involvement events • Needing help to attend, such as transportation • Limited access to the internet or devices for online involvement • Concerns relating to the venue if held in person, for example acoustic problems or not being familiar with the venue. • Less likely to volunteer to be involved in longer term projects due to increased chance of experiencing increasing or sudden periods of poor health.
Disability	Reduced involvement due to: • May require additional support to attend, for example transport. Transport would need to be accessible and convenient (20). • A physical environment that is not accessible. For example, steps and curbs that would provide a barrier for someone with mobility impairment entering a building. • Pragmatic barriers, for example not setting enough time aside to fully support someone to be involved. • Accessible wording of consultation/ involvement • A lack of relevant assistive technology if involvement purely online.
Gender reassignment	Reduced involvement due to: • Not feeling comfortable attending in person consultation events/community involvement due to a fear of being harassed or identified as transgender (10). • Research shows many people who identify as transgender avoid clubs, social groups and public transport which all provide barriers to community involvement. • Previous negative experience or attitudes from services.
Marriage and civil partnership	• We could not find evidence that there are specific barriers to community involvement related to a person's marital status.
Pregnancy and maternity	Reduced involvement due to: • Space for breastfeeding (19) • Requiring childcare support. • Lack of accessible venues with easy access to baby changing facilities • Not having a clear time commitment communicated
Race	Reduced involvement due to: • Potential cultural barriers, which may make it less likely people will access 'official' space where consultation and engagements are carried out/ advertised.

	• Language barriers (19)
Religion or belief	• We could not find evidence that there are specific barriers to community involvement related to a person's religion or belief.
Sex	• We could not find evidence that there are specific barriers to community involvement related to a person's sex
Sexual orientation	Reduced involvement due to: • Not feeling comfortable attending in person consultation events/community involvement due to a feelings of shyness, anxiety and a lack of confidence linked to negative public perceptions of people who identify as LGBTQ+ (16).
Socio-economic groups	Reduced involvement due to: • Cost of attending if in person (19) • Access to electronic devices and internet if online
Care experience	• We could not find evidence that there are specific barriers to community involvement related to a person's care experience.

To address the highlighted inequalities we will:

1. Establish community involvement as standard practice. We will ensure all projects and updates presented to the Health and Wellbeing Board have been informed by community involvement, wherever possible.
2. Give equal weight to insights as data. The Joint Strategic Needs Assessment Steering Group will develop processes to ensure that community insights are a fundamental part of all needs assessments. The Health and Wellbeing Board will promote a culture shift that increases the value given to community insights in discussions.
3. The Joint Strategic Needs Assessment Steering Group will lead development of better mechanisms to share community insights between Health and Wellbeing Board members organisations. Board members will learn from each other by openly discussing the types of community involvement which have taken place, what worked well, and what could be improved.
4. Develop a programme of strength-based community involvement to complement Health and Wellbeing Board meetings. We will develop meaningful ways to involve local communities in the annual programme of Health and Wellbeing Board meetings.
5. Make the Health and Wellbeing Board and Joint Strategic Needs Assessment more relevant and accessible for communities. We will refresh the Health and Wellbeing Board annual report and ensure other key documents are made accessible and relevant to communities.
6. Champion community involvement within organisations. Health and Wellbeing Board members will promote community involvement approaches and share lessons learned within their organisations.

Commitment area 2: Building a programme of place-based working

Health is determined through many interacting factors and depending on where people live in South Gloucestershire, experience and needs will be different. South Gloucestershire is largely rural in area but most of its population lives within the fringe of Bristol. Local approaches developed with communities gain deeper understanding of the variety of local assets and challenges. This helps services meet the diverse needs of residents.

Evidence shows that place-based working is an effective way to involve communities, tackle core determinants of health and reduce inequalities (22). Working in this approach is in response to stakeholder and community preferences, in addition to bringing us in line with national priorities (23–25). Our data and insights also show that for some groups such as older adults, services are not currently situated where most older adults live (6).

To address the highlighted inequalities, we will follow a place-based approach. More specifically, we will:

1. Work with partners to develop a shared vision around what place-based working means in South Gloucestershire, based around how residents define their local neighbourhood and communities. We will support the Locality Partnership to lead a conversation on Place with communities and local partners.
2. Support the Locality Partnership-led programme of work around Place. In Spring 2025, the Locality Partnership launched a new bottom-up approach to place-based working in South Gloucestershire. Communities, frontline professionals, the voluntary sector and local providers are at the heart of planning and local leadership. The Health and Wellbeing Board, Council and Locality Partnership colleagues will act as enablers.
3. Foster a culture that recognises the unique challenges and opportunities of place-based working. We commit to place-based working as a long-term approach that requires investment and trust in our communities.

We anticipate that there will be some barriers in place for effective place-based working that will impact Protected Characteristic groups. The same barriers identified for commitment 1 will also apply to this commitment and consideration should be given to them throughout the implementation of work.

Commitment area 3: Doing more to reduce inequalities

Working to reduce inequalities is essential for enabling the best start in life - to help break the cycle of poverty and disadvantage, building a strong economy and for using limited resources efficiently and fairly (26–28). In addition, reducing health inequalities is a statutory duty of the Health and Wellbeing Board and aligns with national and local priorities (25,29–31).

As highlighted in section 2, there are inequalities in health and wellbeing when broken down by the Protected Characteristics. Previous Joint Local Health and Wellbeing Strategies have recognised the importance of inequalities by addressing it as a cross-cutting theme. However, we are seeing an increase in inequalities experienced by our population. The commitment to do more to reduce inequalities, places addressing inequalities at the forefront of the Health and Wellbeing Boards' role.

To address the highlighted inequalities and committing to doing more to reduce inequalities we will:

1. Promote a consistent and shared narrative about local inequalities within the Board and among partners. All Board members and Health and Wellbeing Board partners will be able to describe inequalities in South Gloucestershire.
2. Foster a culture where reducing inequalities is everyone's business. We use an inequalities lens in all our discussions as a Board. Health and Wellbeing Board members will act as champions for reducing inequality within their organisations.
3. Promote proportionate universalism as the recommended approach to allocating funding to reduce inequality in South Gloucestershire. This method addresses inequality through a combination of universal and targeted interventions, delivering services at a scale and intensity proportionate to the level of disadvantage. Whenever the Board discusses a universal service, it should ask what is being done to ensure the service is reducing inequalities and is not widening inequalities.

4. Develop a support offer for partners to increase engagement with the Joint Strategic Needs Assessment process. The Joint Strategic Needs Assessment Steering Group will work with partners to develop ways to support better use of data and community insights to identify need and help target resources.
5. Support the South Gloucestershire Tackling Inequalities Plan 2024-28. The Health and Wellbeing Board shares the ambition set out in this plan to 'take a proactive, action-based approach to tackling inequalities'. We will monitor progress against delivery of the health and wellbeing objectives set out in the Tackling Inequalities Plan.

It is not considered that any of the Protected Characteristic groups will be negatively impacted by this commitment. However, to ensure that inequalities are not missed it is also important to look at inequalities due to interacting factors. The strategy makes explicit its intention to increase the attention given to intersectionality and the way inequality is driven by multiple overlapping factors. The Strategy seeks to create a common narrative about inequality in South Gloucestershire that recognises how many of the inequalities experienced by individuals and communities can be hidden if we look at any single risk factor in isolation.

Commitment area 4: Shifting upstream with a focus on prevention

Evidence shows that a system focus on prevention is essential for improving wellbeing and it is an effective way to reduce inequalities (23,28,32). Action at a primary prevention level to tackle the core determinants of health have been found to have the greatest impacts (23).

What we will do:

1. Involve young people. The Health and Wellbeing Board will create opportunities to hear from young people in South Gloucestershire and build their insights into decision-making. This will include collaborating with the Youth Board around how to enable young people locally to live healthier lives.
2. Ensure that discussions around prevention include action to tackle core determinants of health.
3. Commit to allocating long-term resources to early intervention and prevention activities in communities to ensure that wider determinants of health are addressed before health deteriorates
4. Support alternative prevention-focused funding models. The Health and Wellbeing Board will support efforts to develop new funding models that give longer term support to community prevention projects.
5. All Board members commit to support the workforce and volunteers across our partnership to help them to achieve good health and wellbeing
6. Foster a culture where prevention is everyone's business. Health and Wellbeing Board members will be encouraged to be directly involved in community prevention projects, for example by signing up to mentoring young people in care.

There are different levels of prevention:

- Primary prevention – investing in the wider determinants of health to stop problems happening in the first place
- Secondary prevention – focusing on early detection of the problem to support early intervention and treatment or reducing the level of harm
- Tertiary prevention – minimizing the negative consequences of a health issue through careful management

As a concept, we would not anticipate taking a preventative approach to negatively impact any Protected Characteristic groups as evidence shows it is important for improving wellbeing and reducing inequalities. Currently, service commissioners face the risk of widening inequalities if they target resources at need but inadvertently ignore need in other areas. This can be a risk when interventions are put in place for individual areas but services are taken up only by those experiencing the least disadvantage. The Strategy seeks to reduce this risk by actively setting out

its ambition that whenever the Board discusses a universal service, it should ask what is being done to ensure the service is not widening inequalities.

Commitment area 5: Holding ourselves to account with data and insights

Robust use of data and insights is crucial for tackling inequalities. It is essential to ensure that resources are allocated effectively, to the right people. In addition, the Health and Wellbeing Board have a statutory responsibility to produce a Joint Strategic Needs Assessment (25)
We will:

1. Strengthen partner engagement with the Joint Strategic Needs Assessment development process, ensuring comprehensive membership to the steering group.
2. Support partners to improve their use of Joint Strategic Needs Assessments to inform decisions. Require more regular on new developments and regular demonstrations on how to use the tools.
3. Require that any proposal brought to the Board is informed by the Joint Strategic Needs Assessment.
4. Commit to using the Local Government Association self-assessment tool to review how well the Board uses data and community insights to inform decisions.
5. Use quarterly Joint Development Sessions to plan and monitor progress of Health and Wellbeing Board Annual Focus Areas. Each session will focus on one of the Health and Wellbeing Board focus areas. The session will include a review of plans and progress against the five Health and Wellbeing Board commitments.
6. Refresh the Health and Wellbeing Board Annual Report so that it is relevant and accessible to communities and celebrates new ways of working.

Although the use of data and insights is important for tackling inequalities, local inequalities are complex, often shaped by multiple overlapping factors. We risk widening inequalities if we do not recognise this complexity when identifying groups at greatest need. We recognise we can do more to understand the stories behind the data and strengthen our use of community insights to inform decision making. Identifying inequalities and intersectionality can be difficult, particularly where numbers are small.

Section 4 – Actions to be taken

The following process will take place to monitor progress of the strategy:

1. Each year, we will identify four Health and Wellbeing Board Annual Focus Areas for the year ahead. This will ensure that the strategy drives tangible action against its core commitments. These targeted areas for collective action will be chosen during an annual review of the strategy and published in an action plan. Focus areas will be selected each year in response to local data, insights and wider system priorities. They may be iterations of previous focus areas or new priorities for the system.
2. We will monitor progress of the strategy throughout its lifetime. We will monitor our impact using health and wellbeing outcomes, community insights and reports from members and partners on how they have developed ways of working.
3. Our refreshed accountability process will include opportunities for ongoing reflection and iteration. We recognise that we may need to adapt this strategy and our actions in response to what we learn. We will theme each of our quarterly Joint Development Sessions around one of that year's focus areas, using the time to review plans and progress with partners. We will use our strengthened approach to community involvement to get ongoing feedback from our communities on how the strategy is making a difference for local people.
4. During a themed full Health and Wellbeing Board meeting each year, the Board will review progress against strategy commitments and reflect on lessons learnt. We will use this time to review delivery of Health and Wellbeing Board focus areas and

agree new areas for the coming year.

5. A refreshed Health and Wellbeing Board annual report will summarise Joint Local Health and Wellbeing Strategy progress, celebrate successes and set out plans for the year ahead. The document will be accessible and relevant for our communities.

To mitigate potential unintended consequences impacting any of the Protected Characteristic groups, the below highlights actions we will undertake.

Commitment area 1: Strengthening community Involvement

We recognise that there are risks when working on community involvement and we will:

- Ensure community involvement is welcoming to all residents of South Gloucestershire.
- Recognise that real co-production and asset-based community development takes time and resources.
- Ensure community involvement is meaningful and leads to change.
- Have robust processes to choose the most appropriate strength-based approach.
- Work with our communities and ensure we do not pass risk to them by expecting them to do it all.
- Recognise that real Asset Based Community Development work means that we cannot control the conversation.

Commitment area 2: Building a programme of place-based working

We recognise that there are risks when working in a place-based approach and we will:

- Establish a shared understanding of what we mean by place-based working.
- Involve local communities in an ongoing and meaningful way. This will involve proactive engagement with hose communities who are historically under-represented.
- Recognise different approaches may be needed in different areas and we may see progress at different speeds across South Gloucestershire.
- Take an iterative approach. We may fail at first in some places but we will reflect on challenges and build back better.
- Ensure that all our partners buy into this approach
- Recognise that frontline professionals are central to this work.
- Learn from good practice elsewhere.

Commitment area 3: Doing more to reduce inequalities

We recognise that there are risks when working to reduce health inequalities and we will:

- Recognise that action to reduce inequalities takes time. National trends show that inequality has been rising over time, meaning that the process of addressing it is challenging. Sustained longer-term efforts are needed. We may not see a reduction in local inequalities within the timeframe of this strategy. However, we can measure the changes in service provision and action on wider determinants that we expect will reduce inequalities in the longer term.
- Use local and national data and insights to understand the complexity of local inequalities and identify where to target resources and for whom.

Commitment area 4: Shifting upstream with a focus on prevention

We recognise that there are risks when working in a preventative approach and we will:

- Remember to focus on Core Determinants of Health. Prevention efforts can easily focus

only on preventing deterioration for someone with a disease (secondary prevention). Action on core determinants addresses the root causes of ill health and helps reduce inequalities.
- Collaborate across the system. Health and Wellbeing Board members have varying degrees of influence over the core determinants of health. At each level of the system there is potential to shift our focus further upstream.
- Be creative. We can learn from innovative approaches in other areas and create longer-term sustainable funding models for truly inclusive community prevention programmes.
-

Commitment area 5: Holding ourselves to account with data and insights

We recognise that there are risks when working in a preventative approach and we will:

- Foster an open and honest learning culture. We will actively encourage Board members and partners to share any challenges they have faced so we can work together to find creative solutions.
- Ensure that self-reflection is not a one-off event and that we continue to monitor the Strategy throughout its lifetime.
- Recognise that our monitoring process should be iterative. We may need to adapt what we measure in response to what we learn.
- Ensure there is analytical resource and partner commitment to deliver the new process for improving accountability.

Section 5 – EqIAA Outcome

This is an Initial EqIAA and as such, there is no outcome at this stage. As a result of engagement, feedback will be analysed, this EqIAA will be updated and will form part of decision-making moving forwards.

Section 6 – Sources of Evidence Informing this EqIAA

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