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'To Follow' Agenda Items

This is a supplement to the original agenda and includes reports that were marked 'to follow'.

Nottingham City Council
Health and Wellbeing Board

Date: Wednesday 28 July 2021

Time: 1:30pm

Place: The Ballroom - The Council House, Old Market Square, Nottingham, NG1 2DT

Governance Officer: Adrian Mann **Direct Dial:** 0115 8764468

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Health and Wellbeing Board
28 July 2021

	Report for Resolution
Title:	Update on the proposal for the alignment of the Nottingham City Health and Wellbeing Board (HWB) with the Nottingham City Integrated Care Partnership (ICP) and Nottingham and Nottinghamshire Integrated Care System (ICS)
Lead Board Member(s):	Councillor Adele Williams – Chair of the HWB and member of the ICP Forum Dr Hugh Porter – Vice Chair of the HWB and Interim Lead / Clinical Director of the ICP
Author and contact details for further information:	Lucy Hubber – Director of Public Health, Nottingham City Council Rich Brady – Programme Director, ICP
Brief summary:	Following the recent publication of the Health and Care Bill, this report provides an update on the proposal for the alignment of the HWB with the Nottingham City Place-Based Partnership (NCPBP), the Nottingham and Nottinghamshire Integrated Care Board (ICB) and the ICP. This proposal will enable the HWB, NCPBP, ICB and ICP to establish the interfaces needed to better support the delivery of integrated care as set out in the Health and Care Bill. This will support the development of the NCPBP to become a key partnership able to take on delegated functions from the ICB and Nottingham City Council to effectively support the transformation of integrated health and care delivery in Nottingham.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

- **Note** the update on the work being undertaken to align the HWB, NCPBP, ICB and ICP, to establish the interfaces needed to better support the delivery of integrated care in Nottingham, and the timescales for approval.

- **Approve** the development of a new Joint Health and Wellbeing Strategy for Nottingham, building on the revised approach to joint strategic needs assessments, programme priorities of the NCPBP and the current ICS health inequalities strategy.

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities.	The proposed changes will have a significant impact on the design of the new Joint Health and Wellbeing Strategy and its delivery.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy.	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles.	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health.	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well.	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and wellbeing.	

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
The proposed changes will enable greater integration of care between services in Nottingham, reducing inequalities experienced by citizens and improving mental health and wellbeing.

Background papers:	Enclosure 1 – ICS Health Inequalities Strategy

Alignment of the Nottingham City Health and Wellbeing Board with the Nottingham City Integrated Care Partnership and Nottingham and Nottinghamshire Integrated Care System

Important nomenclature

In the Health and Care Bill, it is proposed that the previously termed, 'ICS Health and Care Partnership' is to be named the 'Integrated Care Partnership'. At present, the term 'Integrated Care Partnership' is used to describe the place-based partnership in Nottingham City. For the purpose of this paper, the Nottingham City Integrated Care Partnership will be referred to as the 'Nottingham City Place-Based Partnership' (NCPBP).

Background

1. On 6 July 2021, the Health and Care Bill[1] was laid before Parliament introducing proposals first set out in the government's Health and Social Care White Paper, published in February 2021. The Bill builds on proposals in the NHS Long-Term Plan, establishing 44 Integrated Care Systems (ICS). These will consist of a new NHS Body, the Integrated Care Board (ICB) and an Integrated Care Partnership (ICP), which will be a joint committee.

2. ICBs will replace clinical commissioning groups (CCGs) which are to be abolished in April 2022. The ICB will take on the commissioning functions previously held by CCGs, together with some commissioning functions of NHS England. It will also have new duties including promoting integration, the 'triple aim' duty to promote better health for everyone, better care for all and efficient use of NHS resources, as well as reducing health inequalities.

3. The Bill marks a shift from the competition that underpinned the 2013 health reforms to a more collaborative model with greater flexibility around NHS procurement and opportunities for joined-up care. While some aspects of the Bill are prescriptive, recent guidance avoids outlining a one-size fits all model and a number of decisions are being left to local systems and leaders.

4. Since the 2013 reforms, Health and Wellbeing Boards (HWB) have been the statutory committee responsible for driving improved health and wellbeing outcomes and for supporting integration at 'place'. The on-going role of HWBs is confirmed in the Bill with ICS Integrated Care Partnership expected to work closely with constituent HWBs. The Bill sets out requirements for the ICS Integrated Care Partnership to consult with HWBs in developing the ICS strategy and as part of this also have regard to Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments – both are statutory duties of Health and Wellbeing Boards.

5. Place-based partnerships feature prominently in the accompanying, Integrated Care Systems Design Framework[2], with an expectation on place-based

[1] Health and Care Bill (July 2021) https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf
[2] Integrated Care Systems: design framework (June 2021) https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

partnerships to be a delivery vehicle of some ICB statutory functions. There is however no statutory underpinning for 'place', but there is a clear expectation that ICSs ensure that any place-based partnerships have appropriate resource, capacity and autonomy to support place-based partnerships to deliver its functions, especially in terms of addressing community priorities.

6. Both in national documentation and locally in the Nottingham and Nottinghamshire ICS the principle of subsidiarity is recognised. It is recognised that the delivery of integration and improving population health can be improved by collaboration at 'place'. Influencing how place will work and the relationship it should have with the ICB and ICP is therefore important to ensure the design and commissioning of health services happens with, and is sensitive to, local communities.

Governance

7. In preparation for the Health and Care Bill, between March and June 2021, the Local Government Association facilitated three workshops in Nottingham. Participants included members of the HWB, Nottingham City Place-based Partnership (NCPBP), CCG and City Councillors to reconfirm partners' commitment to a place-based partnership on the geography of the City, and to consider the options for future governance arrangements.

8. A governance proposal has been developed between partners that will enable the HWB, NCPBP, the ICB and ICP to establish the interfaces needed to better support the delivery of integrated care as set out in the Health and Care Bill. The proposal will support the development of the Nottingham City Place-based Partnership to become a key partnership able to take on delegated functions from the ICB and Nottingham City Council to effectively support the transformation of integrated health and care delivery in Nottingham City.

9. Subject to legislation the proposed model will give the HWB greater influence on the health and care activity in the city through direct alignment between the NCPBP with the HWB. The role of HWB would extend to include:

    - Overseeing the development of the Joint Health and Wellbeing Strategy. This will be based on the joint strategic needs assessment (JSNA) and population health management data.
    - Supporting the Integrated Care Partnership in development of the wider ICS strategy, informed by the JSNA and population health management data.
    - Overseeing the development of associated NCPBP programmes, which will deliver core elements of the HWB strategy and wider ICS strategy.
    - Reviewing statutory frameworks to ensure health and wellbeing (and linked HWB strategic priorities) is embedded in all policies.
    - Supporting member organisations in ensuring health and wellbeing (and linked HWB strategic priorities) is embedded within each member organisation.

10. This outline proposal will be submitted to Nottingham City Council and Nottingham and Nottinghamshire ICS for review and further development, to

ensure alignment with forthcoming legislation and associated statutory guidance. A finalised governance model which is legislatively compliant will then be brought back to the HWB before formal submission to Nottingham City Council and Nottingham and Nottinghamshire ICS.

11. As a committee of Nottingham City Council, amendments to terms of reference for the Health and Wellbeing Board will require approval from full Council. Therefore, subject to the agreement of the Bill and local ICS structures it is proposed that the governance model is brought back to the January Health and Wellbeing Board meeting.

Joint Health and Wellbeing Strategy

12. The most recent Joint Health and Wellbeing Strategy (JHWS), *Happier Healthier Lives* expired in March 2020. Prior to the first wave of the coronavirus pandemic plans had been put in place to refresh the JHWS but as a result of the impact of the pandemic on the needs of the population this was delayed. In light of the anticipated changes expected through the Health and Care Bill and the formal alignment with the Nottingham City Place-based Partnership it is timely to refresh the JHWS.

13. In October 2020 the Nottingham and Nottinghamshire Integrated Care System (ICS) approved a Health Inequalities strategy (**Enclosure 1**). This strategy is designed to help establish a shared commitment and vision for addressing health inequalities across the health and care system in Nottingham and Nottinghamshire. The strategy recognises that access to and quality of health care services is only a small contributor to overall health outcomes and to tackle inequalities there must be a focus on addressing wider determinants of health.

14. It is proposed that the review JHWS should be thematic, focusing on tackling the contributing factors to inequalities. This would:
    - Support the system commitments and focus on inequalities in the partnership agreement
    - Reflect the exposure of the impact of inequalities throughout the pandemic
    - Provide a bridging strategy to connect the wider system (ICB) and place (NCPBP), reflecting the breadth of partnership working of the HWB

15. The proposed JHWS will set out key priority areas for action (outcomes), measures of success, interdependencies and operational governance. Engagement/co-production with communities will be critical in the development of the strategy.

16. It is intended to develop the draft JHWS to present to HWB at the January meeting.

Recommendations:

The Health and Wellbeing Board is asked to:

- **Note** the update on the work being undertaken to align the Health and Wellbeing Board, Nottingham City Place-based Partnership, Integrated Care Board and Integrated Care Partnership to establish the interfaces needed to better support the delivery of integrated care in Nottingham City.

- **Approve** the development of a new Joint Health and Wellbeing Strategy for Nottingham City, building on the revised approach to joint strategic needs assessments, programme priorities of the Nottingham City Place-based Partnership and the current ICS health inequalities strategy.

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Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Care System

Health Inequalities Strategy 2020-2024

7 October 2020 v1.8

Please cite 'this work has been informed by the Nottingham and Nottinghamshire ICS' when referencing this strategy or approaches used. This information has been placed in the public domain in order to benefit patients across the country as we believe the experience and approach may be useful for others, however we request that acknowledgement to the work in Nottinghamshire is made and referenced in all materials. This helps us to understand the wider impact benefits of our programme.

Foreword

Across Nottingham and Nottinghamshire there are more people living longer in ill health, unprecedented levels of demand for care and support, workforce shortages and considerable funding constraints. Combined these factors continue to place an ever-increasing strain on the local health and care system and looking to continue to do more and more of the same each year is not sustainable.

In response to this the leaders of our local health and care system have come together to develop a five-year strategic plan, underpinned by the ICS Clinical and Community Services Strategy, that sets out a shared vision to ***'both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age'***. Delivery of this vision will be characterised by moving from a health and care system that is often siloed and reactive in nature to one where all partners are focused on the entire spectrum of interventions from prevention and promotion to health protection, diagnosis, treatment and care – and integrates and balances action between them.

Dr Andy Haynes
ICS Executive Lead

Addressing Health Inequalities

Health inequalities are the unjust differences in health experienced by different groups of people. In **Nottingham & Nottinghamshire today there is a significant gap in healthy life expectancy between the most and least affluent areas of the country**.

Closing this gap is one of the biggest challenges we face, **this about much more than access and quality of health and care services given wider determinants contribute 80% towards health outcomes**. Health actions are necessary but not sufficient and this strategy covers a wide range of issues which affect our health and wellbeing including employment, education, our living situation and relationships.

To successfully address health inequalities we need to:

- Increase our understanding around health inequalities and our local population
- Promote ways of working across ICS partners, key stakeholders and communities most likely to reduce health inequalities
- Provide system outcomes which are key to reducing inequalities in health and well being

Dr John Brewin
Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust
&
ICS Lead for Health Inequalities

This strategy is designed to help establish a shared commitment and vision for addressing health inequalities across the health & care system. The strategy recognises the impact of COVID-19 (direct and indirect), and it supports the ICS Clinical and Community Services Strategy and the five year strategic plan. As recovery plans become clearer and have an impact on existing organisations' strategies, the strategy will iterate to reflect those changes.

If we get this right how will it feel for people

As **a citizen living** in Nottingham and Nottinghamshire this means:

- We will not worsen health inequalities; we will work to reduce them.
- We will support our population by providing them with the skills, training and tools to access digitally enabled health and care services in order to empower and enable them to manage their health and care and reduce health inequalities and social isolation (supported by digital inclusion programme)
- We will listen and engage with communities who need most support, deepening partnerships with community and voluntary sector.

As a **person receiving support** from our health and care system:

- Health and care services are accessible for all, particularly those at risk of exclusion because of personal, economic or social factors .
- We will improve how we proactively identify the health and care needs of our population in order to identify and put in place support and treatment that our population need in order to stay well.
- We will accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes.

As **a person working** in our health and care system:

- Health and care staff are valued and supported to maintain wellbeing and so deliver high quality care in all settings.
- We will strengthen leadership and accountability, with a named executive board member responsible for tackling inequalities in place in every ICS partner, alongside actions to increase the diversity of senior leaders.
- We will provide the people involved in providing health and care with the information and tools to understand and respond to health inequalities.

Our vision for health inequalities is that everyone has the same opportunity to lead a healthy life no matter where they live or who they are and that our front line professionals are valued and supported to deliver high quality care.

The context for this strategy

Overview

Our health and care partners across Nottingham and Nottinghamshire came together in 2016 in a Sustainability and Transformation Partnership (STP) with the collective goal of improving the quality and sustainability of health and care services.

This collaboration subsequently evolved into an Integrated Care System (ICS) in 2018 focussed on becoming a fully population health focused health and care system – a system where all partners are focused on the entire spectrum of interventions, from prevention and promotion to health protection, diagnosis, treatment and care; and integrates and balances action between them.

ICS members include:

- Nottingham City Council
- Nottinghamshire County Council
- City Care
- Nottingham and Nottinghamshire CCG
- Nottingham University Hospitals NHS Trust
- Sherwood Forest NHS Foundation Trust
- Nottingham Healthcare NHS Foundation Trust

The ICS covers a diverse population of over 1 million people living in the City of Nottingham (332,000) and Nottinghamshire County (764,700), however this does not include the residents of Bassetlaw as they are part of the South Yorkshire and Bassetlaw health care system

Challenges to be addressed

The key challenges faced and therefore to be addressed by the Nottingham and Nottinghamshire Integrated Care System can be grouped into three categories, that have a reinforcing effect on each other: the health and wellbeing of the population, the provision of services and the effective utilisation of health and care system resources.

Health and Wellbeing

- More people are living longer in ill health
- Deprived communities and certain groups of people have greatest exposure to factors that impact adversely on health
- COVID-19 has had a disproportionate impact which has widened the health inequalities gap

Service Provision

- Current health & care services have been set up to help sick people get well, often in a hospital setting
- Do not routinely and systematically identify and support people with ongoing needs
- Inequity of access to services (including digital and virtual services) has widened the health inequalities gap

Resource Utilisation

- Increasing vacancies in health and care workforce
- Ageing estate with high level of backlog maintenance
- Significant financial deficit forecast over next 5yrs, underpinned by recurrent deficit, non-delivery of savings plans and increasing activity/demand
- Resource allocation does not reflect population health need

Inequalities and the wider determinants of health

What are health inequalities?

To address the challenges we face as a health and care system and deliver our overall vision, through our 5-year ICS Strategic Plan we have identified five priorities, one of which is 'Prevention, Inequalities and the Wider Determinants of Health'

Health inequalities are ultimately about avoidable differences in the status of people's health. But the term is also commonly used to refer to differences in the care that people receive and the opportunities that they have to lead healthy lives, both of which can contribute to their health status. Health inequalities can therefore involve differences in:

- Health status, for example, life expectancy and prevalence of health conditions;
- Access to care, for example , availability of treatments;
- Quality and experience of care, for example, levels of patient satisfaction;
- Behavioural risks to health, for example, smoking rates; and
- Wider determinants of health, for example, quality of housing.

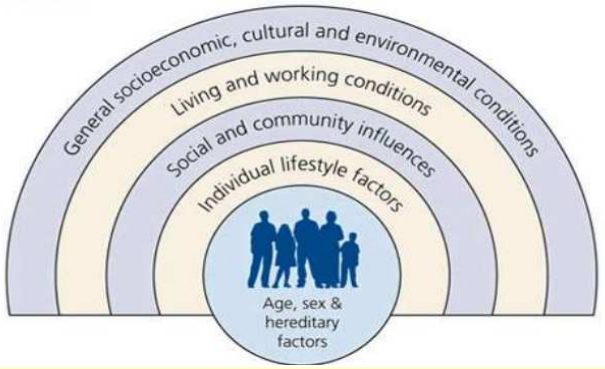
ICS Vision (Strategic Plan 2019-24)

We seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age

What affects health and wellbeing

Access to and quality of health care services contribute to overall health outcomes and health inequalities. However, this is relatively small compared to what are known as the wider determinants of health. These include:

- Personal characteristics - age, gender, ethnicity
- Individual lifestyle factors - smoking, alcohol consumption, diet, physical activity
- Social and community influences – includes family and wider social circles
- Living and working conditions – access and opportunities in relation to jobs, housing, education and welfare services
- General socioeconomic, cultural and environmental conditions – factors such as disposable income, taxation and availability of work



The purpose of this strategy is to provide an over-arching framework for the ICS and its constituent members for addressing health inequalities and the wider determinants of health.

Where are we starting from?

We fully recognise that access to and quality of health care services is only a small contributor to overall health outcomes.

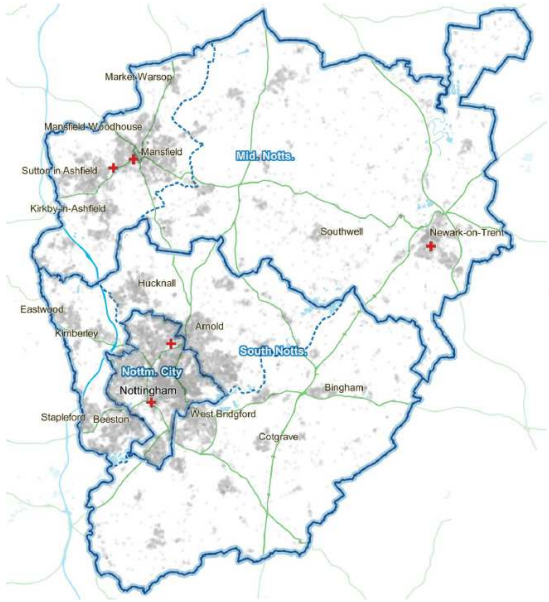
Health Behaviours 30%	Socioeconomic Factors 40%	Clinical Care 20%	Built Environment 10%
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet / Exercise 10%	Employment 10%	Quality of Care 10%	Built Environment 5%
Alcohol Use 5%	Income 10%		
Poor Sexual Health 5%	Family / Social Support 5%		
	Community Safety 5%		

The wider determinants of health contribute 80% of health outcomes

Deprivation is a key driver of illness and ill health. It is our deprived communities that often have the greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. Lifestyle risk factors such as smoking, physical inactivity and poor diet, area also often most prevalent in these communities.

Ethnicity is also a key factor in health risks and behaviours, for example smoking is more common in mixed-ethnicity and white populations and some diseases are more prevalent in some ethnic groups.

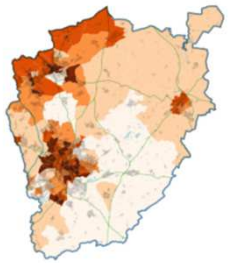
Mental health and learning disability inequalities are also often linked with wider cultural and societal systems of disadvantage which impact a person's wellbeing, including (but not limited to) adverse childhood experiences, stigma, discrimination and housing security.



The Nottingham and Nottinghamshire ICS covers a diverse mix of urban and rural, cities, towns and villages.

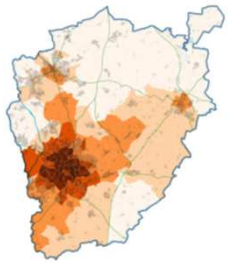
Darker shading – higher proportion

Deprivation



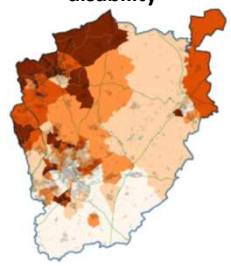
Most deprived communities are found in parts of the City and around Mansfield & Ashfield

Ethnicity



Percentage of population varies between 2% and 59% from BME ethnicity

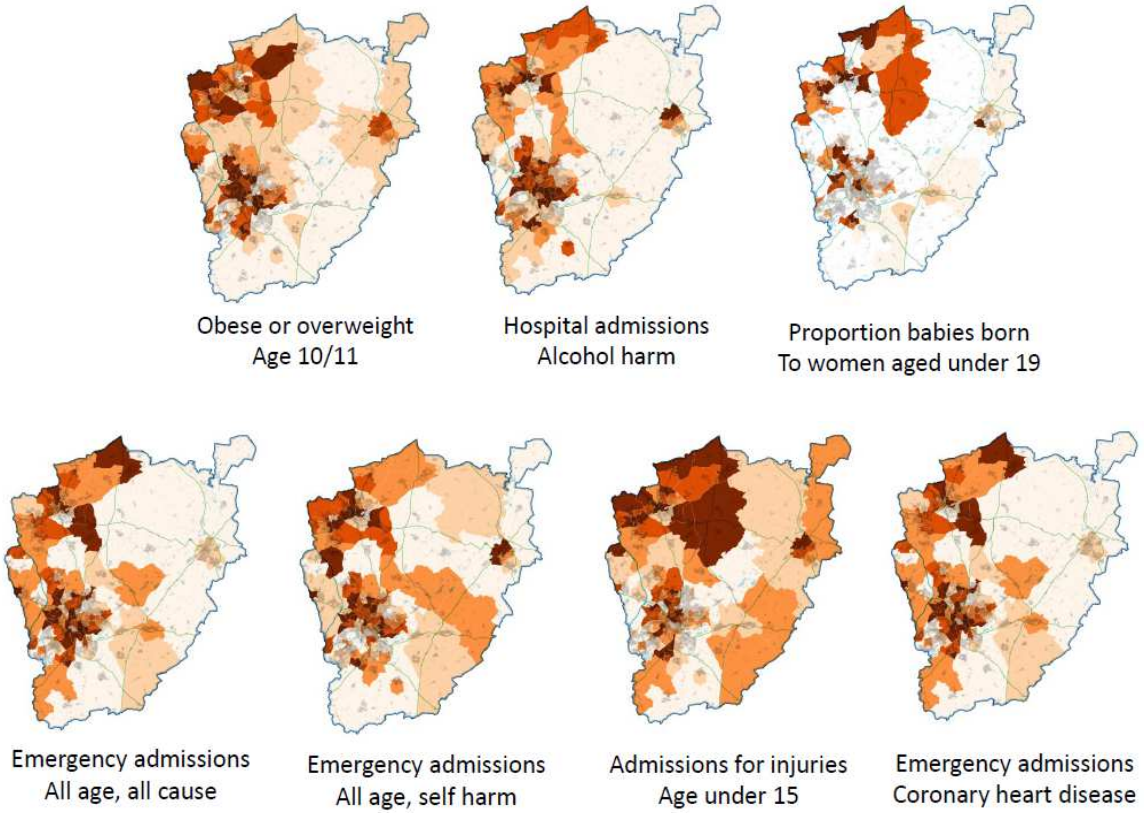
Long-term illness or disability



Up to a third of people report a long-term illness or disability that affects their daily activity

Where are we starting from?

Lots of indicators show a similar pattern…



Obese or overweight
Age 10/11

Hospital admissions
Alcohol harm

Proportion babies born
To women aged under 19

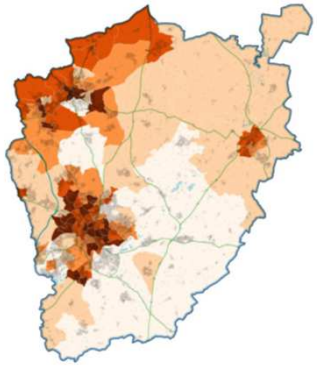
Emergency admissions
All age, all cause

Emergency admissions
All age, self harm

Admissions for injuries
Age under 15

Emergency admissions
Coronary heart disease

Many health and healthcare usage indicators are worse in areas with higher deprivation



Darker shading – higher proportion live in most deprived areas

This influences how long people live (life expectancy) and how much of their lives people spend in ill-health (healthy life expectancy)

Where are we starting from?

Life Expectancy

Life expectancy is a measure of the average number of years somebody born in an area is expected to live. Life expectancy at birth for females in Nottingham City and Nottinghamshire is 81.1 and 81.9 years respectively, and for males 77.0 years and 78.5 years.

One way in which health inequalities can be measured is by comparing the gap in life expectancy between the most deprived and least deprived areas. In Nottingham City this is 12.8 years for females and 11.9 for males, in Nottinghamshire it is 14.4 for males and 14.9 for females.

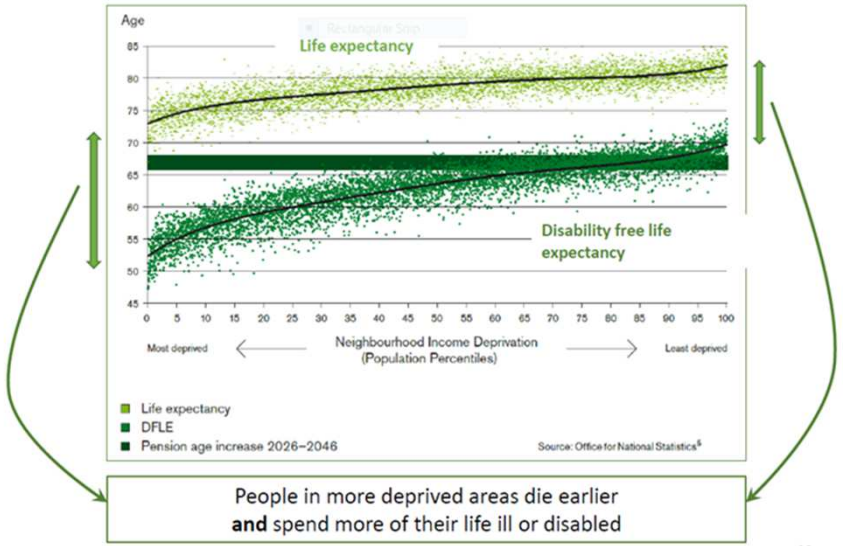
Cancer, Circulatory and Respiratory disease are the greatest contributors to the overall life expectancy gap between the most and least deprived. For females these contribute to c.55% of the life expectancy gap between the most and least deprived areas, and for males c.65%.

Healthy Life Expectancy

Healthy life expectancy is another important measure for understanding health inequalities. The gap between healthy life expectancy and life expectancy gives an indicator of morbidity, i.e. the amount of time somebody spends living in ill health and requires care support.

In Nottingham City on average the amount of time spent living in ill health is 26.0 years for females and 19.5 for males. For Nottinghamshire it is 20.5 years for females and 18 years for males.

However, we know this varies between geographies with people living in more deprived areas generally spending more of their life in ill health.



We must tackle the inequalities that exist across our ICS by focusing on those people and conditions that have the greatest impact

The impact of COVID-19 on health inequalities

The likely impact of COVID-19 on inequalities?

Prior to the COVID-19 pandemic there were stark inequalities in the social determinants of health, risk factors, health care provision and clinical outcomes across socio-economic, disadvantaged and inclusion health groups.

COVID-19 has exacerbated these inequalities and substantially increased them in both the short and long term. The likely higher COVID-19 mortality in deprived communities is likely to be compounded by subsequent worsening of ill health and pre-mature mortality due to economic and social impacts of the pandemic.

There are several different mechanisms by which COVID-19 may increase inequalities including:

1. Direct impact of COVID-19
   - *Disproportionally higher infection in more deprived areas*
   - *Disproportionate long-term impact in survivors*
2. Indirect: Health & Care Services
   - *Services reduced or stopped as a result of COVID-19 response*
   - *Access to services:*
     - *Change in access*
     - *Fear of accessing services*
     - *Ability to access e.g. digital, virtual*
3. Indirect: Wider Determinants
   - *Reduced agency (e.g. housing, social)*
   - *Unemployment / economic downturn*
   - *Education and school closures*
   - *Mental Health (impact of COVID-19, isolation and lockdown)*

Groups disproportionally impacted by COVID-19

Certain groups have been identified as being disproportionality impacted by the COVID-19 pandemic.

5. Mental health & Learning Disabilities

1. Black, Asian and minority ethnic (BAME) groups

People in black, Asian and minority ethnic groups are twice as likely to be living in poverty and are more likely to be employed in a key worker role or experiencing housing deprivation.

2. Disadvantaged communities

People facing greater socio-economic disadvantage risk greater exposure to the virus; for example, as key workers or through crowded housing conditions. These groups are also more likely to be in poorer health to begin with (such as respiratory conditions or heart disease) and therefore more severe symptoms and hospitalisation.

3. Vulnerable groups

People who belong to inclusion health groups face marginalisation or social exclusion, and subsequently poor health, directly because of a certain characteristic or experience: rough sleepers, people in temporary accommodation, Gypsy/Roma/Traveller communities, migrant worker, people recently released from prison, people with learning disabilities and autism, people with severe mental illness

4. Frailty and older people

People in this group are at far greater risk of worsening mental health: people living with mental health problems who access to services has been interrupted, people who live with both mental health problems and long term

We must address the widening health inequalities as a result of COVID-19 by focusing on these groups

What is the basis of our Health Inequalities Strategy?

Integrated Care System
Nottingham & Nottinghamshire

1

Metrics

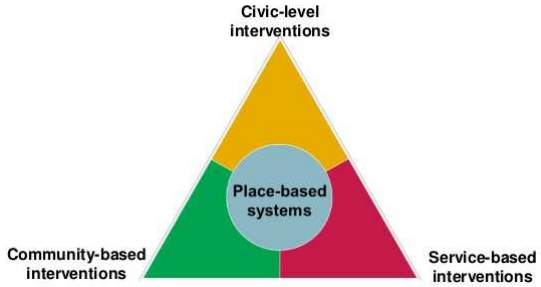
Define metrics (process, output & outcome) and data sets that will inform and identify where health inequalities exist across our prioritised groups for action ***and monitor***

- ***1. BAME Population***
- ***2. Disadvantaged Communities***
- ***3. Vulnerable Groups***
- ***4. Frailty & Older People***
- ***5. Mental Health & Learning Disabilities***

2

Population Intervention Triangle (PIT)

We have adopted the Population Intervention Triangle to guide and shape the specific actions to address the health inequalities identified and defined – ***these actions will be co-produced with our communities***.



This model brings together important elements of **effective place-based working *delivered through ICPs and neighbourhoods (PCNs)*:**

- Civic-level interventions – Policies, strategies, legislation and planning that act on the drivers of health inequalities, including the wider determinants – driven through the Health in All Policies approach and Health & Wellbeing Boards
- Service-based interventions – Where interventions have the potential to generate population-level change, a graduated and targeted support to the populations in greatest need, who are not using those services to the best effect.
- Community-based interventions – The main pillars are i) strengthening communities ii) volunteer and peer roles iii) collaborations and partnerships iv) access to community resource

3

Areas for action

We will build health inequalities action plans around areas for action across the prioritised groups recognising that the ***impact of actions will be short, medium and long term.***

Action Plans

Health & Care Services

- Protect the most vulnerable from COVID
- Restore health & care services inclusively
- Digitally enabled care which increase inclusion
- Accelerate preventative programmes
- Particularly support those who suffer mental health

Short-term impact

Lifestyle Factors

- Alcohol
- Smoking
- Diet and physical activity
- Children and Young People

Medium-term impact

Living & Working Conditions

- Environment
- Economy / Employment
- Housing
- Education/life learning

Long-term impact

These will not constituent a separate programme, they will cut across existing programmes

Health Inequality Strategy Objectives - Health & Care Services

Integrated Care System
Nottingham & Nottinghamshire

Area for action	Strategic objectives – Short-term Impact	PIT		
		CI	SBI	CBI
Protect the most vulnerable from COVID-19	• Ensure plans for protecting people at greatest risk during the COVID-19 pandemic are regularly updated, including:			
	• Ensure people who may be clinically extremely vulnerable to COVID-19 infection are identified and supported to follow specific measures (e.g. shielding) when advised and to access restored services when required.		✓	
	• Ensure plans set out how insight into different types of risk and wider vulnerability within communities will be improved, including through population health management and risk management approaches and deeper engagement, including carers.		✓	
	• Ensuring information on risks & prevention is accessible to all communities, including culturally competent campaigns.			
	• Using the benefits of ICPs to provide a place based approach allowing for proportionate universalism in supporting this group.		✓	
	• ICS constituent organisations/ICPs develop/deliver action plans following completion of COVID-19 risk assessments of staff.		✓	✓
	• Directly supporting the resilience of the community and voluntary sector through a system wide approach and framework.			✓
Restore health & care services inclusively	• Restore health & care services inclusively so they are used by those in greatest need:			
	• Guided by performance monitoring of service use & outcomes amongst those from the most deprived (20%) neighbourhoods and from BAME communities. Consideration will be given to how to expand the approach to those with a disability.		✓	
	• Monitoring will compare service use and outcomes across emergency, outpatient and elective care including cancer referrals and waiting time activity.		✓	
	• Ensure mandatory recording of ethnicity in clinical databases cited in specialised services specifications (by 31 March 2021)		✓	
Digitally enabled care which increase inclusion	• Ensure all ICS constituent organisations, no matter how people choose to interact with services, receive the same level of access, consistent advice and the same outcomes of care, by:			
	• Testing new care pathways are achieving a positive impact on health inequalities, starting with – 111 First; total triage in general practice; ;digitally enabled mental health; and virtual outpatients.		✓	
	• Assessing empirically how the blend of different 'channels' of engagement (face-to-face, telephone, digital) has affected different population groups.		✓	
	• Putting in place mitigations to address any issues.		✓	✓
Accelerate preventative programmes	• Improve uptake of flu vaccination in underrepresented 'at risk' groups.		✓	
	• Ensure care and support planning is continued - General Practice/PCNs/ICPs develop priority lists for preventative support and LTC management – priority groups for programmes such as obesity prevention, smoking cessation, alcohol misuse, cardiovascular, hypertension, diabetes and respiratory disease prevention should be engaged proactively.		✓	
	• Ensure everyone with LD and SMI is identified on their register and annual health checks/follow ups are completed.		✓	
	• Ensure the proportion of black and Asian women and those from the most deprived boroughs on continuity of carer pathways meets and preferably exceed the proportion of the population as a whole.		✓	
	• Implement place-based communications strategy targeting groups most at risk to reduce delays in seeking care.		✓	
Particularly support those who suffer mental ill-health	• Validate plans to deliver the system's mental health transformation and expansion programme, with a particular attention to advancing equalities in access, experience and outcomes for groups facing inequalities across different mental health pathways.		✓	
	• Improve the quality and flow of mental health data to allow more robust monitoring of disproportionalities in access and experience and tale action where problems are identified.		✓	

Health Inequality Strategy objectives – Lifestyle Factors

Area for action	Strategic objectives – Medium-term Impact	PIT		
		CI	SBI	CBI
Alcohol	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• Increase population understanding of risk and harm through IBA (identification and brief advice) and targeted communications campaigns, working with partners outside health and care e.g. police and fire		✓	✓
	• Strengthen communication links between ED and primary care, developing a system wide approach		✓	✓
	• Case management approach to high volume service users		✓	✓
	• Using PHM, recognise and support service change and a system wide approach to dual diagnosis due to the increasing risk of suicide, self-harm, mental ill health, domestic violence and increasing dependency on drug and alcohol		✓	
	• Alcohol Care Teams to support entry into appropriate care and treatment to align with and integrate with community services to ensure whole systems approach.		✓	
	• Employee Health and Wellbeing – all ICS partners will Include alcohol as a priority for employee health and wellbeing, building opportunities through the ICS HR and OD Collaborative.	✓		
Smoking	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• In the short term, to enhance the focus on prevention across the system recognising that those practicing unhealthy behaviours may have increased as a result of COVID19		✓	✓
	• Increase population understanding of risk and harm through VBA (very brief advice) and targeted communication campaigns		✓	✓
	• Place based approach to resources, investing in actions to reduce the prevalence of smoking, with a particular focus on low income groups, experiencing poor mental health and maternity	✓	✓	✓
	• Provide an integrated smoking cessation service, moving to a hub and spoke model		✓	
	• For the longer term, actively monitoring changes in habits impacted by a recession and taking a system wide approach to respond accordingly i.e. impact of price on product choice/policies on illicit tobacco	✓		
Diet and physical activity	• Targeted Population Health Management (PHM) approach by ICPs and neighbourhoods (PCNS):			
	• With Public Health expand on planning at place level to focus on provision of services in areas with high obesity rates, deprivation and BAME communities, with an immediate focus on the impact of COVID-19 e.g. reduced physical activity		✓	✓
	• Support wider roll out of successful Active Nottinghamshire programmes (targeted approach)		✓	✓
	• Taking the Government strategy on obesity implement targeted communication campaigns	✓		✓
	• Recognising the importance of tier 3 services for obesity, through the Clinical Services Strategy co-produce and redesign the delivery of targeted weight management services from tiers 1 to 4 from the basis of the impact on health inequalities		✓	✓
	• To continue to promote and support the Diabetes Prevention Programme		✓	✓
Children and young people	• Recognising the impact of COVID-19 for children and young people (school disruption and access to health & care services), take a system wide approach in recognising and prioritising return to school and remobilising	✓		
	• Accessibility to services as part of restoration (this includes recognising the increased pressure on certain services due to increased demand as a result of COVID19), taking a planned approach across ICPs.		✓	

Health Inequality Strategy objectives – Living and Working Conditions

Area for action	Strategic objectives – Long-term Impact	PIT		
		CI	SBI	CBI
Environment	• To support the strength of community assets through the system wide leadership and structures including ICPs and neighbourhoods (PCNs)		✓	✓
	• To ensure that as a system actions are taken to maintain accessibility to health and care services by those who lack digital literacy or do not have the means to use digital resources (supported by Patient Facing Digital Strategy and ICS Digital Inclusion Programme)		✓	✓
	• Explore opportunities of how the health and care system can manage it's lands and estates to support broader social, economic and environmental aims	✓		
	• System partners work together to support actions to improve air quality	✓		
Economy/ Employment	• Work across the civic-service interface to ensure as much of the health and care spend is retained, to have secondary economic effects locally e.g. through procurement supply chains	✓	✓	
	• Investment in the local labour market for service employment (e.g. work and skills provision - job fairs, recruitment and retention practices and apprenticeships)	✓		
	• Civic-service public health and NHS supported healthy workforce initiatives across the system	✓		
	• Target actions directly in response to a recession and the impact on health inequalities - take a PHM approach to a framework that allows to monitor risks in order to take action at an early stage (increased tobacco use increases tobacco-related poverty, further exacerbating the impact of the recession on low income families); job losses and economic instability may lead to overweight and obesity increases)	✓	✓	✓
Housing	• To identify and commit to actions that further provide for safe homes and are targeted to areas of highest need	✓	✓	✓
	• Supporting actions that help to keep people in their homes at a time of financial insecurity and increasing unemployment		✓	
	• As a system, provide support to community assets that are essential services for people in their own homes		✓	
	• Social housing embedded as part of integrated discharge approach		✓	
Education / Life Learning	• All partners to record data relevant to health inequalities i.e. ethnicity, such that as a system have a greater awareness of the monitoring and impact on health inequalities		✓	

	• The system (including ICPs and neighbourhoods) will work with partners outside of health and care to develop plans to work together to support:
	  • Giving every child the best start in life
	  • Enabling all children, young people and adults to maximize their capabilities and have control over their lives
		✓	✓	✓

	• Establishing partnerships with other key local "anchor institutions" including universities, schools and businesses	✓		

Ensuring delivery of our the strategy – conditions for success

Culture & Commitment

- All ICS partners are committed to addressing the health inequalities gap for Nottingham & Nottinghamshire.
- All ICS Partners recognise the significant impact of wider determinants on health inequalities (80% of health outcomes) and commit to work together to implement system-wide actions.
- All strategies should consider health inequalities, driven through the Health in All Policies approach and Health & Wellbeing Boards.

Commissioning Services of Health & Care Services

- The impact on health inequalities is set out prior to any changes in the commissioning or provision of services.
- Commissioning processes reviewed to ensure any unintended structural racism or bias is addressed.
- Strengthened engagement with communities who need most support, working with ICPs and neighbourhoods to deepen partnerships with community and voluntary sector.
- Services, and recovery actions are accessible for all, particularly those at risk of exclusion because of personal, economic or social factors.
- Where there is any flexibility, health and care services should always be allocated based on healthcare need, striving in particular for equity of access.
- Allocation of resources recognise targeted funding for health inequalities.

Governance

- All ICS partners have a named executive board member responsible for tackling inequalities in place
- ICS Prevention & Inequalities Board, supported by System Executive lead for Health Inequalities.

Implementation Plan

The strategy will be supported by an implementation plan. It is important that the plan:

- Captures the priorities and necessary actions as a result of COVID-19. This will require the system to fully assess and understand the impact at a local level. Work is underway across the system with targeted Population Health Management work, a wider impact assessment through the Local Resilience Forum and review of health & care data. Appendix 1 outlines a health inequalities framework to consistently review the local analysis and use this to inform commissioning and service priorities.
- Is appropriately resourced.
- Supported and aligned plans across ICS constituent organisations, ICPs and neighbourhoods (PCNs). See page 15.

Robust approach to monitoring and evaluation

- The system's monitoring and evaluation approach will support all system partners (commissioners , providers and ICPs) to consistently evaluate system change and transformation initiatives/interventions.
- This will be achieved through an agreed set of measures (service delivery, staff, patient/citizen, quality/patient safety etc) that align to the ICS System Outcomes Framework (see Appendix 2 & 3) and therefore delivery of the system's five-year strategic plan overall.
- Health and care data systems will collect information on risk factors and protected characteristics including ethnicity, to underpin our understanding and response to health inequalities.

Schematic to show relationship between system level health inequalities strategy and health inequalities action plan

An over-arching framework for the ICS and its constituent members for addressing health inequalities and the wider determinants of health

ICS constituent organisations, ICPs and PCNs develop health inequality implementation plans for health & care services, lifestyle factors and living & working conditions - aligned to the ICS Health Inequalities Strategy

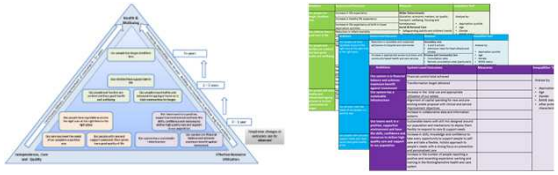
Implementation

	Health & Care Services	Lifestyle Factors	Living & Working Conditions
Nottinghamshire CC Nottingham CC N&N CCG NUH SFH NHC City Care			
Mid Notts ICP City ICP South Notts ICP			
Nottingham & Nottinghamshire ICS	***= System's Phase 3 response to COVID for addressing inequalities***		

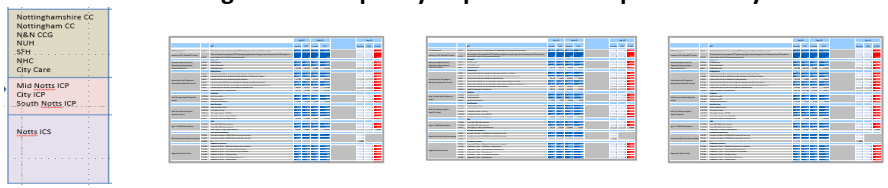
Plans iterated based on ongoing monitoring and evaluation

Monitoring & Evaluation

Set of Health Inequalities metrics aligned to System Outcomes Framework established to monitor progress of strategy



Systems and processes established for monitoring Health Inequalities metrics and evaluating health inequality implementation plan delivery



Appendix 1

A framework for assessing the impact on health inequalities as a result of COVID-19

This framework outlines a population health approach for assessing the impact of COVID-19 on health inequalities and prioritising where system and/or organisational actions are needed to address the worsening or developing health inequalities. The framework has been developed by the Provider Public Health Network.

Assess the impact on health inequalities

Nottingham & Nottinghamshire ICS Framework

Mechanisms for worsening or developing health inequalities:

Direct COVID
- Disproportionally higher infection in more deprived areas
- Disproportionate long-term impact in survivors

Indirect: Health & Care Services
- Services reduced or stopped as a result of COVID response
- Access:
  - Change in access
  - Fear of accessing health/care services
  - Ability to access e.g. digital, virtual

Indirect: Wider Determinants
- Reduced agency (e.g. housing, social) and voluntary sector in some communities
- Unemployment / economic downturn
- Education and school closures
- Mental Health (virus & lockdown)

At risk / target patient cohorts

Develop Metrics / Indicators

Model local situation

Matrix of Evidence
Assessment of risk factors/impacts across the at risk/target patient cohorts

Prioritise

Principles for prioritising where action is needed (organisation and/or system)

The **impact on health inequalities** among patients should be set out prior to any changes in the commissioning or provision of health or social care

Services, and recovery actions, should be made **accessible for all**, particularly those at risk of exclusion because of personal, economic or social factors

Where there is any flexibility, health and care services should always be allocated based on **healthcare need**, striving in particular for equity of access.

Wider determinants of health should be addressed at a place-based level and harness available community assets

Health and care staff should be valued and supported to maintain wellbeing and so deliver high quality patient care in all settings

Local impact assessment and principles inform key priority actions for system

Appendix 2

Metrics for our health & care services action plans

Integrated Care System
Nottingham & Nottinghamshire

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	**Protect the most vulnerable from COVID-19**	No. of people identified as clinically extremely vulnerable to COVID-19 infection - health and care workforce population and total population	Input			**Analyse by:** **•BAME Population** **•Disadvantaged Communities** **•Vulnerable Groups** **•Frailty and Older People** **•Mental Health & Learning Disabilities** **and** **•PCN** **•ICP** **•ICS**
		Sickness absence rate	Output	✓		
2	**Restore health and care services inclusively**	GP consultation rates	Output			
		GP referrals for first outpatient appointment	Output			
		Consultant-led first outpatient attendances (across acute and MH) and DNA rates	Output			
		Number of incomplete RTT pathways at the end of the month	Output	✓		
		Total elective spells (day case and ordinary)	Output			
		A&E activity	Output			
		Non-elective admissions - Same Day Emergency Care / LoS 7+ / LoS21+	Output	✓		
		Referral rates for 2ww cancer diagnosis	Output			
		Cancer staging at first diagnosis	Output	✓		
		Admission rates for heart attacks and strokes	Output			
3	**Digitally enabled care which increases inclusion**	111 access rates - online and telephone	Output			
		GP total triage rates - online and telephone	Output			
		GP consultation rates - video/telephone/face-2-face	Output			
		Digitally enabled mental health therapy rates incl. DNAs	Output			
		Consultant-led first outpatient rates - telephone/video/face-2-face incl. DNAs	Output	✓		
4	**Accelerate preventative programmes**	Flu vaccine coverage - health and care workforce population and total population	Output			
		Children and young people immunisation programme	Output			
		Number of people supported through the NHS Diabetes Prevention Programme	Output	✓		
		Proportion of people on with a learning disability on GP register receiving an annual health check	Output	✓		
		Percentage of women placed on a continuity of care pathway at booking appointment	Output		✓	
5	**Particularly support those who suffer mental ill-health**	Number of people accessing IAPT services	Output	✓		
		Number of children and young people accessing NHS funded mental health services	Output	✓		
		Mental health crisis activity	Output		✓	

Metrics for our lifestyle factors action plans

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	Alcohol	Admission episodes for alcohol-related conditions	Outcome	-	-	Analyse by: •BAME Population •Disadvantaged Communities •Vulnerable Groups •Frailty and Older People •Mental Health & Learning Disabilities and •PCN •ICP •ICS
		Attendance at A&E for alcohol-related conditions	Outcome	-	-	
		Average length of stay for alcohol-related conditions	Outcome	-	-	
		Number/proportion of (appropriate) people given intervention advice	Output	-	-	
		Number of comprehensive physical and mental assessments provided by Alcohol Care Team	Output	-	-	
		Number of brief advice interventions provided by Alcohol Care Team	Output	-	-	
		Number/proportion of affected people (appropriately) referred to specialist services / alcohol support programme	Output	-	-	
2	Smoking - general	Prevalence of current smokers	Outcome	-	-	
		Proportion of patients with smoking status recorded in secondary care	Output	-	-	
		Proportion of smokers offered support and treatment from GP within preceding 12 months	Output	-	-	
		Proportion of smokers who receive smoking cessation support in hospital/achieve temporary abstinence	Output	✓	-	
		Proportion of smokers who receive smoking cessation support from community service	Output	-	-	
	Smoking - during pregnancy	Proportion of pregnant women quit smoking at 4 weeks (of those engaged in programme)	Outcome	-	✓	
		Proportion of pregnant women smoking at delivery	Outcome	-	-	
		Proportion of pregnant women smoking at booking	Input	-	✓	
		Proportion attending 1st tobacco addiction appointment	Output	-	✓	
		Proportion taking up full intervention	Output	-	✓	
3	Diet and physical activity	Reception: Prevalence of overweight (including obesity)	Outcome	-	-	
		Year 6: Prevalence of overweight (including obesity)	Outcome	-	-	
		Percentage of physically active children and young people	Outcome	-	-	
		Proportion of population meeting the recommended '5-a-day' on a usual day (adults)	Outcome	-	-	
		Percentage of adults (aged 18+) classified as overweight or obese	Outcome	-	-	
		Percentage of physically active adults	Outcome	-	-	
4	Children and Young People	Percentage of children achieving the expected level in personal-social skills at 2-2.5 years	Outcome	-	-	
		Percentage of children achieving the expected level in communication skills at 2-2.5 years	Outcome	-	-	
		Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years)	Outcome	-	-	
		Hospital admissions caused by unintentional and deliberate injuries in children (aged 15-24 years)	Outcome	-	-	
		Percentage of looked after children whose emotional wellbeing is a cause for concern	Outcome	-	-	

Metrics for our living & working condition action plans

Area for action		Metric	Measure type	ICS 5 Year Plan Metric		Inequalities 'lens'
				Headline	Programme	
1	Environment	Violent crime - violence offences per 1,000 population	Outcome	-	-	Analyse by: •BAME Population •Disadvantaged Communities •Vulnerable Groups •Frailty and Older People •Mental Health & Learning Disabilities and •PCN •ICP •ICS
		The rate of compliants about noise	Outcome	-	-	
		The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	Outcome	-	-	
		The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the night-time	Outcome	-	-	
		Utilisation of outdoor space for exercise/health reasons	Outcome	-	-	
2	Economy / Employment	16-17 year olds not in education, emplyment or training (NEET) or whose activity is not known	Outcome	-	-	
		Gap in the employment rate between those with a long-term health condition and the overall employment rate	Outcome	-	-	
		Gap in the employment rate between those with a learning disability and the overall employment rate	Outcome	-	-	
		Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate	Outcome			
		Percentage of people aged 16-64 in emplyment	Outcome	-	-	
3	Housing	Adults with a learning disability who live in stable and appropriate accomodation	Outcome	-	-	
		Fuel poverty	Outcome	-	-	
		Social isolation:percentage of adult social care users who have as much social contact as the would like (18+yrs)	Outcome	-	-	
4	Education / Life Learning	Percentage of children achieving a good level of development at the end of Reception	Outcome	-	-	
		Percentage of children achieving the expected level in the phonics screening check in Year 1	Outcome	-	-	
		Percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	Outcome	-	-	
		Percentage of children achieving at least the expected level of development in communication and literacy skills at the end of Reception	Outcome	-	-	
		Pupil absence	Outcome	-	-	

Appendix 3

The ICS Outcomes Framework

System Level Outcomes Framework

Our vision for the ICS is ambitious: Across Nottingham and Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

To provide a clear view of our success as an Integrated Care System and to act as a foundation for population health and population health management, we have developed a system level outcomes framework.

Our System Level Outcomes Framework sets out the outcomes the whole ICS will work together to achieve and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes.

Through this framework we will show:

- How outcomes for citizens are being achieved across the system **including how health inequalities are being reduced across the population**;
- Focus plans and inform priorities through clearly articulated measures; and
- Support organisations to work as one health and social care system to deliver impact and continually improve.

System Level Outcomes Framework Design

Our ICS System Level Outcomes Framework is based on the triple aim (improved health and wellbeing, transformed quality of care, and sustainable resources) and the priorities within the Health and Wellbeing Board Strategies. The Health and Wellbeing Board strategies are informed by the needs of our population and have undergone consultation and engagement with local health and social care stakeholders and the public.

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
Measure	Indicators to demonstrate progress towards or achievement (or not) of our outcomes

The tables on the following pages set out how our Health Inequalities measures described in Appendix 2 map across into out System Level Outcomes Framework Domains, Ambitions and Outcomes

The ICS Outcomes Framework: Health and Wellbeing

Ambitions	System Level Outcomes	Measures
Our people live longer, healthier lives	Increase in life expectancy	
	Increase in healthy life expectancy	• Violent crime – violence offences per 1,000 population • The rates of complaints about noise • The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime • The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the night-time • Utilisation of outdoor space for exercise/health reasons • 16-17 year olds not in education, employment or training (NEET) or whose activity is not known • Gap in the employment rate between those with a learning disability and the overall employment rate • Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate • Percentage of people aged 16-64 in employment • Adults with a learning disability who live in stale and appropriate accommodation • Fuel poverty • Social isolation: Percentage of adult social care users who have as much social contact as they would like (18+)
	Increase in life expectancy at birth in lower deprivation quintiles	
Our children have a good start in life	Reduction in infant mortality	• Children and young people immunisation programme
	Increase in school readiness	• Percentage of children achieving the expected level in personal-social skills at 2-2.5 years, Percentage of children achieving the expected level in communication skills at 2-2.5 years • Percentage of children achieving a good level of development at the end of Reception, Percentage of children achieving the expected level in the phonics screening check in Year 1, Percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception, Percentage of children achieving at least the expected level development and communication and literacy skills at the end of Reception • Pupil absence
	Reduction in smoking prevalence at time of delivery	• Proportion of pregnant women quit smoking at 4 weeks (of those engaged in programme), proportion of pregnant women smoking at delivery, proportion of pregnant women smoking at booking, proportion attending 1st tobacco addiction appointment, Proportion taking up full intervention

The ICS Outcomes Framework: Health and Wellbeing

Ambitions	System Level Outcomes	Measures
Our people and families are resilient and have good health and wellbeing	Reduction in illness and disease prevalence	• Flu vaccine coverage – health and care workforce population and total population • Reception prevalence of overweight (including obesity), Year 6 prevalence of overweight (including obesity), percentage of physically active children and young people, proportion of population meeting the recommended '5-a-day' on a usual day (adults) • Percentage of adults (aged 18+) classified as overweight or obese
	Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population	• Smoking: prevalence of current smokers, proportion of smokers with smoking status recorded in secondary care, proportion of smokers offered support and treatment from GP within preceding 12 months, proportion who receive smoking cessation support in hospital/achieve temporary abstinence, proportion who receive support from community service • Alcohol: admission episodes for alcohol related conditions, attendance at A&E for alcohol-related conditions, av. Length of stay for alcohol-related conditions, no./proportion of people given intervention advice, no. of comprehensive physical and mental assessments provided y Alcohol Care Team, no./proportion of affected people referred to specialist services/alcohol support programme
	Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing	• Number of people supported through the NHS Diabetes Prevention Programme • Parentage of looked after children whose emotional wellbeing is a cause for concern
Our people will enjoy healthy and independent ageing at home or in their communities for longer	Reduction in premature mortality	• No. of people identified as clinically extremely vulnerable to COVID-19 infection in health and care workforce and total population
	Reduction in potential years of life lost	
	Increase in early identification and early diagnosis	

The ICS Outcomes Framework: Independence, Care and Quality

Ambitions	System Level Outcomes	Measures
Our people will have equitable access to the right care at the right time in the right place	Reduction in avoidable and unplanned admissions to hospital and care homes	• A&E activity • NEL admissions – SDEC / LoS 7+ / LoS 21+ • 111 access rates – online and telephone • Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) • Hospital admissions caused by unintentional and deliberate injuries in children (aged 15-24 years)
	Increase in appropriate access to primary and community based health and care services	• GP consultation rates • Admission rates for heart attacks and strokes • Number of people accessing IAPT services • Number of children and young people accessing NHS funded mental health services • Mental health crisis activity
	Increase in the number of people being cared for in an appropriate care settings	• GP referrals for first outpatient appointments • Consultant-led first outpatient attendances (across acute and MH) and DNA rates • Number of incomplete RTT pathways at the end of the month • Total elective spells (day case and ordinary) • Referral rates for 2ww cancer diagnosis • GP total triage rates – online and telephone • GP consultation rates – video/telephone/face-2-face • Digitally enabled mental health therapy rates incl. DNAs • Consultant-led first outpatient rates – telephone/video/face-2-face incl. DNAs
Our services meet the needs of our people in a positive way	Increase in the proportion of people reporting high satisfaction with the services they receive	
	Increase in the proportion of people reporting their needs are met	• Proportion of people with a learning disability on GP register receiving an annual health check • Percentage of women placed on a continuity of carer pathway at booking appointment
	Increase in the number of people that report having choice, control and dignity over their care and support	
Our people with care and support needs and their carers have good quality of life	Increase in quality of life for people with care needs	
	Increase in appropriate and effective care for people who coming to an end of their lives	

The ICS Outcomes Framework: Resource Utilisation

Ambitions	System Level Outcomes	Measures
Our system is in financial balance and achieves maximum benefit against investment	Financial control total achieved	
	Transformation target delivered	
Our system has a sustainable infrastructure	Increase in the total use and appropriate utilisation of our estate	
	Alignment of capital spending for new and pre-existing estate proposal with clinical and service improvement objectives	
	Increase in collaborative data and information systems	
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	Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs	• Health and care staff sickness absence rates due to COVID-19
	Increase in skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care	
	Increase in the number of people reporting a positive and rewarding experience working and training in the Nottinghamshire health and care system	

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