Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Care System Health Inequalities Plan

Introduction

Integrated Care System
Nottingham & Nottinghamshire

Integrated care systems (ICSs) are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. ICSs have four key aims listed below, and the Nottingham and Nottinghamshire Health Inequalities plan sets out our approach and commitment to tackling inequalities in outcomes, experience and access whilst also ensuring a foundation and robustness to delivering across the other aims.

ICS Key Aims

- improving outcomes in population health and health care
- tackling inequalities in outcomes, experience and access
- enhancing productivity and value for money
- helping the NHS to support broader social and economic development.

Furthermore, the plan supports the achievement of the Nottingham and Nottinghamshire ICS shared purpose of **Every Citizen Enjoying Their Best Possible Health and Wellbeing**. The purpose recognises the need to improve outcomes in the context of stark differences across our communities with people dying earlier and living with ill health longer than they should. As a result, in order to achieve the greatest impact, the ICS Partnership adopted **Equity as a core principle** and the ICS Health Inequalities Plan describes how this principle will be applied along with the Core20+5 approach.

The ICS Health Inequalities Plan is underpinned by the Joint Health and Wellbeing Strategies and will form part of a wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities. Place and Neighbourhood are central and it is through understanding our population and the barriers and enablers to health that we can impact on both met and unmet need. Therefore, how we function as a system and continually enhance on the enablers and tools outlined in the plan will be fundamental to our success in impacting on the health of our local communities and the sustainability of our health and care system.

Summary of the Plan

Integrated Care System
Nottingham & Nottinghamshir

In communities across Nottingham and Nottinghamshire people are dying earlier and living with ill health longer than they should. There are stark differences across Nottingham and Nottinghamshire between the most and least deprived. This creates a difference in the outcomes for the population, with those in the least deprived areas often having some of the worst outcomes.

In order to tackle health inequalities in Nottingham and Nottinghamshire we need to work together as an integrated care system to embed equity as a core principle in our approach to planning and managing services.

Place based approaches are central in understanding and enabling our local populations, capturing local knowledge and ensuring services work for local people.

We need to embed a continuous cycle of understanding our populations, the drivers of inequality and the barriers which prevent them accessing care based on need.

We need to integrate across partners as the health and care system, using local and national strategies to help tackle health inequalities and how best to target our local populations.

We need to embed equity as a principle across the system and ensure the services we provide consider the populations they serve.

We need to use place-based approaches, population health management, utilise enablers and establish the need/supply/demand of services as well as identifying unmet need.

To mobilise all partners around our communities recognising the opportunity to have an established and sustainable equitable health and care system which is reducing health inequalities in our population and improving outcomes for those in the most deprived areas.

Summary of the Plan

Integrated Care System
Nottingham & Nottinghamshire

Approach

1. Equity as a Core Principle

- Identifying need and unmet need and how impacted differently across communities by barriers to access and in experience
- Changing the dynamic between need, demand, supply including focus on unmet need
- Focus on preventative measures
- Implementing building blocks in how services are delivered and resources allocated i.e. shared decision making through to differential funding and distribution of services, along with a focus on wider determinants
- Applying tools as an ICS including strength of place and enabling and engaging with communities, data integrity and analysis, financial resources, integration and partnerships

2. Core 20+5

- Place and 20% most deprived recognising that this includes 57% of Nottingham City and pockets in Nottinghamshire.
- Inclusion health groups are identified through priorities of PBPs and include, but not limited to severe multiple disadvantage, different ethnic groups, carers.
- ICS programme on smoking cessation impacting across the five clinical areas
- Actions across the five clinical areas including a focus on 20%+

Strategies

1. ICS Health Inequalities

Based on place based approaches to health inequalities including a varying emphasis on civic, community and service based interventions.

Strategy Includes three areas of focus impacting on short, medium, long term:

- NHS Five Priority Actions – restoring services, digitally enabled care, accelerate preventative programmes, datasets, leadership and accountability
- Lifestyle Factors – smoking, alcohol weight mgmt
- Living and Working Conditions – economy and environment

2. Joint Health and Wellbeing Strategies

Nottingham City priorities include Severe Multiple Disadvantage; Smoking and Tobacco Control; Health Eating &Physical Activity

Nottinghamshire County priorities include Best Start; Mental Health; Healthy Weight; Tobacco Control; Air Quality; Alcohol; Homelessness; Food Insecurity; Domestic Abuse

Place Based Partnership Plans

Each Place Based Partnership has identified plans at place and neighbourhood level that apply the ICS approach and delivery to the strategies. Plans focused on differing needs across neighbourhood and place including but not limited to:

- Community development
- Health and wellbeing coaches
- Social prescribing
- Long Term Condition case finding, prevention and management reaching out to and engaging with local communities
- Childhood Immunisations
- Improving uptake for imms and vaccs
- Improving access for those with a Learning Disability
- Supporting carers
- Mental illness with a focus on those with a severe mental illness
- Lifestyle management programmes targeted at specific communities
- Redefining pathways for homeless and severe multiple disadvantaged

ICB and Provider Plans

Targeted action across the five clinical areas in the Core20+5 including maternity, SMI, respiratory, cancer, CVD
Focus on inequities in waiting lists and restoring NHS services inclusively
Ensure datasets are complete and timely including work to improve ethnicity data capture
Preventative programmes including a focus on diabetes plus smoking, alcohol, weight management
Children and young people transformation programme
Anchor institution, environment and employment

Enablers

Data, profiling, modelling and evaluation including PHM
Connected Communities and Personalisation
Partnership & Leadership including Training
Research

Glossary

Integrated Care System
Nottingham & Nottinghamshire

Health Inequalities - Health inequalities are avoidable, unfair and systematic differences in health between different groups of people (Kings Fund, Aug 21). These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing (UK Government, 2021).

Health Disparity/health inequity - Used in the context of a specific type of inequality that denotes an unjust difference to health. Health disparities/health inequities are individual/population/group differences reflecting an unfair distribution of health risks and resources i.e. differences in access, experience and/or outcomes.

Health Equity (Equity) - Health equity is achieved when everyone can attain their full potential for health and well-being (WHO).

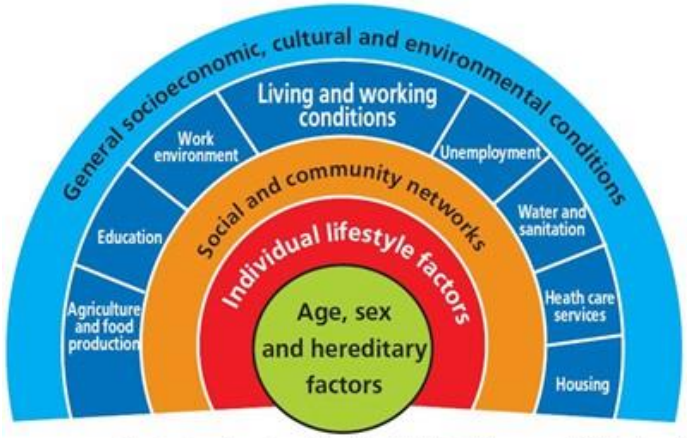
Table of Contents

Integrated Care System
Nottingham & Nottinghamshire

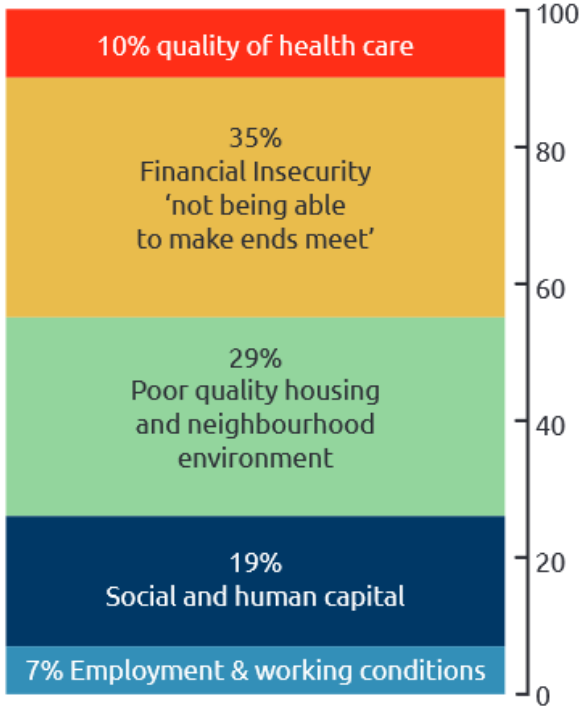
Purpose of the ICS Health Inequalities Plan

Integrated Care System
Nottingham & Nottinghamshire

- The ICS has a stated aim to improve the health and wellbeing of the population of Nottingham and Nottinghamshire.
- It is clear from data on health of our population that there are significant differences (inequalities) in outcomes.
- These inequalities can be connected to things you are born with, things that happen in your life, such as the food you eat or how much you exercise. However, the largest contributions to outcomes are from 'wider determinants', which include things like household income, housing, education and work.
- This plan will focus on how the health and care services in Nottingham and Nottinghamshire can make sure they not only improve access to and quality of healthcare but also contribute to reducing the impact of wider determinants.



The Determinants of Health (1992) Dahlgren and Whitehead

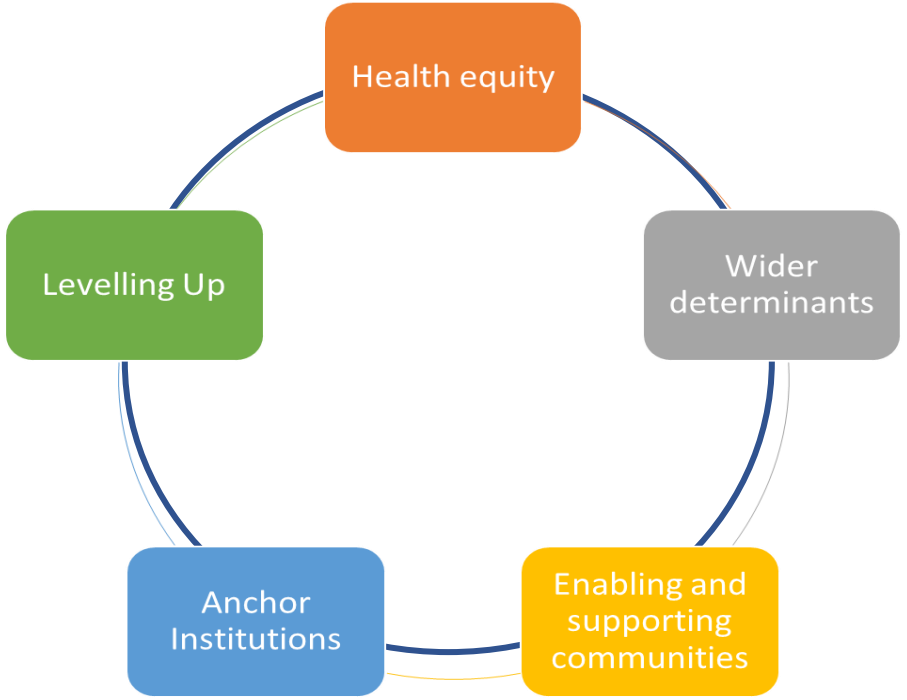


From health-inequalities.eu

How does this plan fit with system work on health inequalities?

Integrated Care System
Nottingham & Nottinghamshire

- It is the responsibility of the wider system to address the challenges of health inequalities.
- The ICS Health Inequalities Plan will focus on the role of health and care services in addressing inequalities and wider determinants of health.
- It will form part of a wider response from across the system, that builds a multi-agency approach responding to national policy, organisational responsibility and working with our communities.
- The ICS Plan will consider both direct areas of responsibility for action and identify areas for shared working.



Integrated Care System
Nottingham & Nottinghamshire

A. Key Strategies

Working and Aligning as a System

Integrated Care System
Nottingham & Nottinghamshire

Since writing the ICS Health Inequalities strategy, the context and partnerships have developed further, as we move closer to the legislative status of becoming an ICS. With the impact of COVID, working effectively as a partnership is even more vital to address health inequalities, recognising what can be achieved through healthcare along with the role of the ICS in relation to wider determinants. The role of the ICS in relation to wider determinants will be directly informed by the Joint Health and Wellbeing Strategies supported by a place based approach to health inequalities.

The figure below provides an overview of the ICS partners. Leadership and partnership with a clear focus on health inequalities will be instrumental in order to have an impact and to mobilise resources around population need. This is supported by Place being at the centre as outlined in the PHE/UK Health Security Agency Population Intervention Triangle.

<table>
<tr><td colspan="8">Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)</td></tr>
<tr><td colspan="2">Nottingham City PBP 396,000 population</td><td colspan="2">South Nottinghamshire PBP 378,000 population</td><td colspan="2">Mid Nottinghamshire PBP 334,000 population</td><td colspan="2">Bassetlaw PBP 118,000 population</td></tr>
<tr><td colspan="2">8 PCNs</td><td colspan="2">6 PCNs</td><td colspan="2">6 PCNs</td><td colspan="2">3 PCNs</td></tr>
<tr><td colspan="8">NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)</td></tr>
<tr><td colspan="4">Nottingham University Hospitals NHS Trust</td><td colspan="2">Sherwood Forest NHS Foundation Trust</td><td colspan="2">Doncaster and Bassetlaw NHS Foundation Trust</td></tr>
<tr><td colspan="8">Nottinghamshire Healthcare NHS Foundation Trust (mental health)</td></tr>
<tr><td colspan="2">Nottingham CityCare Partnership (community provider)</td><td colspan="6">Nottinghamshire Healthcare NHS Foundation Trust (community provider)</td></tr>
<tr><td colspan="8">East Midlands Ambulance NHS Trust</td></tr>
<tr><td rowspan="2" colspan="2">Nottingham City Council (Unitary)</td><td colspan="6">Nottinghamshire County Council</td></tr>
<tr><td>Broxtowe Borough Council</td><td>Gedling Borough Council</td><td>Rushcliffe Borough Council</td><td>Ashfield District Council</td><td>Mansfield District Council</td><td>Newark & Sherwood District Council</td><td>Bassetlaw District Council</td></tr>
<tr><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td><td colspan="2">Voluntary and community sector input</td></tr>
</table>

Health and Wellbeing Strategies + Place

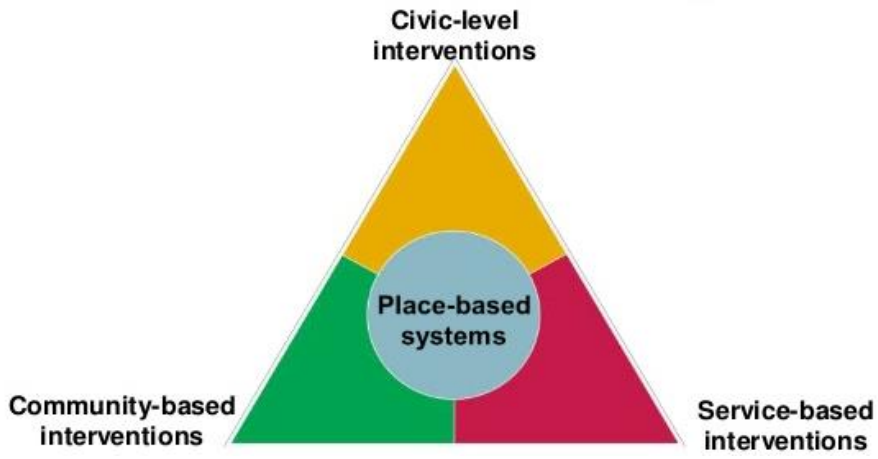
In order to have due regard and to ensure the right focus on health inequalities, the ICS Plan is informed by and integrates with the Nottingham City and Nottinghamshire County Health and Wellbeing Strategies and the ICS health inequalities strategy. The priorities of the Health and Wellbeing Strategies provide the priorities for the ICS in order to impact on health inequalities and it's how these can be delivered through healthcare along with opportunities at a community and wider place level.

Integrated Care System
Nottingham & Nottinghamshire

The ICS Health Inequalities Plan is informed by and integrates with the two health and wellbeing strategies. Each of the Local Authorities have defined principles and priorities that will drive forward what is happening at a place level and inform the priorities for the ICS.

As well as delivery to the strategies, it is through the place based and neighbourhood structures that there is the intelligence and relationships with local communities to inform change. This includes a level of understanding to support a preventative approach that can be targeted by being culturally and environmentally relevant.

It will therefore be important that the enablers for the Health Inequalities Plan are also underpinned by due regard to the Health and Wellbeing Strategies.



Within the ICS structure the key strength is in relation to Place Based Partnerships and PCNs and the opportunity these provide to work with and in our local communities and to impact on wider determinants. The relationships they hold and the focus driven through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategies will provide a solid operating model for addressing health inequalities, working alongside Local Authorities and Public Health.

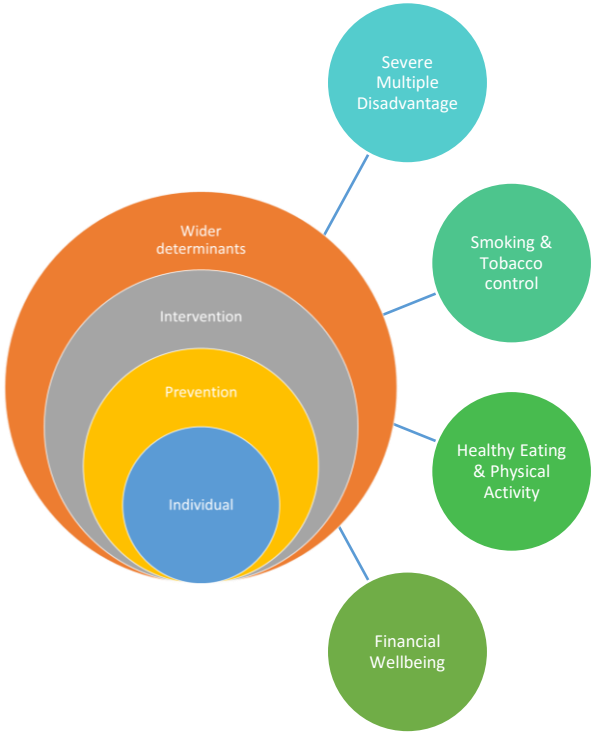
Health and Wellbeing Strategy Priorities

Integrated Care System
Nottingham & Nottinghamshire

The Health and Wellbeing Strategy priorities will inform the opportunity as an ICS to impact on health inequalities. In particular, if the ICS is going to impact on health inequalities for the Core20+, then this has to be done by supporting the priorities as outlined in the Health and Wellbeing Strategies

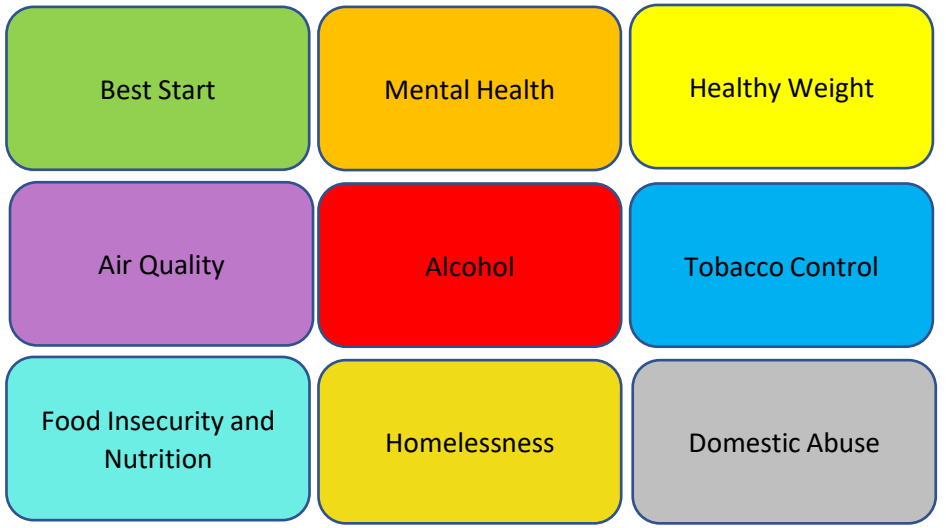
Nottingham City

Nottingham City has purposely focused on a small number of priorities that are focused on delivering outcomes which can have the biggest impact on the mental and physical health and wellbeing for city residents. The priorities are ones that will require collaborative efforts from a wide range of partners and stakeholders through a renewed focus.



Nottinghamshire

Nottinghamshire County priorities also recognise the importance of partnership working and are related to four ambitions including to give every child the best chance of maximising their potential, creating health y and sustainable places, ensuring all can access the right level of support to improve their health and to keep communities safe and healthy.



ICS Health Inequalities Strategy

The ICS Health Inequalities Strategy 2020-2024 mobilised partners and provided a shared commitment and vision for addressing health inequalities. Since writing the strategy both Councils have agreed new Joint Health and Wellbeing Strategies which therefore directly inform the ICS health inequalities plan, along with the Core20+5 and the ICS health inequalities strategy.

Integrated Care System
Nottingham & Nottinghamshire

At the time of writing in 2020, the strategy recognised the impact of COVID-19 (direct and indirect), and it reflected the ICS Clinical and Community Services Strategy and the ICS Five Year Strategic Plan (including the Joint Health and Wellbeing Strategies). The ICS Health Inequality strategy includes areas for action impacting on health inequalities across the short, medium and long term.

18 months on, the ICS Health Inequalities plan is an opportunity to outline progress against priorities and to highlight the opportunities in relation to the newly forming ICS structures and the strength of partners and partnerships across Nottingham and Nottinghamshire. Also, a key dimension is that the plan is directly informed by the two newly developed Joint Health and Wellbeing Strategies and aims to recognise the contribution that can be made through health alongside the necessity to impact on the wider determinants.

ICS Health Inequalities Strategy – Areas for Action

Short Term

Health and Care Services

1. Protect most vulnerable from COVID
2. Restore health and care services inclusively
3. Digitally enabled care
4. Accelerate preventative programmes
5. Particularly support those who suffer mental ill health

Medium Term

Lifestyle Factors

1. Alcohol
2. Smoking
3. Diet and physical activity
4. Children and young people

Long Term

Living and Working Conditions

1. Environment
2. Economy/employment
3. Housing
4. Education

The CORE20 Plus 5 and ICS Strategies & Plans

Integrated Care System
Nottingham & Nottinghamshire

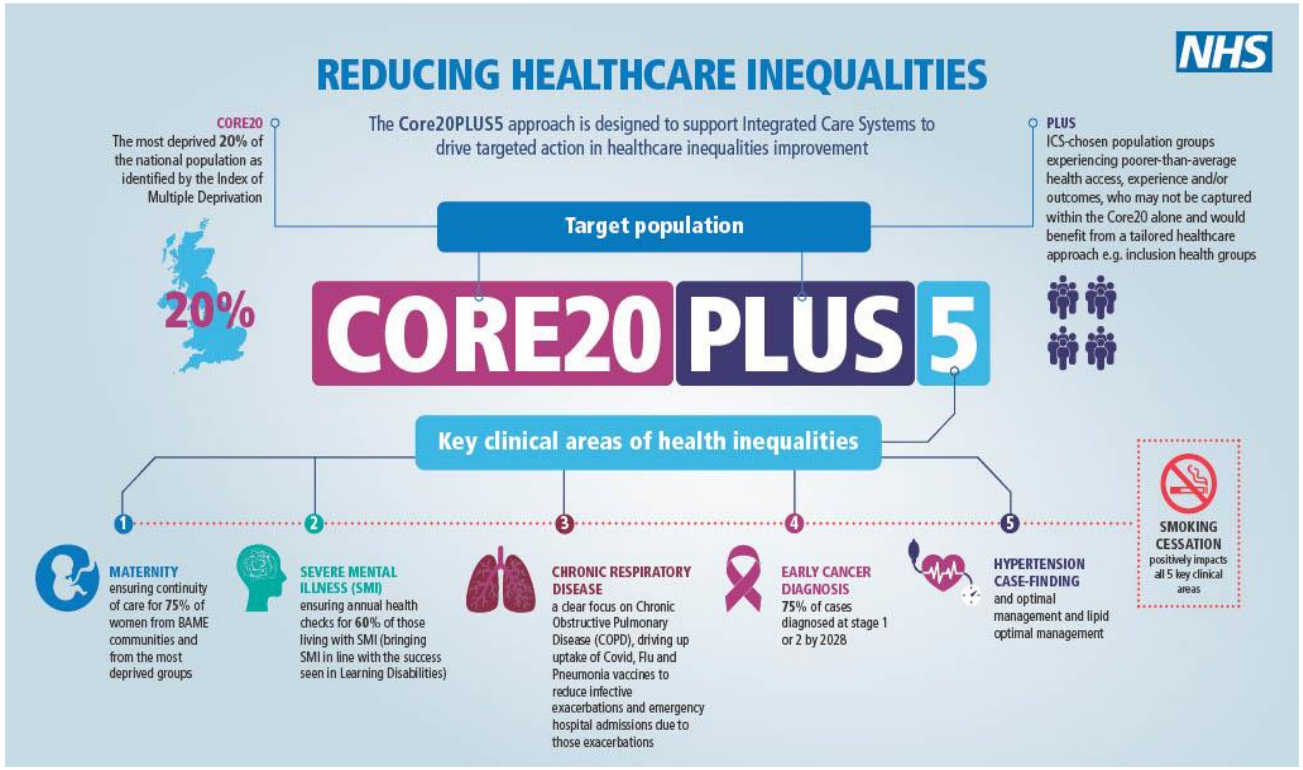


Figure 6 - Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

More detail on the Core20Plus5 can be viewed in section C.

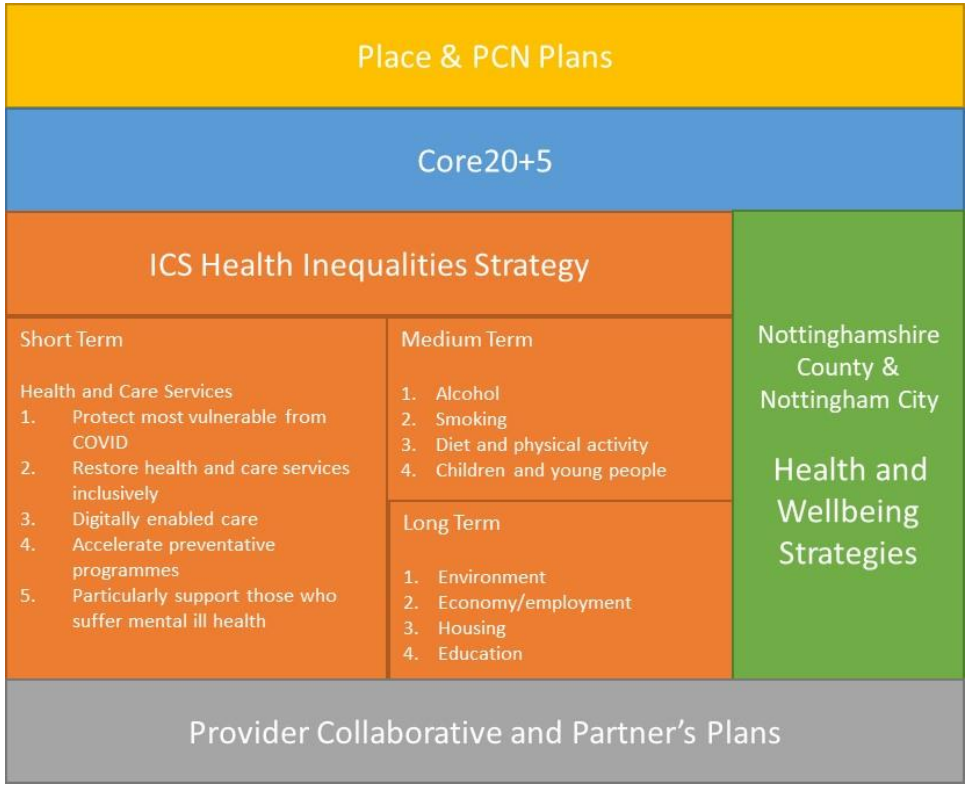


Figure 7 illustrates the combination of plans, along with the Core20+5 approach, that as a collective will aim to impact on health inequalities informed by the health inequality strategy and Joint health and wellbeing strategies.

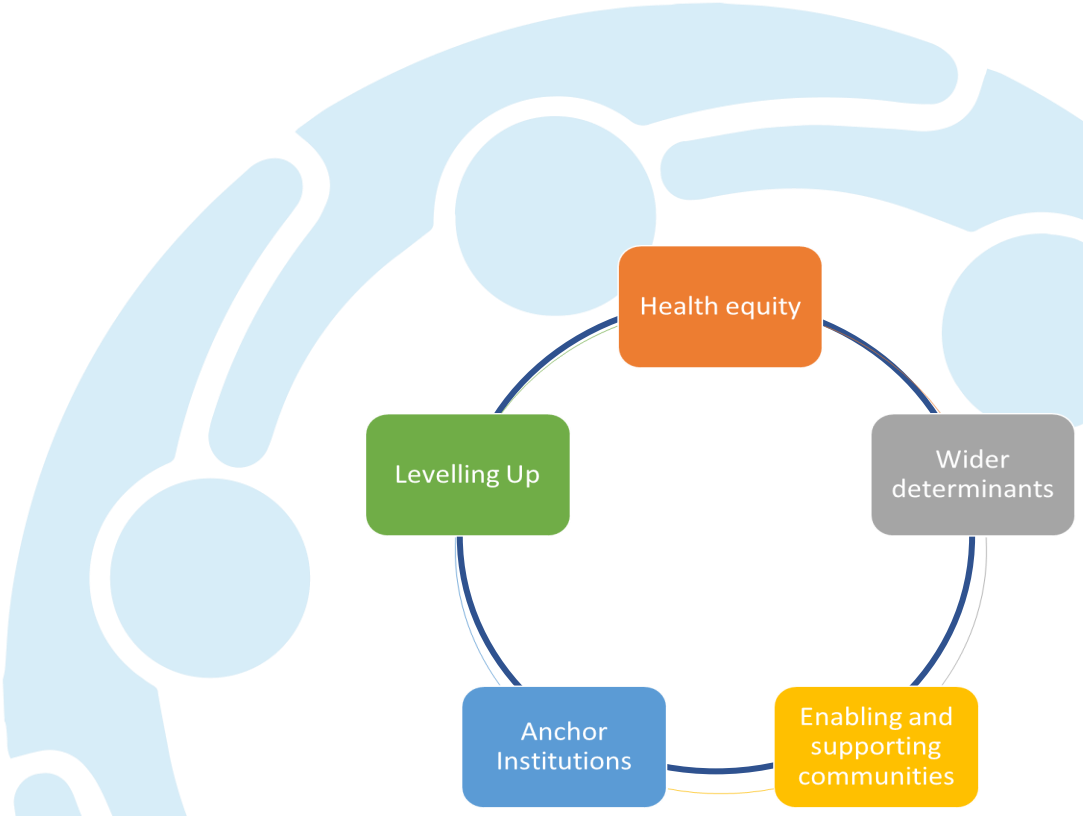
Therefore, the ICS health inequalities plan is written with the communities at the centre with a line through from PCNs and PBPs to the ICS.

Integrated Care System
Nottingham & Nottinghamshire

B. ICS Approach

The ICS approach to health inequalities is underpinned by Equity as a Core Principle. The following section outlines what this means and how this sits alongside the Core20+5 approach.

For Health, Equity as a Core Principle will be supported by the NHS Core20+5 approach. These elements combined will drive forward change.



Equity as a Core Principle of the ICS Health Inequalities Plan

Integrated Care System
Nottingham & Nottinghamshire

We know that health inequalities exist in our system and across the country which are unfair and avoidable.

Health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants. Structural determinants (political, legal, and economic) with social norms and institutional processes shape the distribution of power and resources determined by the conditions in which people are born, grow, live, work, play and age.

A “one size fits all” approach to health and social care services has led to groups being under-represented in our services or not receiving the right help they need at the right time, leading to worsening health outcomes.

In order to tackle this we need to systematically identify and eliminate inequities resulting from differences in health and in overall living conditions. Once these inequities are identified, we can establish what each of our communities need and target our resources differently and more effectively to reach different groups of people, helping to reduce barriers to access and encouraging positive outcomes.

Why Equity?

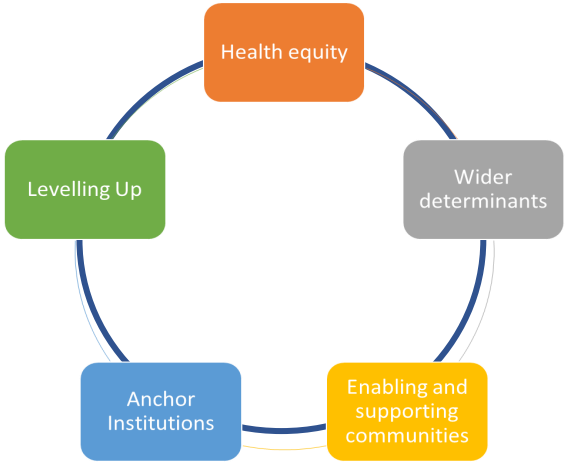
Integrated Care System
Nottingham & Nottinghamshire

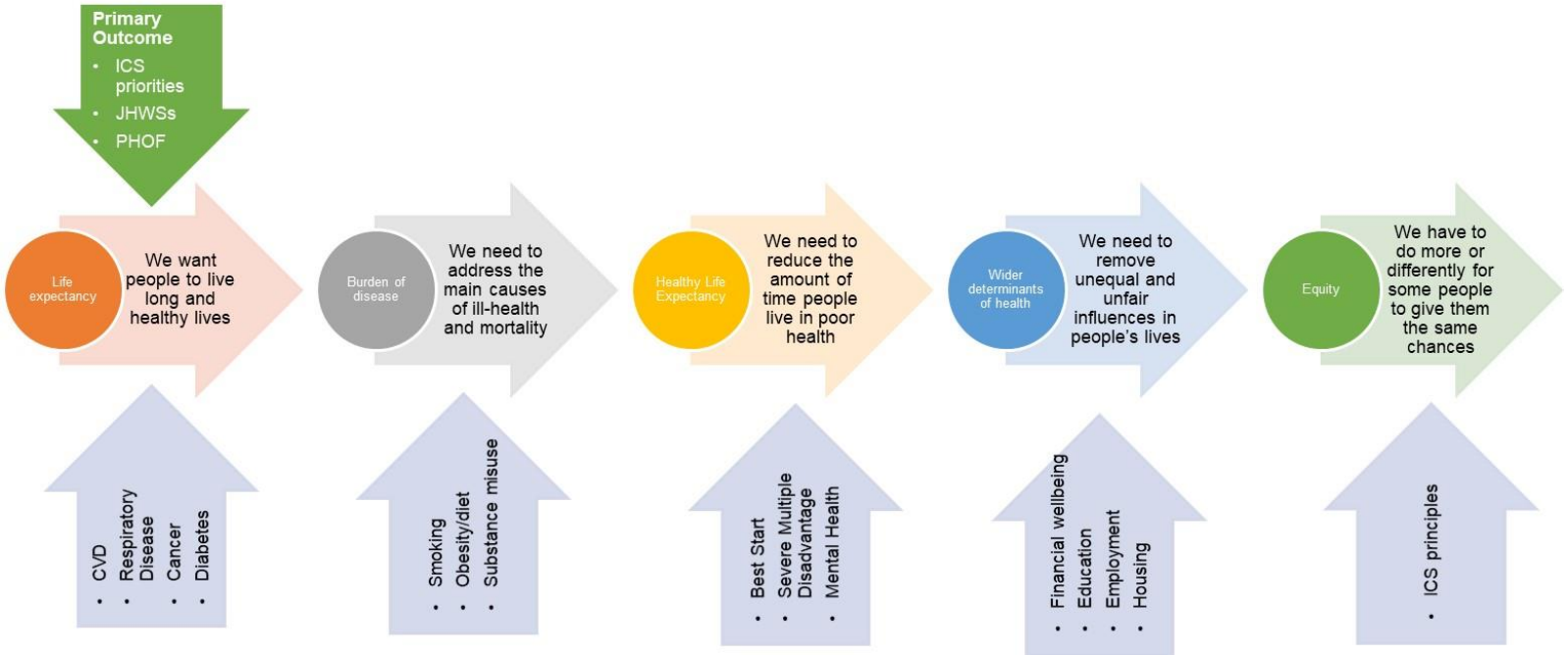
Equity has been adopted as the core principle in impacting on health inequalities . This provides an approach that recognises that a “one size fits all” method for services can exclude certain groups of people. Equity recognises that we need to use our resources in different ways to help include those who may experience barriers to accessing services.

Equality is about sameness, equity is about fairness. This means that sometimes, to give people equal health outcomes, we have to do something more or different for some people, to make it fair.

If we want to change life expectancy, we need to understand why what affects people’s health and what might make it difficult for some people to lead healthier lives.

Health and care services need to use this information to think differently about how they inform people about their health, provide services and link in with other partners to tackle the wider determinants of health.



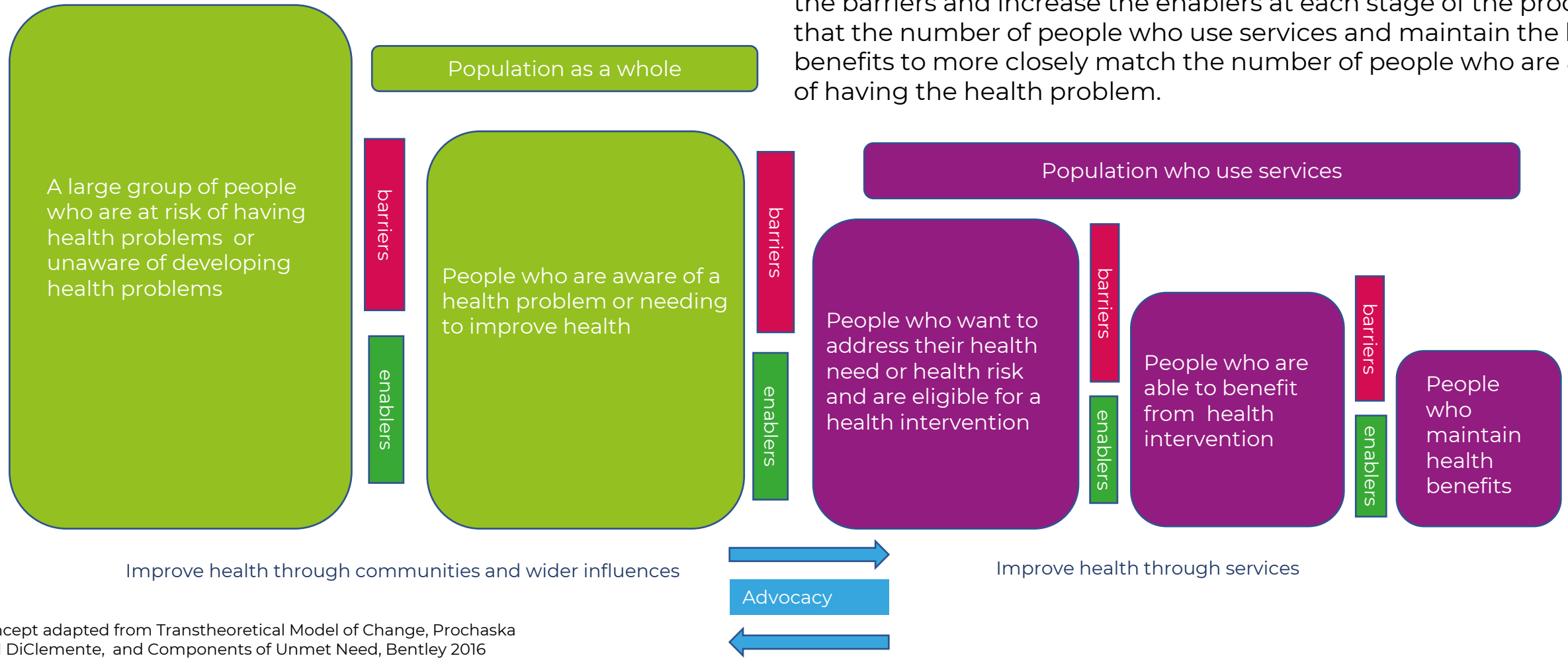


Equity and breaking down barriers and enablers in the current system

Integrated Care System
Nottingham & Nottinghamshir

The current health and care system relies on patients knowing the signs of ill health, knowing who to contact and coming forward to present to health professionals. Patients will experience both barriers to this as well as things which will enable this. These barriers and enablers change through the progression of the diagram and leads to a smaller percentage of people maintaining the health benefits of treatment.

In an ideal system, due to preventative measures, less people would be at risk of health problems. We would also be able to break down the barriers and increase the enablers at each stage of the process so that the number of people who use services and maintain the health benefits to more closely match the number of people who are at risk of having the health problem.



Concept adapted from Transtheoretical Model of Change, Prochaska and DiClemente, and Components of Unmet Need, Bentley 2016

Inequalities and Barriers in the Health and Care System

Integrated Care System
Nottingham & Nottinghamshire

How Inequity is Reflected in the Wider Health and Care System

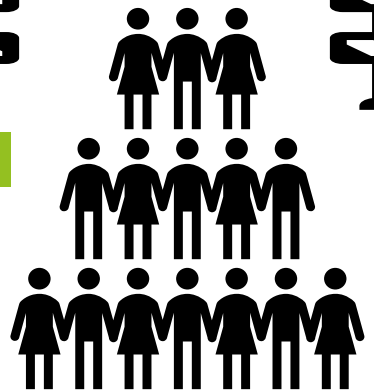
- Higher levels of DNA and cancellations in services
- Multi-morbidities, more complex patients
- Worst health outcomes
- Overuse of medications i.e. opioids
- Increasing levels of basic care to allow people to remain independent (increased demand)
- Unable to complete or continue with treatment
- Increase risk of premature death
- Increased attendances at ED
- Presenting at a later stage of disease progression so higher acuity
- Higher number of urgent vs elective admissions
- Longer waiting times
- Receiving different treatments at different stages
- Higher disease prevalence in specific population cohorts

How Barriers Translate into Health Inequalities within local communities

- Unable to make or afford healthier food options
- Unable to take time off work or change shift pattern for appointments
- Unhealthy coping mechanisms may be used to relieve stress; alcohol, substances, smoking, unhealthy foods.
- Living in a state of worry can lead to chronic stress, anxiety and depression, which can lead to more barriers.
- Inability to afford prescriptions
- Inability to afford transport to appointments
- Poor housing conditions such as cold, damp homes can exacerbate existing conditions, especially respiratory conditions.
- Higher priority is given to other life issues other than health

How are Barriers Experienced by Local Communities

- Challenges in communicating needs, being heard or understanding advice
- Limited transport options
- Worries over money, lifestyle, family, housing and other insecurities
- Unsure how to access and navigate the complex health and care system
- Insecure or irregular work
- Poor mental health can affect decision making, lifestyle and ability to engage with services
- Services that are not flexible to meet individual needs
- Physical disabilities can make access to services difficult, experiences of accessing serviced may also be worse
- Lack of trust and confidence in the healthcare system

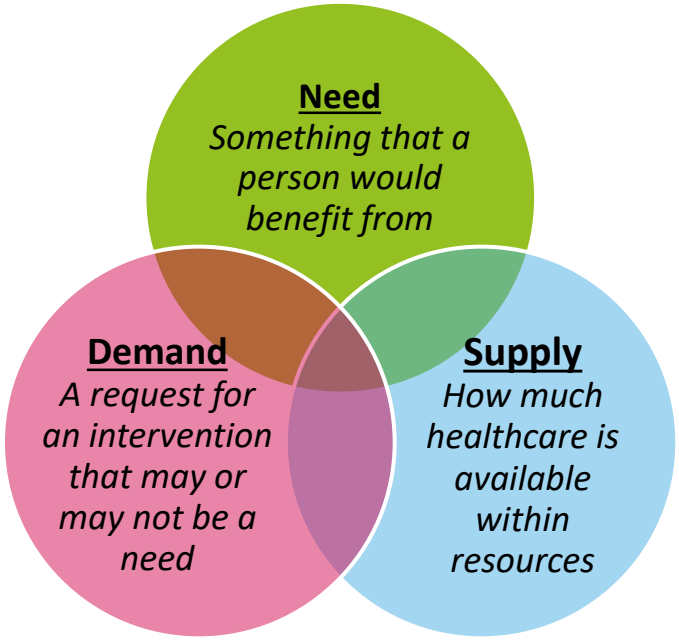


Applying equity in understanding how people access health care services in our system

Integrated Care System
Nottingham & Nottinghamshire

Through understanding our population and the barriers and enablers we can impact on both met and unmet need, in turn improving outcomes and helping to manage demand relevant to supply. Generally, the NHS relies on people 'demanding' health services. This might be making a routine dental check-up, or seeing your GP when you have symptoms or going to the Emergency Department after an accident.

We know that some people who really need healthcare don't come forward. There are lots of reasons for this but this unmet need can mean worse health outcomes for some individuals and communities.



We know that getting treated earlier can make a big difference in things like cancer and heart disease. It is also true that making small changes, such as a healthier diet or stopping smoking can make a huge difference. This means that prevention and earlier intervention is really important.

To reduce unmet need, we need to improve awareness, access, availability and acceptability of services. These all require us to understand our population and the barriers, as well as making structural changes to address the wider determinants.

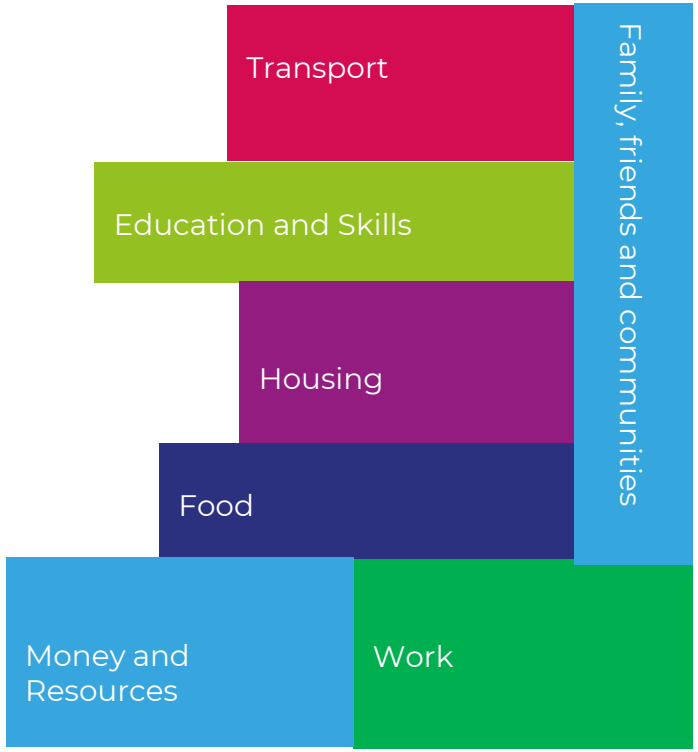
Building Blocks to Health Equity

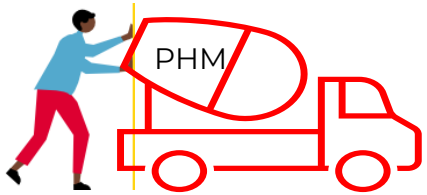
Integrated Care System
Nottingham & Nottinghamshire

In understanding how inequities present themselves and the barriers experienced by patients and citizens, it is easy to see that in order to make a difference a range of building blocks are required that together will have an impact. These sit alongside and are influenced by the wider determinants, the blocks that build a health society and how these are constructed differs across our different communities. How the building blocks are constructed depends on the gaps in our communities and scale and type of disparities being experienced.

Health and Care Services

Place, Neighbourhood & Anchor Institutions





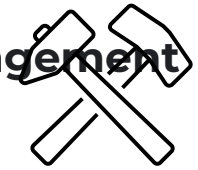
Population health management approaches, understanding our local population, is “cement” holding the building blocks together. We need to understand the needs of the population and how we can address this at every aspect of the approach.

Key Tools help build an equitable health and care system

Integrated Care System
Nottingham & Nottinghamshir

We have discussed the building blocks of health equity and PHM approaches as the cement. However there are also tools we can use which will help to enable us to build a more equitable healthcare system.

1. Local Insight, Engagement & Place



Knowing, engaging, enabling our local communities

Structure around Place & Neighbourhood

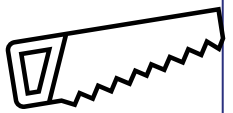
2. Data Quality and Analysis

Using population health management approaches

What are the disparities, inequities and how can we impact

Consistency in defining and measuring outcomes

3. Finance



Targeted use of resources

Allocations and investment

4. Partnership Working and Integration

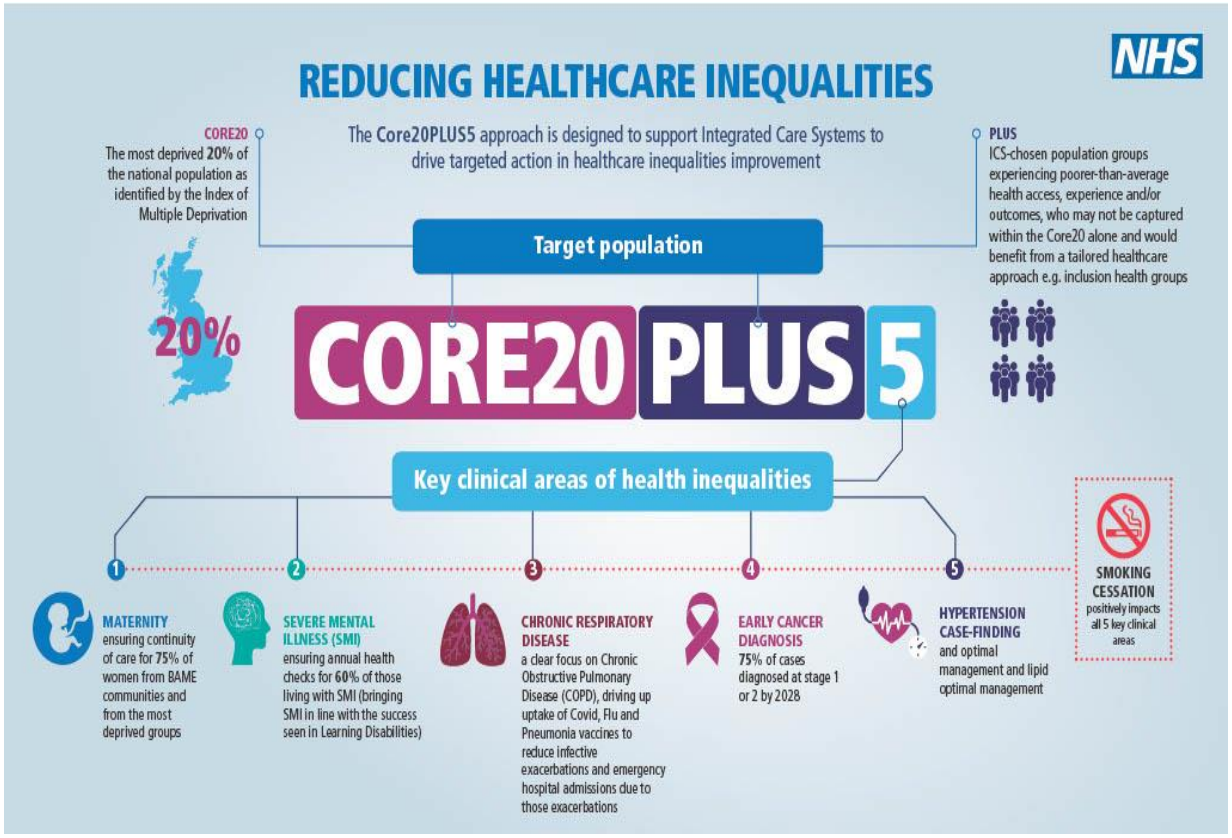
Wider Determinants

Local Authorities and wider partners including voluntary sector

Core20+5

Alongside equity, the ICS has adopted Core20+5 as an approach. More detail is included in subsequent sections and detail below confirms the approach.

Integrated Care System
Nottingham & Nottinghamshir



Core 20 – all analysis identifies the relevance and impact in relation to the 20% most deprived. As outlined in the population profile, this indicates a highly concentrated approach in Nottingham City with specific pockets across the county.

Plus – are inclusion health groups. These are identified through Place Based Partnership Plans, and linked to Health and Wellbeing Strategies. A system wide view may be taken for specific inclusion health groups but the approach will be relevant to local needs and Place.

Five – The ICS Health Inequalities Strategy has prioritised smoking and includes a partnership approach across the ICS and with Local Authorities. Priorities, including with a focus on the core20+ have been identified for each of the five clinical areas as outlined in subsequent sections of the plan.

ICS Leadership Commitments

In adopting equity as a core principle, the ICS Partnership Board also agreed leadership commitments. Leadership commitments support all partners within the ICS to apply equity as a core principle and to highlight how a consistent approach will be taken across the system.

Integrated Care System
Nottingham & Nottinghamshire

The starting point is always understanding and describing the local population and inequalities in our communities

- Using data and lived experience to create an intelligence-led approach to understanding inequalities
- Describing and understanding our populations for what they are as the starting point – geography, protected characteristics, inclusion health, socio-economic factors
- Connected communities and co-production

Taking an intelligence led approach and targeting solutions and resources based on evidence

- Using population health tools to design and deliver services based on different needs
- Building intelligence into service/programme planning and delivery – implementing intelligence systems that surface the 'gaps'
- Opportunities and constraints in equitable distributions of services
- Taking an approach that embraces opportunities and constraints in differential investment and differential access
- Being transparent will be central in relation to the management of and shifts in resources

Enabling our communities and recognising the role the ICS in addressing wider determinants

- Engendering a key focus and commitment to enabling and supporting our local communities
- Integrating addressing wider determinants into our service/programme planning and delivery
- Using our role as anchor institutions to impact on local communities, informed by the Local Authorities
- Alignment with the Health And Wellbeing Strategies and delivery of priorities through Place

Delivering accessible, quality healthcare services

- Informed changes in relation to addressing disparities across access, experience and outcomes and providing equity
- What should we expect and what is happening
- Ensure a strong core service to support all communities whilst recognising the differences and strengths
- Building and maintaining trust and connected communities through place and neighbourhoods is central

Changing the conversation

- In Boards, meetings, teams and with patients – focusing on building trust and breaking down barriers
- Recognising and valuing the characteristics of local communities across Nottingham & Nottinghamshire
- Jointly planning and commissioning services based on population need
- Providing a mandate to be responsible collectively
- Taking a learning approach – approaching as a journey where failure is a valuable experience for learning

Provider framework

The provider framework pulls the different elements together to identify where providers can have the biggest impact in relation to health inequalities that is aligned with the system approach and supports the Core20+5.

Integrated Care System
Nottingham & Nottinghamshire

A. Core 20 plus 5

- Identify what existing performance / routine data needs a 'CORE 20' analysis
- Plus – support for place based initiatives and targeted action in relation to the inclusion health groups. Recognising and working with place on different needs of plus groups
- The '5' – through a greater awareness of the five clinical areas, delivering care and treatment plans that align through neighbourhood, place, system, organisation

B. Measure equity in patient

- Access – analysing and taking action in relation to inequities in access
- Experience – capturing patient level data in relation to experience. Identifying performance data that aligns with experience
- Outcomes – acting on inequalities in outcomes

C. Address health inequalities where they can be influenced including a targeted approach. Opportunities include but are not limited to:

- Peri-operative care
- Prevention (smoking, alcohol, weight)
- Digital inclusion
- Staff health

D. Planned care

- Recovery patterns by deprivation and ethnicity
- Strategic approach based on inequities and targeted action across the pathway

E. LTP 'must-do's

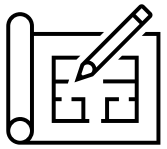
- specific commissioned activity

In Summary

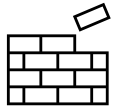
Integrated Care System
Nottingham & Nottinghamshire

In order to reduce health inequalities across Nottingham and Nottinghamshire and improve outcomes for the most in need, we must build an Equitable Health and Care System.

To build and equitable health system we need to:

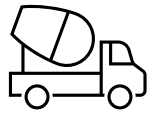


Set the foundations: Through strong partnership working; utilising the Joint Health and Wellbeing strategies and understand our local population, their needs, the barriers they face and the drivers of inequality.



Understand the building blocks: The factors which affect people using the health and care system and how inequalities present themselves. We need to look at this from a system wide perspective, combining the issues to create solutions which can be tackled by all partners.

"Cement" the building blocks together: using PHM approaches to understand the population health needs and how these differ between areas and conditions and what the inequalities are.



Use "tools" effectively: Use resources available to us across the ICS, such as data, finance and other partners to help target specific population groups and know what is available to tackle the inequalities

To maintain an equitable health and care system and make a difference to the lives of those in our ICS, we need:

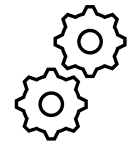
Leadership commitments from across the ICS

To work in place-based-partnerships to help combat health inequalities specific to our local areas.

Increase and maintain staffing capacity and ensure staffing is representative of the population we serve.

To follow national workstreams such as the Core20Plus5

To utilise our enablers to help projects run smoothly



To monitor the need/supply/demand of services across the ICS, to ensure resources are being targeted effectively and in the right way.

Integrated Care System
Nottingham & Nottinghamshire

C. Nottingham and Nottinghamshire Population Profile

- Population Profile
- Drivers of Inequality
- Core20+5

ICS Population Profile Overview

Nottingham and Nottinghamshire has many diverse communities, and the health inequalities plan aims to recognise the characteristics and strengths of the local communities along with understanding the disparities and systematic differences in health, mortality and quality of life.

Integrated Care System
Nottingham & Nottinghamshire

There are 4 geographical locations which make up Nottingham and Nottinghamshire ICS; Nottingham City, South Nottinghamshire, Mid-Nottinghamshire and Bassetlaw, with a total population of 1,170,475 (mid-year 2020).

Each district has a different population profile where inequalities vary, however the starkest difference is the gap between life expectancy and healthy life expectancy in the most and least deprived areas of the ICS. Nottingham City has some of the lowest life expectancy ages in England.

- Those in the least advantaged areas spend an additional 14 years living in ill-health, compared to those living in most advantaged areas. Life Expectancy is 8.4 years lower for men and 8.6 years lower for women in the most deprived areas of Nottingham and 7.5 years in Nottinghamshire.
- Infant mortality is also an indicator of the general health of an entire population and reflects the social, economic and environmental conditions in which children live, including their health care. Nottingham is among the ten worst areas in England for child poverty and child mortality rate. Alongside this, most indicators for infancy and early years in Nottingham are worst that the values for England and Nottinghamshire Count. This demonstrates some of the challenges in the City compared to the rest of the ICS.

Life Expectancy across the ICS

Females

81 in Nottingham City compared to the England average of 83.1.

83 in Nottinghamshire County.

Healthy life expectancy is 55.6 in the City (2nd lowest in England) and 61.6 in the County.

Males

76.6 in Nottingham City, compared to the England average of 79.4.

80 in Nottinghamshire County.

Healthy life expectancy in Nottingham City is 56.4 (3rd lowest in England) and 63.4 in Nottinghamshire County.

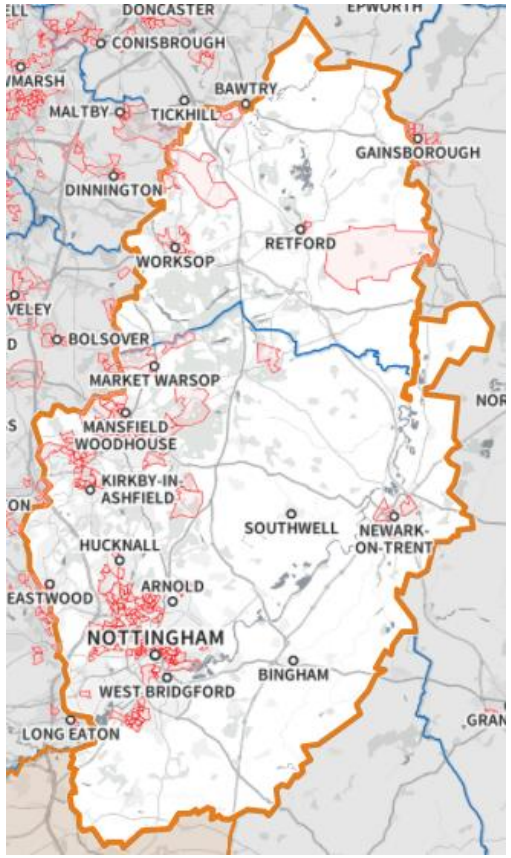
Deprivation across the ICS

Integrated Care System
Nottingham & Nottinghamshire

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD combines 7 domains of deprivation to give an overall deprivation score. The scores are compared across 32,844 Lower Super Output Areas (LSOA) in England. Scores are given on a scale of 1 – 10, with 1 being the most deprived and 10 the least.

.

20% Most Deprived Areas



Areas outlined in red are in the 20% most deprived nationally. The majority are concentrated in the City, followed by Mid-Notts, however every district has pockets of deprivation.

The Index of Multiple Deprivation (IMD) is the official measure of deprivation in England. The IMD combines 7 domains of deprivation to give an overall deprivation score. The scores are compared across 32,844 Lower Super Output Areas (LSOA) in England. Scores are given on a scale of 1 – 10, with 1 being the most deprived and 10 the least.

The 7 domains used to measure deprivation are listed below.

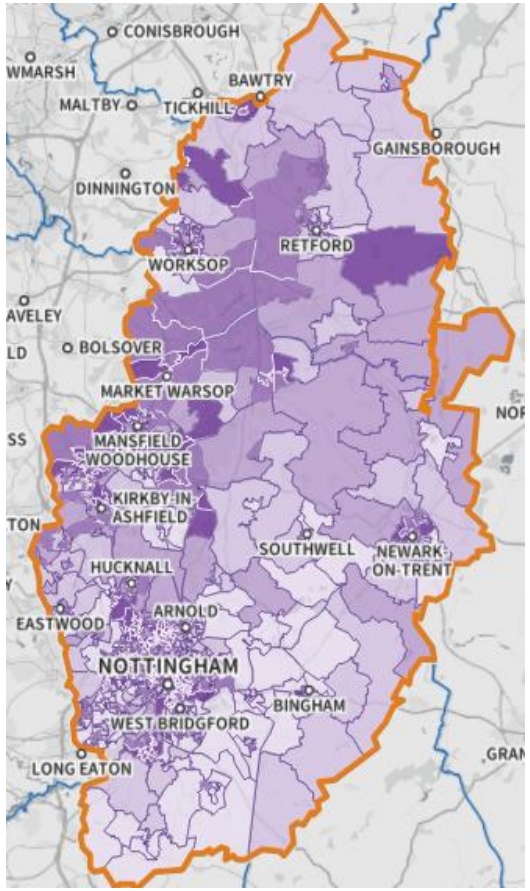
- Income
- Health
- Employment
- Education
- Crime
- Barriers to Housing and services
- Living environment

Deprivation scores are linked to health and wellbeing outcomes. Those living in the most deprived areas are more likely to have a lower life expectancy, have higher mortality rates from diseases and have poorer health outcomes in general. There are also higher rates of lifestyle factors which link to adverse health outcomes such as smoking and obesity. Deprivation scores allow the ICS to see which areas may require more support and resources to improve the population outcomes, which forms part of an equity approach.

Within Nottingham 56 of the 182 LSOAs fall amongst the 10% most deprived in the country. 104 fall in the 20% most deprived, which is an increase from the 2015 indices. Therefore 57% of Nottingham falls within the 20% most deprived.

In Nottinghamshire there are 31 LSOAs in the 10% most deprived concentrated in the districts of Ashfield, Mansfield, Bassetlaw and Newark and Sherwood. There are 79 LSOAs in the 20% most deprived.

Index of Multiple Deprivation (IMD)



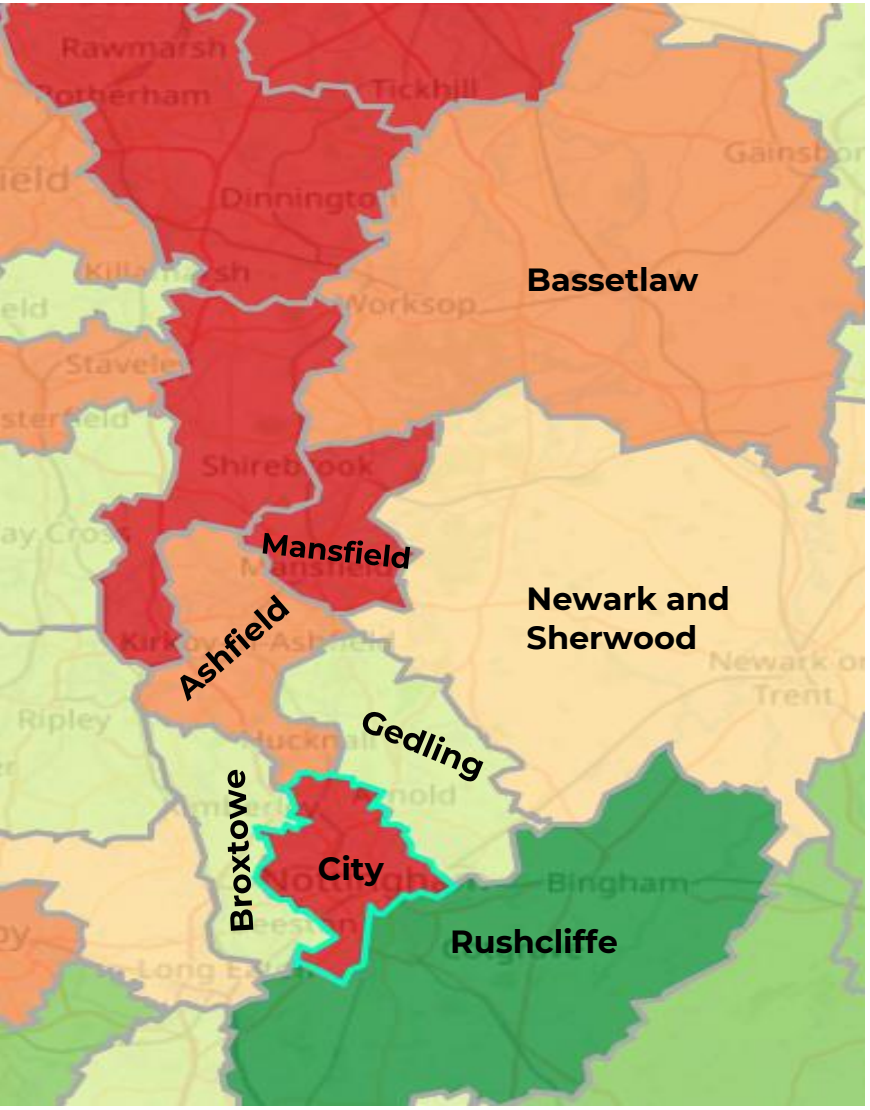
The higher the deprivation, the deeper the purple.

Health Literacy Across the ICS

Health Literacy is a person's ability to understand and use information to make decisions about their health. Those with low health literacy may struggle to read and understand health related information and therefore may not know how to take action or access appropriate services. Health literacy is more likely to affect those from disadvantaged socioeconomic groups and migrant populations and those from BAME backgrounds.

.

Integrated Care System
Nottingham & Nottinghamshire



The map on the left shows the levels of health literacy across the ICS. The red areas reflect the lowest levels of health literacy. Lower levels of health literacy corelate with higher levels of deprivation:

- In Nottingham, 53.5% of the population are below the threshold for health literacy. In Mansfield this is 48.81%.

- The most affected areas are Nottingham City and Mansfield, followed by Bassetlaw and Ashfield.

HEALTH LITERACY - Home (geodata.uk)

Impact on patients with low health literacy:

- May not be able to make informed choices about their care.
- May struggle to access the right services at the right time, resulting in more A&E attendances and longer inpatient stays.
- Medication instructions may be harder to understand and so may be mis-taken
- It may be harder to self manage conditions
- Patients with low health literacy are more likely to have depression and have higher mortality.
- Patients with low health literacy are more likely to have lifestyle factors which negatively impact health

The Ethnicity Profile of the ICS Population:

Integrated Care System
Nottingham & Nottinghamshire

The ethnicity of the population is a key factor to consider when planning services and tackling health inequalities. Different ethnicities may be more at risk of developing certain health conditions and may face different challenges and experiences when accessing health and social care services. Through the Place Based Partnerships there is an in depth knowledge of the strengths within these and an understanding of how best to focus resources and support, with more information provided in the PBP section of the plan. The ICS holds an overall view of the population recognising the different needs across population characteristics as determinants of health.

Ethnicity	% of the ICS Population	Key Notes
White/White British	85%	Mortality from Cancer, dementia and Alzheimer's is higher in white groups.
Asian/British South Asian	3.6%	Those of South Asian heritage are more likely to develop high blood pressure, cardiovascular disease and diabetes.
Asian/British Chinese	0.8%	Chinese people have a relatively low uptake of health and social care services across the UK.
Black British/African/Caribbean/ Other	2.5%	Women from black backgrounds are 4x more likely to die in childbirth than white women. Rates hypertension and diabetes are also higher in black people and mortality rate from strokes and are more likely to have strokes at a younger age. The risk of developing certain cancers (e.g. prostate) can also be higher. Adult and Childhood obesity rates tend to be higher in black ethnicities.
Mixed/Multiple Ethnic Groups (Asian/Black/British/Other)	2.8%	Those with a mixed ethnicity may still carry the risk factors in developing conditions from their heritage groups. Those from mixed groups have the lowest life expectancy than other ethnicities in the UK. Smoking rates in mixed groups also tends to be higher.
White Gypsy or Irish Traveller	0.1%	Newark and Sherwood as a higher traveller population than the rest of the county with around 400 pitches in the district alone. The number of pitches across the ICS is set to increase by 193. Travellers are a marginalised group with some of the worst health outcomes, life expectancy 10-15 years lower than the rest of the population. Mental health problems and risk of suicide is higher in this population. Housing, education, working conditions and poverty are also pressures for this population.
Other	4.6%	This other group may represent people from a variety of lesser known ethnicities who may find it harder to be catered for if they are not represented in the system. As an ICS we must ensure inclusion in our pathways to support people from all backgrounds.

Ethnicity proportion can also vary between age groups and should be considered when planning services targeted at certain age groups..

As a whole BAME populations have poorer access and health outcomes overall than the white population although there are some differences between each different group.

It should also be noted that ethnicity alone doesn't capture the full picture of the ICS profile and languages spoken should also be considered. There is a high Eastern European population across the ICS with Polish one of the most common languages spoken. Those who's first language is not English can struggle to access and navigate the system. Although translation services are available, It can still be difficult for them communicate their needs to professionals.

Ethnicity by Place:

Integrated Care System
Nottingham & Nottinghamshire

The ethnicity profile varies significantly between each place based in the ICS. Understanding the ethnicity profile of each area will help us to understand the needs of each area and how we need to be mindful of this when planning services. It is also important for the system workforce to be representative of the population we serve.

Ethnicity	% of the ICS Population	% of City Population	% of South Notts Population	% of Mid-Notts Population	% of Bassetlaw Population
White/White British	85%	65.4%	90%	94.5%	94.5%
Asian/British South Asian	3.6%	9.1%	2.5%	0.6%	0.7%
Asian/British Chinese	0.8%	2%	0.6%	0.6%	0.2%
Black British/African/Caribbean/ Other	2.5%	7.3%	0.96%	0.5%	0.5%
Mixed/Multiple Ethnic Groups (Asian/Black/British/Other)	2.8%	6.63%	1.91%	1%	0.88%
White Gypsy or Irish Traveller	0.1%	0.1%	0.06%	0.1%	0.1%
Other	4.6%	9.55%	3.89%	3.23%	3.2%

Population Profiles – Nottingham City

Nottingham and Nottinghamshire varies significantly between each place. The prevalence of health conditions, health outcomes and inequalities vary from district to district.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Population Overview

- An urban, densely populated area
- The 11th most deprived district in England and the most deprived in the East Midlands Region.
- 57% of the City neighbourhoods fall into the 20% most deprived groups nationally
- Approx. 34% of the population are from BAME backgrounds (Higher than England average). Asian/Asian British is the
- A younger population demographic, 30% aged 18-30.
- A more transient population
- More than 1 in 4 Children live in low income families
- GCSE Attainment and people in employment are both lower than the England averages

Mortality Outcomes in Relation to the England Average

Indicator	Comparison to the Eng. Average
Life expectancy at birth	Worse for both males & females
Under 75 mortality rate from all causes	Worse
Mortality rate from cardiovascular diseases	Worse
Mortality rate from cancer	Worse
Suicide Rate	Similar

Child Health in Relation to the England Average

Indicator	Comparison to the Eng. Average
Teenage conception rate	Worse
Smoking status during pregnancy	Worse
Infant mortality rate	Worse
Breast feeding initiation	Worse
Y6 Obesity prevalence	Worse

Lifestyle factors:

Approx. 64% of the adult population is classified as overweight or obese.

Smoking rates are worse than the England averages and below current reduction targets. Smoking remains the leading risk factor for ill health and death in the City.

Hospital admissions for alcohol related conditions are also worse than the England average.

What are the health inequalities in the City population?

Integrated Care System
Nottingham & Nottinghamshire

High levels of deprivation are associated with poorer health outcomes and lower life expectancy.

Lower GCSE attainment can affect employment prospects in later life which can affect income. Income , employment and education are 3 factors which are used to measure deprivation. Lower income households may live in lower quality housing which can affect physical and mental health. Income can also affect ability to travel to health appointments. Working conditions can also affect ability to access services and appointments due to shift patterns or losing pay to take time off , this has higher impact on lower income households. Lower income households may also have limited access to technology, data and phone credit which would allow them to access digital services.

Nottingham and Nottinghamshire has the lowest rates in the East Midlands region for baby's first feed being breastmilk. Breastfeeding can help reduce baby hospital admissions and illnesses as well as helping to prevent against illnesses in later life for mothers and babies.

People from BAME backgrounds are more likely to experience poorer health outcomes and poorer experiences of using health services.

Although the population demographic is younger, in the city there are still high rates of people living with ill health or disability.

The leading causes of ill health and death in the City are linked to lifestyle factors such as smoking and obesity.

Smoking during pregnancy is more likely to lead to lower birth weight babies and still birth. Lower birth weight can affect babies development and be a risk factor for infant mortality and poorer health in later life.

Children living in lower income households are more likely to:
- Have poorer education attainment
- Develop chronic health conditions
- Have poor nutrition
- Experience mental health issues
- Have poorer cognitive development

Population Profiles – Nottinghamshire County

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire is made up of 7 districts. Overall, the statistics in the county show better outcomes for the population than those in the City, however there are wide variations between the North and South of the County were the health status and life expectancy differ significantly.

Nottinghamshire Population Overview

- There are more rural areas across Nottinghamshire
- Has an older demographic than the national average and the City, the average age is 43.8.
- Nottinghamshire is the 9th most deprived shire county in England (out of 26). However, the Rushcliffe district is in the 3% least deprived districts in the Country. Mansfield however is in the top 20% most deprived districts in England.
- 1 in 10 adults live with a moderate or severe disability
- 4% of the population are from a BAME background, this is lower than the England average.
- Unemployment rates are lower than the national averages

Mortality Outcomes in Relation to the England Average

Indicator	Comparison to the Eng. Average						
	Rushcliffe	Broxtowe	Gedling	Mansfield	Ashfield	Bassetlaw	Newark & Sherwood
Life expectancy at birth	Better for both males & females	Better for both males & females	Better for both males & females	Worse for both males and females	Worse for both males and females	Males: Similar Females: Worse	Similar for both males and females
Under 75 mortality rate from all causes	Better	Similar	Similar	Worse	Worse	Worse	Better
Mortality rate from cardiovascular diseases	Better	Similar	Better	Similar	Worse	Similar	Better
Mortality rate from cancer	Better	Similar	Similar	Worse	Worse	Similar	Similar
Suicide Rate	Similar	Similar	Better	Better	Similar	Worse	Similar

Child Health in Relation to the England Average

Indicator	Comparison to the Eng. Average						
	Rushcliffe	Broxtowe	Gedling	Mansfield	Ashfield	Bassetlaw	Newark & Sherwood
Teenage conception rate	Better	Similar	Similar	Worse	Similar	Similar	Similar
Smoking status during pregnancy	Worse	Worse	Worse	Worse	Worse	Worse	Worse
Infant mortality rate	Similar	Similar	Similar	Similar	Similar	Similar	Similar
Breast feeding initiation	Better	Better	N/A	Worse	Worse	Worse	Worse
Y6 Obesity prevalence	Better	Better	Similar	Similar	Similar	Worse	Similar

What are the health inequalities in the County population?

Integrated Care System
Nottingham & Nottinghamshire

Inequalities in the Mid and the North of the County

- Deprivation is higher. Life expectancy is lower and people also live in poorer health for longer here.
- Poorer access to public transport especially in more rural areas. This can affect access to services.
- There are higher levels of unemployment and lower qualifications, which can affect a persons life trajectory, living conditions, housing and overall health and wellbeing.
- Levels of self-reported poor/very poor health and limiting long-term illness were highest here.
- Rates of teenage pregnancy is higher. Babies born to teenage mothers are more likely to live in lower income families. be at risk of poorer lifestyle factors and be low birth weight.
- People are more likely to have lifestyle factors which negatively impact on their health e.g. smoking, obesity, alcohol misuse
- A higher proportion of Gypsy, Roma and Traveller populations live here. These are a marginalised group who often have poorer health outcomes.

Inequalities in the South of the County (excluding City)

- Higher concentration of people from BAME backgrounds, mainly Asian and Mixed Ethnic backgrounds.
- Although South Notts is less deprived than Bassetlaw and Mid-Notts, there are still some areas in the 20% most deprived such as Eastwood in Broxtowe and Arnold in Gedling
- A higher proportion of people are non-UK born resident live here than the rest of the county. This can impact access to services, knowing how to navigate the health and social care system and getting the right support at the right time.

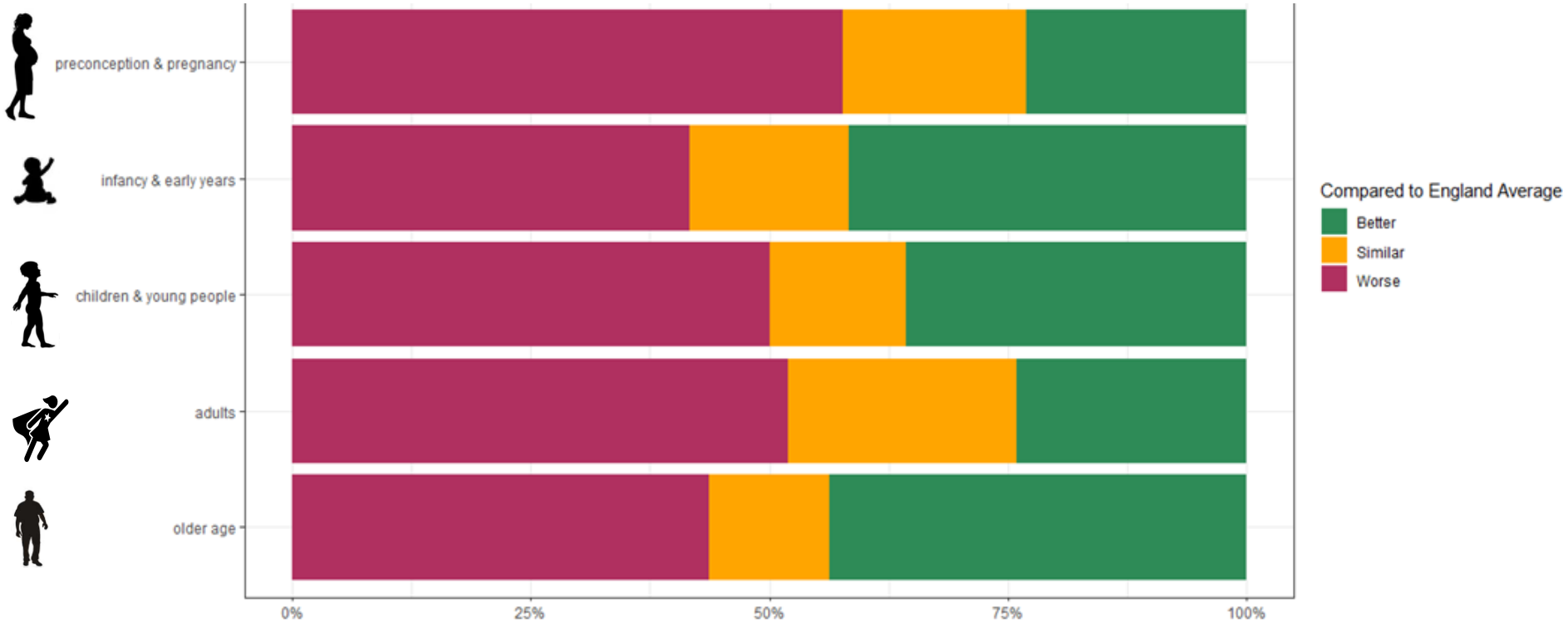
Inequalities facing the whole County

- Aging population. Means more people living alone, more carers and more people likely to be living with disability.
- There are high disability rates in Nottinghamshire, although levels are associated with higher deprivation. Disabilities can affect a persons quality of life and available opportunities.
- Smoking rates in pregnancy are higher than the England Average across the county. Smoking in pregnancy is linked to higher infant mortality, babies development in the womb and low birth weight.

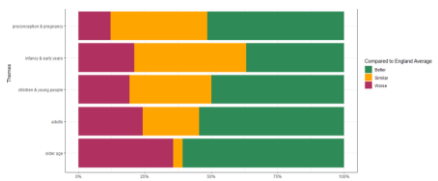
How inequalities across the ICS affect the life course of the population

Integrated Care System
Nottingham & Nottinghamshire

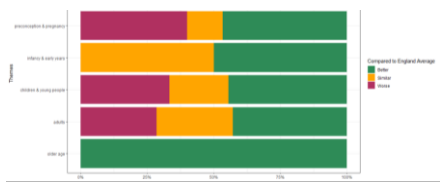
It's important that an understanding of health inequalities reflects the full life course. Too often we focus on adults without understanding the impact and relevance of the early years. Growing up in poverty can have a negative impact on a child's health and wellbeing as well as adversely impacting their health and quality of life in adulthood. The higher the proportion of red reflects worst population health.



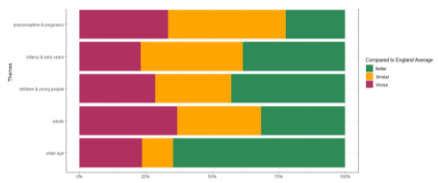
Leicester, Leics & Rutland



Lincolnshire



Derbyshire



A recent report from NHS Midlands public health team and UKSA presented composite indicators to characterise health and healthcare use at each stage of the lifecourse, based on the priorities in the NHS Long Term Plan. This includes characteristics of the population which drive the need for healthcare, factors which are a product of differences in access to healthcare and factors which are amenable to healthcare.

The chart to the right shows that about half of all indicators used at each stage of the life course for Nottingham and Nottinghamshire are worse than the England average. There is also a stark difference with neighbouring ICSs in the Midlands.

Drivers of inequality across infants

Infant mortality is an indicator of the general health of an entire population. It reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care.

Integrated Care System
Nottingham & Nottinghamshire

Infant mortality is an indicator of the general health of an entire population. It reflects the social, economic and environmental conditions in which children (and others in society) live, including their health care. Nottingham City has infant mortality rates higher the England averages, reflecting the higher needs in the City.

The first 1001 days from conception to age two are extremely important for setting the foundations for lifelong health and wellbeing. This is a period of rapid development both physically and cognitively.
Evidence shows that healthy development in the early years is supported by a stable environment and nurturing relationships with parents or caregivers.

Investment in the first 1,001 days can prevent problems developing later in life, such as mental health disorders, youth violence, substance misuse, obesity and poor educational attainment.

Factors which can support a more positive first 1001 days of life such as healthy birth weight and breastfeeding initiation are lower in more deprived areas.

Regular and prolonged levels of stress can impact on pregnancy and impact the interactions between parents and the baby which can affect development.
Those living in poverty are more likely to have higher stress levels which can adversely impact on these outcomes, creating inequalities throughout life.

Indicator	Nottingham	Nottinghamshire
Infant mortality (2018-2020)		
Low birth weight of term babies (2020)		
Hospital admissions for dental caries 0-5 (2020)	6th worst in the region (out of 9)	2nd worst in region (out of 9)
A&E Attendances aged under 5 (2017-2020)		
Emergency admissions for injuries in under 5 years old (2015-2020)		
MMR for one dose (2yrs old %) 2019/20		

Drivers of inequality across children and young people

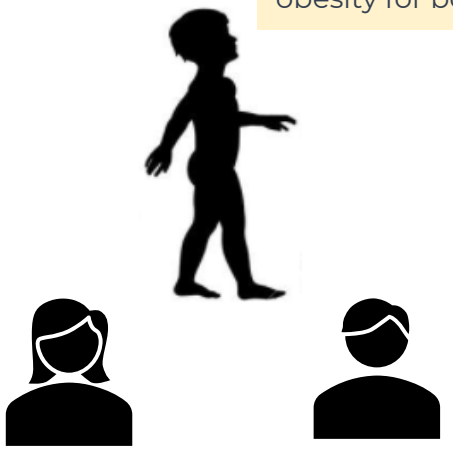
Integrated Care System
Nottingham & Nottinghamshire

Having the best start in life isn't just limited to the first 1001 days, health in later childhood and teenage years can also affect health in later life. The experiences we have early in our lives and particularly in our early childhoods have a huge impact on how we grow and develop, our physical and mental health, and our thoughts, feelings and behaviours

Children living in more deprived areas are more likely to experience poorer outcomes by the time they start school than those in less deprived areas. Most indicators for childhood and adolescence in Nottingham are worse than the values for England and Nottinghamshire County, reflecting the poorer socio-economic status of the City compared to the rest of the ICS.

Growing up in poverty can have a negative affect on children's health and well-being as well as adversely impacting their health and life in adulthood. Nottingham is among the ten worst areas in England for child poverty with around a third of children and young people in Nottingham are living in workless households

Adverse childhood experiences (ACE) can increase the risk of physical and mental health conditions in later life; 1 in 3 diagnosed mental health conditions in adulthood directly relate to ACEs. The longer an individual experiences or has more exposure to these experiences, the bigger the impact this will have on development.



Across England the incidences of childhood obesity and severe obesity is increasing. The prevalence in Nottingham and the more deprived areas of Nottinghamshire are significantly worse than the England averages. Obese children are more likely to become obese adults which significantly increases the risk of long-term conditions and reduced life expectancy.
There is a correlation between deprivation and severe obesity but in the City there is also a significantly higher ratio of severe obesity for those from Mixed, Black and Asian ethnicity compared to the national ethnicity ratio. There is also a significant growing gap in rates of severe obesity for boys compared to girls.

School readiness is an important marker on the life course trajectory. School readiness can be considered as a social determinant of health in that better development at this early age improves a child's ability to make the most of his or her learning opportunities, achieving higher grades and better employment prospects. This creates a cycle for those who grow up experiencing poverty being able to improve their outcomes in later life.

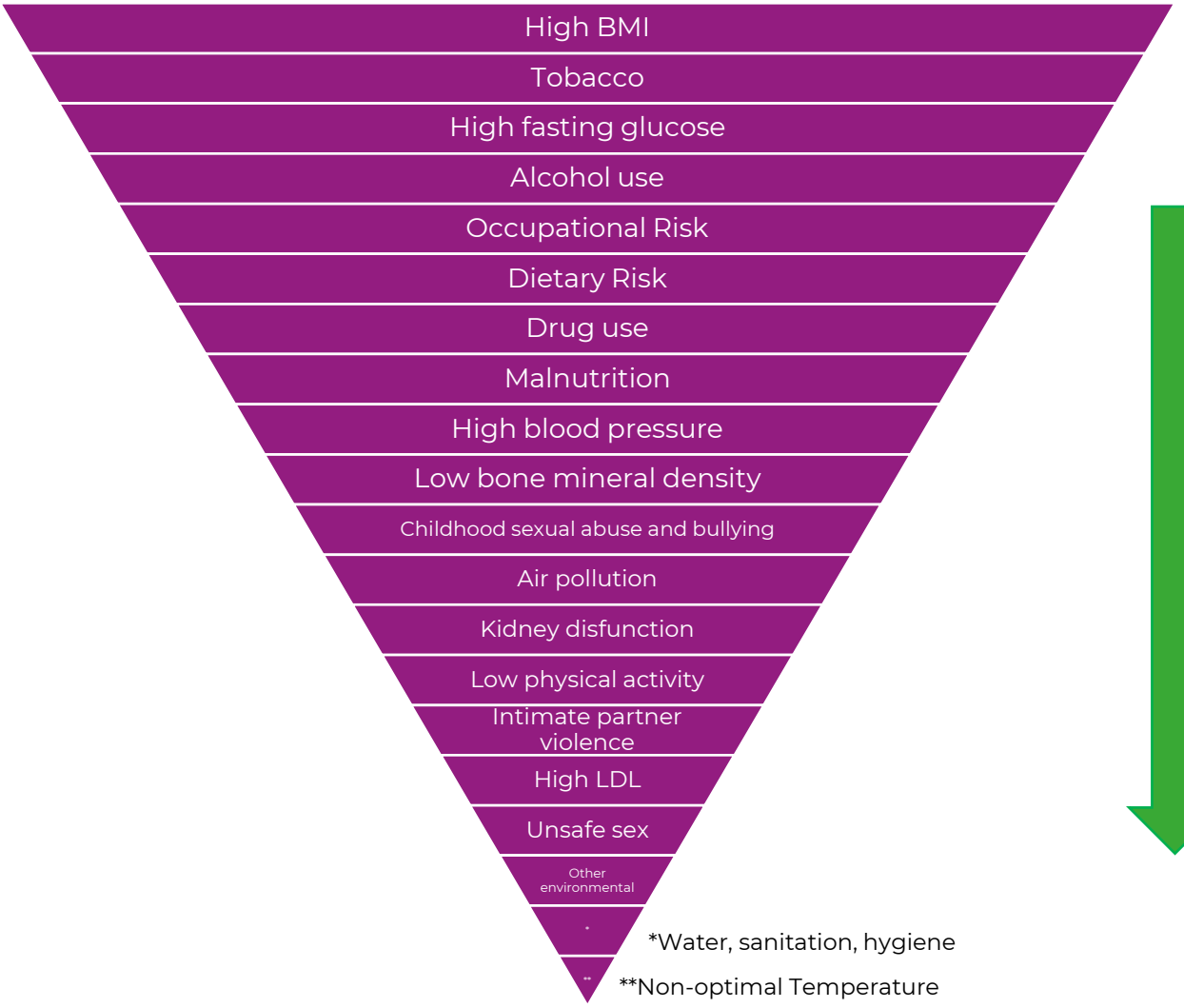
Indicator	Nottingham	Nottinghamshire
Children in absolute low income families (under 16) 2020/21		
Child mortality rate (1-17yrs)		
School readiness: % of children receiving a good grade at end of reception		
Hospital admissions for Mental Health conditions under 18s (19/20)		
Y6 Obesity prevalence		
Children in care		
Smoking prevalence at age 15 – Current smokers (2014/15)		
Admission episodes for alcohol specific conditions under 18		

Leading risk factors for ill health

The Global Burden of disease shows us that the leading risk factors for ill health in Nottingham and Nottinghamshire are smoking, high BMI and harmful alcohol use. These are all modifiable factors, are socioeconomically patterned and contribute significantly to widening health inequalities.
If we can reduce smoking and obesity rates across the ICS, it would have a positive impact on the health of the population.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City



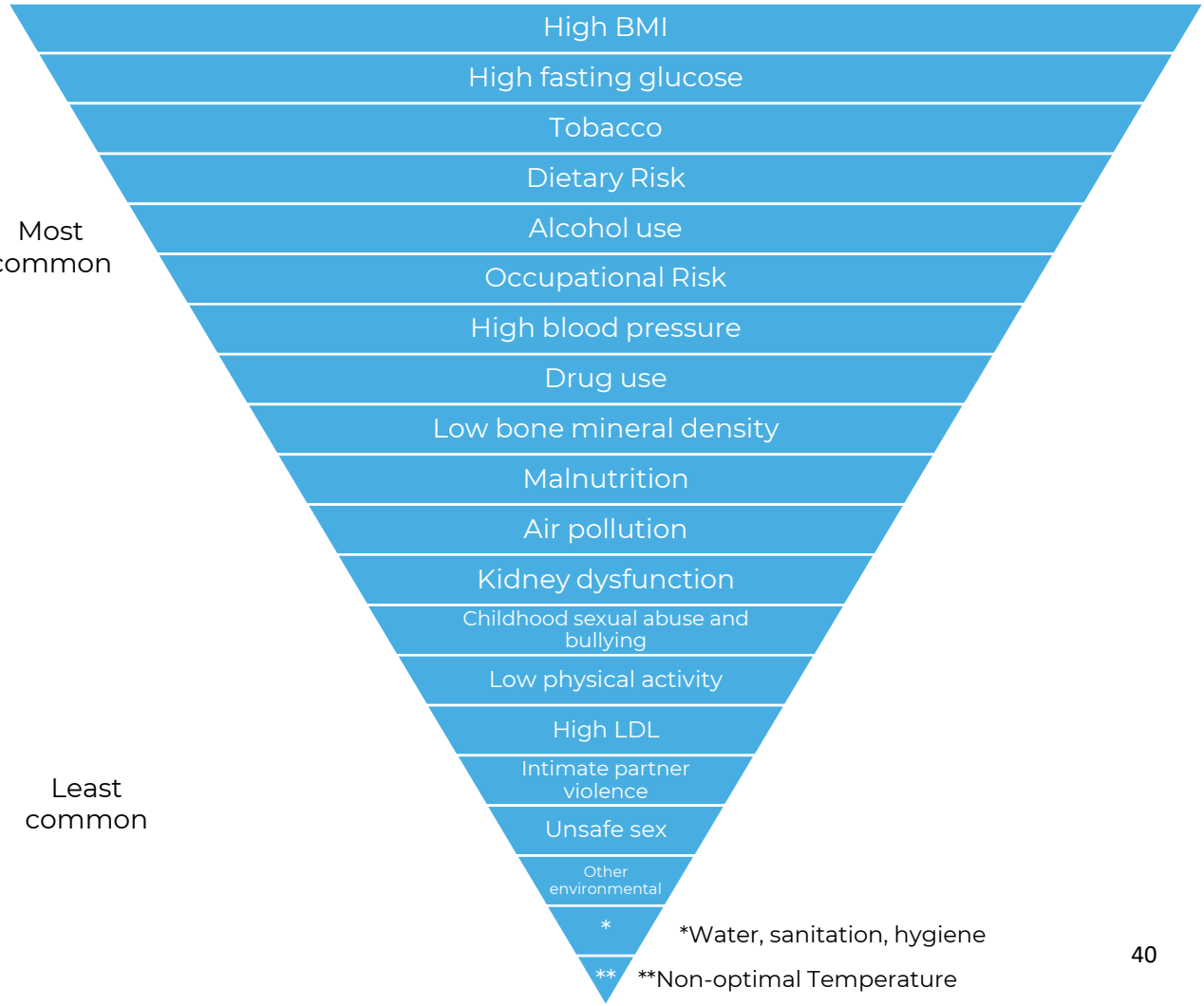
*Water, sanitation, hygiene

**Non-optimal Temperature

Most common

Least common

Nottinghamshire



*Water, sanitation, hygiene

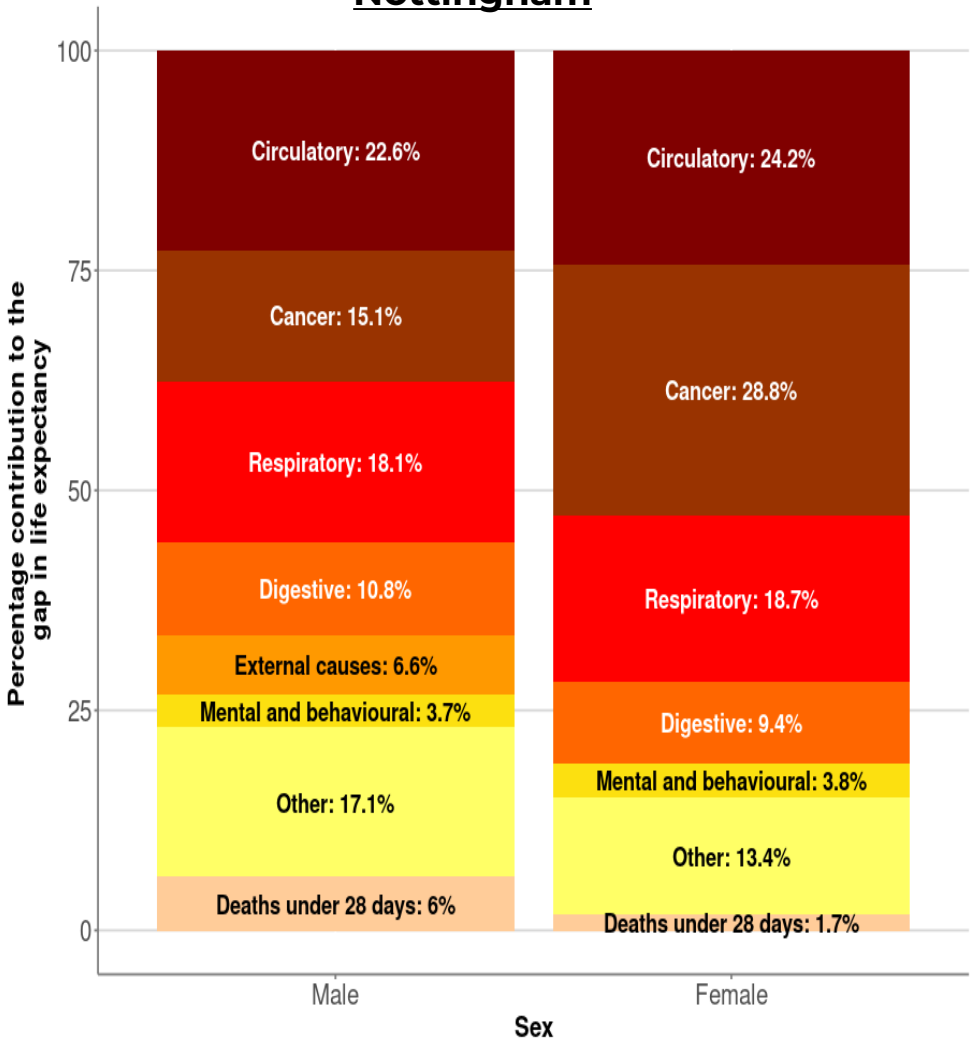
**Non-optimal Temperature

Drivers of inequality in life expectancy across the ICS

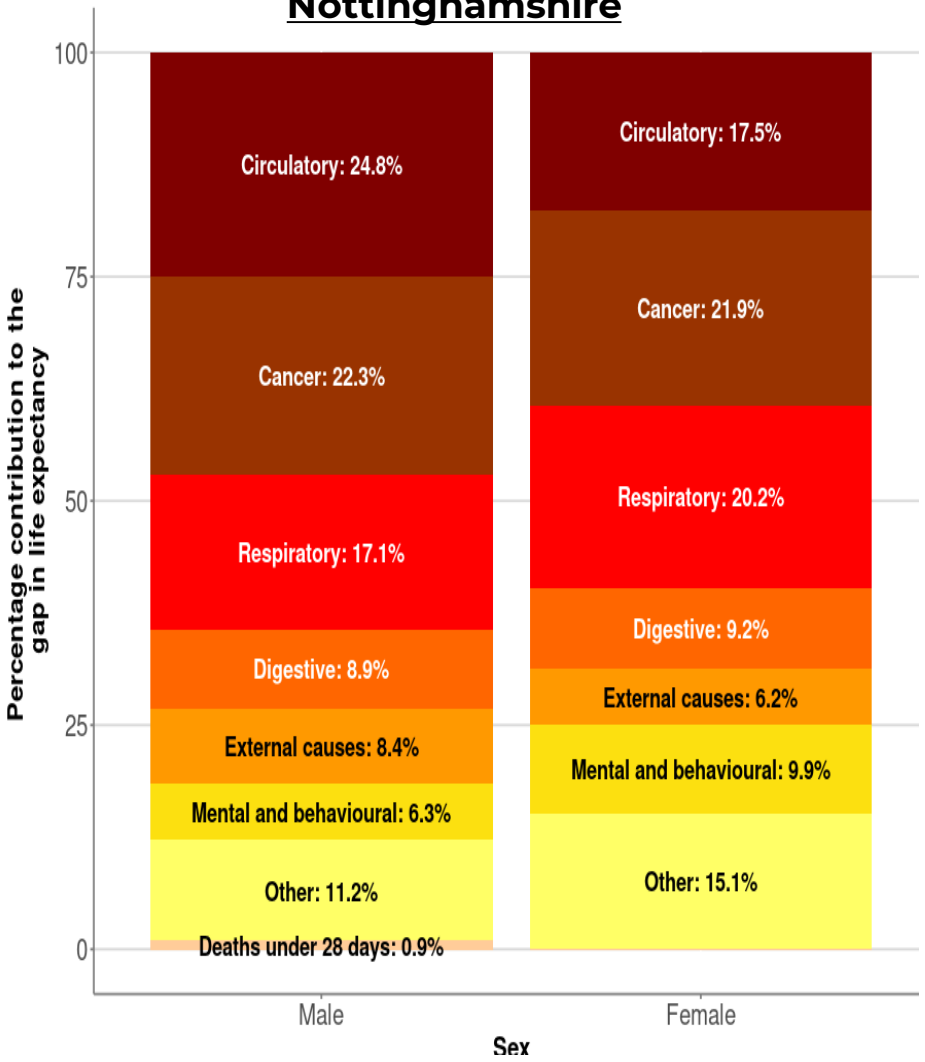
Integrated Care System
Nottingham & Nottinghamshire

The charts below give an indication of the drivers of inequality in life expectancy and the differences across males and females (PHE segment tool). The % indicates the level of contribution to the gap in life expectancy between the least and most deprived emphasising the importance of focusing on cancer, diabetes, CVD and respiratory programmes in relation to prevention (primary and secondary) and treatment, through a targeted approach. There are similar themes in the drivers across England.

Nottingham



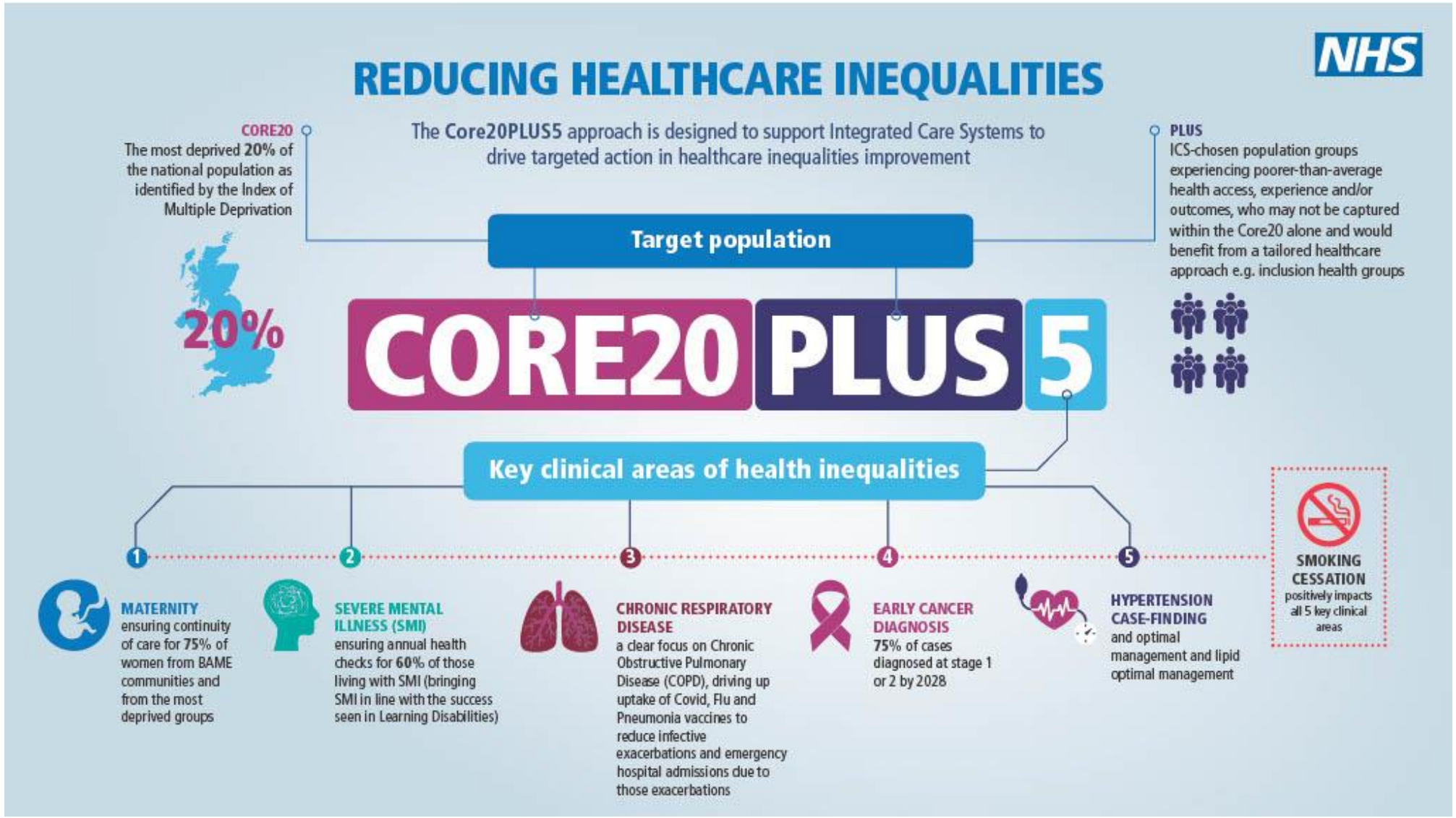
Nottinghamshire



The CORE20 Plus 5

Nationally, there are conditions which are driving health inequalities. Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Integrated Care System
Nottingham & Nottinghamshire



The Plus 5 – ICS current position

Integrated Care System
Nottingham & Nottinghamshire

ICS Smoking Rates: City: 13.4% (2020) County: 11.4% (2020)

	Maternity Ensuring continuity of carer for 75% of women from BAME communities and the most deprived groups	Severe Mental Illness (SMI) Ensuring annual health checks for 60% of those living with SMI	Respiratory A clear focus on COPD driving uptake of flu, COVID and pneumonia vaccs	Cancer 75% of cases diagnosed at stage 1 or 2 by 2028	Hypertension Case finding and optimal management and optimal lipid management
Key Stats	• Maternal mortality is more than 4x higher in black women, 2x higher for mixed ethnicity women and 2x as high for Asian women. Stillbirths and infant mortality are highest amongst Pakistani and Black ethnicities. NUH has a high percentage of BAME mothers. • A higher proportion than the national average of mothers are from the most deprived areas • 15.6% mother present as smokers at time of booking across the ICS, 12.8% self report as smokers at time of delivery - worse than the England average across every district in the ICS.	• People with a SMI on avg have 15 to 20 years shorter life expectancy • Premature mortality in adults with SMI is much higher in Nottingham than the England Average. • Smoking prevalence is 24.5% in Nottingham and 20.7% in Notts. • The ICS is targeted to undertake 6,237 SMI health checks for 2022/23. 12 month performance currently sits at 41% of this target. Although performance has increased since 2021/22, it has plateaued in Q1 2022/23, this is now similar to the regional average but slightly below national average.	• 2% of the total ICS population have a diagnosis of COPD. The highest rates are in Bassetlaw and Mid-Notts . • Nottingham City has the lowest prevalence of COPD but has higher COPD emergency hospital admissions than the rest of the ICS and is higher than the regional and national averages. • Uptake of the flu and covid vaccines is lower in the most deprived areas but also amongst BAME communities, regardless of deprivation quintile. • 33% of COPD patients across the ICS are smokers, 41% of COPD patients in Nottingham City are smokers.	• 20/21 saw an improvement with approx 30% of cancers diagnosed at an early stage. • In Nottinghamshire as whole, under 75s mortality rate from cancer is similar to the England average, however in Mansfield and Ashfield it is significantly worse. • Under 75 mortality rates from cancer in Nottingham City is also significantly worse than the England average and the worst in the East Midlands Region.	• Approximately 14.4% of the N&N population have a hypertension diagnosis. • 64.2% of expected cases have been diagnosed. Target is 80% by 2029. • 71.5% of hypertension cases are treated optimally. Target is 80% by 2029. • Hypertension is more prevalent in areas of higher deprivation in the ICS. Those from Black backgrounds are twice as likely to be diagnosed with hypertension than those from White backgrounds.

Integrated Care System
Nottingham & Nottinghamshire

D. How place based partnerships and PCNs plan to tackle health inequalities

Nottingham City Place Based Partnership

Integrated Care System
Nottingham & Nottinghamshire

The Nottingham City Place-Based Partnership (PBP) is made up of a range of different partners who can influence the health and wellbeing of people within the city.
This includes social care, urgent and emergency care, mental health, voluntary services, primary and community care. The partners have worked together to identify a programme of priorities to improve the health and wellbeing outcome of the citizens of Nottingham.

Nottingham City Place Based Partners

Nottingham City General Practice Alliance

NHS Nottingham and Nottinghamshire Integrated Care Board

Nottingham City Council

8 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Nottingham City Homes

CityCare Building Healthier Communities

Nottingham Community and Voluntary Service

Framework For your future

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

healthwatch Nottingham

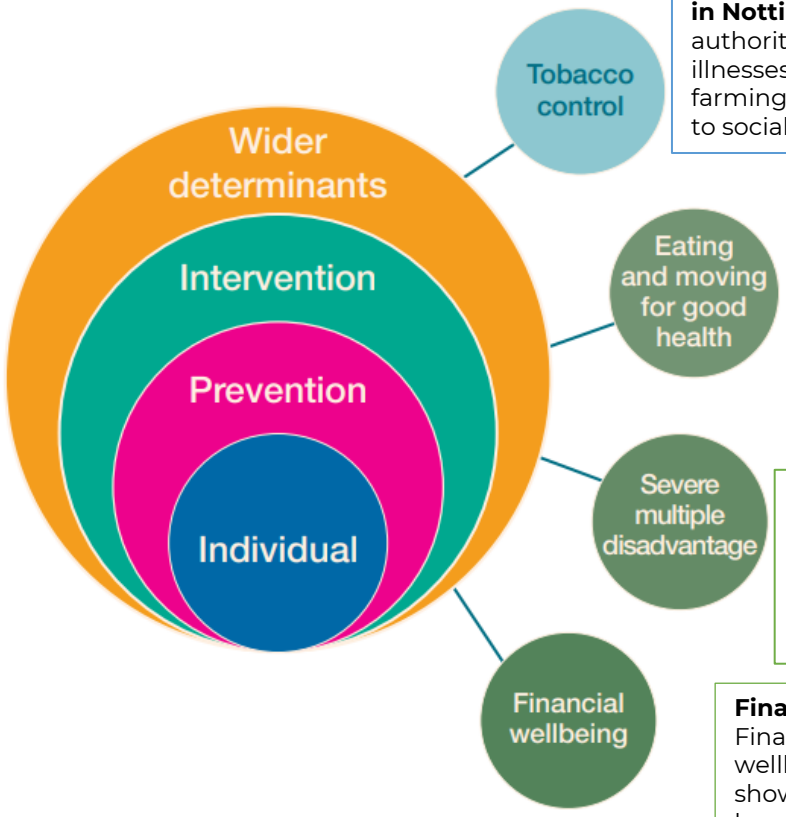
Nottingham City Place Based Partnership Priorities

The Nottingham City Integrated Care Partnership (place-based partnership) shares the same geography as Nottingham City Council and the Health and Wellbeing Board for Nottingham City. The Joint Health and Wellbeing Strategy 2022-2025 was published in Spring 2022 and it was agreed the place-based partnership have responsibility for the oversight in the delivery of the strategy.

Integrated Care System
Nottingham & Nottinghamshire

Joint Health and Wellbeing Strategy for Nottingham (2022-2025) Overview

The overarching ambition of this Strategy is to increase both the life expectancy and healthy life expectancy of Nottingham's residents, as well as reducing the inequality gap for these outcomes. The health and wellbeing strategy will focus on four areas:



Smoking and Tobacco Control
Smoking is the single largest cause of preventable death and disease in Nottingham. It is one of the largest drivers of health inequality. **1 in 5 adults in Nottingham are current smokers** – this is significantly higher than the England average and is the 4th highest smoking prevalence of all local authority areas in England. Tobacco imposes an economic burden on society. As well as the direct medical costs of treating tobacco-induced illnesses there are other indirect costs including loss of productivity, fire damage and environmental harm from cigarette litter and destructive farming practices. Each year it is estimated that smoking costs Nottingham about £137M; this includes £12M in healthcare costs; and £6.82M in costs to social care.

Eating and Moving for Good Health
Nottingham has high rates of people who are overweight or obese across its child and adult population. The latest data tells us that **1 in 4 (25.2%) of Reception children are overweight or obese and this increases to 2 in 4 (40.8%) of children by the time they are in Year 6.** Nottingham's rates are increasing at a faster pace than the national average and the gap to elsewhere is widening. Everyone experiences multiple barriers and challenges to eating and moving for good health. These factors are complex and broad and can be outside the control of individual choices: for example: how easy it is to walk or cycle in the community; if we live surrounded by fast food shops; the skills we acquire as we grow up and affordability of healthy food, activities and equipment needed to be active. Therefore this is not just about individuals but involves looking at the facilitators and barriers that can only be solved by involving communities and making changes to the local system or built environment.

Severe Multiple Disadvantage (SMD)
People who experience (SMD) are categorised as experiencing 3 of 5 sources of disadvantage; homelessness, mental ill-health, substance misuse, offending or domestic abuse. **Nottingham has the 8th highest prevalence of SMD in England**, approximately 50% are whom are female. People experiencing SMD can feel services are difficult to access and that their care and support can feel fragmented or stigmatising. People experiencing SMD can sometimes be frequent users of emergency services, but their outcomes are still poorer than the general population.

Financial Wellbeing
Financial wellbeing means being able to meet current needs comfortably and being able to maintain this in the future. A lack of financial wellbeing contributes to stress and poor mental wellbeing, and has a negative influence on our health behaviours and choices. National data shows us that there is a strong correlation between household income and healthy life expectancy. Areas with higher average household income have higher average healthy life and areas with lower average household income have lower average healthy life expectancy. **Nearly 17,000 children in Nottingham live in low income families – that is more than 1 in 4 children (27.2%).**

Nottingham City Place Based Partnership Priorities

In addition to the programmes that will be delivered though the Joint Health and Wellbeing Strategy, the place-based partnership will continue to have a focus on partnership programmes of work that add value to the work on individual partners.

Integrated Care System
Nottingham & Nottinghamshire

Additional Place Identified Inclusion Health Groups

Those with Mental Health Conditions

Good mental health and well-being is fundamental, it drives everything we do, how we think, how we behave and more importantly how we feel and act. As a diverse population we are all susceptible to mental health problems, however the risk of experiencing mental ill-health is not equally distributed across the population, it is often those who are living in deprived communities who are at highest risk of experiencing difficulties with their mental health. Since the COVID-19 pandemic and the associated measures that have been introduced (i.e. lockdown, social distancing), the longer-term socioeconomic impacts have increased, impacting on the inequalities that contribute towards the increased prevalence and unequal distribution of mental ill-health across the population.

Inequalities experienced in black, Asian and minority ethnic communities

People from Black, Asian and minority ethnic (BAME) communities generally experience poorer health than the overall population and that significant health inequalities exist between different population groups. People from black, Asian and minority ethnic communities are twice as likely to be living in poverty. There is clear evidence that people from BAME communities are at higher risk of dying from COVID-19 than the rest of the population though that risk may not be the same for all ethnic groups.

Care Leavers

Care Leavers, sometimes referred to as care experienced young people, often experience higher levels of health inequality, are more likely to experience challenges with their mental and physical health and are over represented in the criminal justice system when compared to the wider population. Children in care have poorer outcomes than the general child population across a variety of indicators primarily because of the impact of their early life experience prior to entering care, indicators include educational attainment, school attendance, school exclusion, offending behaviour, emotional and mental health, teenage pregnancy and substance misuse.

Working with communities

Working with communities forms a key part of place based partnerships and tackling health inequalities. The Place Based Partnership has brought together key partners to develop a coordinated response to reducing specific inequalities, to help engage with communities and remove barriers to accessing services. This has been especially important so far in increasing COVID vaccine uptake in the City and engaging with BAME communities.

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshir

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Dementia (PCN Health Inequalities DES) Admiral Nurse 8.7.2	Carers (Children, Adults) who are caring for loved ones with Dementia	• Providing support by way of clinics, telephone, counselling or face to face consultation • Asset mapping, creating links engaging with other organisations such as working age dementia service, dementia support groups, carers hub, links to translators, locate free course help reduce inequalities • Education, sharing information around risk factors and risk reduction • Improving ways to identify and support carers	• Improvement in the quality of life and mental health outcomes for both carers and their loved ones with Dementia • Educate carers around the disease, informed decision making, preventing a crisis • Reduction in GP appointments and A&E attendances • Hospital admissions avoidance	City South Clifton and Meadows BACHS Bulwell & Top Valley	✓	✓	
Annual Dementia Reviews (PCN HI DES) 8.7.3 (d)	Carers (Children, Adults) who are caring for loved ones with Dementia	• Opportunistic enquiries re informal carers, annual dementia reviews, documenting in patients records and the carers record, directing to carers hub. Signposting on practice websites	• Key part of a person with dementia's health and wellbeing. • Opportunity to discussing planning ahead and support for carers. Getting right care at the right time	City South	✓	✓	
Diabetes and Pre-Diabetes (PHM Improvement Project)	Patients at risk of pre-diabetes and Type 2 diabetes with an emphasis on BAME community	• Engage with patients who do not currently access services • As an outlier improve offering of patient education and opportunity to upskill staffing – increasing knowledge • Improve the general lack of awareness and symptoms for BAME population	• Reduction in the risk of pre-diabetes to improve quality of life outcomes and the debilitating impact and risk factors associated • Prevent heart disease, stroke and kidney failure making healthy changes • Reduce the burden on the NHS	City South BACHS	✓	✓	
Community Days of Action (PCN Health Inequalities DES) 8.7.2 (b)	All	• Engaging with local assets to deliver pop up stalls for the public to provide information available in their local area • Digital NHS App support • Providing information in different languages	• Increase awareness of local services to promote and self manage, behaviour change to make the right choices	City South Clifton and Meadows BACHS Bulwell & Top Valley Radford & Mary Potter Bestwood & Sherwood City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Recording ethnicity of all patients registered within the PCN (PCN Health Inequalities DES) 8.7.1 (c)	Ethnicity of the registered population	• All practices continue to record the ethnicity of all new registrations – achieved 90+% to date	• Routine monitoring of access, use of services, and key processes and outcomes of care by race and ethnicity is essential to ensuring compliance	City South BACHS Bulwell & Top Valley	✓	✓	✓
Increase awareness of PCN services and improving staff occupational health (PCN Mid-Career Fellow) (PCN Health Inequalities DES) 8.7.1 (c)	Patients with health conditions and Staff welfare	• Ensure local assets are up to date (identify any gaps), accessible and that patients are aware of local services • Engage with stakeholders to formulate a regular internal and external Newsletter • Mid-Career Fellow sets out a plan for occupational health	• Improvement in quality of life for patients increasing knowledge local services and assets • Improve staff morale and look forward to a sustainable future	City South	✓	✓	
Cardiovascular Disease (Mid-Career Fellow) PCN HI DES & PCN Improvement Project	Socioeconomically deprived patients at risk of COPD, Cancer and other related Long Term Conditions	• Involving and engaging stakeholders and partners to plan a campaign aimed at smoking cessation to improve the cardiovascular health and quality of life	• Reduction in smoking rates. improve cardiovascular disease risks and affects associated with a long term condition	Clifton and Meadows	✓	✓	✓
Cancer & Breast Screening (PCN Health Inequalities DES) Mid-Career Fellow PHM	All	• Role is part funded by Macmillan and PCN6 & 8. Self-Help UK are the lead employer • Cancer care co-Ordinator undertaking holistic reviews (beyond cancer model) of patients recently diagnosed with cancer • Contacting directly non participants in cancer screening programmes • Identifying issues causing non attendance • Connecting with partners to address reasons for non-attendance e.g. linking in with community leaders, considering promotion	• Focused on improving cancer screening uptake and increasing cancer review numbers in PCN • Increase in early detection rates and making a difference to the quality of life outcomes for patients • To improve access and reduce health inequalities	Clifton and Meadows	✓	✓	✓
LD Screening (PCN Health Inequalities DES) Mid-Career Fellow PHM	Patients with Learning Disabilities	• Ensure LD register is up to date by sending pre-screening list to GP practices so that eligible patients with LD can be identified in advance and sent easy-read information • Ensure appropriate coding in the notes of screening events	• Patients with LD experience poorer health outcomes. Improved screening may help identify unrecognised health needs and avoidable health inequalities • Form a strategy for improving access to screening services	Clifton and Meadows	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Social Prescriber Link Worker	Forging links with local population, Ethnic Groups and solutions encountered by language barriers	• Engaging with local assets, linking in with tertiary voluntary sector organisations • Increasing links with population by way of a Newsletter • Initiating local regular venues for holding group activity • Apply for funding to help implement an allotment to grow produce that can be consumed by the community • Support by way of cooking hints and tips groups	• Improvement in quality of life for patients increasing knowledge local services and assets • Improving physical activity and education around the importance of diet and wellbeing	Clifton and Meadows BACHS	✓	✓	
Lung Cancer hotline (PCN Health Inequalities DES) (PHM Improvement Project)	Socioeconomically deprived patients at risk of lung cancer PCN has the highest rate of 2ww lung referrals in the City	• Letters and text messages sent out to patients if they have any of the NICE NG12 red flag symptoms for lung cancer • Symptoms assessed and high risk individuals invited to attend for a chest CT	Rapid access to diagnosis leads to decreased mortality Reduce the burden on the NHS	BACHS	✓	✓	✓
Pulmonary Rehab (PCN Health Inequalities DES) (PHM Improvement Project)	Socioeconomically deprived patients	• Collaborative partnership with City Care Integrated respiratory service • Targeted education through the teams with colleagues in practices. • Review patients who did not take up the offer of pulmonary rehab • Work with the Social Prescribing team	Improvement in quality of life, dyspnea, and functional capacity independent of baseline disease burden	BACHS	✓	✓	✓
Obesity and Cardiovascular (PCN Health Inequalities DES) (PHM Improvement Project) (Mid-Career Fellow)	Socioeconomically deprived patients with health conditions such as diabetes and cardiovascular disease	• Asset mapping • Engagement with partners, community, practices, Health and Well Being coaches and providers of weight management services • Descriptive study and case studies looking at the perceptions of obesity • Design an intervention and pathway which will include the Health and Well Being Coaches	Reduction in the risk of diabetes and cardiovascular disease	BACHS	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting atleast 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	BACHS	✓	✓	
Childhood Immunisations (PCN Acceleration Programme) (PHM Improvement Project)	Unvaccinated pre-school children from young, disadvantaged, deprived families Low income and immigrant families	• Targeted approach/programme of work including a draft proposal/model • Engagement with partners, community and schools • SSBC Family mentor approach	Reduction in infant mortality	Bulwell & Top Valley Radford and Mary Potter	✓	✓	
Healthy Lifestyle (PCN Acceleration Programme) (PHM Improvement Project)	Socioeconomically deprived patients with health conditions such as diabetes and cardiovascular disease	• Asset mapping • Engagement with partners, community and schools • Understand from experience and models of delivery • Design an intervention and pathway which will include the Health and Wellbeing Coaches	Reduction in the risk of diabetes and cardiovascular disease	Bulwell & Top Valley Radford and Mary Potter	✓	✓	
Mental Health (PCN Acceleration Programme) (PHM Improvement Programme) (Mid-Career Fellow)	Low income, high long-term unemployment, disadvantaged patients	• Address and improve the mental health and wellbeing of citizens • Improve access to relevant teams and services • Engagement with partners, community and schools • Support and mentor the new Mental Health Practitioner • Upskill all the staff in mental health education	Improvement in mental health and wellbeing	Bulwell & Top Valley	✓	✓	
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting at least 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	Bulwell & Top Valley	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Identify and include all patients with a learning disability on the LD register and to deliver an annual LD health check and health action plan (PCN Health Inequalities DES)	Patients with Learning Disability Patients with Learning Disability from BAME communities	• Identifying and including all patients who are aged over 14 with a Learning Disability on the LD register • Supporting at least 75% of those patients to get an annual LD health check and health plan • Signposting patients and their families to any support required from health services or social care • Offering support to further appointments if required • Using an interpreter if required	Promoting health and wellbeing Early diagnosis leads to decreased mortality Support with long term conditions, if they are diagnosed	Bulwell & Top Valley	✓	✓	
Engagement with schools (PCN Health Inequalities DES)	Children and young people Young, disadvantaged, deprived families Low income and immigrant families	• Poster competition with the theme 'looking after your body' • Clinicians having conversations with children and their parents, carers and families about how they can look after their health, including healthy eating, exercise, being active and not smoking; along with information about careers in the healthcare sector; and to share information with them on coping with anxiety, immunisations etc • Social Prescribing Link Workers and Health and Wellbeing Coach engaging with schools and community • School representation at BTV Health Forum and Childhood Immunisations working group	Improvement in physical and mental health and wellbeing	Bulwell & Top Valley	✓	✓	
COVID vaccine uptake in marginalised populations (Vaccine programme)	Muslim families Non English speaking families Black African, Caribbean and British families	• Provision of dedicated clinics at a range of appropriate religious/cultural community settings - mosques, churches • Patient engagement for vaccine sanctuaries • Provision of interpretation and translation in patient engagement - dedicated phone contact • Development of resources in appropriate languages and formats • Dedicated GP time for Q&A for COVID vaccine hesitant patients	Increased uptake of COVID vaccine	Radford and Mary Potter	✓	✓	✓

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Green Social Prescribing (PHM Improvement Programme)	Marginalised patients	• Promoting exercise and nature based activities including Community Walking Group, Community Garden Project, Community chair based exercise and social wellbeing groups. • Appropriate referrals and engagement with the social prescribing team looking at the potential difficulties with smoking patients whilst being supported by the stub it programme. • Encouragement, support and guidance to patients who are reluctant to attend social activities from the social prescribing team to ensure that all patients are able to access local community services.	Promoting a healthy life style and wellbeing. Reducing loneliness, improving mental health and reducing obesity	Radford and Mary Potter City East	✓	✓	
Increasing access to PC services (PCN Improvement Project)	Promoting and maintaining health, preventing and managing disease, reducing unnecessary disability and premature death	• Implementing a GP+ spoke model in the PCN to enable patients to receive access to services that are currently unavailable	• Enabling patients to received the right care, from the right professional including access from and to other PC and GP services such as urgent care	City South	✓	✓	
Childhood Immunisations (PHM Improvement Project) (Mid Career Fellow project)	Adult patients in the Obese and Morbidly Obese BMI categories Paediatric patients in the Obese and Overweight BMI categories	• Aiming to improve engagement with preventative services for this cohort • Targeted approach/programme of work alongside partners in community health local authority, commercial and third sector partners • Clinical data analysis • Engagement programme with community and schools	• Improved understanding of ethnicity and disability data for this cohort • Dedicated clinics and messaging for adult and paediatric cohorts • Improved in uptake of preventative services from this cohort • Increased proportion of patients with recent weight recording • Increased referral rates to prescribed weight loss programmes	Bestwood and Sherwood City East	✓	✓	
Social Prescribing (PHM Improvement Programme)	Marginalised patients experiencing social and mental health issues	• Promoting exercise and nature based activities including Community Walking Group, Community Garden Project, Community chair based exercise and social wellbeing groups. • Promoting preventative health service engagement within this cohort • Encouragement, support and guidance to patients who are reluctant to attend social activities from the social prescribing team to ensure that all patients are able to access local community services.	• Promoting improved self management of health conditions • Reducing isolation and improving mental health	Bestwood and Sherwood	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Review SMI register and review data to deliver physical health checks (PCN Health Inequalities DES)	Patients with a SMI, high intensity users with poorly controlled chronic disease	• Appointed Health Improvement Worker, Mental Health Practitioner and Health & Wellbeing coaches • Practices took part in a review of SMI register to identify individuals for a health check • HIW working with practices to achieve at least 60% • Supporting those with mental health problems beyond the expertise of Primary Care	Avoid reaching the accepted thresholds for secondary care input Improving poorly controlled chronic disease, recurrent but ineffective presentations to practices and OOH services including ED	BACHS Bulwell & Top Valley Radford and Mary Potter Bestwood and Sherwood	✓	✓	✓
SSBC Non-English Speaking Families (PCN Acceleration Programme) (PHM Improvement Project)	Non – English speaking young Families with language barriers	• Engagement via survey with non-English speaking parents with young families within Nottingham City East to better understand the barriers in accessing health care including immunisations and nursery places. • Sisters of Noor (local organisation) were awarded £12k lottery funded contract to perform survey's with 100 local families - 25 each speaking Urdu, Arabic, Tigrinya, Czech. • Multi agency steering group - plans for Coproduction and involvement of the community and coproduction in future projects	• The results of this project will be used to inform improvements to the clinical delivery offer to meet the individual needs of children 0-5, which aim to improve health outcomes for these children. • Improve knowledge of parents around the services they can access including nursery places	City East	✓	✓	
On boarding Videos (PHM Improvement Programme)	Local population – Including BAME – non English speaking asylum seekers/ refugees	• Project entails educating patients by creating video based information in their own languages • working closely with refugee forum to establish how patients can effectively access primary care. Information will be personalised to NCE population to support those patients who don't speak English and are new to the UK.	• To increase understanding of the role of Primary Care and how to access services. • To improve health outcomes • Enabling patients to receive the right care, from the right professional including access from and to other PC and GP services and reduce inappropriate use of primary care and A&E.	City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Community Fibroscan Pilot (PHM Improvement Programme)	Targeting patients at high risk of fatty liver and Cirrhosis. Obesity, those at risk of pre-diabetes and Type 2 diabetes and people with high alcohol consumption	• Liver Fibro scans to check at risk patients for fatty livers • To offer lifestyle advice and connections to weight and alcohol management services	• To improve health outcomes by promoting healthy life style and wellbeing • Reduction in the risk of long term conditions • To improve quality of life outcomes and the debilitating impact and risk factors associated	City East	✓	✓	
Cancer & Breast Screening (PCN Health Inequalities DES) PHM	Reviewing screening rates for all patient group and carrying out Cancer Reviews	• Role is part funded by Macmillan and PCN 6 & 8, Self Help UK are the lead employer • Cancer care co-ordinator undertaking holistic reviews (beyond cancer model) of patients recently diagnosed with cancer • Contacting directly non participants in cancer screening programmes • Identifying issues causing non attendance • Connecting with partners to address reasons for non- attendance e.g. linking in with community leaders, considering promotional events etc.	• Focused on improving cancer screening uptake and increasing cancer review numbers in PCN. • Increase in early detection rates and making a difference to the quality of life outcomes for patients. • to improve access and reduce health inequalities.	City East	✓	✓	✓
Safeguarding Care Coordinators (PCN Health Inequalities)	Targeting children and adults with safeguarding risks	• Employment of two care coordinators to improve the processes within GP practices in order to identify and manage the risks of those who are at risk of abuse • To improve liaison and communication with other agencies involved in the care of this cohort	• To reduce risk of abuse in vulnerable cohorts • To improve health and wellbeing • To improve liaison with services	City East	✓	✓	
Local Church Pilot (Mental Health)	Those experiencing bereavement and loss	• Trained church of England clergy and church lay workers providing sessions for people experiencing loss and bereavement with the main therapy being supported listening	• Improve mental health and prevention of deterioration	City East	✓	✓	

Nottingham City Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Student Carer Identification & Support (PCN DES HI Project)	Students with caring responsibilities for family and/or friends in Nottingham or their home city	• Health promotion to identify and offer support to the carers population within the student body • Identify new carers champion across both GP surgeries • Engagement with university partners and services	• Identification of carers • Provision of support for carers • Signposting to appropriate resources or services • Improvement in mental health and wellbeing • Raise awareness with the wider team of the specific challenges carers face and support that is available • Improvement in data collection • Aim is to improve physical health in this cohort	Unity	✓	✓	
Personality Disorder Physical Health PHM Project (ESDS)	Patients with mental health problems often suffer with worse physical health than the wider population. Patients with personality disorders are often hard to engage. GP resource and targets are not often directed at this cohort of patients.	• Aim to improve the data collection of BP, BMI, Smoking status and alcohol intake in this cohort. • Offer brief interventions where appropriate • Offer of support from SPLW and health and wellbeing coach.	• Improvement in data collection • Aim is to improve physical health in this cohort	Unity	✓	✓	

Nottinghamshire Priorities

Integrated Care System
Nottingham & Nottinghamshire

Nottinghamshire has 3 place-based partnerships; South Nottinghamshire, Mid Nottinghamshire and Bassetlaw who are working to deliver the priorities in the Nottinghamshire Joint Health and Wellbeing Strategy.

Joint Health and Wellbeing Strategy for Nottinghamshire (2022-2026) Overview

The overall aim of the strategy is to work together to enable everyone in Nottinghamshire to live healthier and happier lives, to prosper in their communities and remain independent in later life. There are 4 ambitions outlined in the strategy which present a range of opportunities, these ambitions have been broken down into 9 areas of focus, chosen due to the big impact they have on health and wellbeing.
The ambitions and focus area are shown below:

1. Give every child the best chance of maximising their potential:

We will work together for every child in Nottinghamshire to have the best possible start in life, because we know that a good start shapes lifelong health, wellbeing and prosperity

2. Create healthy and sustainable places:

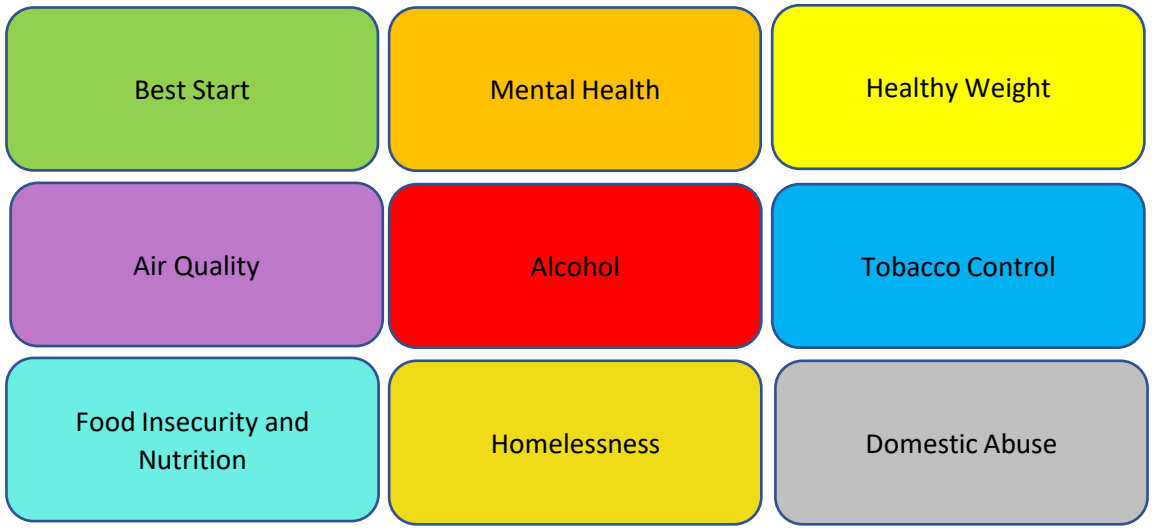
Everyone will grow, live, work and age in places that promote good health, tackle the causes of health inequalities and address the climate crisis.

3. Everyone can access the right support to improve their health:

Health, care and community services will work together to strengthen their focus on promoting good health and wellbeing and preventing illness, by building on people's strengths.

4. Keep our communities safe and healthy:

We will support people who are marginalised in our communities to ensure they are safe from harm and their needs are met. Services will support people to build on their strengths to live the lives they want



South Nottinghamshire Place Based Partnership

South Nottinghamshire PBP are working together to join up health and social care services across Broxtowe, Gedling, Rushcliffe and Hucknall (Ashfield). Their aim is to support people to live healthier lives and get the care and treatment they need, in the right place, at the right time.

Integrated Care System
Nottingham & Nottinghamshire

South Nottinghamshire Place Based Partners

Nottinghamshire County Council

Broxtowe Borough Council

Gedling Borough Council

Rushcliffe Borough Council

Ashfield District Council

NHS Nottingham and Nottinghamshire Integrated Care Board

Rushcliffe Community & Voluntary Service

pics Primary Integrated Community Services Ltd

Partners Health Stronger Together

Newark & Sherwood CVS

active notts

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

healthwatch Nottingham

6 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Chilwell/Beeston, Stapleford and Kimberley Insights	Residents of Chilwell, Beeston, Stapleford and Kimberley	• Working with stakeholders and residents to gain a real understanding of their lives, enabling a co-produced and collaborative approach to reducing physical inactivity and improving health. Understanding the link between mental health and physical activity for individuals in Broxtowe	• Improving health outcomes for the residents of Broxtowe	N/A - Broxtowe Borough Council	✓	✓	
Hypertension Case Finding	Patients aged 18+ who are not diagnosed with hypertension but who have had a BP reading of >140/90 recorded in their medical records in the last 2 years.	• Identify any groups who are overrepresented in the number of citizens currently living with undiagnosed hypertension and look to engage community partnerships to understand the needs of this population and how we can reduce this inequality relating to hypertension • . Exploring community partnership opportunities to provide access and support for healthier lifestyle choices to reduce long term conditions and early fatality. • Through cross organisational working with GP Clinical Leads, Community Pharmacies, Broxtowe Borough Council, Liberty Leisure, Partners Health, religious and charitable organisations, and Nottingham CCG to identify appropriate patient cohorts and hear from them how they would most like to access blood pressure monitoring and care pathways. • Recruit a 'Cardiology' team, who will be prescriber-led to work closely with community pharmacies to support appropriate members of our community to navigate and access BP monitoring, subsequent follow up and treatment. As well as improving access to wider lifestyle advice and support to reduce health inequalities and improve health outcomes in line with CORE20PLUS5 priorities.	• Reduction in strokes and myocardial infarctions through improved detection and management of undiagnosed hypertension, • Reducing obesity and improving smoking cessation outcomes by appropriate referral to targeted services as identified through the hypertension case finding work.	Nottingham West Rushcliffe	✓	✓	✓

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Durban House Community Hub: developing a health and wellbeing centre of excellence Eastwood	Low level mental health	• Provide a multi-functional central space for local service users and services to come together • Within Broxtowe we have seen how an inclusive centre of health and wellbeing support can work positively through the model of the Middle Street Resource Centre in Beeston. • Durban House will provide formal and informal support networks, co-located with commissioned healthcare services and spaces available for CVS groups to congregate for activities. • There will be a café which provides both a safe space for centre users as well as supported employment opportunities for the citizens of Eastwood, including those whose life circumstances may make employment difficult to access through more traditional routes.	• Improved provision of employment, training and development opportunities for citizens of Eastwood. • Improved access to preventative services • Improved access to non-medical health and wellbeing support services • Improved local support networks for local citizens	Nottingham West	✓	✓	✓
Utilising the PCN digital inclusion officer(s), we will develop and implement a digital inclusion strategy to support those digitally excluded across Nottingham West PCN..	Those that are digitally excluded. The Ukrainian community residing or moving to Nottingham.	• Support those who are currently digitally excluded to access primary care services. We have begun making relationships with organisations locally who support Ukrainian nationals with a view to us being ready to focus this work, should it become necessary, to support those fleeing civil war in the Ukraine in line with domains 1 and 5 of the PHM ESDS Action plan 22/23. • Help to navigate access to; Register with a GP, Repeat prescriptions. Care for long term conditions, Health Checks, Women and Children health needs, Mental health support • Aim to engage the whole of the PCN to support those seeking refuge in our neighbourhoods to not only access health care systems but also wider societal networks to give these families the best start to their resettlement within Notts West PCN. We will plan other similar interventions should we identify any other predictors of unequal access to health care as we progress this current work plan.	Supporting those digitally excluded within Nottingham West PCN to access primary care services to maintain their wellness / ongoing medical needs without the need to access secondary care services. Improved experience of resettlement and community integration for Ukrainian national looking to resettle within Nottinghamshire.	Nottingham West Rushcliffe	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing the uptake of cervical screening amongst the South Asian community in Broxtowe.	South Asian female community.	• Identified that this cohort have a low uptake for their cervical screening. • Completed some community engagement and using this feedback have begun to create an information video with key leaders / people within this community speaking on the importance of taking up the offer of cervical screening (and other intimate health examinations). • We plan to edit this with Punjab subtitles and then circulate via WhatsApp - a platform that the community told us is widely used to communicate due to the voice message functionality etc.	• Improved access to preventative screening services • Improved access to, and experience of, women's health services	Nottingham West	✓	✓	✓
"Working it Out" in conjunction with Liberty Leisure and Broxtowe Women's Project.	Women experiencing domestic abuse.	• A partnership with Liberty Leisure and Broxtowe women's project has seen the creation of the their "Working it Out" project to help reduce social isolation and promote wellbeing for women experiencing domestic abuse. • Funding has been secured to facilitate some safe space events coaching and to run activities aimed at getting this group of women more active and build friendships. • Virtual classes have been set up to allow participants to test a number of different types of exercises and once they evaluate these options we plan to run some targeted exercise classes of their choice, again in a managed 'safe space'. • Fund 30 free gym passes through this project and plan to move these members onto the exercise referral scheme once this ends to encourage lifelong health and wellbeing.	• Improved social connection and social confidence amongst this cohort • Improved access to health and wellbeing services • Improved ability in managing health and wellbeing	Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing the uptake of cervical screening amongst the South Asian community in Broxtowe.	South Asian female community.	• Identified that this cohort have a low uptake for their cervical screening. • Completed some community engagement and using this feedback have begun to create an information video with key leaders / people within this community speaking on the importance of taking up the offer of cervical screening (and other intimate health examinations). • We plan to edit this with Punjab subtitles and then circulate via WhatsApp - a platform that the community told us is widely used to communicate due to the voice message functionality etc.	• Improved access to preventative screening services • Improved access to, and experience of, women's health services	Nottingham West	✓	✓	✓
"Working it Out" in conjunction with Liberty Leisure and Broxtowe Women's Project.	Women experiencing domestic abuse.	• A partnership with Liberty Leisure and Broxtowe women's project has seen the creation of the their "Working it Out" project to help reduce social isolation and promote wellbeing for women experiencing domestic abuse. • Funding has been secured to facilitate some safe space events coaching and to run activities aimed at getting this group of women more active and build friendships. • Virtual classes have been set up to allow participants to test a number of different types of exercises and once they evaluate these options we plan to run some targeted exercise classes of their choice, again in a managed 'safe space'. • Fund 30 free gym passes through this project and plan to move these members onto the exercise referral scheme once this ends to encourage lifelong health and wellbeing.	• Improved social connection and social confidence amongst this cohort • Improved access to health and wellbeing services • Improved ability in managing health and wellbeing	Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Keyworth Insight	Residents of Keyworth	• Identify barriers to physical activity, mapping community assets and increasing/improving the opportunities for young people to be physical active in Keyworth, an area with some of the highest health inequalities in the borough, working with local community groups, schools and organisations.	• Improve health and wellbeing outcomes for the residents of Keyworth	N/A – Rushcliffe Borough Council	✓	✓	
Rushcliffe Community Cohesion Network	All Rushcliffe residents	• A forum to ensure voices from all sectors of Rushcliffe's communities are represented, to influence the work of the council to ensure policies and strategies engage everyone.	• Ensure community voices are heard in council planning activities, allowing barriers to be reduced based on feedback	N/A – Rushcliffe Borough Council	✓	✓	
Reach Rushcliffe	Those living in areas of deprivation and vulnerable cohorts at risk of loneliness	• A fund to support local initiatives that aim to tackle loneliness and social isolation in the borough, aiming to identify and support areas of deprivation and vulnerable cohorts of the population	• Reduce adverse affects of loneliness and isolation • Prevent worsening mental health	N/A – Rushcliffe Borough Council	✓	✓	
Reduce potential ED attends by providing guidance, information and support to those seeking asylum and who may use urgent and emergency services as first line for primary care needs.	Those seeking asylum and refugees	Through cross organisational working with Rushcliffe Borough Council, GP Clinical Lead, Partners Health, Nottingham CCG, and Connected Notts will implement a digital platform which both identifies patient cohorts and supports them to navigate and access wider health, social care and voluntary services to reduce health inequalities, improve access at the right time and place and improve health outcomes. This will work along side care co-ordination which already established in Rushcliffe is likely to need further capacity. Develop and implement a digital inclusion strategy for asylum seekers, to access healthcare, right time, right place, promoting health prevention and selfcare through greater knowledge and inclusion	• Increase ability to selfcare through improved lifestyle choices, to prevent new onset and/or deterioration of long-term conditions; adding quality to life years with digital inclusion as a starting platform	Rushcliffe PCN	✓	✓	
Carlton Insight	All Carlton Residents	Community representatives come together with professionals to assess data, develop local coproduced health solutions and address gaps in provision.	• Improve health and wellbeing outcomes for the residents of Carton	N/A Gedling Borough Council	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Hucknall (Broomhill & Butler's Hill)		ADC are committed to prioritising resources and focus on areas of greatest need for health improvement. Work in Hucknall will remain a priority area. Key priority areas identified are: - Disabled people, including those with a LTC - Adults experiencing multiple disadvantage - Low income families, including children and young people within them - Residents significantly impacted by Covid 19 pandemic	• Improve the health and wellbeing of the residents of Broomhill and Butlers Hill, especially those who are most deprived.	N/A – Ashfield District Council	✓	✓	✓
Health promotion Working in collaboration with Borough Councils and partners to help increase awareness to those living in the most deprived areas of the PCN to increase access to preventative services. An additional focus on pre-diabetic patients.	Those living in Arnold and Calverton and Hucknall	• Promote preventative services via link worker and Base 51 and practice staff. • Increase awareness of diabetes via social media platforms, Gedling BC contacts/newsletter • Increase awareness of preventative services via Envisage screens, mobile phone messaging, conversations with patients • Increase referrals to link workers and Base 51 to enable signposting to preventative services • Invite pre-diabetic patients in for screening • Working closely with SIM health workers to screen patients for diabetes • To work with a digital inclusion officer to support health promotion in all age groups.	• Increased number of additional patients screened for diabetes through the NHS Health Check and opportunistically; • Increased number of referrals of those identified with pre-diabetes; Increased number completing a preventative programme for weight management. • CPCS to increase access to patients and promote good health management and BP measurement and support appropriately with conditions that do not require a GP appointment • Extended Hours continue to be on offer for patients to access to help manage their health care needs and requirements • Patient experience to continue to be monitored via comments on social media platforms, NHS Choices and Friends and Family surveys • Review data to understand outcomes and how the intervention impacts	Arnold and Calverton Byron	✓	✓	✓

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Hucknall Cavell Centre	All registered patients of Byron PCN GP practices, with a focus on Diabetes, Cardiology, Respiratory, Alcohol and Drug misuse, and Elderly Care/Frailty	Cavell Centres will offer a range of joined-up health and social care services closer to home for the patient. The Centres form part of a national estates programme and are designed around a core primary care offering, but also promote the co-location of community services, outpatients, diagnostics and other NHS health services in addition to third sector and Local Authority services (e.g. social care and housing support); helping to support the wider determinants of health. Occupation of the Centres will be informed by Primary Care Networks (PCNs) and local system priorities based on population health data and demographics.	• Access to both medical and non-medical health and wellbeing services closer to home • Improved patient experience • Emphasis on preventative care will result in a reduction of long term, chronic illnesses • Emphasis on service integration will result in better holistic care and improved patient outcomes	Byron	✓	✓	✓
Cancer Screening for patients with Learning Disabilities	LD patients within Arrow Health PCN.	The PCN have in place a GP Fellow who will be working with the 6 PCN practices to identify necessary cancer screening interventions for LD Patients i.e. cervical and breast cancer.	• Putting interventions in place and assessing its effectiveness. • Detection of cancer at earlier stages in patients with LD	Arrow Health	✓	✓	✓
Advice on Prescription	Patients presenting to primary care due to social welfare issues, such as debt, housing and benefit issues,	There is a direct link to the health and wellbeing of people and their access to money and resources. There is also evidence that people experiencing social welfare issues, such as debt, housing and benefit issues, present more frequently to primary care services and that primary care clinicians are spending increasing amounts of time discussing such non-clinical issues with their patients. Advice on Prescription is a service in which people can be supported to address difficulties with their financial situation is through specialist advice. Clear findings of Advice of Prescriptions services is that is very different to broader social prescribing services, and they meet patient's needs in different ways. Advice on Prescription supports clients with their advice needs, and is seen as a 'problem-solver', which can then mean that they are better able to engage with social prescribing services, and gain more from these services.	• Improving the health, wellbeing and resilience of the population • Reducing deprivation • Promoting the resilience of general practice by reducing workload that is linked to debt and benefits	Synergy Health, Arrow Health, Bryon, Arnold & Calverton, Nottingham West	✓	✓	

South Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Reduction of the Heart Failure backlog	Patients with a diagnosis of heart failure awaiting cardiac rehabilitation.	A heart failure transformation group has been established to address inequalities that exist for current heart failure patients in the South locality. The aim is to pilot a cardio-pulmonary rehabilitation service over a 4-month period to address a current backlog of heart failure patients. These patients will be reviewed by a clinical team to ensure care and medication plans are in place and robust, to manage their current presentation to avoid attendance and/or admission to hospital. A multi-disciplinary approach will be taken through a range of health care professionals including a clinical pharmacist, physiotherapist, heart failure nurse and Community Pharmacy PCN leads. This will include an education programme for patients with a diagnosis of heart failure or COPD or both.	• Quicker access to cardio-pulmonary rehabilitation services • Better self management of condition • Better ability to identify exacerbations early to prevent significant deterioration and admission to secondary care • Improved physical ability and quality of life for patients	Synergy Health, Arrow Health, Bryon, Arnold & Calverton	✓	✓	
Recruitment of Digital and Social Inclusion Co-ordinator	Older people, people in lower income groups, those with disabilities, people with fewer educational qualifications.	Through digital inclusion we plan to support those within our PCN who are currently digitally excluded to access primary care services.	• Supporting those digitally excluded within the PCNs to access primary care services to maintain their wellness / ongoing medical needs without the need to access secondary care services.	Synergy Health, Arrow Health, Bryon, Arnold & Calverton	✓	✓	

Mid-Nottinghamshire Place Based Partnership

Integrated Care System
Nottingham & Nottinghamshire

Mid-Notts PBB will work together to create happier, healthier communities and reduce the gap in healthy life expectancy across Mansfield, Ashfield, Newark and Sherwood.

Mid-Nottinghamshire Place Based Partners

Nottinghamshire County Council

NHS Nottingham and Nottinghamshire Integrated Care Board

Ashfield District Council

Mansfield District Council

Newark & Sherwood District Council

NHS East Midlands Ambulance Service NHS Trust

Ashfield Voluntary Action

Newark & Sherwood CVS

pics Primary Integrated Community Services Ltd

healthwatch Nottingham

Mansfield Community & Voluntary Service

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

6 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Bellamy Road Estate, Mansfield	Residents of Bellamy Road Estate	To gather general practice intelligence and to develop a whole-system approach to support these priority areas to look at opportunities to do things differently led by the needs of the community. • A whole-system approach will be developed to support these priority areas to look at opportunities to do things differently led by the needs of the community. • Positive outcomes are already being achieved through the work being undertaken by the community officer working on the estate, collaborating with a local college has seen a horticulture course, first aid and food hygiene course being undertaken on the estate and attended by a number of residents.	Improving access to healthcare for health and inequalities and meeting the needs of the local population.	N/A – PBP Partners	✓		
Coxmoor Estate, Kirkby in Ashfield	Residents of Coxmoor Estate	To gather general practice intelligence and to develop a whole-system approach to support these priority areas to look at opportunities to do things differently led by the needs of the community. • A whole system approach will be developed to support these priority areas to look at opportunities to do things differently led by the needs of the community. • Talks with services already on the estate are ongoing and the option of using a local church to hold events and a drop-in session going forward are happening, also they are currently looking for community resource gaps within the community, they have also done a drop in at Ashfield Health Village for Men and LGBTQ community.	Improving access to healthcare for health and inequalities and meeting the needs of the local population.	N/A – PBP Partners	✓		
Vaccination Health Inequalities	Targeted work on particular communities and cohorts with low uptake	Targeted work on particular communities and cohorts with low uptake • To promote and encourage vaccination for areas and cohorts of low uptake (race and ethnicity, inequalities by geography and deprivation, age, clinically extremely vulnerable, maternity, LD & autism, homeless refugees, asylum seekers, dementia, SMI and vaccine hesitancy) • Data is utilised to agree immediate priority areas of focus and cohorts. • The vaccination vans offer a door-to-door vaccination service and pop-up clinics in communities. Vaccination sanctuaries are also being held to address any vaccine hesitancy or concerns. • Health and Wellbeing hubs are also being based in key locations engage and support local communities and provide advice to help people keep themselves protected against Covid-19 and improve their health and wellbeing.	Reduced inequality in vaccine uptake rates leading to reduced inequalities in outcomes	N/A – PBP Partners	✓	✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Health and wellbeing pop up clinics	Health promotion activity and interventions	· Health and wellbeing pop ups organised (one in each district and according to geographical area). · Pop ups include covid testing, handing out lateral flow tests, GP registration and care navigation. · CVS deliver leaflets to promote, advertise via social media and provide care navigation for patients (directing patients into the correct services including extended hours).	Making health care more accessible	N/A – PBP Partners		✓	✓
Opt Out Smoking Cessation Referrals - Primary Care	Patients who smoke who live in socio economic decline 1 (10% most deprived)	· If the patient doesn't opt out within 14 days, they are referred to the smoking cessation service. · Patients will then be contacted by Your Health Your Way, Nottinghamshire's integrated wellbeing service, and offered enrolment onto a smoking cessation programme. · As of July 2022, 3 practices in Ashfield have participated. In total there were 643 patients who did not opt out of the text message and were therefore referred to Your Health Your Way. This project is now being rolled out across all practices in Mid Notts	Decrease in the number of smokers.	All		✓	✓
Opt Out Smoking Cessation Referrals - Secondary Care	Smokers who are on the elective waiting list for surgery.	• All patients that are on the waiting list for elective surgery are matched with an active smoking status in GPRCC. An opt out text message is then sent to all smokers. If the patient does not opt out within 14 days, they are referred to Your Health Your Way.	To decrease the number of smokers and improve surgical outcomes.	N/A – PBP Partners		✓	✓
DWP Access to Work Project – Ashfield South PCN	To try and support patients on long term sick to get back into work	• Access to work can offer discretionary grant-based awards to pay for work related support to try and get people who are on long term sick back into work. This includes mental health support, specialist equipment, travel, support workers etc. • Patients are identified using a SystmOne report and contacted by a SPLW to discuss a referral. • 50% of patients contacted in Ashfield agreed to a referral to the Access to Work scheme. This is now being expanded across Mid Notts.	Providing services to patients out of work due to ill health.	N/A – PBP Partners			✓
GP Registration (Mansfield)	To encourage people who aren't registered with a GP practice to register and provide support doing this	• GP registration is a joint project with Mansfield PCNs and Mansfield CVS. GP registration sessions are being held in Mansfield assisting people with completing the necessary forms for registering with a GP practice. • Priority areas of focus are homeless and non-English speaking residents – however all cohorts are being targeted. • CVS Health and Wellbeing pop ups include GP Registration. • Comms have been sent to all GP practices ensuring practices all have the correct information on their websites regarding GP registration (patients do not need ID or proof of address to register).	Ensuring people at risk of health and inequalities have access to healthcare.	N/A – PBP Partners	✓		✓
Financial Incentives for Pregnant Women who smoke	To encourage pregnant women to stop smoking	• Young pregnant women in the lowest socioeconomic decile are most likely to be smokers at delivery. Financial incentives have shown to be effective in pregnant smokers. • Sherwood Forest Hospitals are offering financial incentives for pregnant women to stop smoking. Patients who join the financial incentive scheme can get up to £400. • The financial incentive scheme is now in month 5 (as of July22) – SFH are collecting milestones and outcomes for each participant for evaluation.	Decrease in the number of pregnant smokers.	N/A – PBP Partners		✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Fuel Poverty	Patient who are at the highest risk of cold related harm to be referred to the Healthy Housing Service.	• Patients living in fuel poverty who are at risk of cold-related harm and hospital admissions are identified using e-Healthscope. • Patients are then contacted and offered a referral to the Healthy Housing Service who can offer free or subsidised home heating upgrades such as insulation and fuel vouchers and a range of other interventions. • This has been piloted in Rosewood PCN. 31 referrals have been made into the healthy housing service. This is now being expanded to Ashfield North and Sherwood PCN.	To prevent hospital admissions due to cold related harm and to improve health through living conditions.	Rosewood Ashfield North Sherwood		✓	
Virtual Wards	Supporting early discharge	• Supporting early discharge from hospital using pulse oximeters and digital remote monitoring.	Reducing length of stay	N/A – PBP Partners		✓	
Asthma Biological Therapy	To improve access to severe asthma biologics	• Patients with severe asthma to be identified using e-Healthscope and referred via email for Asthma Biological Therapy. • A virtual MDT will then be held by the respiratory consultant at SFH to discuss whether the patients are eligible. • Eligible patients will then be given monoclonal antibodies by subcutaneous injection every 2-8 weeks. • The purpose of the injections is to reduce the need for systemic corticosteroids in order to spare patients from their long-term side effects.	To help improve asthma and decrease the risk of long term side effects from corticosteroids	Piloted at Abbey Medical Centre – to rolled out across Mid-Notts		✓	
Diabetes Case Finding (Sherwood PCN)	To invite patients at high risk of type 2 diabetes for a HBA1C.	• The aim of the project is for early diagnosis of Diabetes. • Patients at risk of type 2 diabetes are identified using E-Healthscope. These patients are then invited for a HBA1C blood test. There is a payment associated for referrals into the National Diabetes Prevention Programme. Newly diagnosed patients may be suitable for the NHS Low Calorie Diet Programme.	To prevent CVD	Piloted at Abbey Medical Centre – to rolled out across Mid-Notts	✓	✓	
Hypertension Case Finding (PCN DES)	To identify patients with a last high blood pressure reading without diagnosis of hypertension.	• Patients living in socio economic decile 2 (20% most deprived) with a last high blood pressure reading without diagnosis of hypertension are identified using e-Healthscope. Patients are contacted by the Health and Wellbeing Coach and advised to record a home blood pressure diary for 5-7 days. • If the average reading is raised - GP review for further management.	Case finding patients to prevent CVD.	N/A – PBP Partners	✓		✓
NHS Low Calorie Diet	Obese type 2 diabetic patients are identified for the programme.	• Patients to be identified using e-Healthscope. • This is a 12-week meal replacement drink programme that encourages rapid weight loss. • Over half achieve remission of Diabetes • Clinician needed to refer because medications are stopped when meal replacement starts.	Improve the management of diabetes	N/A – PBP Partners		✓	

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Pulmonary Rehab Case Finding	Patients with COPD to be referred for pulmonary rehab.	• Patients with COPD who haven't had pulmonary rehab in the last 24 months are identified on e-Healthscope and contacted by the care navigator to discuss a referral.	To help improve COPD rates and outcomes	N/A – PBP Partners		✓	
National Population Health Management Programme – PLACE Workstream PCN Coaching Sessions	To develop a scalable plan to restore services inclusively and address inequalities by linking elective data with person level population health analysis	The Population Health Management Development Programme's Place Workstream has commenced. At the 3rd Action Learning Set it was agreed that the focus cohort for the rest of the programme would be Younger People with Mental Health Conditions and planning interventions and assessing impact on the system as a result. Due to the time commitments for the PCN workstream it was agreed to incorporate the PCN workstream into the PLACE wokstream. The GP Coaching sessions provided by Optum have been used to help PCNs design a proactive intervention. Ashfield North are case finding patients aged 20-39 who are obese and have asthma. Patients with mental health problems are excluded. Identified patients are signposted into existing community assets and services.	Meeting the future needs of local populations and reducing future risks to ill-health, utilisation and financial risk Changes to care delivery to address unwarranted variation in health outcomes.	N/A – PBP Partners		✓	
Dementia - Recruitment of Admiral Nurses. (PCN DES)	Target carers (Children, Adults) who are caring for loved ones with Dementia	• Providing support by way of clinics, telephone, counselling or face to face consultation • Asset mapping, creating links engaging with other organisations such as working age dementia service, dementia support groups, carers hub, links to translators, locate free course help reduce inequalities • Education, sharing information around risk factors and risk reduction • Improving ways to identify and support carers	Improvement in the quality of life and mental health outcomes for both carers and their loved ones with Dementia Educate carers around the disease, informed decision making, preventing a crisis	N/A – PBP Partners	✓	✓	
Social Prescribing Link Workers and Health and Wellbeing Coaches	To help reduce health inequalities by supporting people with complex issues affecting their wellbeing	•Engaging with local assets, linking in with tertiary voluntary sector organisations • Initiating local regular venues for holding group activity	• Improving quality of life for patients • Increasing knowledge of local services and assets • Improving physical activity and education around the importance of diet and wellbeing	N/A – PBP Partners		✓	✓
Social Prescribing in ED	Engagement with patients that are by-passing Primary Care by choosing to have their primary care needs met in an urgent care setting.	By collaboratively working with secondary care colleagues, social prescribing support will be provided to patients arriving at ED with complex socio-economic issues rather than requiring medical intervention. Patients will be advised on how to correctly access services, provided with support to register at a GP practice of their choice and will receive holistic care tailored to their needs through onward referrals to established services within their community. Education will also be provided to staff in ED on services that are available that will help reduce inappropriate attendances at A&E.	To create a health prevention and promotion environment in ED that takes a behavioral/lifestyle approach rather than the current medical approach.	N/A – PBP Partners	✓	✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Strength Based Approaches	All	Managing resources and work with partners across the department and the wider system effective, efficient and consistent in supporting good outcomes for people.	Support people to enjoy meaningful lives where they can make positive contributions to their families, networks and communities. Support people to live as independently as possible Enabling them to be in control of their lives and support and having a better quality of life	N/A – PBP Partners	✓	✓	
Community Urgent Response and Rehab Team (CURRT) via Call for Care	Patients at risk of hospital admission	The CURRT Team provide care navigation, urgent response and short-term intensive rehabilitation to support timely discharge from hospital and prevent unnecessary hospital admission. Providing additional project management capacity to support the integration of the delivery of the Strength-Based approach innovation site programme funded by Nottinghamshire County Council to include the Living Well Social care teams, health, relevant PCN ARRS roles and community and voluntary sector within the innovation sites. Urgent Response – Following a referral from health and social care professionals the team will provide a face-to-face assessment to prevent hospital admission within 2 hours. Also, initiation of most appropriate community service and signposting to other health and social care providers. Hospital at home – Diagnosis, treatment and review of medically unwell patients who do not require acute medical intervention and are stable to be cared for at home. Supporting timely discharge for continued medical monitoring and /or intensive rehabilitation at home.	Reduction in emergency admissions and ED attendances. Increased access to alternative services. Reduce avoidable hospital admissions	N/A – PBP Partners	✓	✓	
GP Prescription Scheme	Patients with a new diagnosis of depression or anxiety	Membership to try and help improve their mental health. Also signposting into IAPT. Patients with diabetes or obesity are offered a gym membership. Patients are identified using e-healthscope. Also, in the process of creating a pop up in SystmOne. Patients to then be contacted and offered a referral onto the GP exercise referral scheme.	To improve mental health To encourage weight loss in obesity and patients with diabetes	N/A – PBP Partners	✓	✓	
Reducing alcohol consumption	Patients with harmful drinking	Patients who are drinking harmfully are identified using e-healthscope. Patients are then contacted by a social prescribing link worker to discuss a referral to Change Grow Live, Nottinghamshire's drug and alcohol support.	Reducing alcohol consumption	N/A – PBP Partners	✓	✓	
Smoking Cessation	Smokers	Comms campaign to encourage smokers to use e-cigarettes instead of smoking. E-Cigarettes have been found to be a lot less harmful than smoking.	To decrease the number of smokers.	N/A – PBP Partners	✓	✓	✓

Mid-Notts Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	CS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Exploration of the care pathways for children and young adults with mental health or behavioural symptoms around the health, education and social care services.	Children ages 5-16 with mental health or behavioural symptoms.	• Consult stakeholders in the pathways of care from wellness to illness affecting children and young people (such as schools, healthy families team members, child and adolescent mental health services, educational psychology, community sector leaders and organisations). • listen to their experiences and reflect on how to do things differently in the future. • Increase awareness of health services amongst children and young people (through greater engagement with schools, local media and consultation with third sector organisations who have close links with young people).	To remove barriers to healthcare	Ashfield North		✓	
Patients with mild to moderate COPD	Patients with Chronic Obstructive pulmonary disease	• To invite patients within the PCN with mild to moderate COPD for an appointment. The aim is to educate patients about their condition, advise on self-management and when to seek help. • To also design a workshop based on group sessions to encourage and offer advice on exercises, health living, educate to increase Covid / Flu / Pneumonia vaccination, to reduce infection exacerbation and prevent emergency admissions. • To work with the smoking cessation project to encourage COPD patients to stop smoking .	To educate patients with mild to moderate COPD on self-management and lifestyle advice to reduce emergency admissions.	Ashfield South		✓	✓
Physical health checks for patients with SMI	Patients with SMI	To provide a PCN clinic to complete physical health checks for patients with SMI with help from the health improvement worker.	To improve physical health in patients with SMI	Ashfield South		✓	✓
Increase the uptake of annual health checks for learning disability patients	Patients with LD	A LD Practitioner has been employed by the PCN to focus on pts on the LD register, who have not had a completed annual health check. The focus is for increasing uptake on patients that have not engaged with the practice and appointments can be offered in their own homes or day centres etc.	To improve the care for learning disability patients	Mansfield North and Rosewood PCNs		✓	
Identify, support and increase uptake of health checks for patients with severe mental illness.	Patients with Severe Mental Illness	To employ an SMD Care CoOrdinator, SMD Social Prescriber, Mental Health OTs, Mental Health Nurse and Health & Wellbeing Coach to support patients experiencing Severe Mental Illness. The team are to support patients to explore opportunities available to them to improve their mental wellbeing, look at the lifestyle and offer support for areas which could be/are contributing to the level of the SMI as well as offering support with 1-2-1 Mental Health and Health & Wellbeing sessions	To improve physical health in patients with severe mental illness	Rosewood		✓	✓
Improve understanding of barriers to accessing healthcare in the most deprived Type II Diabetic population in Sherwood PCN.	Patients with type II diabetes who live in socio economic decile 1	• Conduct in-depth interviews with the ten most deprived Type II Diabetic patients from each practice population to discuss their management, self-management and any barriers they experience to care. This may involve onward referral/signposting to appropriate services, support groups, PCN Social Prescribing Link Workers and/or Health & Wellbeing Coach. • To feed back findings to PCN practices and local services to highlight any changes needed to design services around our most deprived population. This may include group consultations to encourage the development of support from within communities themselves.	Long term improved outcomes for patients with type II diabetes.	Sherwood	✓	✓	✓
Improve lifestyle factors for patients at CVD and Stroke Risk	Patients at risk of CVD and stroke	To look at potentially treatable lifestyle factors for CVD and stroke prevention such as untreated hypertension, atrial fibrillation, diabetes and lifestyle factors such as obesity, smoking and alcohol excess. To implement targeted support and interventions for these cohort of patients including patients who don't present to primary care by collaborating with local partners for health promotion in the community.	To decrease the risk of CVD and Stroke through improving patients lifestyles.	Newark		✓	✓

Bassetlaw Place Based Partnership

Bassetlaw Place Partners have collaboratively developed 6 place priority areas and a range of initiatives to support achieving key local ambitions

Bassetlaw Place has a focus on marginalised communities due to rurality, deprivation and ethnicity, with minority ethnic group including individuals from Eastern European communities.

21% of the Bassetlaw population live within an area of high deprivation

Integrated Care System
Nottingham & Nottinghamshire

Bassetlaw Place Based Partners

Nottinghamshire County Council

NHS Nottingham and Nottinghamshire Integrated Care Board

3 Primary Care Networks (PCNs):
GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices.

Bassetlaw DISTRICT COUNCIL — North Nottinghamshire —

healthwatch

BCVS Bassetlaw Community and Voluntary Service

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

Bassetlaw Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Recreational green spaces	All Bassetlaw population	Publication of Bassetlaw Local Plan: Planning and Open Spaces Chapter.	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners	✓	✓	
Green social prescribing initiatives	All Bassetlaw population	VCSE initiatives focused on green and blue social prescribing across Place, promoting healthier lifestyles and reduced air pollution	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners		✓	
Respiratory care	Those with respiratory conditions	Respiratory care pathway review as part of virtual ward development leading to Reduction in emergency admissions related to respiratory (adults and children) (Baseline 19/20)	Increased access. Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners		✓	✓
Financial sustainability	Those at risk of financial insecurity	Financial sustainability for Place and system to deliver local initiatives that reduce HI and improve outcomes.	Access, experiences and outcomes	N/A – PBP Partners		✓	
Bassetlaw Emergency Village	Those at risk of hospital admissions	Meeting same day/urgent care needs and developing pathways of care across high volume patient flows into ED. Increasing monthly average of patients presenting at ED streamed into alternative pathways of care including self care.	Increased access. Increasing ill health prevention. Improved outcomes experiences	N/A – PBP Partners	✓	✓	
Increased crisis Support	Those with a mental health crisis	Increase in crisis support for people with SMI e.g. crisis sanctuaries, safe spaces, crisis helpline, 24/7 CRT	Increased access . Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners	✓	✓	
2hr Urgent Community Response Service	Those at risk of hospital admissions	Supporting admission avoidance, patients are supported to remain safely at home with appropriate services in place Reduced non-elective activity – ED attendances and non-elective admissions· Reduce ambulance dispatches and conveyances to ED Community.	Increased access . Increasing ill health prevention. Improved outcomes experiences.	N/A – PBP Partners	✓	✓	
Reducing Childhood Obesity	Children classified as overweight/obese	Childhood obesity/family weight management. Programmes with partners including a focus on most deprived areas	Reduction in childhood obesity, improve health outcomes for CYP.	N/A – PBP Partners	✓	✓	✓
Improving access to mental health and wellbeing initiatives	CYP in most deprived areas with	Community mental health and wellbeing services for children and young people including a focus on most deprived areas: PCN based CYP Social Prescribing Link workers School based MHST VCSE delivered mental health provision LGBT+ support Kooth on line mental heath support	Increased access. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓
Evergreen COVID and Flu vaccination campaign	Under 25s	PCN COVID and Flu vaccination clinics- community based vaccinations utilising health bus for eligible CYP <25 years including a focus on most deprived areas.	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners	✓	✓	✓

Bassetlaw Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Improving Early Starts initiatives	Pregnant smokers	Improved Maternity care services working in parentship with DBTH. COVID and flu vaccination programmes to increase uptake in pregnant women Smoking in pregnancy support	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners	✓	✓	✓
Harworth and Bircotes Youth Hub	CYP	Multi service Youth Hub for young people, promoting earlier access to appropriate services.	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners		✓	
Increasing volunteering initiatives and opportunities	CYP	VCSE led- Point of View Volunteering Project, increasing access to volunteering initiatives for younger people	Improved experiences. Improved access to services. Improved outcomes. Increasing ill health prevention.	N/A – PBP Partners		✓	
Severe Mental Illness (SMI) initiatives	People with SMI	Individual Placement Support (IPS) Employment support service, increasing number of people on SMI register supported into employment Health checks for people with SMI and LD	Increased access. Increasing ill health prevention. Reducing HI. Improved outcomes experiences	N/A – PBP Partners	✓	✓	✓
Mental health and wellbeing initiatives	Adults with mental health issues	Increase in provision of mental health services and roles for adults: Admiral Nurses and Mental Health Practitioner roles in PCN's IAPT Services Bereavement support services Street Watch Programmes VCSE mental health services and projects Peer support workers Community based Health & Wellbeing Coaches Working Win employment support services Implementation of Comms initiatives to support public awareness of local mental health services	Increased access to services Improved mental health and wellbeing outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	
Suicide Prevention Alliance and Initiatives	Those affected by suicide	Development of Suicide Prevention Alliance, local pledges and initiatives reducing reported rates of self-harm and suicide Men's suicide prevention support groups Survives of Bereavement from suicide support groups Street Watch Programmes Suicide prevention initiatives via the Small grants schemes	Increased access. Improved mental health and wellbeing outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	
Early cancer diagnosis focused task and fish groups and initiatives		Increase cancer cases diagnosed at Stage 1 or 2 as a result of local initiatives: Implementation of Targeted Lung Health Checks -50yrs+ ex-smoker/occupation. Implementation of 'C the Signs' initiative across all GP practices Increased cancer Screening programmes Cancer Alliance Behavioural Science nudge techniques implementation across all GP practices Comms and public engagement cancer awareness campaigns supported by all partners PCN Cancer Champions	Increased community engagement. Increased access to services. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓

Bassetlaw Place Based Partnership & PCN Initiatives

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Smoking Cessation initiatives	Smokers	Quit Programmes reducing health inequalities and premature mortality related to smoking. Pharmacy sign up local e-voucher NRT scheme	Increased access to services. Improved outcomes. Increasing ill health prevention. Improved experiences.	N/A – PBP Partners	✓	✓	✓
Bassetlaw Food Insecurities Network	Those living in more deprived area	Development of food hubs with a focus on deprived areas. Slow cooker meal preparation courses delivered within the community. Community eating events.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners		✓	
Increasing access to community prevention initiatives	Overweight adults	Adult weight management, Physical Activity, Alcohol reduction. Homeless Health Team-Out of Hospital support	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	
Evergreen COVID and Flu vaccination campaign	All	PCN COVID and Flu vaccination clinics- community based vaccinations utilising health bus	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Health Improvement Team (HIT) focused on increasing access to care	Those living in more deprived area	Bassetlaw Health Improvement Team (HIT) focusing an annual physical health checks and follow up care for patients in deprived areas	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Marginalised Communities initiatives	Marginalised communities	Increase community engagement and prevention initiatives. Improving equity of access for more marginalised communities due to rurality, deprivation or ethnicity (i.e. Bassetlaw's Eastern European communities). Focusing on addressing equity of access and outcomes for 20% most deprived communities, (IMD1 & 2 cohorts) fully aligned with both Core20Plus5 expectations and Bassetlaw District Councils Thriving Neighbourhoods Strategy 2021-2025.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	✓
Community engagement and participation initiatives	LGBT+ Communities	Increased engagement and focus on reducing health inequalities across LGBT+ communities, improving mental and physical health outcomes	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓	✓	
Increased public engagement and Health Promotion initiatives	All	Mobile Health bus utilization for health promotion/advice. Communication and public awareness plans. Community events, increasing citizen engagement and awareness of health promotion and local services. Promoting earlier access to appropriate services.	Increased access. Improved health and wellbeing outcomes. Increasing ill health prevention. Improved experiences	N/A – PBP Partners	✓		

Bassetlaw Place Based Partnership & PCN Initiatives

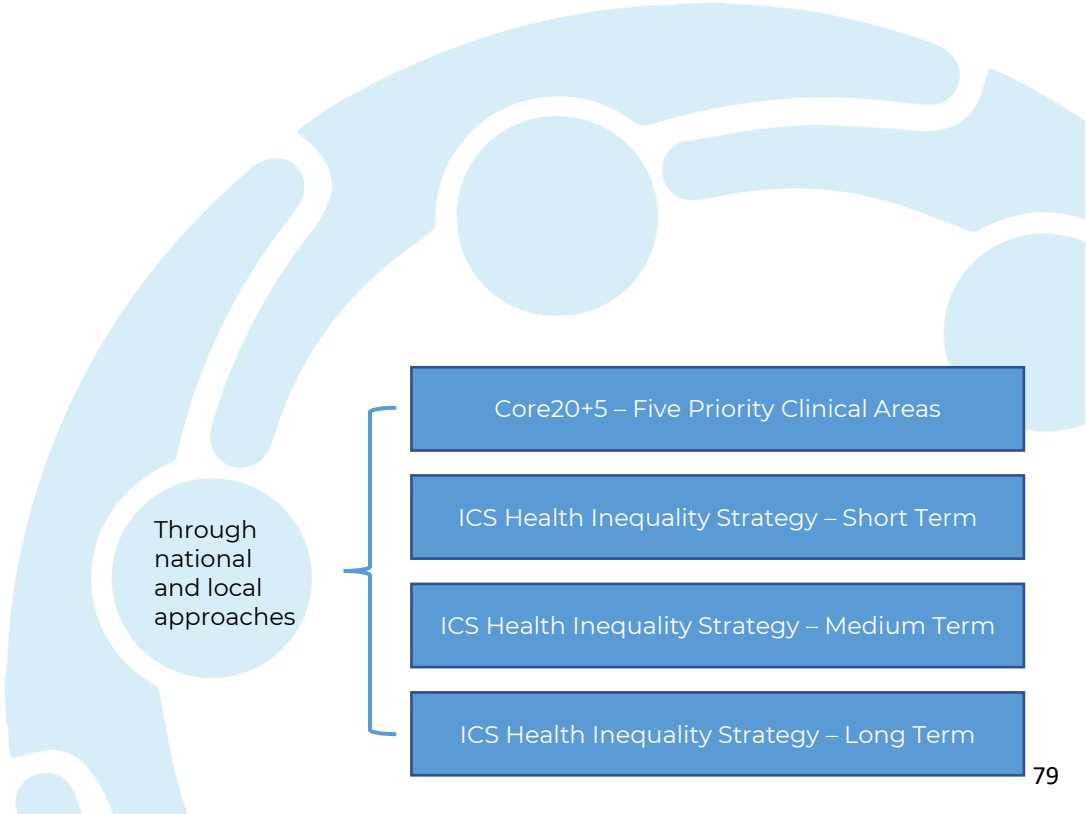
Integrated Care System
Nottingham & Nottinghamshire

Initiative	Population Cohort & Inclusion Health Group	Description	Impact on H.I. through Access/Experience/Outcomes	PCNs Involved	ICS H&W Strategy	Joint H&W Strategy	Core20 Plus 5
Increasing inclusiveness & independence initiatives	Those at risk of digital exclusion	Digital confidence and competence initiatives, increasing digital confidence and competence and reducing HI Roving exercise support for rural communities and older people	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	✓
Increased all age frailty support	Those at risk of frailty	Virtual Wards- Frailty and Respiratory focusing on patients deemed to be frail and those unable to access services	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners		✓	
Reducing social isolation and loneliness initiatives	All	Social prescribing roles. VCSE delivered community programmes. Community transport schemes	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	
End of Life and Palliative Care	Those at end of life	Integrated pathway development	Increased access to services Increased ill health prevention. Improved outcomes and experiences	N/A – PBP Partners	✓	✓	✓

Integrated Care System
Nottingham & Nottinghamshire

E. System Implementation Plans

Includes system level initiatives, complimenting and building on targeted actions taking place through from PCNs and Place Based Partnerships.



The Plus 5 – The ICS Plan

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes
Maternity Continuity of Carer (COC)	Ensuring continuity of carer for 75% of women from BAME communities and from the most deprived groups	✓	✓	• Achieving full implementation of COC continues to remain a considerable risk. It is anticipated that the LMNS will not achieve the national target for CoC due to current staffing challenges, and are likely to be at least a year behind target achievement. • An equity analysis for the system has been completed which will inform our planning of how to tailor COC to those most in need. • Priorities for implementation for COC being redefined. • A new digital maternity information system will be implemented which will support the opportunity to understand maternity care across different population cohorts • NUH have received external funding from Small Steps Big Changes to recruit and train a new Maternity Support Workforce.	Experience and Outcomes
SMI Health Checks	Ensuring annual health checks for 60% of those with SMI (regional average is currently at 28.3% and national average at 30%)	✓		The ICS are working to the LTP Ambitions Toolkit. In 21/22 this equates to 4,881 patients having an annual healthcheck. The system is at approx. 38% which is above the national averages . Health Improvement Workers (HIW) have had a significant impact on uptake. • Monthly monitoring of practice and PCN level data, identifying areas requiring additional focussed support. Performance dashboards are reviewed at GP and PBP level. • Continued engagement with the regional PH SMI clinical network meetings, sharing learning and implementing best practice. • The PHSMI Local Enhanced Service (LES) started this year with 98% of practices signed up to the incentive scheme to deliver the 5 additional supporting indicators as part of the physical health checks. • Performance against the PHSMI LES is monitored monthly, enabling the system to respond in a timely manner and flex support accordingly. This data is shared with the PH SMI Steering Group to agree prioritisation of outreach support from the Health Improvement Workers (HIWs) to primary care. Communications to practices continue to promote the undertaking of physical health checks. • HIW posts continue to support the uptake of physical health checks for patients accessing secondary care mental health services.	Access, Experience and Outcomes

The Plus 5 – The ICS Plan

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience /Outcomes
Chronic Respiratory Disease	A clear focus on COPD, driving up uptake of COVID, Flu and Pneumonia vaccines	✓	✓	• Lung Health Check Units are in areas where there is higher prevalence of respiratory disease. This is being used as an opportunity to find those who are undiagnosed with chronic respiratory conditions. • COVID and flu vaccination programmes are targeting those who are clinically vulnerable. Strategy being developed for 22/23 that will align the approach and combine efforts across flu, pneumonia and COVID vaccines • Weekly reporting is utilised to monitor and target uptake	Access, Outcomes
Early Cancer Diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028 N&N have seen an increase in 20/21 resulting in approx. 30% of cancers diagnosed at an early stage.	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓	**Targeted Lung Health Check:** Will help to diagnose cancer earlier. Implemented in Mansfield and Ashfield where have higher risk. Initial CT Scans – 1729. 3 Month follow ups – 187. Cancers diagnosed – 13 (20 patients still on an active diagnostic pathway). 7 early stage, 6 late stage. 13% of scans identified incidental findings requiring either secondary care or primary care actions. Nottingham City Project to start in 22/23. **Rapid Diagnostic Concept/Centres** (RDC): Over £1m funding received to streamline cancer diagnostic pathways. Implementing one stop diagnostic shops, holistic assessment of symptoms, coordinating diagnostic tests, single point of contact for patients. Excellent progress being made with several pathways to go live in Q4. **Galleri blood test pilot:** national study to evaluate role of a cancer blood test to diagnose 50 types of cancer before symptoms are apparent to patients. Underway in Mansfield with all 2000 appointments booked. Will also be implemented in Nottingham City. **Lung cancer hotline:** pilot in Nottingham City with opportunity to roll out wider if successful. Patients will be invited to contact the hotline if experiencing any listed symptoms of lung cancer. Callers will be triaged and have urgent chest CT booked if appropriate. The pathway will therefore bypass GP visit, 2WW referral and chest x-ray. **Community diagnostic hubs:** will be important enablers for all the projects above. ICS received indicative capital funding envelope of £24m over 3 years. Awaiting confirmation of revenue allocation. • Work with Cancer Alliances to develop and implement a plan to - make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower. • Timely presentation and effective primary care pathways - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)	Access/Outcomes Access/Experience/ Outcomes

The Plus 5 – The ICS Plan

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes
Hypertension Case Finding	To allow for interventions to optimise blood pressure and minimise the risk of M.I. and stroke	x		• Hypertension Task & Finish Group set up March 2022 to support implementation and progression of hypertension case finding model as well as ongoing management and optimisation of patients. • Pilot PCNs to be identified using Core20PLUS5 principles to implement model from May 2022. Initially one PCN from each Place Based Partnership (PBP). • Model will build on BP@Home project utilising BP monitors supplied as part of the project. • Community Pharmacy to be key component of the model linking with the Hypertension Case Finding Service. • Work taking place with Connected Notts to provide support to patients via NHS App/PKB with personalised care and support plans – June 2022 • Exploring the use of PCN additional roles to support the case finding in primary care. • Proactive Care Framework for Hypertension to be used to support primary care with the management and optimisation of identified patients, working alongside the case finding model.	

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/Outcomes	1	2	3
Restoring NHS Services Inclusively	Waiting List Analysis Long Term Condition Mgmt Mental Health	✓ ✓ ✓		Waiting list data health inequalities • Quarterly system wide roundtable established to review waiting list data and take forward type and format of analysis • Deep dive analysis carried out in relation to deprivation and ethnicity from referral through to discharge across the urology and cardiology pathways – to be further developed and utilised to inform decision making • Waiting list data being utilised for waiting well services and piloting Link Worker support in this context – wider programme to be developed • Peri-op diabetes pilot implemented and to be evaluated in 22/23 Long Term Condition Management • Specific analysis undertaken has included the impact of COVID on CVD, respiratory and diabetes non-elective admissions – being utilised to inform targeted efforts • Will be analysing missing cancer patients by location and deprivation in order to target efforts A&E • A&E attendances and "health seeking behaviours" analysis being utilised to inform Mental Health • LD/SMI healthchecks • Targeted work being carried out in relation to lower access to IAPT for Asian and South Asian population	Access/Experience/Outcomes	✓		

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Ensure Datasets are Complete and Timely	ICS approach to data integrity through the SAIU	✓	✓	Additional information is included in the enablers section. All organisations across the ICS have processes in place to improve the completion rate and accuracy of capturing ethnicity in their patient records – focus will continue during 22/23 ICS will be using local technology that will allow systems to communicate with each other in order to safely share ethnicity information. This will allow individual organisations to use this shared access to improve completion rates and processes can be put in place to improve accuracy if there are any conflicting records. Local databases of GP records have been used to identify Primary Care Networks with a high proportion of 'Not Stated' or 'Unknown' ethnicity codes (ranges from 3%-18%). Practices within these PCNs have been targeted for a pilot programme using direct messaging to patients with 'Not Stated' or 'Unknown' ethnicity code, patients are asked to complete a short survey to update their ethnicity. Project in place to substitute ethnicity codes from secondary care settings where they are available but missing from the primary care record. The governance structures of the ICS includes a Strategic Analytical Unit with representation from analysts across all partners. The SAIU is supported by an operational group and strategic oversight board. The ICS also has a Data and Information Board with a focus on data sharing and data integrity.	Access/Experience/Outcomes	✓	✓	✓
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Vaccination Uptake (including COVID, flu and pneumonia)	✓	✓	**Vaccination uptake:** Since first going live with the vaccination programme, the ICS has had a strategy and operational focus on increasing uptake for those groups most at risk. The initiatives to target specific areas has developed throughout the programme, recognising the complexity and need for locally designed interventions, which have been supported by robust reporting and the SHAPE tool. A COVID and vaccine inequality report is updated weekly and this is used to target activities. Comprehensive weekly reporting is also produced for uptake of the flu vaccine with teams and PBPs working with practices to target specific populations. Targeting local communities has been effectively implemented through partnership working with the CVS, community champions and local authorities. Plans are currently being produced for the ongoing management of a COVID vaccination programme that includes learnings from actions being taken and the success of these in targeting populations.	Access, Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Diabetes (see also transformation programme for children)			Extensive PHM review has been refreshed which will support the implementation of impactful interventions and targeted actions taking into consideration the impact of COVID on the local population. Continuing with transformation programme including pre-op case management for high risk individuals, specifically with a focus to impact on inequities in access and outcomes. Low Calorie Diet – targeted approach to promoting and take up in order to reach the communities most in need. Structured Education – Returning to face to face sessions. Actively promoting structured education. Plans to provide Diabetes UK Type 2 Packs through community pharmacies which supports structured education. NDPP - Targeted campaign to increase uptake of NDPP in cohorts and areas where this is lowest including additional communications and promotional efforts in relation to self-referrals, progress work of local educators that speak multiple languages, attending community events, provider is continuing to recruit patient locality champions (includes 20% most deprived and inclusion health groups). Care Processes & Treatment Targets - LES for diabetes management that supports an improvement in the care processes and treatment targets, including in areas of highest risk.	Access, Experience, Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Diabetes (see also transformation programme for children)	✓	✓	Children Transformation programme to address : CYP with type 1 diabetes from ethnic minority backgrounds are more likely to have higher than average HbA1c levels. CYP from the most deprived areas are most likely to have higher HbA1c levels. Those living in the most deprived areas were founds to have a higher risk of retinopathy and albuminuria, and were found to require more psychological support There is evidence showing a lower use of insulin pumps in ethnic minority groups. There is a gap in the percentage of CYP from the most deprived areas and least deprived areas using insulin pumps. This gap is widening. Addressing this inequality is important because technology, such as insulin pumps and glucose monitors, can help people regulate and monitor their diabetes, reducing the risk of hypoglycaemic events, DKA and other long term complications.	Access, Experience, Outcomes	✓	✓	✓
Accelerate Preventative Programmes **(see medium term for alcohol, smoking, obesity)**	Respiratory	✓	✓	Targeted work is being undertaken in relation to disparities in non-elective admissions Assistive technology projects inclusive of digital inequalities approaches Programme progressing to support an increase in the uptake of and completion of pulmonary rehab Severe asthma reviews and asthma biologics. Children Transformation Programme to develop plans to address asthma outcomes which are worst for CYP in more deprived areas and significantly higher rates in minority ethnic groups.	Access, Outcomes	✓	✓	✓
	CVD			Hypertension case finding is part of the ICS CVD priorities and includes working with PBPs to identify “teachable” moments with a holistic approach that is relevant to communities of highest risk. As in the Core20+ approach the PBPs have identified inclusion health groups where consideration of protocols is being undertaken. In relation to CVD management the ICS are progressing with a risk stratified approach to managing the backlog of people with hypertension Working with AHSN and medicines management team to undertake AF screening and review, approach to opportunistic atrial fibrillation screening being reviewed Targeting Blood Pressure at Home through practices in more deprived areas plus consideration of how Social Prescribers can support self-management plans.	Access, Outcomes			

ICS Health Inequality Strategy – Short Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Smoking Cessation	Tobacco control strategy, Long-term plan commitments	✓	✓	**NHS Staff** – piloting a system wide NHS staff smoking cessation service. Implement programme through smoking cessation app. Part of pilot is to evaluate whether app increases or hinders access (will be informed by digital inclusion work) Programme supported by a robust comms and engagement strategy Long Term Plan Priorities	Access/Experience/Outcomes	✓	✓	✓
		✓	✓	**Maternity** – In house (SFH and NUH) smoking cessation services for pregnant mothers. Early implementer service for maternity commenced in SFHT in December 2021. Smoking cessation incentive scheme is being piloted in SFH, targeted at young pregnant ladies and partners. Through NUH targeted smoking cessation services for pregnant ladies in two of the most deprived areas is in place and plans are being developed for implementation of the NHS maternity model.				
		✓	✓	**In-patient** - Plans to expand on existing inpatient services in NUH and SFH are being developed ready for roll out during 22/23.				
		✓	✓	**Mental Health** - NHT have been accepted as an early implementer for the inpatient/outpatient mental health model. This will complement the existing smoking cessation programme and in-patient services are offered through the Trusts with the opportunity to expand on these.				
				See also PBP plans. ICS to work with and take direction from Public Health in relation to the Tobacco Control Strategies plus the CLEAR approach. This will allow for a wider consideration to the Long Term Plan commitments.				

ICS Health Inequality Strategy – Medium Term

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Obesity	Provision of weight management services and progressing strategy that recognises the complexity of obesity (obesogenic environment)	✓	✓	Implementation of Low Calorie Diet programme – will target areas of highest need Implementing a fixed term tier 3 service for adults that addresses current gaps and increases capacity in order to respond to the impact of COVID (increased waiting lists, changes to referral criteria) Tier 3 weight management service for children being implemented that includes a whole family approach Promoting Digital Weight Management Service Working with Public Health to review weight management services as an overall programme across the system including addressing gaps for tier 3 and the more severe obese Along with HWS plans to work at PBP, with Public Health to identify system wide actions that fall outside of weight management services	Access/Experience/ Outcomes	✓	✓	✓
Alcohol	Long Term Plan commitments in relation to ACTs and local priorities	✓	✓	Alcohol Care Team operational in NUH. Working with NUH to evaluate and understand how best to integrate services to meet the needs based on population cohorts accessing, recognising that COVID has changed the demographics for high risk drinkers. In order to understand and match services to population need (recognising the Core20+ approach), a mapping exercise is being carried out of existing services which will inform the type and level of service required across Nottingham and Nottinghamshire. Progressing with plans to target high risk communities with local fibroscanning.	Access/Experience/ Outcomes	✓	✓	✓
Children and Young People	Children's Transformation Plan and a focus across mental and physical health. To progress with a plan that supports HWS Best Start in Life programmes across City and County. To ensure that all workstreams consider the lifecourse.	✓ ✓ ✓	✓ ✓ ✓	Children's Transformation Plan including: Asthma, Diabetes, Infant mortality, obesity, Epilepsy, hospital/ED admissions Mental Health – Advancing mental health inequality framework for under 18s. Being driven by JSNA Actions LD/Autism – Progressing three year road map for children and adults with learning disabilities and autism which includes 10 activities to improve physical health, community provision, partnership working and active learning and development. Physical – In addition to the transformation plan is the tier 3 weight management services outlined in Obesity. The CYP Planning submission template was informed by Nottinghamshire's JSNA for mental health for CYP aged 0-25, the local transformation plan refresh and engagement with young people.	Access/Experience/ Outcomes	✓	✓	✓

ICS Health Inequality Strategy – Medium Term

Integrated Care System
Nottingham & Nottinghamshire

Children and Young People Transformation Priorities

Obesity

Nationally
9.9% children 4-5 years were obese.
1 in 5 children 10-11 years were obese
Nottingham City
12 % children 4-5 years were obese
1 in 4 children 10-11 years were obese
Nottinghamshire County
9 % children 4-5 years were obese
1 in 5 children 10-11 years were obese

Asthma

Nationally
158.3 emergency admissions for asthma per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 99.8% of other areas in England with a rate of 96 emergency admissions for asthma per 100000 children 0-19 (number =85)

Hospital / ED admissions

Nationally
655 ED attendances per 100000 children under 4 years
Nottingham City
717 ED attendances per 100000 children under 4 years (number =14900)
Nottinghamshire County
553.2 ED attendances per 100000 children under 4 years (number =24830)

Epilepsy

Nationally
77.2 emergency admissions for epilepsy per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 55.5 emergency admissions for epilepsy per 100000 children 0-19 (number =130)

Diabetes

Nationally
51.1 admissions for diabetes per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 38.4 admissions for diabetes per 100000 children 0-19 (number =90)

Infant mortality

Nationally
3.9 deaths per 1000 live births for babies under 1 year
Nottingham City
5.6 deaths per 1000 live births for babies under 1 year (number =22)
Nottinghamshire County
3.8 deaths per 1000 live births for babies under 1 year (number = 31)

ICS Health Inequality Strategy – Long Term

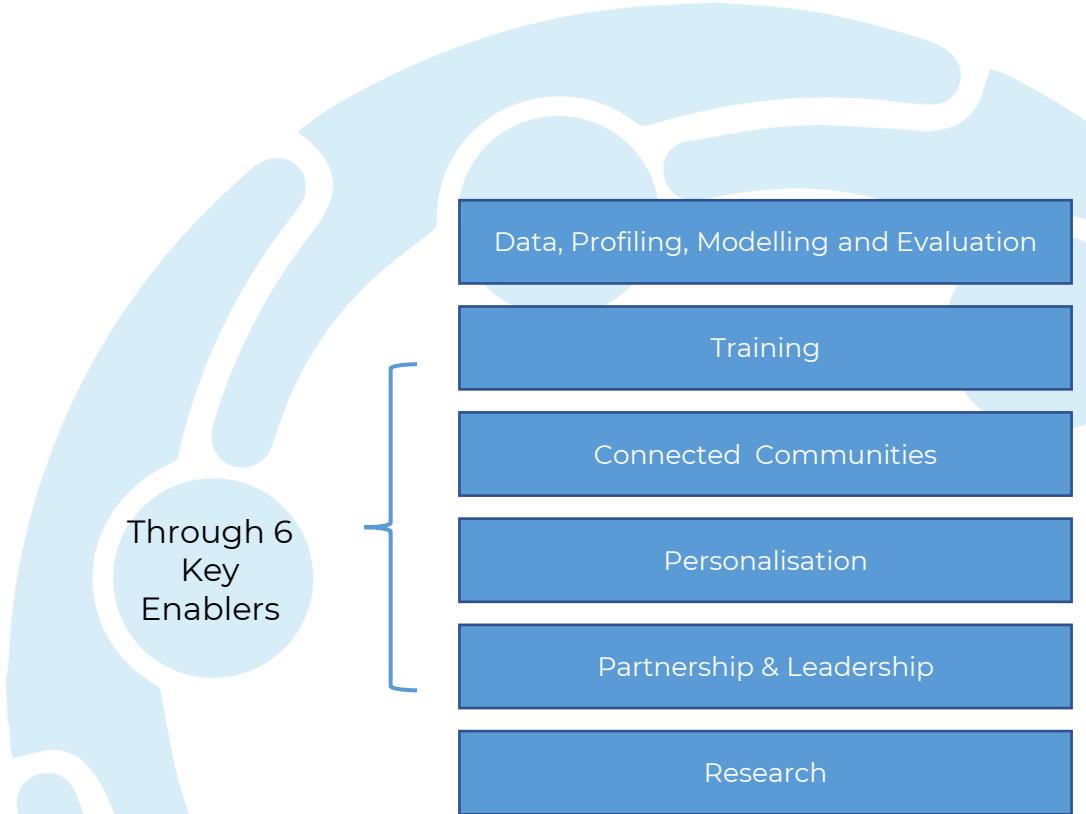
Integrated Care System
Nottingham & Nottinghamshire

Initiative	Aim	Impl 22/23	Develop into 23/24	Description & Actions	Impact on H.I. through Access/Experience/ Outcomes	1	2	3
Environment	Green Plan	✓	✓	The ICS Green Plan will sit alongside the environmental plans of the Local Authority and is informed by partner organisations plans. As part of the ICS Green Plan it highlights that the NHS will work to reduce its own contribution to air pollution and work with partners on actions to improve air quality and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation. Air pollution disproportionately affects people in these areas, many of whom are already at risk of poorer health outcomes. Examples of the links between climate change, sustainable development and health inequalities are seen across the country	Outcomes	✓	✓	✓
Employment	Nottingham & Nottinghamshire Universities Alliance	✓	✓	Participation in the Universities for Nottingham programme by the ICS and individual health and care partners is one of the ways that the ICS is working with other local partners to support local recovery from the pandemic and leverage the wider public sector efforts to improve our local area. Signatories of the UfN agreement have agreed that, “We are bound by a shared mission to improve levels of prosperity, opportunity, sustainability, health and wellbeing for local citizens, families and communities”.	Outcomes	✓	✓	✓

Integrated Care System
Nottingham & Nottinghamshire

F. Enablers

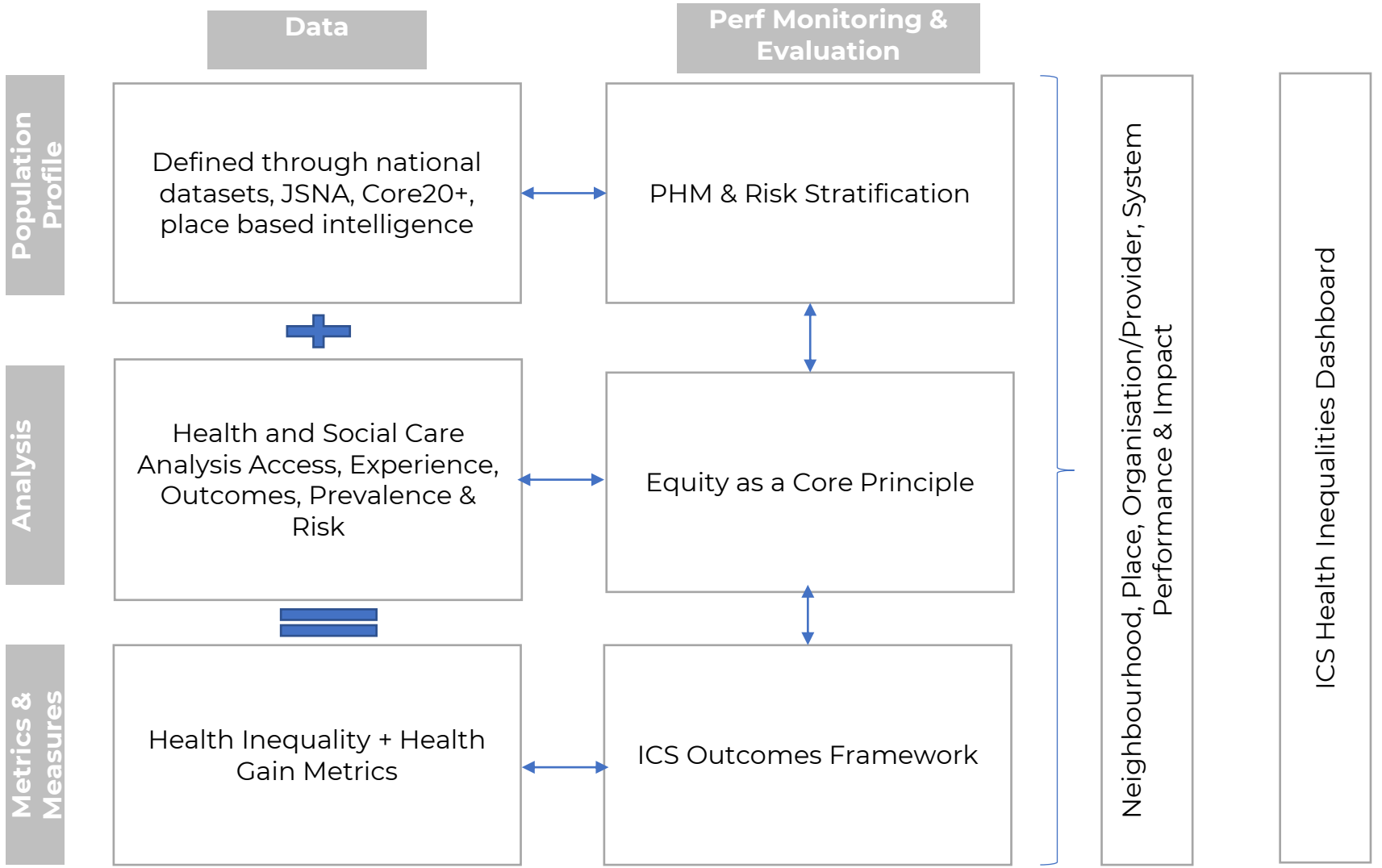
Providing a robust infrastructure to support focus, traction, impact across the ICS. These are resources we can use to help further create an equitable health system and are fundamental in making changes to the wider system



1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

Through the structures and partnership working the ICS has the foundations for data driven improvement. The diagram illustrates how the different elements of data and monitoring and evaluation interact. The ICS has progressed with embedding a structure for effective monitoring, analysis and evaluation for health inequalities and this is supported by the implementation of the Systems Analytics Intelligence Unit (SAIU)



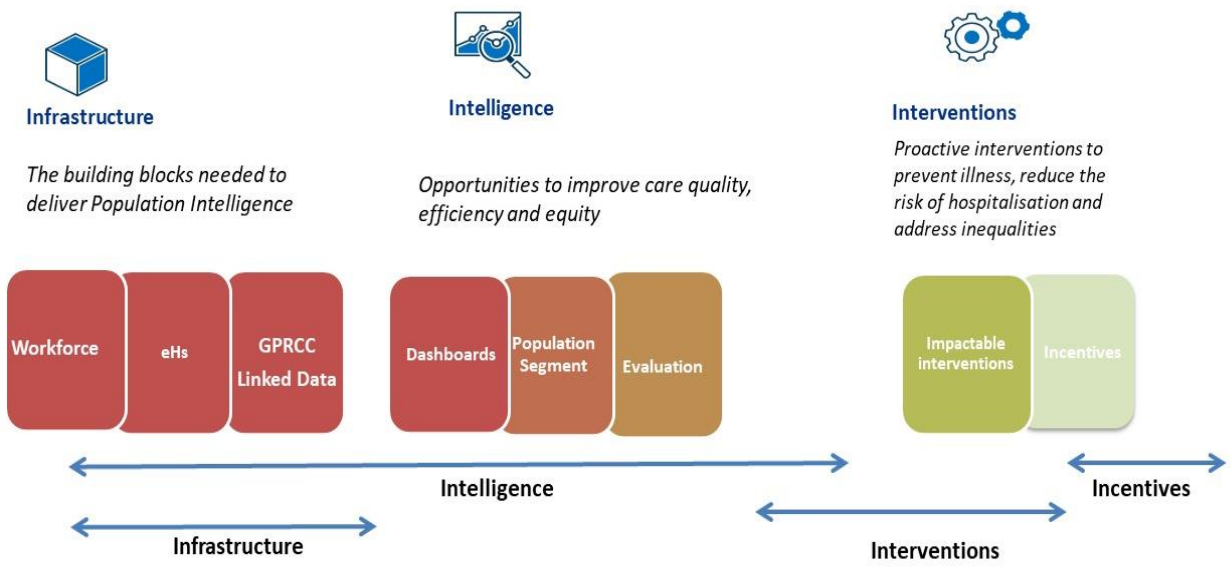
1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

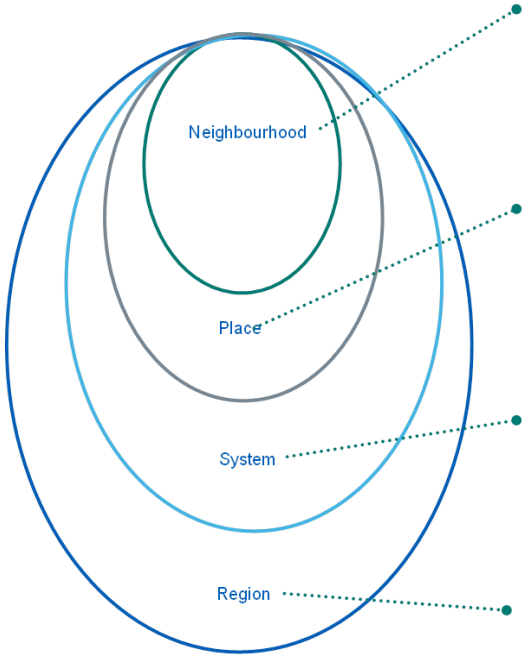
The core deliverables of the SAIU includes the PHM elements of infrastructure, intelligence and interventions which together contribute to actionable insight across the ICS . The SAIU operates as a central unit working across all partners and with all sources of data, embedding health inequalities principles as part of the analytical approach. The SAIU has a structured approach with a focus from a neighbourhood through to a regional understanding.

The SIAU is the ICS System Analytics & Intelligence Unit which is helping us move from a traditionally "data heavy" system, to an "intelligence rich" system. The SAIU is supporting us to collect meaningful data and analysis which can support population intelligence and support decision making. This data will actively help us identify inequalities and gaps in the system which we can then act upon.

Core Deliverables of the SAIU



Functions of the SAIU



Population profiles and implementing individual care packages for patients based on recommended interventions and targeting.

Describing the needs of different groups. Pathway modelling and implementation supporting transformation with PBPs, along with consideration of wider determinants.

Whole population segmentation and forecasting change. Supporting strategic overview of performance, peer review of unwarranted variation and productivity opportunities. Transformation between partners.

Clinical service planning across multiple systems. Specialised commissioning decisions driven by integration with other data systems.

1. Data, Profiling, Monitoring & Evaluation

Integrated Care System
Nottingham & Nottinghamshire

The SAIU provides the platform to have a system wide approach to data integrity, analysis and interpretation of data in relation to health inequalities. Taking a system wide approach not only means that we have the right focus on population characteristics and access, experience and outcomes in relation to service but also, incorporating the wider determinants. The ICS has an established PHM approach that supports the work on health inequalities. PHM is being used by the system and local teams to understand and look for the best solutions to people's needs – not just medically but also socially – including the wider determinants of people's health.

Initiative	Development focus	22/23	23/24
Health Inequalities & Population Health Management Approach	Using local data intelligence enables strategic commissioners to procure integrated care for the citizens of Nottingham/Nottinghamshire, improve outcomes, reduce duplication and use our resources more effectively bringing equity for all.		
	• Production and development of a population/health inequalities profile, using wider determinant data in conjunction with the PHM deep dives, support and embed the development of the Health Inequality framework system wide.	✓	
	• Production of health needs Profiles in line with JSNA and HWBB (working with PH colleagues)	✓	
	• Production and maintenance of inequalities system intelligence dashboard – (SID) and System Intelligence Reports (SIR's)	✓	
	• Developing a Health Inequality Framework; including reporting methods to support inclusion across all analytical teams dashboards and functions	✓	
	• Aligning annual plan, population demographics and high level model to strategically agreed outcomes.	✓	
	• Presenting how inequalities are likely to shape provision and highlight/mitigate risk between provider organisations	✓	
	• Working with primary care/digital colleagues to improve – defining segments, coding (ethnicity), outcomes etc	✓	
	• Supporting further HI analytical development of training with partnership organisations	✓	
	• Development of an overarching evaluation framework; how to evaluate positive outcomes, meet the local and national outcomes framework and strategic priorities of the system.	✓	
	• Monitors and evaluates performance against a consistent set of quality measures for health and care services	✓	
	• Evaluate performance on population segment basis	✓	
	• Service pathway metrics benchmarked against comparable/local organisations and national averages		
	• Embed adoption of evaluation and service improvement initiatives system wide.		

1. Data, Profiling, Monitoring & Evaluation

There will be an ICS approach in order that across the system there is a shared understanding of Nottingham and Nottinghamshire health inequalities across prevalence, risk factors, access, experience and outcomes.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Improving ethnicity coding	• Work is underway to improve ethnicity coding in Primary Care – using direct text messaging to patients. This work is targeted in areas that have a high percentage of patients with "Unknown" or "Not stated" ethnicity codes. • Data mapping exercises are being carried out to use secondary care data to fill in the gaps in primary care data for population health management and health inequalities analysis.	✓	
Developing a local Health Inequalities Dashboard	• A Health Inequalities dashboard is being developed to explore health inequalities across domains of Access, Experience and Outcomes. • The dashboard will pull together datasets from primary, secondary, community, mental health as well as external data from PHE fingertips and other sources. • Metrics relating to CORE20PLUS5 deprivation and areas of clinical focus will also be presented at system, ICP and PCN levels. • This dashboard will allow exploration of inequalities across the system, to develop a shared understanding of what inequality and deprivation mean, what inequalities exist within our system and where. Which can feed into the population health management approach for system transformation. • The Health Inequalities dashboard will be supported by 10 other dashboards exploring Place, Demand and Capacity, Quality and Patient Experience, Maternity, Care Homes, Urgent Care and Planned Care. Where possible these dashboards will incorporate metrics broken down by IMD, ethnicity, sex and age.	✓	
Developing Health Inequalities System Information Reports	• Once complete the Health Inequalities Dashboard will be used to produce 'System Information Reports' focused on exploring the health inequalities visible in the dashboard in more detail. • These reports will provide deep dive analysis into an area of health inequality and can be used at place level to identify areas for transformation. • Reports will align with Population Health Management work programme and system priorities.	✓	✓
Developing a local framework for monitoring and evaluation	• A local framework for monitoring and evaluation is being developed to evidence impact of transformation programs on ICS outcomes. • The framework will encourage a process of understanding population health, using research and evidence to inform change, aligning change initiatives to system outcomes framework and ensuring a robust monitoring and evaluation process.	✓	✓

1. Data, Profiling, Monitoring & Evaluation

The ICS has an established outcomes framework and in 2022/23 this will be supported by five year ambitions for health inequalities. Work is also progressing on a value framework and recognising health gain metrics as being central to prioritisation.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Outcomes Framework	• The ICS has developed an Outcomes Framework which covers three domains – Improving the health and wellbeing of tour population, Improving the overall quality of care and life our service users and carers ae able o have and receive and improving the effective utilisation of resources. The metrics across all three of these aims relate to an understanding of the impact on health inequalities in relation to access, experience and outcomes as well as recognising the value of health gain alongside financial value. (see appendix 1)		
	• Actions to be carried out to further reflect the impact on health inequalities through the outcomes framework includes:	✓	
	• Agreeing ambitions with the ICS Partnership Board	✓	
	• Identifying proxy measures which includes assigning initiatives from the health inequalities plan to the outcomes	✓	
	• Ensuring that we reflect the impact of inequities through access and experience		
	• Validating that it effectively represents outcomes for the Core20+		
	• Idenfitying opportunity and expected impact		✓
	• Illustrating line through from neighbourhood initiatives to system		
Value Framework	• Representing the value of the contribution of health alongside factors and initiatives taken elsewhere		✓
	• Monitoring and re-evaluating impact and measures		
	The ICS is developing a value framework which recognises health gain.		
	• Health gain metrics that can be utilised to support prioritisation to be identified	✓	
	• Aligning the value framework alongside the finance framework	✓	

2. Training and Education

Upskilling and increasing an awareness of how to understand health inequalities, interpret the value of impacting on disparities and addressing inequities in relation to health and care services and the wider determinants is central to delivering the cultural change required.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Health Economics, PHM & Health Inequalities for the ICS and partners.	A series of six interactive workshops to be held with service change, finance and analytical colleagues on health economics, including understanding the three types of value – personal, technical and population (allocative efficiency) and including practical sessions using prepared data and the Social Technical Allocation of Resources (STAR) tool. Action learning sets for analysts will focus on segmentation, risk stratification, impactability, machine learning and quasi-experimental design to support PHM.	✓	
ICS Workshops – Understanding the analysis	Following a successful workshops in 20/21 on elective recovery waiting lists, inequalities in access to secondary care, ED and health seeking behaviour the ICS is planning on holding workshops ongoing to support learnings across the system. A schedule of workshops to be produced for 22/23.	✓	✓
Health Equity Assessment Tool (HEAT) Training Sessions	HEAT training has been promoted in 21/22 and following colleagues attending the Train the Mentor course, a programme of mentoring will be progressed across the ICS. The ICS will develop an internal programme that combines effectively using and understanding HEAT, EQIAs, effective service change and the outcomes framework.	✓	✓
PCN Health Inequality Forums	Bi-monthly workshops have been established with PCNs as an open forum for discussion and collaboration on health inequalities. The sessions will alternate between delivery of plans and an education session which will include external speakers as well as internal experts.	✓	✓
NHS Confed Health Inequalities Leadership Framework	The NHS Confederation has developed a programme of health inequalities improvement seminars for Chairs and Non-Executives on provider boards within Integrated Care Systems, to provide a legacy for the future as well as tools for immediate application.	✓	

3. Connected Communities

Integrated Care System
Nottingham & Nottinghamshire

Connected Communities is about working with, alongside and in our local communities ensuring that we are inclusive and representative of the Core20+. The COVID vaccination programme has provided considerable opportunity to understand how we can more effectively reach out to our local communities and has informed our approach as an ICS. The following tables outline the ICS approach which sits alongside the PBPs, with plans to progress from 22/23. The strength of connected communities is in our Place Based Partnerships and the relationships they hold with the voluntary sector, community groups and citizens. The overall aim and approach is to ensure that as an ICS all elements actively listen to the communities and local population.

Initiative	In place	Development focus	22/23	23/24
ICS Citizens Intelligence and Engagement Strategy		The Citizens Intelligence approach dovetails with co-production and the community connectors and champions in PBPs. Citizens Intelligence is described as a process of actively listening to citizens to understand their experiences of health and care services to enable a focus on areas that need improvement or changes. An on-going cycle of activities that generate genuine citizen insights to guide the work of transformation and commissioning		
Citizens' Panel		Our **Citizens' Panel** will provide a consultative body of 1000+ residents who are representative of the population of Nottingham and Nottinghamshire. Panel members will be part of an on-going engagement process whereby members opt-in and agree to engage on a regular basis. Our Citizens Panel will provide; • A broad, representative and balanced input from our citizens to inform strategy and planning at system level • Analyse insight via geographies to support place-based partnerships and primary care networks • Engage on areas/services of interest to support planning, commissioning and service provision • Allow engagement to be conducted at relatively short notice • Deliver potentially higher survey responses than one-off surveys • Allow for the tracking of local views and sentiment over time Training - we will develop a training package for individuals working with people and communities to ensure the necessarily skills, confidence and tools they need to generate and utilise high quality citizen intelligence and insight.	✓ ✓	✓

3. Connected Communities

In order to assimilate, disseminate and use the intelligence gained through co-production and engagement the ICS are establishing an engagement practitioners forum and community insights hub. The community insights hub will be a repository of information on our local communities and will help to inform programmes on community needs and characteristics.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
ICS Engagement Practitioners Forum	To provide a platform for all system partners working with people and communities to work collaboratively, share resources, knowledge and expertise and maximise existing knowledge and insights. Membership will be inclusive of NHS, local government (District, Borough, City and County Councils), Healthwatch, VCSE sector and colleagues leading on patient experience and co-production. To be established during the first quarter of 22/23	✓	
Community Insights Hub	Our **Community Insights Hub** will be a key resource for capturing and reporting community intelligence that includes findings drawn from all system partners including statutory sector, VCSE, Healthwatch, citizens' panel and networks at place and neighbourhood level. It will also draw in data and insights created and published from outside our system, e.g., census data, ONS reports and wider public sector focussed reports and research. All of this will be captured and recorded in a database (to be developed over time) enabling a systematic record of what we know about certain communities or geographies. The Hub will be a key way that the primacy of Place will be delivered but that a system-wide view of our available insights would also be able to be produced.	✓	✓
PCN Toolkit	PCN Toolkit - Primary Care Network (PCN) Engagement toolkit was coproduced with our Patient and Public Engagement Committee and VCSE sector colleagues. This is being revisited and refined to reflect the changes in the system and will be disseminated to support the generation of community intelligence at neighbourhood and place.	✓	

3. Connected Communities

Nottingham and Nottinghamshire ICS are 1 of 10 sites to develop and embed coproduction (peer support and funding) via NHS England and NHS Improvement Experience of Care Team programme. The project benefits from access to peer networks, learning from other sites and national best practice, as well as £20,000 funding to support development of the strategy and involvement in national evaluation work. Co-production is part of the wider engagement strategy that has evolved and strengthened over the past two years of Nottingham and Nottinghamshire working as an ICS.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Co-production	To embed a system wide approach to co-production by building on existing initiatives and that is aligned with Core20+ and initiatives in PBPs. The PBPs are developing and supporting community-based roles that empower and provide a voice to link with decision makers and highlight the barriers across not only health services but also prevention. Through their programmes of work the PBPs are also defining processes for lived experience involvement and it's through them that the ICS will have robust links with communities and community leaders.		
	The aspiration is for genuine coproduction to be embedded within all elements of system design and delivery, including transformational activity, commissioning activity, service/system redesign and quality improvement.	✓	
	A system wide coproduction strategy and practical coproduction toolkit will be developed (for staff and people with lived experience) with expertise and learning from all elements of the system, including experts by experience. This will set out the coproduction principles and expectations for the system, with partner strategies on coproduction aligning to the system-wide strategy.	✓	
	A training package for both staff and people with lived experience to ensure that people have the skills, confidence and tools they need to work together in partnership and coproduce effectively. For staff this will mean ensuring they are confident at coproducing with people with lived experience, moving to a facilitator role rather than someone that knows all the answers. For people with lived experience this will mean ensuring that they are activated and confident in sharing the views of people with lived experience effectively and consistently in different meeting settings or in key communications. The toolkit will be accessible for staff, people with lived experience and the public.	✓	
	Establishment of a strategic coproduction group to ensure that strategic decisions and planning around the future of the ICS includes people with lived experience as an equal partner. Our intention is to establish a group of people with lived experience to advise on system design, delivery and commissioning. This group will be a core group that will be involved in key priority work across the system and will also report into and represent the group at ICS Board.	✓	
	Culture change across the system to support the coproduction approach This will form the basis of system wide culture change, supported by shared system commitment and ownership, along with key coproduction champions in key areas/organisations of the system.		

4. Proactive care, self-management and personalisation

Integrated Care System
Nottingham & Nottinghamshire

A key enabler to progress the ICS health inequalities strategy and through 21/22 there has been an increased awareness of the importance in relation to addressing inequities in health across access, experience and outcomes. The programme is reviewed through a Personalisation Board.

Initiative	Development focus	22/23	23/24
Increasing Primary Care roles Expand social prescribing, Health and wellbeing coaches and Care Co-ordinators roles in Primary Care Networks	• Support the recruitment of DES funded social prescribing link workers in PCNs across the ICS. • Increase the CCG funded number of social prescribers to support the increasing numbers of referrals for people with mental health issues. • The increase in social prescribers also targets groups of people who need support, using our Population health management data • Restoring and increasing access to primary care services by working with Primary Care Networks (PCN) to actively recruit, retain, support and develop social prescribers/link workers, health and wellbeing coaches and care coordinators. • Each ICP in collaboration with commissioners, LAs and VCSE organisations, will develop a local plan using Population health management data, PCN Maturity Matrix, this will help form a system wide social prescribing strategy • Each Place based partnership to develop a strategic plan and maturity framework o Leadership, strategy and governance o Planning and commissioning o Workforce development o Digital and technology o Evidence and impact • Work with all system partners in the ICS to build community assets	✓	✓
Green Space	Green Space is a nationally funded, 2 year test & learn project working to build a network of trusted groups and organisations to embed green social prescribing throughout Nottingham City and Nottinghamshire. The aim of the project is to test how to embed green social prescribing into communities in order to: o Improve mental health outcomes o Reduce health inequalities o Reduce demand on the health and social care system o Develop best practice in making green social activities more resilient and accessible.	✓	✓
Increase the number of personalised care and support plans (PCSPs) for identified cohorts in line with the standard replicable PCSP model.	Continue to increase the numbers of services having personalised conversations with people and completing a care and support plan, that can be shared with health and social care. Work with the NHS app and Patient Knows Best to increase the digital use of peoples care and support plan, and a one page profile – All about me - so it can be shared and used as a starting point to understand what matters to people, and what they want to achieve in relation to their health and wellbeing and how they can achieve it. Areas of development are End of life, Mental health and Elective care	✓	✓
ICS Integrated personalised commissioning signature scheme	To work with our system partners, to join up care and support around the person, to joint commission where it makes sense, and focus on shared market development. To share good practice and the impact through an 'Our stories' booklet, which we aim to develop into pages that are the go to place for personalised care, on the ICS website.	✓	✓
Workforce development	Deliver on the NHSE workforce Memorandum of Understanding to train 1231 staff in personalised care approaches.	✓	✓

4. Proactive care, self-management and personalisation

Integrated Care System
Nottingham & Nottinghamshire

Initiative	Development focus	22/23	23/24
Proactive Care at home Restoring and increasing access to primary care services by developing and implementing a Proactive Care @home pathway	• Introduce the proactive Care @home pathway for patients with hypertension. • Focussing initially on hypertension by increasing access to and uptake of BP@Home. • Prioritise those populations with increased health inequalities identified through population health management. Each PBP to manage distribution of the BP monitors via their PCNs. • Provide BP monitors to patients who are at highest risk in the most deprived areas, each monitor can be reissued if a patient has finished with it during the time of the project • Identify behavioural risk factors for individuals with CVD (linking directly to their condition) and embed personalised care components within the pathway to promote supported self-management	✓	
Elective Care Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service including embedding personalised care into elective recovery programmes	The overall goals are: • To embed shared decision making conversations in the MSK pathway for over 65s • That over 65s with MSK conditions are empowered and prepared to have a shared decision making conversation with clinicians • That people who are over 65 on the MSK pathway are supported to wait well – My planned care and prepare for surgery, thereby maximising surgery and minimising the days in hospital to recover post-surgery. • To use population management health data to target additional support to people with wider determinants of health and address health inequalities • 3 x social prescriber providers appointed to deliver this approach to support people waiting for elective care operations on the MSK pathway and the Pre-rehab Cancer pathway. The support will be focussed to people with health inequalities and wider determinants of health.	✓	

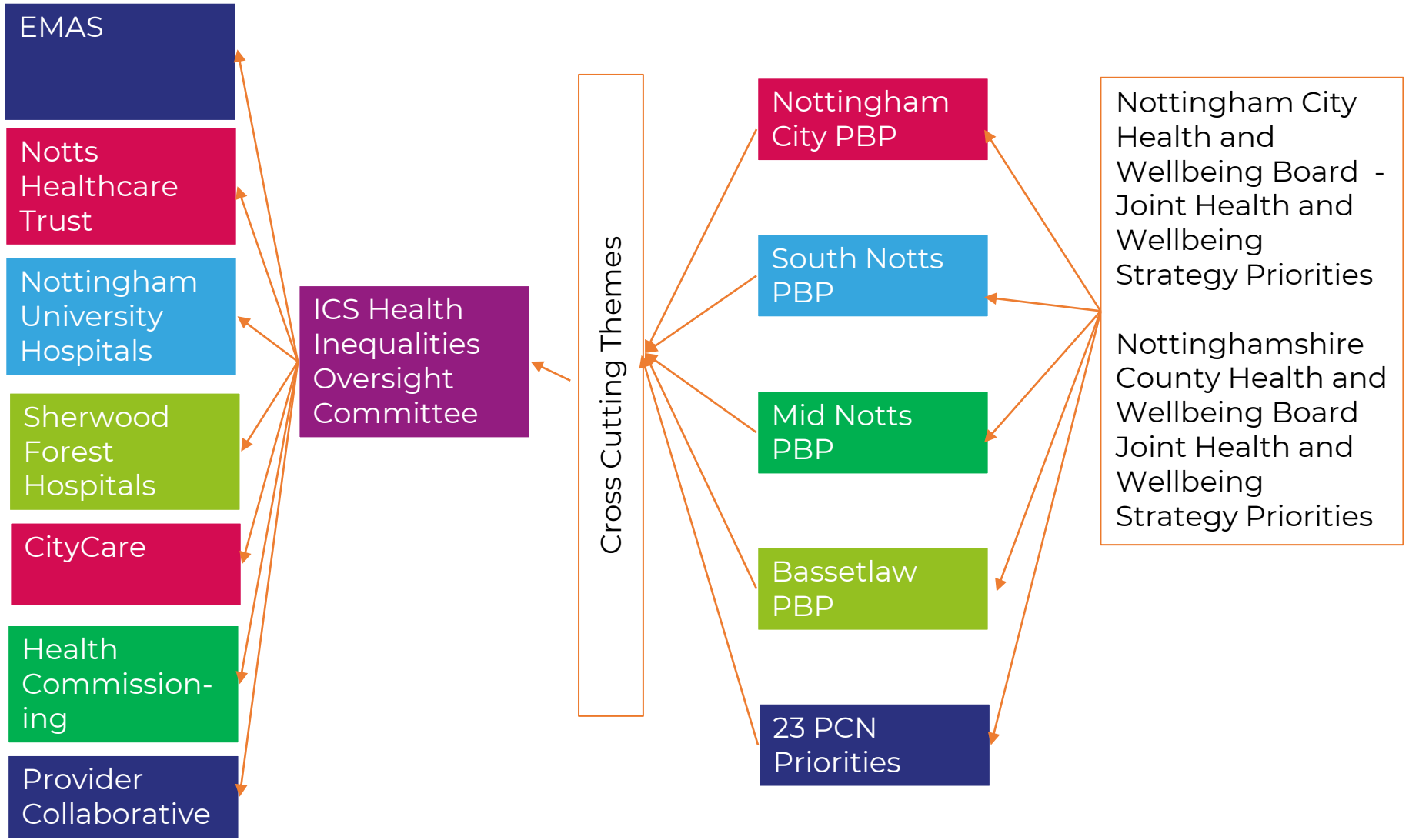
Local Maternity and Neo-natal services
Deliver improvements in maternity care, including responding to the recommendations of the Ockendon review
	• 700 maternity staff trained in personalised care and support planning and Shared decision making
	• Personalised care and support plans and their use will be coproduced with women, and will be reviewed
	  ○ 3 coproduction workshops with women to review quality and use of PCSP
	  ○ Monthly strategic coproduction meetings to review progress and use
	  ○ All 6345 PCSP for 21/22 are coproduced with women
		✓	

Personal health budgets Promote and offer personal health budgets for people with a legal right to have a personal health budget and in priority local cohorts (as identified in the STP/ICS LTP local implementation plan).	Everyone with a right to have will have a personal health budget, providing choice and control over how they manage and organise their health and care needs: People eligible for Continuing Healthcare; Continuing Healthcare FastTrack; Continuing Care; S117 aftercare; wheelchair budgets. They are also provided to adults with joint health and social care funding; NHS carers breaks – to give carers a break from their caring role to manage their own health and wellbeing, You Know Your Mind, for children and young people who are under Local Authority care, to support them to manage their health and wellbeing. Since December 2021, personal health budgets have been provided to support peoples discharge from hospital. Areas of further development of personal health budgets are in End of life care; Learning disability and Autism and Mental health services. Opportunities being explored for link workers to provide personal health budgets.	✓	✓

5. Leadership & Partnership

Through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategies there is the understanding of the priorities to impact on health inequalities. Through the PCBs and PCNs is the integration with local communities that informs the themes and inclusion health groups for the system to drive forward change in relation to disparities and inequities. Therefore, the PBP governance structures include relevant groups and committees that will link into and inform the ICS Health Inequalities Group and through this, wider partners.

Integrated Care System
Nottingham & Nottinghamshire



5. Leadership & Partnership

The ICS Health Inequalities Group reports into the ICS Strategic Oversight Group. The Strategic Oversight Group membership includes partner Chief Execs who sit on the ICS Board.

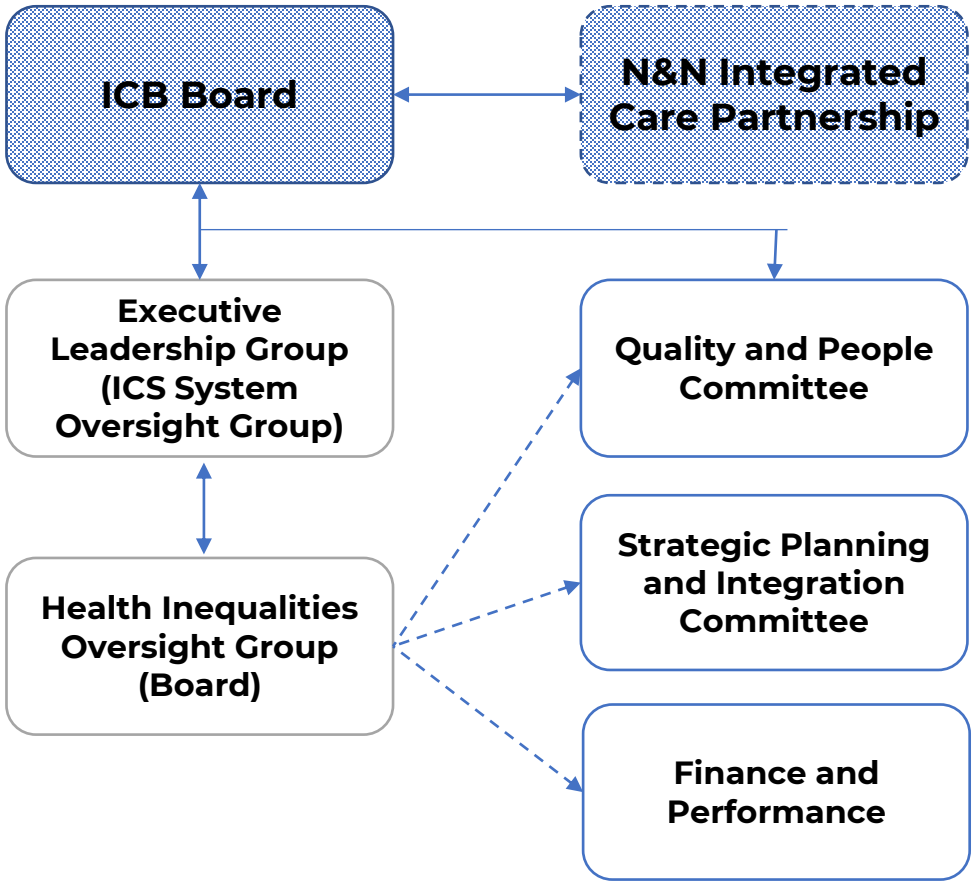
Integrated Care System
Nottingham & Nottinghamshire

Initiative	In place	Structure
ICS Health Inequalities, Prevention and Wider Determinants Oversight Group	x	• Membership includes • ICS Health Inequality Lead • ICS Workstream SRO(s) • Provider Health Inequality Exec Leads • ICS Chief Nurse • Directors of Public Health • PBP and PCN Representatives - Clinical and Managerial • Health and Wellbeing Board Chairs • ICS Health Inequality Champion/Expert • Population Health Management and SAIU Director Objectives of the Group include: Embedding health equity as a strategic priority within organisational, place and neighbourhood partnership strategies and plans – developing a strategic approach that is defined on population need from neighbourhood through to place and ICS Clear and consistent approach in relation to population need, to addressing health inequalities across the system on a short, medium and long term basis. To include 1) short term evidence based actions in health 2) in-service monitoring and impact in relation to access, experience, outcomes 3) longer term health promotion as a system Co-production with Health and Wellbeing Boards in order to provide a balanced focus on the elements of the Population Intervention Triangle (civic level interventions, service-based interventions, community centred interventions). Establishing ICS strategic and shared ambitions that are reflected throughout and are supported by programmes at a system, organisational (including commissioner and providers), place and neighbourhood basis By working effectively with and at ICP/Place level, generating an ICS commitment across all partners based on agreed Nottingham and Nottinghamshire population profiles and priorities Influencing financial planning and budget allocation System wide focus across all age groups and the life course Embed a population health management approach that delivers to the JSNAs and is underpinned by community engagement and robust networks through place/PBPs To create the conditions for frontline staff working in the ICS/across the system to better work together to understand and impact on health inequalities Developing and monitoring against a framework for health inequalities that allows

5. Leadership & Partnership

Integrated Care System
Nottingham & Nottinghamshire

The following diagram outlines the ICB governance structure, specific to health inequalities. ICPs are expected to provide opportunity to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for local populations. ICPs will facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development. What is not reflected in this diagram are the individual groups which each of the PBPs have as they are part of their wider governance structures with place being central to the Health Inequalities Oversight Group.



6. Research

The ICS are encouraging research in relation to health inequalities that will both educate and inform action across the ICS.

Integrated Care System
Nottingham & Nottinghamshire

Initiative	In place	Development focus and actions	22/23	23/24
A research study is being commissioned to develop understanding of the experience of Severe Multiple Disadvantage (SMD) for people from ethnically diverse communities in Nottingham	Approach and funding agreed	• Reducing health inequalities in Nottingham's ethnically diverse population is a key priority for Nottingham City Place Based Partnership (PBP) however there is a gap in evidence relating to inequalities in outcome and access to services for people from ethnic minority groups who experience SMD. • The research findings will influence the Changing Futures Programme in Nottingham and future commissioning approaches in relation to SMD. • The research proposal has been developed by the Nottingham City PBP SMD workstream. • The research will be commissioned and managed by Nottinghamshire Healthcare NHS Foundation Trust. The research is being jointly funded by the Trust, Nottingham City Council and Nottingham and Nottinghamshire CCG. • A procurement exercise for the research study is in preparation as at February 2022. The aim is for the research to be completed and have reported during Quarter 3 2023/24. • A research steering is being set up chaired by the lead for the Nottingham PBP SMD workstream and will include people with lived experience and representatives from local organisations and services. The steering group will report to the Nottingham SMD Partnership.	✓	✓ ✓
Taking forward the recommendations from the 'Improving the mental health outcomes of Nottingham's LGBT+ populations' research study.	Final Research Report	• A research study was commissioned by one of the predecessor CCGs because evidence shows mental health inequalities are experienced by LGBT+ people who are at higher risk of poor mental health, self-harm and suicide and report lower well-being compared to the wider population. This is due to a range of issues experienced including discrimination, harassment, bullying, rejection and social isolation. For some people other factors such as age, religion or ethnicity can exacerbate mental health needs. • The research recommendations relate to: training and cultural competence; systematic recording of patient/service user sexual orientation and (where appropriate) gender identity; the specific needs of LGBT+ people being reflected in the commissioning and delivery of services; visibly inclusive LGBT+ services; improved access to mental healthcare; and developed and/or strengthened relationships between services. • The CCG is coordinating a system-wide action plan with partners to implement the recommendations. This work will be transferred to the ICB at the time of its establishment.		

.

Integrated Care System
Nottingham & Nottinghamshire

G. Appendices

Appendix 1: ICS Outcomes Framework

The ICS System Level Outcomes Framework was agreed by the ICS Board in April 2019 following extensive stakeholder and public engagement and is based on the triple aim (improved health and wellbeing, transformed quality of care, and sustainable finances) and the priorities within the Health and Wellbeing Board Strategies. The Health and Wellbeing Board strategies are informed by the need of our population and have undergone consultation and engagement with local health and social care stakeholders and the public.

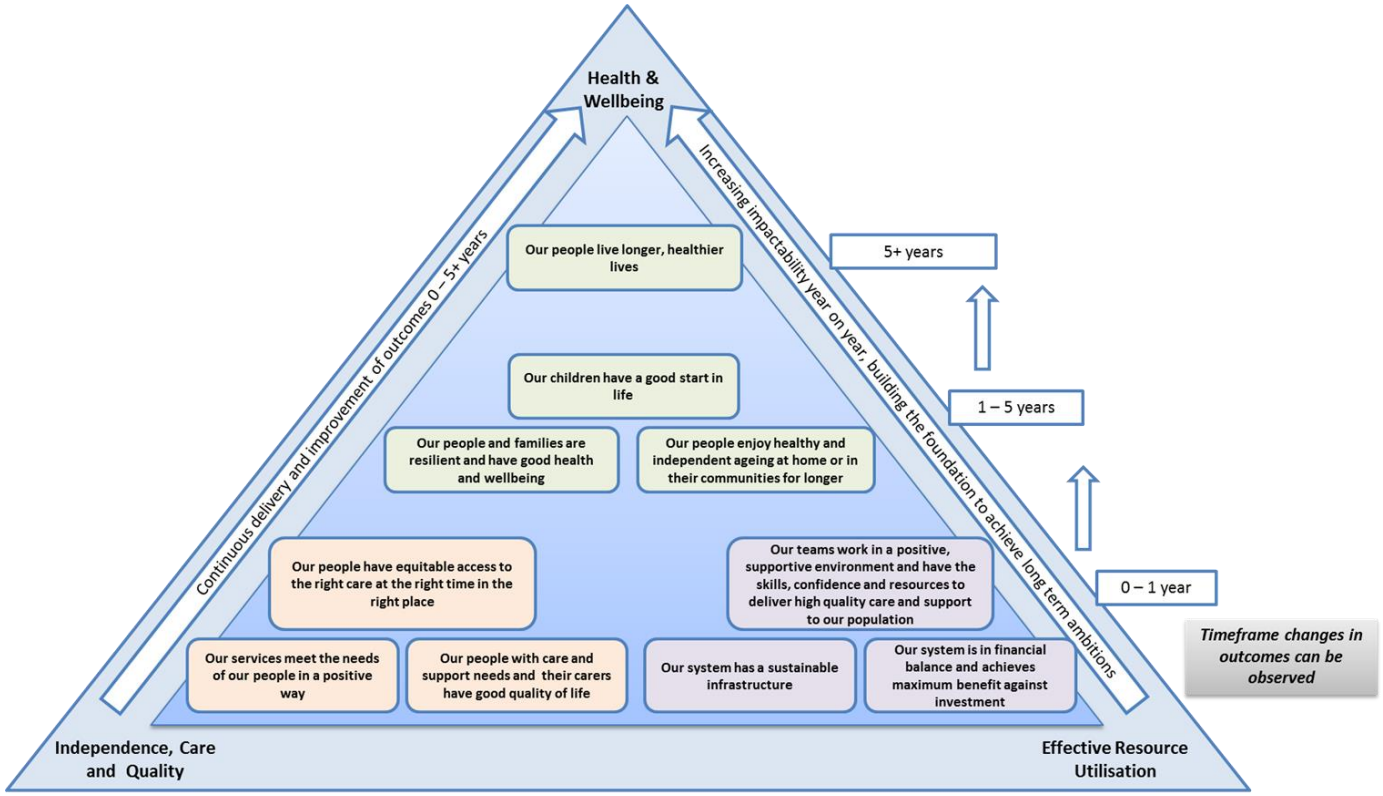
Integrated Care System
Nottingham & Nottinghamshire

The ICS System Level Outcomes Framework does not replace, but instead sits alongside, existing frameworks and indicator sets that will still need to be monitored and delivered e.g. the ICS System Integrated Performance Report, the NHS System Oversight Framework, Quality Outcomes Framework, Adult Social Care Outcomes Framework, NHS Outcomes Framework and Public Health Outcomes Framework. However, it is recognised that the ICS System Level Outcomes Framework development cannot be in isolation from these and the relationships and any interdependencies need to be explicit. Longer term the aim is to reduce the number of outcome frameworks used within the system, where possible, to increase focus and streamline monitoring and reporting.

The intention is that all action and activity within the system, including service transformation, service change and greater integration, will all strive to deliver improvements across the 10 Ambitions, and will be able to identify which Outcomes will be impacted by the change and articulate targeted improvements to be achieved through actions identified.

Domain	3 domains High level grouping or classification based on the triple aim:
	Health and Wellbeing — The impact of health and care services on the health of our population
	Independence, care, quality — The overall quality of care and life our service users are able to have and their experiences of our health and care services
	Effective resource utilisation — The state of our health and care infrastructure and its ability to deliver quality care and improve health and wellbeing long term
Ambition	10 ambitions High level aspiring ambitions for our Nottingham and Nottinghamshire population mapped against the 3 domains
Outcome	28 outcomes System level outcomes and results our health and care system will aim to achieve to deliver our ambitions

Indicators	Indicators to demonstrate progress towards or achievement (or not) of our outcomes
Measures	Measures that align to the indicators and drive action and change at organisation, PCN and ICP level



Appendix 2: Our big system outcome ambitions

Integrated Care System
Nottingham & Nottinghamshire

Aim 1 - Improving the health and wellbeing of our population

1. Our people live longer, healthier lives

2. Our children have a good start in life

3. Our people and families are resilient and have good health and wellbeing

4. Our people will enjoy healthy and independent ageing at home or in their communities for longer

Aim 2 - Improving the overall quality of care and life our people and carers have and receive

5. Our people will have equitable access to the right care at the right time in the right place

6. Our people have a positive experience of care and better outcomes

7. Our people with care and support needs and their carers have good quality of life

Aim 3 - Improving the effective utilisation of our resources

8. Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

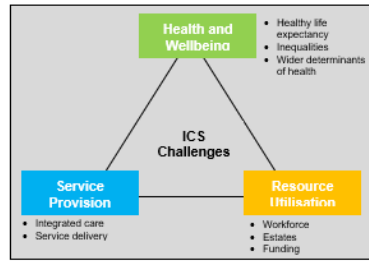
9. Our system has a sustainable infrastructure

10. Our system is in financial balance and achieves maximum benefit against investment

Appendix 3: Our Strategic Aims

Integrated Care System
Nottingham & Nottinghamshire

There are many plans and strategies across the system, however they have not all been developed with clear alignment to the System Outcomes Framework – clarity regarding how the plans / strategies are contributing towards the improved outcomes aims and ambitions. The system needs to undertake a full review of all Strategies & Plans to ensure clear alignment and identification to System Outcomes
.



Aim 1 – Health & Wellbeing

Aim to improve the health and wellbeing of our population

Ambitions:
AMB-01 Our people to live longer, healthier lives
AMB-02 Our Children have a good start in life
AMB-03 Our people and families are resilient and have good health and wellbeing
AMB-04 Our people will enjoy healthy and independent ageing at home or in their communities for longer

Aim 2 – Independence, Care, Quality

Aim to improve the overall quality of care and life our service users and carers are able to have and receive

Ambitions:
AMB-05 Our people will have equitable access to the right care at the right time in the right place
AMB-06 Our services meet the needs of our people in a positive way
AMB-07 Our people with care and support needs and their carers have a good quality of life

Aim 3 – Resource Utilisation

Aim to improve the effective utilisation of our resources

Ambitions:
AMB-08 Our system is in financial balance and achieves maximum benefit against investment
AMB-09 Our system has a sustainable infrastructure
AMB-10 Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population

Supporting System Strategies

H&W Strategy
NHS 5 Year Plan
Anchor Institution Plans
ICS Health Inequalities Strategy
Tobacco Control Strategy
Maternity Strategy
Obesity Strategy
EOL Strategy

NHS Operational Plan
NHS Elective Recovery Plan
Urgent Care Plan
Mental Health Strategy
Cancer Strategy
Personalisation Strategy
Primary Care Strategy
Signature Schemes – Integrated Community Commissioning
Quality Strategy
LD&A Plan

NHS Financial & Workforce Operational Plans
ICS Financial Framework
NHS Greener Plan – local plan
NHS People Plan – local plan
ICS Estates Strategy
ICS DAIT Strategy

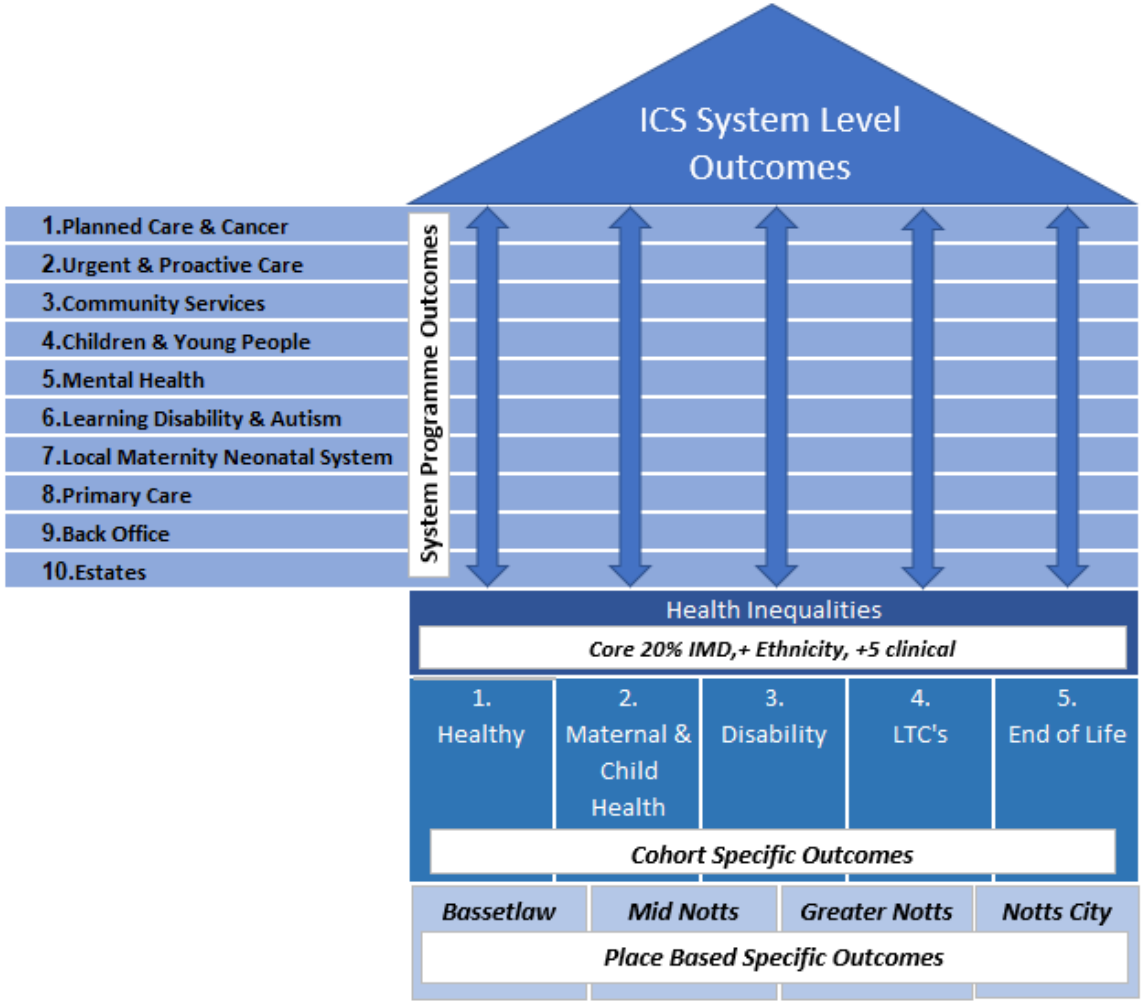
Appendix 4: System Structure Arrangements - Alignment to and Contribution to System Outcomes

Integrated Care System
Nottingham & Nottinghamshire

Clarity is needed as to how the different parts of the system contribute as a whole to the overall improvement of the System Outcomes

What does success look like for each part of the system?

- **All System Programmes** need to be able to articulate how their programme will contribute towards the achievement of the System Outcomes, and how as programme they will monitor improvements against programme outcomes identified
- **Population Health Cohorts** – assessment and identification of need to inform the activities to be undertaken across programmes and place, e.g. Diabetes PHM review, CYP PHM Review – Need to determine how the system ensures that these assessments are being taken forward through programme or place activities
- **Place** – identify targeted population cohorts and areas of need specific to their place, and be able to demonstrate their alignment to the overall system outcome improvements required. Articulation of what improvements they are planning on for their targeted population and how this will be monitored



5 Clinical HI Areas:

- Maternity - Continuity of Carer
- SMI(Severe Mental Illness) - Healthchecks
- Chronic Respiratory Disease /Vaccines & COPD
- Early Cancer Diagnosis
- Hypertension Case Finding

Appendix 5: Our system outcomes and how they inter-relate to programme, service and patient outcomes

Integrated Care System
Nottingham & Nottinghamshire

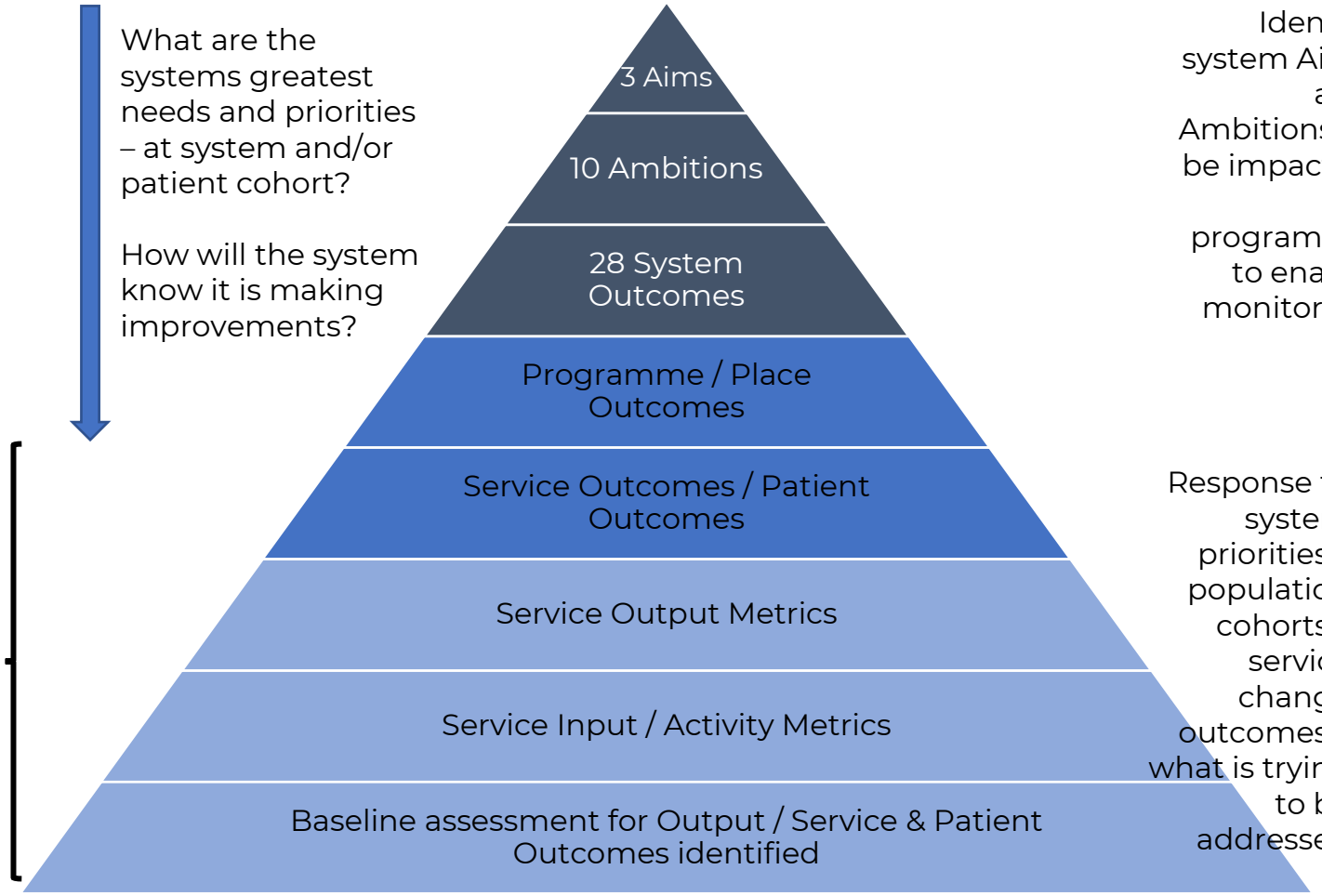
How has the need for service change been identified – what problem is trying to be solved, what is trying to be improved?

System Outcome Monitoring

Service Evaluation & Contracting

What are the systems greatest needs and priorities – at system and/or patient cohort?

How will the system know it is making improvements?



Identify system Aims and Ambitions to be impacted by programme to enable monitoring

ICS System Outcome Framework – identify areas most impacted by the service change being proposed – what will improve as a result of the investment / service

What does success look like for the programme, how does it contribute to improving system outcomes

Response to system priorities – population cohorts – service change outcomes – what is trying to be addressed

What do patients want to improve as a result of service change, what does the service want to improve for patients / staff wellbeing & engagement

Usual measures identified when undertaking service change and service spec – is the service operating as expected, how will you know? Ensure you know the baseline before service change commences

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Care System Health Inequalities Plan