# Case Studies: Treating to Prevent in Bristol



**November 2025**

Version 1.0

# Introduction

Bristol has achieved a great deal in improving health and wellbeing, and we can be proud of the partnerships and programmes that are making a difference.

In our main report “Treating to Prevent” we highlighted menu of well evidenced ‘best buys’ in relation to disease prevention which are affordable, and doable, within health and care settings – and within our communities

Preventative care and treatment are a key part of prevention, with a strong evidence base and which offer good outcomes for individuals and value for money.

This collection of case studies describe opportunities to identify the causes or risk factors for ill health as early as possible and to take action to delay or reduce the chances of them leading to more serious illnesses

They are focused on treating to prevent and are a celebration of the range of effective, innovative programmes in Bristol which will serve as a resource and inspiration as we go forward into the next phase of health, care and community reform and renewal.

We intend to build on this, so please send us your examples and stories and we will add them to this document.

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## Case Study 1: Workplace health checks pilot case study

Bristol's Workplace Cardiovascular Disease (CVD) Health Checks pilot took place from September 2024 to May 2025 to help prevent conditions like heart disease, stroke, and type 2 diabetes.

Bristol City Council, North Bristol NHS Trust (NBT), and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) partnered together to deliver health checks to staff at the hospitals and 14 other local organisations (public and private sector).

As well as full health checks for those aged 40-74, with no existing CVD condition as per the national NHS Health Checks programme, health checks were also offered to those aged 25-84 and not eligible for the NHS Health Check programme.

Over 5,119 health checks were conducted across UHBW and NBT. Engagement was strong among ethnic minorities and younger staff.

The health checks picked up significant numbers of undiagnosed conditions and risks.

- 13% of people receiving health checks had high blood pressure
- One in ten had a QRisk score over 10% (QRisk score indicates CVD risk in 10years).
- 43% required GP Referral.

Feedback from participants was positive. Highlighting the ability to have checks in their workplace, especially if they worked shifts or unusual hours.

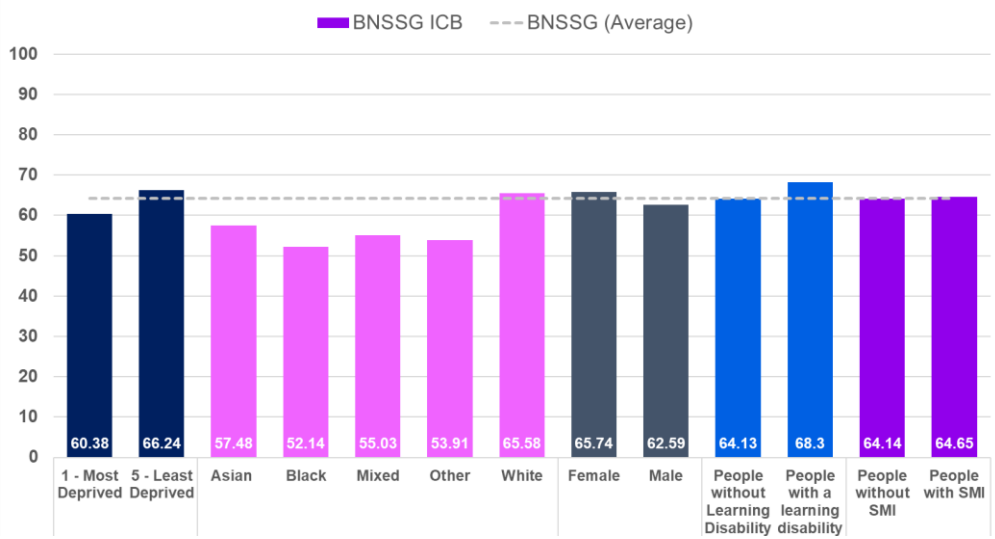
They also highlighted awareness of previously unknown health risks, such as high blood pressure as a benefit of the check.

"Thanks to the NHS for delivering health checks at our work location. The staff were very approachable encouraging and efficient; they were able to answer all my questions about the various tests and did explain about the on-going referral to my GP. Being able to complete this at work was an efficient use of everyone's time, plus the re-assurance of the results put my mind at rest"

Led by Bristol City Council, North Bristol NHS Trust and University Hospitals Bristol and Weston NHS Foundation Trust

# Case study 2: ICB equality objective work on improving hypertension management in Black African and Caribbean communities

Figure 1 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)




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.

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 three 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.

Led by Bristol, North Somerset, South Gloucestershire Integrated Care Board & CVD working group

## Case Study 3: NHS community pharmacy blood pressure check service

Community pharmacies are engaged in a national high blood pressure case finding service . This is to help detect undiagnosed cardiovascular disease within a community pharmacy setting.

Under the programme, pharmacies identify people aged 40 years or older – or, at the discretion of pharmacy staff, people under the age of 40 – with high blood pressure (with no previous diagnosis of high blood pressure), and to refer them to general practice to confirm diagnosis and for appropriate management.

Ambulatory blood pressure monitoring (ABPM) equipment can be loaned to people to help them monitor their blood pressure over a 24-hour period.

Over a year (2024-5) there were 42,019 clinic checks and 2,519 ABPM checks.

- Of the clinic checks almost a quarter of blood pressure readings were high
- Of ABPM checks, almost half showed high blood pressure

Led by Bristol, North Somerset, South Gloucestershire Integrated Care Board, Community Pharmacy Team

## Case Study 4: Community-based Secondary Prevention for Cardiovascular Disease

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), BNSSG ICB and the University of Bristol reviewed the health record data for people, in the first year after being admitted to hospital and found that following a heart attack, patients incurred high costs in the first year with nearly £7.9M spent on initial hospital admissions and a further £6.9M on follow-up care, mostly due to emergency readmissions.

Over half of this spending was concentrated in just 12% of patients, often those with multiple health conditions.

The review also found gaps in secondary prevention, particularly in cholesterol management. More than 10% of patients were not prescribed cholesterol lowering medication within a year, which was linked to higher mortality. These gaps were more common in areas of higher deprivation, such as South Bristol.

In response to this UHBW developed a new pathway to improve follow up care. This includes early post-discharge reviews and a 6 to 9 month check-in, with a pilot clinic in Knowle West Medical Centre.

The service works in partnership with primary care and community nurses to provide timely blood tests after discharge from hospital. The team work holistically and support people with health behaviours (smoking, diet, physical activity) alongside medical treatment for risk factors.

To date, over 800 people have benefited. More than half have now reached cholesterol targets at 6 months, and early analysis suggests a reduction in serious cardiac events. This project was funded by Novartis.

Led by University Hospitals Bristol and Weston NHS Foundation Trust, Bristol, North Somerset and South Gloucestershire Integrated Care Board and the University of Bristol.

## Case Study 5: Bringing healthcare to communities: Cardiovascular Disease Community Prevention Programme Evaluation Report

This CVD prevention programme was funded by NHS England via Bristol, North Somerset, and South Gloucestershire Integrated Care Board and delivered by Accure Healthcare Consultancy.

Using a community-based model, the programme was designed to engage diverse populations. It had three components: CVD case finding, targeted outreach to high-risk groups, and the recruitment of volunteer community champions. Screenings for blood pressure, diabetes, cholesterol, and atrial fibrillation were conducted in community settings.

By providing on-site screenings, lifestyle education, and referrals, the initiative successfully raised awareness and improved early detection of hypertension, high cholesterol, and diabetes among underserved populations.

This initiative has demonstrated the power of bringing healthcare into the community. By embedding services within trusted environments and offering flexible, accessible options, we can improve health outcomes and build stronger, healthier community.

“I’ve always avoided going to the doctor because of my anxiety, but having the clinic here in a familiar space made all the difference. I felt comfortable and at ease.”

“I didn’t even know I was eligible for a health check until I walked past and saw this happening. If this had been at a surgery, I wouldn’t have gone, but being here made it easy for me to say yes.”

Led by Bristol, North Somerset and South Gloucestershire Integrated Care Board and Accure Healthcare Consultancy

## Case Study 6: Lung Cancer Screening

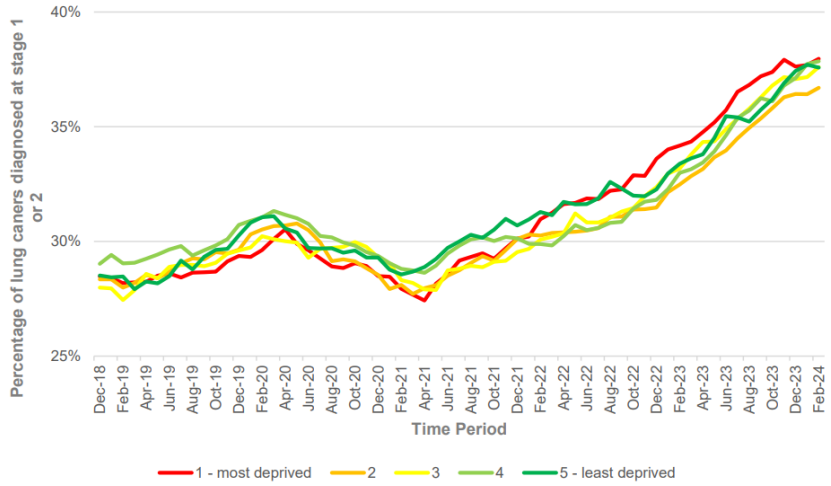
Lung Cancer Screening (LCS), previously known as Targeted Lung Health Check (TLHC), aims to detect lung cancer at an early stage, sometimes before patients have symptoms, when it is much more treatable - ultimately saving more lives[1].

Lung cancer causes more deaths than any other cancer in the UK as it is frequently diagnosed at a later stage than other cancers. There are often no signs or symptoms of lung cancer at an early stage. Since 2022, in the local programme across SWAG:

- over 110,000 participants have been invited for a lung health check
- over 70,000 participants have completed a lung health check
- over 36,000 Low Dose CT scans completed
- 299 lung cancers were detected of which 80% at an early stage. 22 non-lung cancers detected as well.
- 349 people have quit smoking because of the referrals from LCS and support from the local smoking cessation providers

Data shows that the programme is having a significant impact on the improvement in early diagnosis rates for lung cancer for people living in the most deprived areas.

Figure 2: 12-month moving average of lung cancer early diagnosis rate by deprivation quintile (National Data) [2]




Source: NHSE Analysis of Rapid Registration Data.

"If I hadn't have gone for my screening, I think I would be in a very bad way now. Life is good, 5 months after my operation to remove lung cancer." Lung Cancer Screening Patient diagnosed in 2024

Led by Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG)

## Case Study 7: Caafihealth Macmillan Cancer Champions[3]

Caafihealth and Macmillan Cancer Support are working in collaboration to increase cancer survival and improve experiences for Black and Minoritised communities. Everyone's experience of living with cancer is unique, but Cancer outcomes among Black and Minoritised communities are known to be the worst. Caafihealth works to amplify the needs of Black and Minoritised people living with Cancer in the Inner City & East area of Bristol.

People in the inner-city Bristol communities are less likely to get screened for cancer or to see a doctor about early warning signs. They are diagnosed with more advanced cancer, resulting in poorer cancer outcome. People may struggle to understand the information they are given or access the care they should have.

Caafihealth have set up community cancer champions to help support people who may have questions about cancer, myth busting and helps to increase awareness, improve access and ensuring people understand the importance of detecting cancer early.

They run cancer awareness events in the community such as coffee mornings and community drop in tables. People can take information home to read and helping people so make informed decisions about their health.

Many champions speak different languages and work collaboratively with their communities. Cancer champions help to support others and offer support throughout their journey and for attending hospital appointments.

Led by Caafihealth and Macmillan Cancer Support

## Case Study 8: Treating Tobacco Dependency in Secondary Care[4]

Treating Tobacco Dependency services are funded within NHS acute hospital settings across BNSSG. The TTD service is delivered across 3 areas.

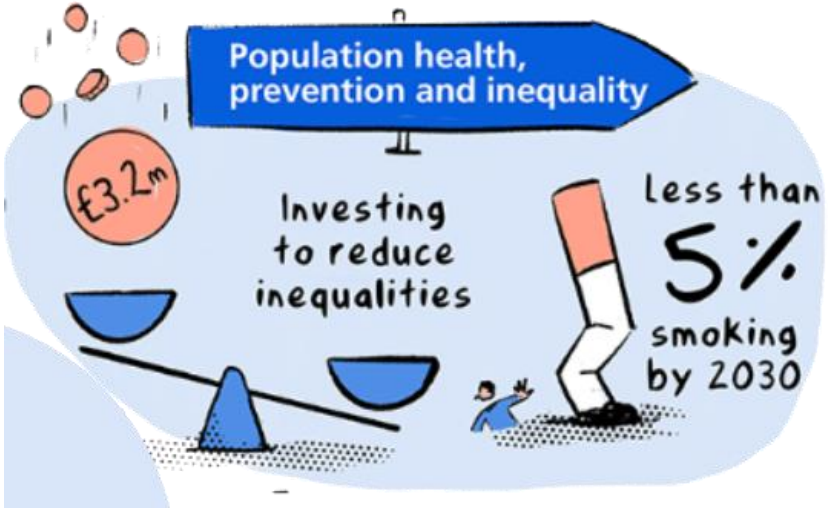
Maternity: North Bristol NHS Trust (NBT) provides support to pregnant women who smoke, starting from their booking appointment. Referrals are made by community midwives and support to stop smoking is offered throughout the pregnancy and can continue after birth if needed.

Hospital Inpatients: Treatment for tobacco dependence is offered to inpatients at Bristol Royal Infirmary (BRI) and Southmead Hospitals and Weston Hospital.

Mental Health Inpatients: There is support for smokers across six mental health hospital sites and an aim to expand to community treatment in the future.

This is a joint system programme which involves three local authorities, Bristol NHS Group and community providers working together.

Led by Bristol City Council, North Somerset Council, South Gloucestershire Council, Bristol NHS Group and community providers across BNSSG.



## Case study 8: Alright my liver?[7]

Alright My Liver? is an NHS England commissioned pilot service led by UHBW in collaboration with SWAG (Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance), working to diagnose liver disease earlier in people at risk.

At-risk groups include people with type 2 diabetes, obesity, history of alcohol excess and risk factors for blood-borne viruses. Initial screening is through a portable brief test called a Fibro Scan which can detect liver scarring. This is offered through specialist nurse outreach to GP practices, drug and alcohol services, health charities, homeless services and more.

Alright My Liver? Has been operational for almost 3 years and assessed 8000 people at-risk of liver disease. Approximately 5% of people assessed are diagnosed with cirrhosis. These patients are then able to access specialist care and support for their condition.

The Alright My Liver? Pathway Navigator contacts patients to remind them of appointments and can offer a taxi when needed.

This personal, responsive model for patient care has led to high levels of engagement[5,6]. Many patients diagnosed through the service have gone on to achieve a healthier weight or reduce their alcohol intake as a result of the intervention.

The pilot service continues to expand, with new exciting collaborations including in reach to mental health inpatient areas and occupational health links at large employers. Further evaluation of the pilot is in progress.

"I was surprised. The doctors and nurses explained my diagnosis really well. I'm now trying to eat more healthy and keep up the swimming. I would advise anyone who was worried about their liver health or at risk to get a scan and seek advice." Patient diagnosed with Liver Disease[7]

Led by University Hospitals Bristol and Weston NHS Foundation Trust and Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance (SWAG)

## References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[6] Archer A, Tilden S, Gitahi J*, et al* P75 A community-based pilot for proactive screening of high-risk groups for chronic liver disease can lead to sustained healthcare engagement of people diagnosed with cirrhosis *Gut* 2024;**73:**A58.
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