Cover

1. Health and Wellbeing Board(s)

Nottingham City and Nottinghamshire County

2. Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The BCF plan reflects the Nottingham and Nottinghamshire ICS's approach to out of hospital care.

This is based on a number of strategies and approaches that have been agreed by system partners including, but not limited to:

- **ICS Outcomes Framework** that sets out the ambitions we wish to achieve for our population and provides a focus for our collective transformation efforts against the triple aim of improving the health and wellbeing of our citizens, as well as inequalities and wider determinants of health.
- **Clinical and Community Services Strategies**: system partners have developed 20 strategies covering a range of population needs including frailty, heart health, diabetes and CVD to stroke.
- **Population Health Management** Six Step Approach designed to ensure a shared understanding of the needs of our population, enabling focus and resources to be tailored to areas where maximum impact can be achieved.
- **Health Inequalities Strategy**: establishes a shared commitment and vision for addressing health inequalities across the health and care system.
- System **Digital, Analytics and IT Strategy** that identifies the key initiatives that will support service transformation to improve population outcomes including public facing digital services, and a single summary health and care record and supported workflows.
- **People and Culture Strategy**: focused on taking a "one workforce" approach across the ICS, including OD for new ways of working as an ICS.

Our BCF plan is a subset of broader system plans. The development of all these has involved NHS and social care providers, with system governance in place to monitor delivery.

Discharge plans and metrics have been agreed with the relevant acute trusts.

We have four Place Based Partnerships within the ICS which lead delivery of integrated services at a local level: Bassetlaw, Mid Notts, Nottingham City and South Notts. District and Borough Councils are key partners in the County place-based partnerships, recognising their role in the broader determinants of health.

There is also strong VCS engagement in these partnerships ensuring their expertise in understanding communities support delivery at a local level. There has been focused VCS involvement in the Discharge to Assess pathway review.

3. Executive Summary

Priorities for 2021-22

The priorities for 2021-22 build on our progress to date, as well as ensuring a robust response to the Covid-19 pandemic and reflecting system transformation priorities.

The BCF continues to support a joined-up approach to integration across health, care, housing and other agencies such as the voluntary sector to support people to live independently at home.

The BCF funding has been used to deliver a wide range of services and new functionality that support integrated approaches e.g. integrated care teams, sharing data across organisational boundaries, integrated approaches to hospital discharge.

Through the COVID pandemic we have worked in a more integrated way and are aware of the greater opportunities for future ways of working. The Local Resilience Forum structures developed during the pandemic supported effective partnership working and the decision has been made to maintain many of these structures to aid collaborative working.

Key changes since previous BCF plan

The Nottingham and Nottinghamshire system has continued to evolve, with an ambition to be a high performing Integrated Care System focused on improving health and wellbeing, quality of service provision and achieving effective use of resources.

As part of our development to becoming a statutory ICS from April 2022, we are progressing the integration of social care and health commissioning between Bassetlaw and Nottingham and Nottinghamshire CCGs, Nottingham City Council, and Nottinghamshire County Council.

We have established a Joint Commissioning for Integrated Care workstream that aims to achieve the vision of Integrated Health and Care within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.

We anticipate that our BCF plans will evolve as we develop our joint commissioning approach.

There are a number of key changes in relation to the operational delivery of the BCF in 2021-22:

- **Hospital Discharge:** important progress has been made over the last 9 months because of the way teams have worked together supported by the national discharge funding. Demand and capacity modelling work is now in place to support decision making.

- **Discharge To Assess Pilots: a**s part of the implementation of the new DTA policy, a range of pilots have been implemented and are being evaluated. These include the Home First Rapid Response Pilot in Mid Notts: trialling an approach using additional access and navigation resource in the Integrated Discharge Hub; trusted assessors for pathway 1; additional reablement and care support.

4. Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Nottingham City

The Health and Wellbeing Board has delegated responsibility for the BCF to the Health and Wellbeing Board Commissioning Sub-Committee. The Sub-Committee is jointly chaired by Nottingham City Council and Nottingham and Nottinghamshire CCG, with representation including clinical leadership, the City place-based partnership and HealthWatch.

BCF planning, reporting and assurance is undertaken by the Sub-Committee on a monthly basis, or as required.

Nottinghamshire County

The Health and Wellbeing Board is responsible for oversight of the BCF.

Officers from the County Council, Bassetlaw CCG and Nottingham and Nottinghamshire CCG have responsibility to ensure appropriate oversight and monitoring.

Partners undertook a review of the BCF governance in 2019, proposing that the BCF Steering Group (which was responsible for the routine monitoring) was replaced by an Integration Board to ensure a focus on integrating health and care commissioning and provision. This proposal was approved by the Health and Wellbeing Board in December 2020.

However, due to the on-going need to respond to the pandemic, the Integration Board was not established. It was agreed in August 2021 that the Board would not be established but that the broader work to develop a Joint Commissioning approach would be allowed to continue to ensure the most appropriate governance is established. In the interim there is a quarterly oversight meeting comprising of senior officer from all key partners and all submissions and proposals received HWBB ratification.

Assurance of the services and projects that make up the BCF plans are undertaken by the relevant system Programme Boards e.g. A&E Delivery Board.

Development of Plan and Sign-off by Health and Wellbeing Boards

The plans have been developed by Bassetlaw CCG, Nottingham and Nottinghamshire CCG, Nottingham City Council and Nottinghamshire County Council. Formal sign off will be undertaken as follows:

Nottingham City: Health and Wellbeing Board sub-committee – 24th November 2021

Nottinghamshire County: Health and Wellbeing Board – 12th January 2022.

5. Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21

Joint priorities for 2021-22

There are a number of transformation programmes that have been established during 2021-22 which support delivery of the BCF objectives. These are multi-year programmes, meaning that some of the benefits will be realised in future years.

Community Care Transformation Programme: a joint health and care programme to deliver a sustainable model of community care provision that aims to optimize people's independence by addressing physical and mental health and social needs, working with communities at a neighbourhood level.

The programme focusses on place-based redesign of community services and develops greater integration between health and non-health services. Through co-production with citizens, staff, partners and stakeholders, the Programme will develop an approach focused on:

- The alignment of health and social care resources and workforce to implement neighbourhood/place-based Community Teams, delivering a consistent model of care across the ICS whilst ensuring services are responsive to local population need.
- Levels of support and care are driven by population health data and intelligence, with a focus on delivering outcomes that reduce inequalities in health and wellbeing.
- Personal and community assets are fully utilised and developed to support outcomes, using a practice framework for an integrated health and social care personalised, strengths and asset-based approach that empowers individuals and communities to take control of their own health and care.
- An organisational development approach for all community care staff to empower practitioners and to support the implementation of the new care model, irrespective of employing organisation and role.
- Adopt a transparent approach across commissioners and providers to ensure we deliver best value for money, moderating costs of care and maximising value (the relationship between quality, outcomes and resources).

The Programme has developed a design framework (referred to as the 'blueprint') for community services based on stakeholder engagement, and an evidence review of local, national and international practice. The blueprint includes core features and the environment to allow improved delivery of community services upon service redesign. The detailed service redesign commences in January 2022.

Ageing Well Programme: a jointly appointed Programme Director is in post, ensuring local alignment with national programme ambitions to:

- Promote a multidisciplinary team approach to provide tailored support that helps people live well and independently at home for longer
- Give people more say about the care and support they receive
- Offer more support for people who look after family members, partners or friends because of their illness, frailty or disability
- Develop more rapid community response teams, to support older people with health issues before they need hospital treatment and help those leaving hospital to return and recover at home
- Offer more NHS support in care homes including making sure there are strong links between care homes, local general practices and community services.

Carers Strategy

A system Carers Strategy Board is developing a carers strategy across the ICS to focus on the needs of our unpaid carers who we recognise have been particularly impacted by the COVID-19 pandemic. The focus is on a developing a single service offer across the ICS that supports the identification of carers, access into advice, assessment, signposting and pre-eligibility carers respite.

As well as key transformation programmes, other key developments are supporting delivery of the BCF plan:

Place Based Partnerships

Our four place-based partnerships (Bassetlaw, Mid Nottinghamshire, South Nottinghamshire and Nottingham City) are ensuring a focus on partners working together at an operational delivery level to develop and deliver community-facing integrated care, joining up community services across sectors and working with community leaders.

This includes supporting the development of Primary Care Networks who are key in delivering our out-of-hospital care.

Quality and Market Management: we are developing an integrated approach across the CCG and County Council to ensure providers are supported and developed to deliver high quality, integrated services.

<u>Approaches to Joint/Collaborative Commissioning</u>

Nottingham and Nottinghamshire ICS are working with the national Better Care Fund team to progress our ambition to develop an integrated commissioning approach that will achieve:

- better outcomes for our residents
- improve access and user experience
- integrated care through provider collaboration
- reduce health inequalities through a greater focus on prevention and early intervention.

A package of facilitation support has been designed with the Local Government Association (LGA) and Institute for Public Care (IPC) to consider local ambitions for joint commissioning, how the system needs to change to meet these ambitions and the priorities that the system will focus on.

A task and finish group has been established consisting of commissioning leads from the CCG and both Local Authorities to:

- Agree a Local Authority and CCG joint commissioning strategy and policy framework to support progress with integrated commissioning and service re-design
- Establish the governance arrangements to support the integration of health and care commissioning and delivery in Nottingham and Nottinghamshire
- Confirm a work programme based on ICS priorities for service delivery areas where there are clear opportunities to improve value through an integrated commissioning approach.

The potential scope of our future joint commissioning is shown below, recognising the breadth of opportunities to improve outcomes for our population through a greater level of integration. This is supported by opportunities in education, environment, leisure, transport, market management and partner roles as anchor organisations in our communities.

Our key areas of focus are:

- Engagement with system partners on the vision for joint strategic commissioning
- Agreement of a joint commissioning strategy and policy framework
- Establishment of a work programme of areas where there is most benefit to be achieved through a joint integrated commissioning approach
- Development and agreement of an appropriate governance and accountability framework that enables joint decision-making, while maintaining compliance with existing legislation
- Identification of capability and capacity within partner organisations to deliver the work programme within the joint strategic commissioning function.

The outputs from the support will shape the ICS's next steps to achieve the vision of Integrated Health and Care, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.

We expect joint commissioning to evolve on an iterative basis taking into account the development of our Place Based Partnerships and the role of the Health and Wellbeing Boards within our system. As part of this programme we will be reviewing our approach to the BCF and how we collectively invest in services, considering alignment across City and County where appropriate.

Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care

Our approach to person-centred care is underpinned by a developing system approach to coproduction, using expertise across our health, social care and voluntary sector partners.

During 2021-22 an ICS Co-production strategy is being developed that will establish coproduction standards across the whole ICS, and to ensure both staff and people with lived experience have access to the tools needed to coproduce effectively in an equal and reciprocal partnership.

This approach will embed coproduction in all work across the Nottingham and Nottinghamshire ICS as a move towards co-production being the default position including transformational activity, commissioning activity, service/system redesign and quality improvement.

The County Council are embedding strength-based practice using the Three Conversations. They have commissioned a strategic partner, Partners 4 Change to support them to do this and they have established sites of innovation to develop their practice. It is built on the assumption that if you collaborate with and allow people to be co-designers of their support then their positive outcomes go up, and their use of health and social care resources goes down.

How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

The BCF funds a range of services aimed at supporting people to live independently in the community that recognises there is a need to provide integrated services to improve outcomes.

Our approach to integration recognises there are different levels at which integration needs to happen: at both the ICS system level, and within our places recognising the needs of local communities. Our County plan reflects the places of Bassetlaw, South Notts and Mid Notts.

The table below summarises key BCF funded services that are integral to our integration approach.

Nottingham City HWB	**Nottinghamshire County HWB**
Description: There is a continued focus on providing co-ordinated care for our residents, recognising that early access to services and support are critical in supporting people to live independently. This includes our local approach to social prescribing which has developed in light of PCN development and is supporting people to engage with their communities, recognising the assets within our communities.	
Scheme name: Access and Navigation Includes the Health and Care Point that supports self-referral and health and care professional referrals to community services, signposting to services best able to meet people's needs within their communities.	**Scheme name:** **C. Reducing non-elective admissions – Integrated Care Planning and Navigation** **F. Proactive Care – Care Planning, Assessment and Review**

Care Navigators are based within Primary Care Networks, having a geographical focus that ensures an understanding of the assets within a person's own community.	Care Navigators are based within Primary Care Networks, having a geographical focus that ensures an understanding of the assets within a person's own community. Care Co-ordination services are an integral part of the delivery of MDT meetings and working within PCNs. Their role includes the identification of patients that may require a health or social care intervention or in complex cases an MDT discussion. The function is a mechanism for early identification of care gaps resulting in interventions much earlier in the patient's journey.
Description: Health and social care teams adopt an integrated approach to ensure that our residents needs are addressed in a holistic way, supporting people to live independently in their own homes, and supporting people to be discharged from hospital in a timely way, with the aim of people returning to their normal place of residence.	
Scheme name: Integrated Care Includes integrated specialist short term care and rehabilitation within the community to prevent unnecessary hospital admission in a crisis situation and enable citizens to regain their independence and to recover from an acute illness requiring a hospital stay, condition or life event. Integrated Discharge Teams work within hospital settings to ensure appropriate support is identified to avoid and admission in ED / assessment units, and to support effective and timely discharge planning for people admitted to hospital. Community beds are commissioned across City and County, working flexibly so support discharge from hospital, but also providing a geographical focus to support people to remain within their communities.	**Scheme name:** **A. Seven day working: Reablement / Rehabilitation** **B. Delayed Transfers of Care: Multi-disciplinary community teams** **C. Reducing non-elective admissions: Multi-disciplinary community teams and geriatrician input** **K. Discharge / Assessment including intermediate care: care planning, assessment and review** Community geriatricians work within a multi-disciplinary team to support frail older people, proactively to avoid hospital admission, and to support people to maintain independence on discharge from hospital. Integrated Discharge Teams work within hospital settings to ensure appropriate support is identified to avoid and admission in ED / assessment units, and to support effective and timely discharge planning for people admitted to hospital. Community beds are commissioned across City and County, working flexibly to support discharge from hospital, but also providing a

	geographical focus to support people to remain within their communities.
Description: GP practices provide services to support the management of long term conditions aimed at supporting people to live as independently as possible and avoid unnecessary hospital admissions.	
Scheme name: Primary Care Enhanced services for GP practices to support proactive care management of long term conditions. This includes services aimed at supporting our most vulnerable citizens e.g. POW Nottingham which provides outreach services to sex workers in light of the barriers sex workers face in accessing mainstream services.	**Scheme name: C. Reducing non-elective admissions: Integrated Care Planning and Navigation** Enhanced services for GP practices to support proactive care management of long term conditions.
Description: Carers are recognised as a key group to be considered for targeted health inclusion and are recognised as a disadvantaged group. It is recognised that there have been increased pressures on Carers during the pandemic who have faced barriers in accessing care and support and report an increased psychological strain from their caring role.	
Scheme name: Carers Partners jointly commission a carers service that includes the provision of a Carers Hub, Carers breaks and Young Carers support.	**Scheme name:** **L. Respite services** **O. Support for Carers** A Carers Hub provides advice and support with access to formal Carers Assessments, support planning and respite support.
Description: Housing is recognised as a key determinant of health outcomes across the UK, and access to suitable housing which is adapted or adaptable is a significant enabler of work to reduce health inequalities.	
Scheme name: **Assistive Technology** **Housing Health** The role of Assistive Technology in supporting people to live independently. There are a number of offers in place including telecare services and the dispersed alarm service. A Hospital to Home scheme is commissioned from Nottingham City Homes. The service works alongside health and social care providers to assess appropriate patients in a range of settings, including but not limited to patients' homes, Nottingham University	N/A

Hospital sites and mental health inpatient and step down facilities. This supports people to move into more suitable properties in a timely manner, enabling recovery and reablement at home, supporting Discharge to Assess and minimising the clinical risks sometimes associated with delays in transfer of care.	

Please note: specific lines within the BCF planning template may have different names in City and County for similar services due to previous commissioning arrangements.

6. **Supporting Discharge (national condition four)**

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

There is a system Discharge to Assess (D2A) planning and commissioning group responsible for the delivery of effective hospital discharge.

The system vision is:

"Home First for all, with the individual at the centre, starting with the premise that home is the preferred place of care. People are holistically assessed at the right time, in the right place, outside of an acute setting to maximise their independence and improve outcomes by removing traditional organisational boundaries".

Key areas of focus are:

- Ensuring that more of our citizens are discharged home on pathway 0 and 1
- Commissioning of wrap around discharge services which support individuals to be assessed and reabled in the most appropriate environment for their needs including:
    1. Integrated Discharge Teams
    2. Integrated Discharge Hubs
    3. Wrap around services for pathway 1
    4. Pathway 2 and 3 services
    5. An appropriate workforce model
    6. Third sector services
- Home and bed based re-ablement services including wrap around intensive support
- Community referrals into reablement services
- Adequate domiciliary care to further promote Home First principles

BCF funded schemes supporting discharge are detailed in the table on pages 8 to 11 above.

Nottingham University Hospitals – specific actions

Targeted work is being undertaken at Nottingham University Hospitals (NUH) focused on admission avoidance, flow, managing length of stay and discharge from hospital. This is within the context of ongoing system workforce challenges including lack of capacity in the home care market, adult social care and community health care workforce, recognising this is a challenge nationally. This impacts on discharges from hospital and the number of 14/21 LOS patients who are medically safe for discharge has seen an increase.

The following **NHSE/I Nottingham System and ECIST Concordat priorities** have been agreed as of 1st November 2021:

- Improving Specialty Collaboration to decrease patient waits and improve flow
- Improve Primary Care and UTC collaboration to improve admissions avoidance and diversion
- Enhance/develop ED avoidance by transfer to virtual wards or SDEC

- Improve the quality and safety of streaming and initial assessment in ED
- Further reduce length of stay pre-medically fit for transfer
- Further develop D2A for the short, medium and long term – restating the system's shared purpose is to transfer patients out of hospital within 24 hours of being medically fit for transfer.

A **Supporting Best Practice for Board/Ward Rounds Rapid Improvement Event** started week commencing 1st November 2021. The focus was on:

- Collaboration with NHSE/I through the Alliance 16 Programme and NUH clinical colleagues
- Aim for board/ward rounds to provide the framework for effective discharge planning giving opportunity to:
    - bring together the good practice currently being delivered in the NHS and enabling compliancy with national policy (Reasons and no reason to reside codes, using criteria led discharge (CLD) to ensure timely and effective discharge, escalation of delays and afternoon huddles to promote accurate planned date medically safe (PDMS) and a forum to ensure jobs are completed on time to reduce delayed/failed discharges)
    - take the learning from the NUH improvement PDSA cycles and 'Always Events' for improving discharge to further encourage "getting it right first time" (GIRFT) and planning tomorrow's work today principles
    - enable clinical teams to self-assess against good practice and identify priorities for improvement
    - offer organisational leaders a template for a standardised approach to multidisciplinary team inpatient assessment, which can be delivered through hospital-wide improvement programmes that enable a drive for reliability and a drive to reduce unwarranted variation
    - describe how care can be delivered in hospital in partnership with patients, families and carers
    - reiterate and update the guidance published in Ward rounds in medicine: principles for best practice (2012). While that guidance was welcomed, it has not been widely implemented.

This approach will initially be focused on four cohorts working over 32 wards over a 12 week period. This approach ensures that the wards that more directly impact ED success are included and would therefore expect to see an impact on hospital flow sooner.

Local Government Association Peer Review

The ICS is participating in a Better Care Peer Led System Review of Discharge to Assess, a sector-led, constructive and supportive process based on the foundation of supporting continuous improvement.

A peer-led whole system review took place on 9th November 2021, with attendance from across the system from health, social care, and voluntary sector system partners including patient representation via Healthwatch and Nottinghamshire Hospice.

A Discharge Policy Gap Analysis Survey designed to identify the key elements of the Discharge Policy which need urgent attention for implementation, drawn from the views of all staff, across the

system and community partners has taken place. A workshop is to take place shortly, to identify and structure the priorities and issues into an action plan and collectively agree the next steps.

Supporting Additional Discharge Capacity for NUH

The System Planning Group and Capacity Cell's jointly led modelling work has identified a number of service improvement and capacity actions. A plan has been developed collaboratively with providers with challenge and confirmation across system groups, using agreed planning assumptions. The plan will be refined and iterated as the system position changes throughout winter.

There are daily meetings to support discharge planning for people who are Medically Safe for Transfer, and the reasons for delay themes are captured, investigated and followed up.

Nottingham City Council has commissioned two pilots to provide a bridging service, which supports improved flow through the Nottingham City D2A system and appropriate discharges from hospital into re-ablement:

1. **The TEST team:** The service takes patients from the City LA internal re-ablement service (clinical intervention is OT intervention where indicated to maximise independence) to allow the service to take additional discharges from acute / community settings. The patients have already been through the re-ablement service, so their care needs are lower than when first discharged, allowing a greater number of patients to be supported than if taken directly from acute /community
2. **Additional interim homecare:** Citizens are then discharged to the block service. This service holds citizens for up to 2-weeks which allows the external market to secure a regular package of care in the regular run.

To address the capacity for assessment both in the acute hospital and in the community-based services based on demand and flow NCC is to recruit additional assessment and supervisory capacity in the TEST Team and IDT/IET support to meet demand in allocation for identification of discharge pathway, and long-term assessment.

7. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people.

Nottingham City Council have produced a draft Housing and Support Strategy Action Plan.

Key Principles: A home that is not just 'good enough' but that actively enables and promotes wellbeing to:

- Support people to live more independently (less restrictive models)
- Focus on preventive approaches to support independence
- Develop solutions with people, providers and the system
- Build on what works well
- Actively shape the market
- Ensure a strong focus on independence

Key Enablers:

- Digital and Technology
- Adaptations, equipment and small aids
- Portable adaptations to enable flexible use of housing
- Housing related/tenancy related support
- Targeted prevention
- Development of creative accommodation and care options

Nottinghamshire County Council has an active programme of DFG delivery working in partnership with the seven district and borough councils to deliver adaptations in people's homes enabling them to be as independent as possible. The DFG programme also supports countywide initiative such as the Warm Homes on Prescriptions and the Handy Person Adaption Service.

Currently the countywide DFG Partnership has been developing a DFG Policy which has been or is in the process of being adapted by each district or borough council. This policy supports the DFG delivery and provides guidance to ensure that there is a collective approach to DFG delivery. The policy will be supported by an MOU that clarifies the relationship between the County Council and the District and Borough Councils identifying respective responsibilities with the overarching aim of ensuring that the adaption meets an individual's need and allows the individual to live a healthy and independent as possible life in a place that they can call home.

Nottinghamshire County Council transfers the full DFG value to the District and Borough Councils, with the exception of the funding agreed for the Handy Person Adaptation Service (HPAS) which provides help and support to keep people safe and secure in their home with essential adaptations and small practical jobs.

8. Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The ICS Health Inequalities Strategy 2020-24 sets out the key objectives for addressing inequalities for people in our system with a focus on:

- Health and care services
- Lifestyle factors
- Living and working conditions.

It is recognised that within Nottingham and Nottinghamshire there is a diverse population and geography with areas of significant deprivation. Covid19 has exacerbated these inequalities. Through the Covid19 vaccination programme considerable efforts have been applied to targeting groups experiencing health inequalities and this has provided extensive learnings in relation to working at place level, taking a culturally competent approach and supporting those most in need. The BCF will continue to reflect the learning at place, ensuring services are designed to address with the needs of those experiencing the greatest inequalities, taking a personalised approach.

Equality Impact Assessments are undertaken when services are reviewed and commissioned. The use of the Public Health England Health Equity Assessment Tool (HEAT) is currently being reviewed as a systematic, continuous improvement framework to assessing the extent to which services and transformation programmes are ensuring health inequalities are being addressed.

BCF services supporting our approach to addressing inequalities include:

- **Carers support:** the ICS is developing a Carers strategy that seeks to develop a single model of support including a carers hub, providing a single point of contact for all Carers to provide advice, assessment and support planning, signposting and a gateway into 'pre-eligibility' Carers' respite ("Short Breaks"). This will provide an early intervention and personalised approach for the provision of support and respite breaks for Carers.

- **POW Nottingham**: a service is commissioned in City to provide outreach services to male and female sex workers in light of the barriers sex workers face in accessing mainstream services. The service supports health and wellbeing needs, recognising that sex workers are at higher risk of poor sexual health, as well as vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems.

- **Hospital to Home (City):** a dedicated housing specialist supports patients who are inappropriately housed, where this is putting them at risk of hospital admission or causing a delay in discharge.

A dashboard is being developed to support the system in understanding inequalities in service use and outcomes. This will be supported by health gain metrics to support prioritisation and demonstrate value in our services.

A learning environment for health inequalities and equity is being created, with workforce development for training on the social determinants of health and understanding the wider context in which our citizens live e.g. housing, education, employment, environment, power and discrimination.

This includes services funded through the BCF and will also support an understanding of inequality of outcomes related to BCF metrics.