Nottinghamshire
Health & Wellbeing Board

Nottinghamshire Joint Health and Wellbeing Strategy 2022-2026: Full Document

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1 Foreword

Nottinghamshire County's third Joint Health and Wellbeing Strategy (JHWS) has been developed in a national context of reduced healthy life expectancy in some communities, increasing health inequalities and global climate change.

Addressing these challenges requires joint working to enable everyone to prosper in their communities and remain independent in later life.

It involves addressing factors which make a big contribution to good health – things like a healthy diet for everyone, somewhere to live that is safe, ensuring every child gets the best start in life, as well as the role that tobacco and harmful drinking plays in eroding wellbeing and increasing inequalities. It also involves improving the way services join up across Nottinghamshire to achieve our vision to **work together to enable everyone in Nottinghamshire to live healthier and happier lives, to prosper in their communities and remain independent in later life**.

Councillor Dr John Doddy

Chair of the Nottinghamshire Health and Wellbeing Board

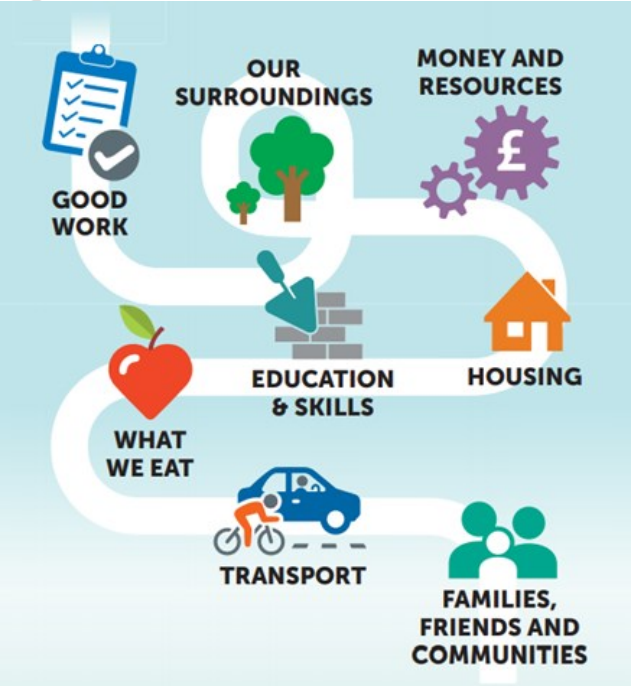
2 Introduction

2.1 What is Health and Wellbeing?

Good health and wellbeing allows us to prosper, live our lives to the full and for longer.

Health is usually described as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2006). Physical, mental and social here mean a person's body, mind and how they interact with the world around them. Wellbeing is a complex combination of these factors. It is strongly linked to happiness and life satisfaction and could be described as "how you feel about yourself and your life" (Victoria Government, 2021).

Our health and wellbeing is a resource which enable us to develop goals and pursue them. The health and wellbeing experienced by communities everywhere is strongly shaped by the conditions in which people are born, grow, live, work and age. These are the foundations and are sometimes called the wider determinants of health. Health and care services have an important role to play but on their own do not create good health and wellbeing.



We also know that the conditions in which people are born, grow, live, work and age are not the same throughout the county. In general, communities with poorer access to good housing, good work, good education, healthy diet, transport also experience poorer health and wellbeing. This is what is

meant by health inequality. Many health inequalities can be reduced or avoided - Taking action requires strong commitment and is often a matter of doing what is fair.

This strategy sets out the vision and ambitions for the Nottinghamshire Health and Wellbeing Board for improving the health and wellbeing of the people of Nottinghamshire by addressing wider determinants and health inequalities. We will achieve this through working together in partnership and with residents in Nottinghamshire.

2.2 Structure of the Strategy

In order to assist readers in understanding the strategy, it will be broken down into five main parts:

Section 3: Where are we now?	• What is the current situation in Nottinghamshire with regard to health and wellbeing needs? • What have we learnt from our engagement so far? • How does this inform our ambitions and priorities for the strategy?
Section 4: Where do we want to be?	• What are our ambitions, priorities and objectives for improving health and wellbeing?
Section 5: How are we going to get there?	• What have we learnt from implementing the previous JHWS? • What is our plan for achieving those ambitions, priorities and objectives?
Section 6: How will we know when we've got there?	• How are we going to monitor and evaluate our progress and successes?
Appendices 1-8: Further information	• What evidence and analysis has informed this strategy?

N.B. Sections 5 and 6 and the appendices are currently a ***work in progress*** and will be informed by a Health and Wellbeing Board (HWB) workshop in March 2022.

3 Where Are We Now?

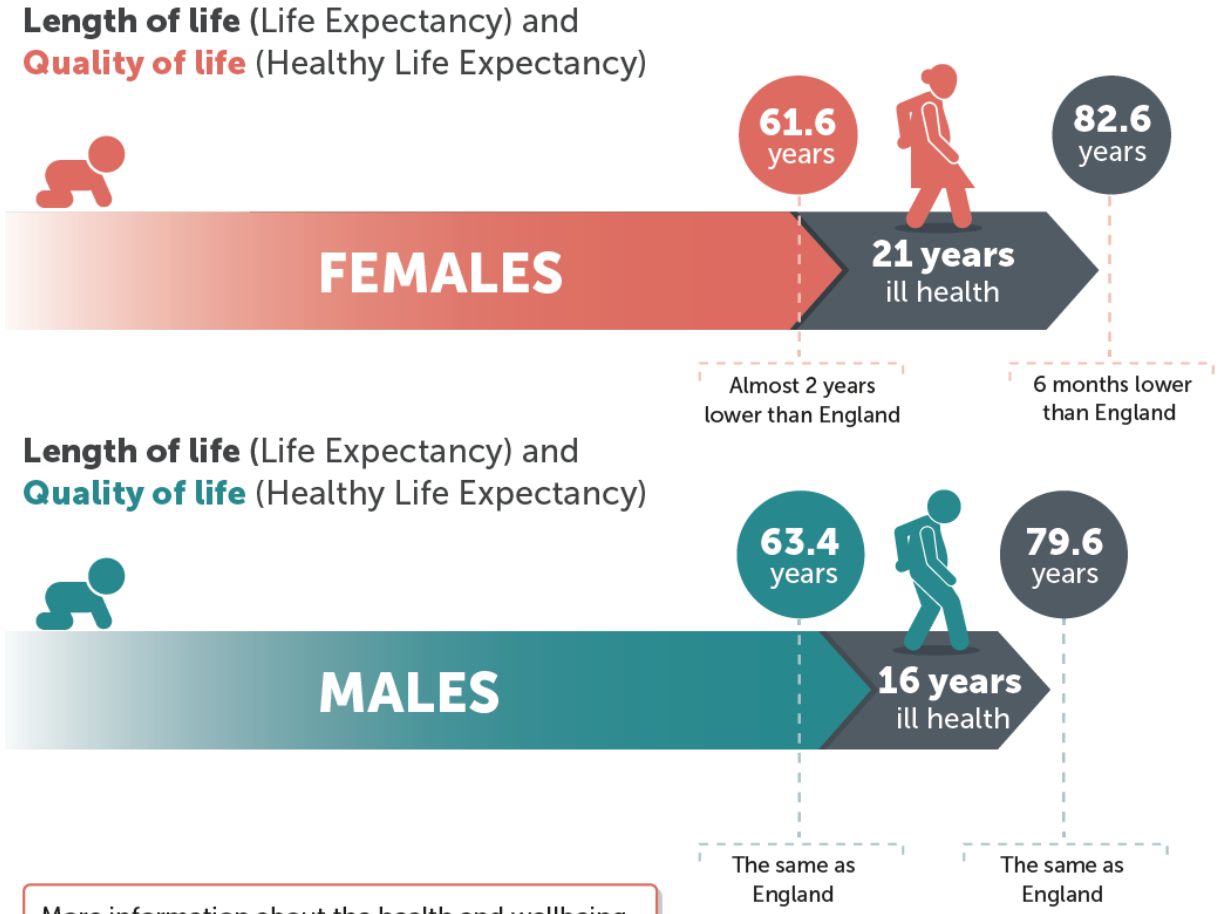
3.1 Current Health and Wellbeing in Nottinghamshire

This section is a summary of the current health and wellbeing in Nottinghamshire (further detail is provided in Appendix 1). The main source for this information is the Joint Strategic Needs Assessment (JSNA). This can be found on the Nottinghamshire Insight website.

It provides the basis for the 4 ambitions and 9 priorities of our JHWS.

3.1.1 Life Expectancy and Healthy Life Expectancy

On average, women in Nottinghamshire live 83 years (which is six months shorter than across England as a whole) and men 80 years (the same as England). In Nottinghamshire, the average length of life in which people enjoy good health (this is called healthy life expectancy) is 62 years for women and 63 years for men. These averages obscure some stark variations between different communities in Nottinghamshire. People living in the least advantaged areas generally die 7.5 years earlier and have spent an additional 14 years living in ill-health, compared to those living in most advantaged areas.



More information about the health and wellbeing of people in Nottinghamshire can be found at: www.nottinghamshireinsight.org.uk

Source: OHID (2022a)

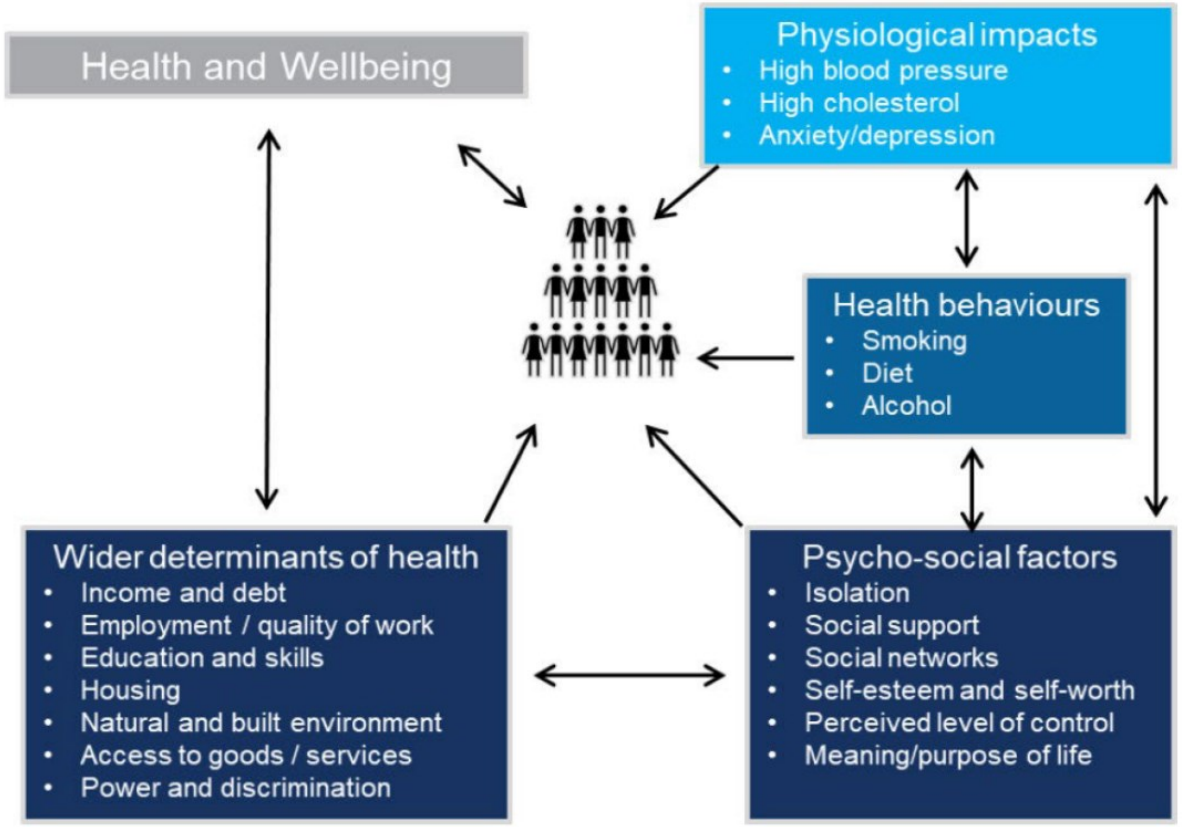
A read of Nottinghamshire's Joint Strategic Needs Assessment shows that inequalities like these are evident in almost every area of health and wellbeing, and in the factors which shape the health of the population. In general, they are not inevitable and can be significantly

reduced. We will return to these inequalities in what follows. Addressing them must be central to our strategy.

In the meantime, we should consider: **what are the factors which exert the greatest influence on our health and wellbeing?**

3.1.2 Factors shaping health and wellbeing and health inequalities

The figure below provides a summary view of the complex interplay of factors shaping our health and wellbeing and the stark variations observed between different communities in Nottinghamshire.



Source: UK Government (2021)

The figure reflects the extent to which the health and wellbeing of a population is shaped by our economic and social environments and their impact on a range of psycho-social factors.

The health behaviours of individuals are an important factor but their origin and expression must be understood in the context of these “wider determinants” and psycho-social factors. The figure also provides a way for us to understand the wealth of biomedical research about the physiological factors which erode health. These are also important to understand – and some of what follows in this document draws on that evidence and on measures which are more closely related to healthcare than health creation. But again, the evidence about the role of these physiological factors needs to be understood in the context of the mediating role of factors relating to psycho-social environment and the health behaviours it shapes.

An understanding of this points us towards the need to base our interventions on an appreciation of the whole system and the complexity of the interplay between these various causes of inequalities.

For example, a health issue experienced by an individual may be strongly linked to the environment in which they live or to insecure employment. Psycho-social factors such as family and social relationships, can also be strengthened or eroded through the influence of these wider determinants.

The table below shows some of the impacts of these wider determinants on the health and wellbeing of people on Nottinghamshire.

Wider Determinant	Impact of wider determinant	Example of Health Inequalities in Nottinghamshire
Good work (employment)	Unemployment causes stress, which ultimately has long-term physiological health effects and can have negative consequences for people's mental health, including depression, anxiety and lower self-esteem.	Employment figures in Nottinghamshire for adults with a learning disability (2.7%) are below regional and national comparisons.
Our surroundings (environment)	Poor air quality has a different effect on health depending on age. The effect of a young child would be: • Slower development of lung function • Asthma • Start of hardening of the arteries	Groups that are more vulnerable include children and older people, pregnant women, and those with heart and lung conditions. 3 particular areas in Broxtowe, Gedling and Rushcliffe have certified high for nitrous oxide pollution.
Money and resources	Growing up in poverty can affect every area of a child's development and future life chances.	Mansfield, Newark and Sherwood, Ashfield and Broxtowe are considered "social mobility cold spots". Good social mobility is a key indicator of how we are preventing poor children from becoming poor adults.
Housing	Inadequate housing causes or contributes to many preventable diseases and injuries, including respiratory, nervous system and cardiovascular diseases and cancer (Kings Fund, 2022). Homelessness is a far wider a problem than the aspect that is most visible to the public – rough sleeping which is considered the tip of the iceberg.	People who are homeless experience worse health outcomes than the general population. The prevalence of serious mental illness (including major depression, schizophrenia and bipolar disorder) is reported as 25–30% in the street homeless population and those living in direct-access hostels. Homelessness is also associated with higher rates of personality disorder, self-harm and attempted suicide
Education and skills	Educational attainment is one of the main markers for wellbeing through the life course making it extremely important that no child is left behind at the beginning of their school life.	Only 70.5% of reception pupils are achieving a good level of development compared to 71.5% in England - this will be worse in more deprived areas

What we eat	Good food is vital to the quality of people's lives and plays an essential role in improving individual and community health and wellbeing (Nottinghamshire Food Charter, 2021).	Over a quarter of pregnant women in Nottinghamshire are classed as obese
Transport	Transport is vital to us all as it allows us to see our family and friends, get to work, go on holiday, access education and health services, and do the activities that we enjoy (Williams, 2018).	Ashfield has the highest rate of people killed or seriously injured (KSI) in the County and is significantly higher than regional and national rates. Older people living alone and without access to a car in the more rural areas of Nottinghamshire, which also have poorer access to public transport (notably Newark and Sherwood and Bassetlaw) are particularly vulnerable to social isolation.
Families, Friends and Communities	There is now widespread recognition that communities have a vital role in improving health and wellbeing (Buck et al, 2021).	Levels of support within communities varies across Nottinghamshire. In the 2016 residents' survey the highest proportion of residents who felt that people from different backgrounds get on were from Rushcliffe (64%) and Broxtowe (58%). The lowest proportions were reported from people living in Newark and Sherwood (34%). Generally, residents felt safer to go out during the day than the night-time, particularly in Bassetlaw, Mansfield and Ashfield.

Source: Nottinghamshire Health and Wellbeing Board (2021)

We can see that wider determinants have a huge impact on health and wellbeing and so should be considered across the whole strategy and its implementation.

Homelessness	Homelessness is of major concern as people who are homeless have multiple issues on top of having no home. Therefore, this should be included as a priority in this strategy.

3.1.3 Health Inequalities

One way of understanding the degree to which Nottinghamshire is characterised by inequalities is to examine data which is collected for every local authority in England concerning health outcomes and the factors shaping health and wellbeing. You will see that some of this data describes risk factors for poor health but much of it relates to healthcare activity. Using what is available to us we can consider:

1. **Health inequalities within the County** - e.g., Mansfield being a more deprived area than Rushcliffe (internal inequalities)

2. **Health inequalities in the County compared to other Upper Tier Local Authorities** (UTLAs) - e.g., do most other local authorities also have inequalities in this topic (external inequalities).

The main results are depicted in the table below. Those in the left column (red box) are of most concern as they show both internal and external inequalities. The column on the right (amber box) shows examples where Nottinghamshire does not compare well to other local authorities.

Examples of where there is a significant inequality in health within Nottinghamshire as well as between Nottinghamshire and other areas	Examples of where there is a significant inequality between Nottinghamshire and other areas
• Births to teenage mothers (low actual numbers) • Emergency admission with chronic chest condition • Admissions for self-harm • Premature preventable deaths • Premature all cause • All age respiratory • Premature circulatory	• Accidents under 15 injury • Obesity age 10/11 • Overweight age 4-5 years • Hospital admissions injury age 15-24 • All emergency admissions under 5s • Emergency admissions all causes • Emergency admissions CHD • Emergency admissions hip fracture • % report Long term limiting illness • All ages all causes • Premature cancer

Source: OHID (2021a)

Drawing this together provides further evidence to support a focus in the JHWS on:

Preventable Deaths	**Healthy Weight**	**Mental Health**	**Cancer**	**Children and Young People**
Circulatory disease – This relates to healthy weight, food and nutrition, physical activity and smoking			**Respiratory disease – This relates to smoking and air quality**	

3.1.4 Main Causes of Death in Nottinghamshire

Earlier on, we considered life expectancy and healthy life expectancy and the fact that the biggest influences on the health and wellbeing of the population relate to the environments in which we grow, live and work. We also considered how the impact of these wider determinants is expressed in health behaviours and physiological factors. We now turn to some of the additional insights brought to this by an analysis of biomedical research about the contribution of various risk factors.

A major study called the Global Burden of Disease identifies the main causes of death and disease in Nottinghamshire which are potentially modifiable for an individual. It provides very important evidence but does not fully reflect the influence of wider determinants. In the table below, we can see the 20 modifiable risk factors which account for the greatest loss of years lost to death or disability for people in Nottinghamshire.

Risk Factors: Years lost to illness and disability

Modifiable risk factors	Contribution to modifiable YLD %
High body-mass index	18.5
High fasting plasma glucose	17.3
Tobacco	17.2
Dietary risks	7.3
Alcohol use	6.6
Occupational risks	6.6
High systolic blood pressure	4.4
Drug use	4.2
Low bone mineral density	3.8
Child and maternal malnutrition	3.4
Air pollution	2.1
Kidney dysfunction	2.1
Childhood sexual abuse and bullying	1.9
Low physical activity	1.8
High LDL cholesterol	1.2
Intimate partner violence	0.9
Unsafe sex	0.3
Other environmental risks	0.2
Unsafe water, sanitation, and handwashing	0.1
Low temperature	0.0
All modifiable risk factors	**100.0**

Almost half (47.2%) of the attributable risks are **metabolic**

Over 40% of attributable risks relate to how **behaviours** affect health

9% of the attributable risks relate to **environmental risks** including at work & from air pollution

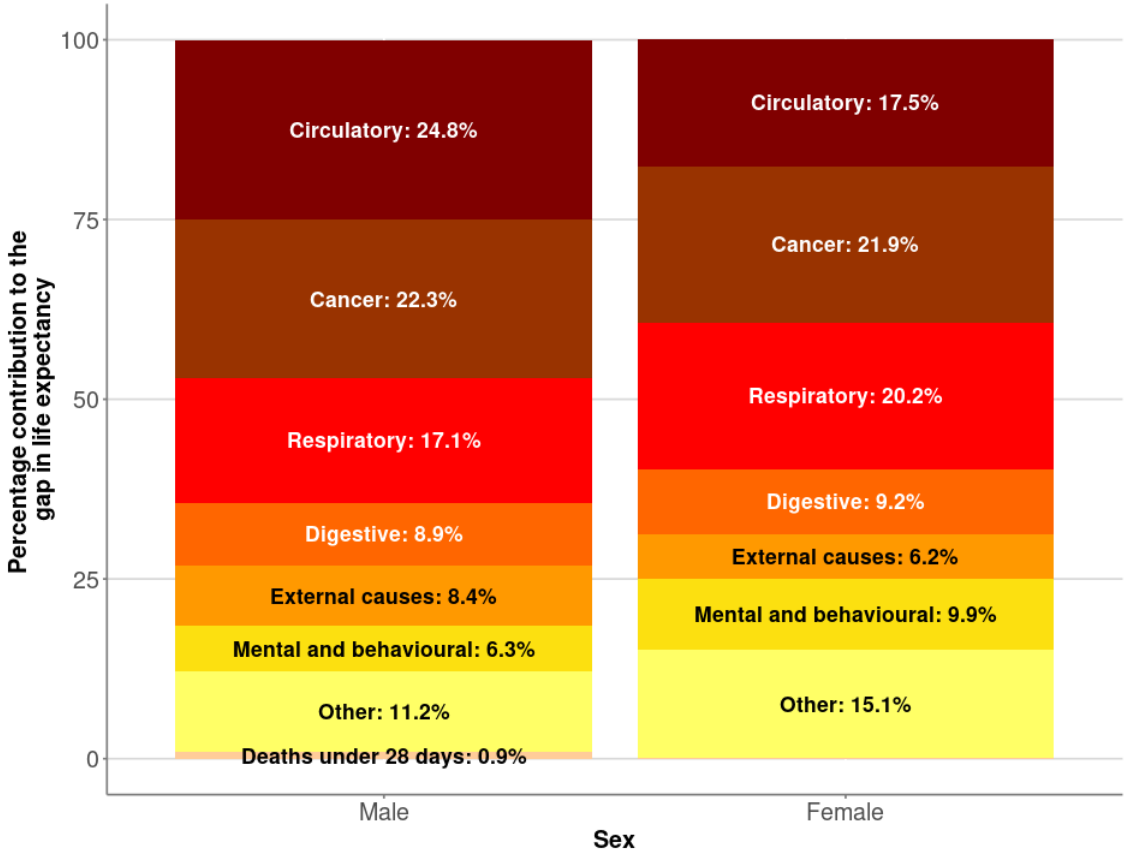
Source: Institute for Health Metrics and Evaluation (2019)

Areas related to the top risk factors that the JHWS and HWB is best placed to have a positive effect on are:

Healthy weight (including physical activity)	**Tobacco**	**Alcohol Use**	**Childhood Development**	**Environmental**

Focussing on the gap in Life Expectancy (between people in most and least advantaged communities), the figure below identifies the contribution of various groups of disease. This provides further indications of where Health and Wellbeing partners can focus their efforts for greatest impact.

Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Nottinghamshire, by broad cause of death, 2015-17



Source: OHID (2021b)[1]

There are differences between males and females in terms of percentage contribution to the gap in life expectancy, but the main causes can be clearly seen in the table above. These also reflect the priority topics identified so far. Latest data from 2020 shows that the highest rates of death were similar but included COVID-19 and nervous system disorders (NOMIS, 2022).

3.1.5 Impact of COVID-19 Pandemic

We are currently undertaking a COVID-19 Impact Assessment for Nottinghamshire which will further inform our implementation and focus of this strategy (please see appendix 2). Nationally, the main areas impacted are:

1. Access to Care
2. Air Quality
3. Behavioural risk factors (Alcohol, Gambling, Physical Activity, Smoking)
4. Grocery purchasing and food usage
5. Life Expectancy
6. Mental Health and Wellbeing
7. Mortality
8. Pregnancy and childbirth
9. Social determinants of health:
   -Access to outdoor space
   -Benefits
   -Employment
   -Home-schooling
   -Mobility[2]
   -Social capital[3]
   -Crime
   -Domestic violence

Source: OHID (2022b)

[1] Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease. Percentages may not sum to 100 due to rounding.

[2] Mobility in this instance refers to the physical ability to move from place to place.

[3] Social capital is the networks of relationships among people who live and work in a particular society, enabling that society to function effectively (Oxford Languages, 2022).

There is also the impact of Post COVID-19 Syndrome, more commonly referred to as Long COVID. Data is just emerging of the extent of this condition, plus of course we are still learning as to its causes, symptoms and treatment. More information can be obtained from NHS Long COVID.

So far in section 3 we can see that there are a number of factors that could be a priority. However, it was important that we engaged with all members of the HWB, our partners, communities and the general public before deciding upon our final ambitions and priorities.

3.2 Summary of Public and Partner Engagement

In addition to undertaking needs assessment and analysis, we have secured further insights by speaking and listening to members of the public and hearing from organisations involved in health, care and community and voluntary services on what they think matters most, alongside our proposed ambitions and areas of focus for the next four years.

Feedback from residents (adults, children, young people) and partners identified many other important concerns. They included poverty, and loneliness, substance misuse and support for families. Climate change and improving access to services (including GPs, dentists, and mental health services) were also important.

We have used this feedback to change and improve our priorities areas of focus and to shape the delivery plan. Some topics people raised (such as substance misuse) are the responsibility of other boards and strategies, so are not included in this strategy, but the Health and Wellbeing Board will continue to contribute to work in that area. People wanted to see that the organisations on the Health and Wellbeing Board would work together effectively and acknowledged that the nine areas of focus are strongly interlinked (see section 4.3).

You said…	**We did…**
Mental health was a very high priority in the survey, and was also highlighted as a top concern by young people.	We will ensure that residents, including young people, are involved in "co-production" and planning the delivery of this important priority.
Warm, safe, good quality **housing** underpins health and wellbeing. We should think about this broadly, not focus only on homelessness.	To ensure this and other wider determinants are clearly recognised in the strategy, wider determinants have been made one of the strategy cross cutting themes (see section 5.3.3).
Poverty has wide-ranging impacts on health and should be part of the strategy.	Please see above.
Climate change and the environment is important for health, and this is not limited to air quality.	Whilst air quality was identified as an area which the Health and Wellbeing Board can particularly influence, climate change and wider environmental issues are central to our ambitions and ways of working, and we will ensure this is embedded into all of the board's work.
Communities are key to addressing social isolation and providing support to people who need it but need	Our place-based approach recognises the importance of neighbourhoods and communities for health. We are developing plans for more "co-production" with communities as part of the delivery

honest communication and long-term commitment.	of the Health and Wellbeing Strategy (see section 5.3.7).
Drug addiction is an important issue alongside alcohol and needs to be addressed.	We know this is a hugely important issue for individuals and communities. There is a new national drug strategy "From Harm to Hope", and a new local drug partnership board will be specifically responsible for delivering this, rather than through the Health and Wellbeing Board.
Gambling is a growing problem with strong links to mental health	We have ensured that gambling is specifically highlighted in our mental health priority and will be part of the mental health delivery plan.
Services for children, young people and families are important to many people and there were concerns about these having been cut in recent years.	Giving children the best start in life is a high priority for the board and will be delivered through a dedicated strategy which has recently been developed.
Healthy ageing is not sufficiently recognised in the strategy. Disabilities and long-term health conditions should also be more clearly included.	Living and ageing well and providing the support people need to live the lives they want, are central to the strategy, are explicitly included in the vision and ambitions through a life course approach.
Some aspects of **physical health** are not emphasized in the strategy.	We know that physical activity is strongly linked to many aspects of health, including healthy weight and mental health, and we will ensure this is reflected in the wording of these priorities.
Crime and community safety impacts health and wellbeing.	We recognise the impact that crime can have on health. However, other organisations take the lead, for example, through the new Police and Crime Plan developed by the Police and Crime Commissioner which will link closely to the JHWS.
Access to health services including GPs, dentists and mental health services, is a major concern for many people in Nottinghamshire.	We understand that timely access to services is a high priority and is a challenge for many. Whilst the board does not directly control this, we will work with our partners in the NHS to try and improve access.

The report on public and partner engagement on the Joint Health and Wellbeing Strategy for 2022 – 2026 is provided in Appendix 3.

3.3 Summary of Health and Wellbeing Need in Nottinghamshire

- The number of years people in Nottinghamshire can expect to live in good health (healthy life expectancy) is 14 years less in more deprived areas.
- How long people live in Nottinghamshire is (life expectancy) is 7 years less in more deprived areas, and people are more likely to die of preventable causes.
- The conditions in which we are born, grow, live, work and age (wider determinants) have a huge impact on the health and wellbeing of Nottinghamshire and there are a large number of inequalities, the homeless population being a stark example.
- The main causes of death in Nottinghamshire are related to diet, healthy weight and smoking. Again, the death rates vary considerably across where people live and population groups.
- Although we don't know the full extent yet, the COVID-19 pandemic has had a profound effect on people's health and wellbeing. Our forthcoming COVID Impact Assessment will further inform our strategy implementation.
- From our engagement process, poor mental health stood out as main concern from respondents.

The analysis of health and wellbeing in Nottinghamshire highlighted a number of themes and topics that the JHWS can make a priority, especially where health inequalities, vulnerable populations, wider determinants and impact of the COVID pandemic are a main factor. From this we can group themes together and formulate our ambitions and priorities.

Some areas cut across all factors such as the wider determinants (including poverty/deprivation), climate change and prevention. These will be cross cutting themes in the strategy, meaning all plans and actions should include these areas (see section 5.3.3).

4 Where Do We Want to Be? Our Plans for the Joint Health and Wellbeing Strategy

4.1 Our Vision

We will work together to enable everyone in Nottinghamshire to live healthier and happier lives, to prosper in their communities and remain independent in later life.

4.2 Our Ambitions

The following ambitions and priorities were identified from the joint assessment of strategic needs and consideration of the potential of the Health and Wellbeing Board partners in addressing some of the major risk factors driving population health outcomes and health inequalities.

1) **Give every child the best chance of maximising their potential**

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

2) **Create Healthy and Sustainable Places**

We'll ensure that the environment we grow, live, work and age in promotes good health and wellbeing. We'll use the planning and transport system, along with economic planning, licensing and policy decisions, to create places that do this. This will also help to reduce health inequalities and benefit the environment, for a better quality of life.

3) **Everyone can access the right support to improve their health**

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

4) **Keep our communities safe and healthy**

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

4.3 Priorities to Focus Our Work

Best Start in Life

The earliest years of a child's life have a huge impact on their long-term development and future life chances. Good care before conception and during pregnancy, and the right support during their early years, gives a child the best chance of maximising their potential.

Mental Health

Good mental wellbeing at all ages supports and enables strong relationships, educational achievement, physical health and access to employment. Mental health, including for children and young people, has been particularly affected by the COVID-19 pandemic.

Food insecurity and nutrition

Everyone should have access to healthy, tasty, affordable food which enables them to live an active and healthy life. Our focus will be people who don't have enough good quality, healthy food and experience what is called food insecurity. The COVID-19 pandemic has highlighted the impact of food insecurity on communities, particularly on children.

Homelessness

Homeless people experience some of the worst health outcomes of all our communities. We want to tackle this by preventing people becoming homeless, and by ensuring health and support services to work together to reduce the high levels of physical and mental health issues that homeless people face. Reducing homelessness will contribute to a reduction in health inequalities and improvements in a wide range of health outcomes.

Tobacco

Helping people to stop smoking (and making sure young or vulnerable people don't take up smoking) helps improve people's health, especially for residents living in our most deprived areas. It reduces the risk of dying early and protects others from second-hand smoke. Alongside this, tackling illegal tobacco reduces harm to our communities.

Alcohol

Deaths due to alcohol have risen during the COVID-19 pandemic. Helping people to cut down their alcohol intake can improve mental health, boost weight loss and reduce the risk of conditions which cause a high number of deaths and reduce quality of life such as cancer, liver and heart disease.

Domestic Abuse

The impact of domestic abuse on both children and adults is devastating and affects all aspects of their lives. We need to improve everybody's understanding of abuse to prevent the causes, respond early and protect those affected. We will provide support to help survivors and their families rebuild their lives, and hold perpetrators to account for their actions.

Healthy weight

We want to support residents to have control over their weight for health and wellbeing. To do this we will work to help make the food available and the environment around us easier to make healthy choices, get moving and to lose weight.

Air quality

Clean air is essential for good health and for the environment and climate. We will work to make positive changes which can also have positive effects in terms of travel to school and work, being active and safety.

4.4 Our Objectives

Some of the ambitions and priorities already have strategies and objectives informed by the JSNA. In other cases, further work is required to define specific objectives. Therefore, what is set out in the following table should be regarded as subject to further development.

The table also shows how the objectives relate to the population intervention triangle, namely: civic (CI), community-based (CB) or service based interventions (SBI):

- **Civic** (Inform-support-enforce) - *What are the barriers that prevent people having good health and wellbeing?*
- **Community** (Empowering-collaborative-self managing) - *How can communities be empowered to take control of their own health and wellbeing?*
- **Service** (Targeted- Sustainable) - *What support can be put in place for people who need specific help?*

More information can be found in section 5.3.4.3

Ambition	Objectives	CI	CBI	SBI
1: Give every child the best chance of maximising their potential	<u>Best Start</u> 1. Prospective parents are well prepared for parenthood- a) Empower a wide range of partner organisations to prepare prospective parents for parenthood b) Children are ready for nursery and school and demonstrate a good level of overall development 2. Work in partnership to ensure all children, particularly Looked After Children, children eligible for free school meals, children with Special Educational Needs and/or Disabilities (SEND), and children for whom English is an additional language achieve a good level of development. 3. Support the most vulnerable children and families to access the right support at the right time whether it be access to childcare or 1-2-1 family support. 4. Narrow the health inequalities gap for low income groups and their peers by commissioning and delivering services and interventions which target localities and groups with poorer health and wellbeing outcomes.	√ √ √ √	√ √ √	√ √ √ √
2: Create Healthy and Sustainable Places	1. Ensure that the environments in which people grow, live, work and age promote good health and wellbeing.	√	√	
	<u>Air Quality</u> 2. Ensure that outdoor air quality supports healthier lives in all communities.	√	√	
	<u>Food Insecurity/Nutrition</u> 3. Enable residents to be able to access to healthy, tasty, affordable food which should also be positive for the environment and the local economy. 4. Tackle food insecurity and make sure that vulnerable residents have access to good food.	√ √	√ √	
	<u>Wider Determinants</u> 5. Ensure our plans for economic recovery, jobs and growth are positive for health and wellbeing and the environment.	√		
3: Right Support to Improve Health	1. Health, care and community services will work together to strengthen their focus on promoting good health & wellbeing and preventing illness, by building on people's strengths.	√	√	√
	2. Coordination of schemes to support people to make informed decisions about their health (such as 3 Lines of Conversation, Make Every Contact Count, Health Literacy and Strength- Based Approach) to maximise community engagement and impact, especially in least advantaged areas.			√

	Mental Health: 3. Commit to further improving the knowledge, competencies and skills of the workforce in relation to mental health promotion and suicide prevention. 4. Sign up to the Prevention Concordat and develop a place based approach to mental health promotion. 5. Work with partners (inc. business and industry and voluntary sector) to promote mental resilience and wellbeing. 6. Increase access to low level, responsive support to prevent needs escalating, including self-harm and suicide.	√ √ √	√ √ √	√ √ √
	Tobacco Control: 7. Create a smoke free generation in Nottinghamshire County by 2030 with a specific focus on reducing inequalities and ensuring tobacco control measures are embedded in the most deprived areas. 8. Embed the treatment of tobacco dependency throughout the NHS. 9. Re-invigorate tobacco declaration and use of the toolkit.	√ √	√ √	√ √ √
	Healthy Weight/Physical Activity 10. Address inequality and empower everyone to be physically active in a way that works for them. 11. Take a whole system approach to address the causes of obesity.	√ √	√ √	√ √
	Alcohol 12. Increase population level understanding of risk and harm. 13. Preventing alcohol harm through wider related local/national policy 14. A systematic approach to Alcohol Identification and Brief Advice (IBA). 15. Identification of 'alcohol champions' in key organisations across the system. 16. Including alcohol as a priority for employee health and wellbeing. 17. Agreeing and embedding pathways for service users with co-existing mental health and substance misuse issues.	 √ √	 √ √ √	 √ √ √ √ √
4: Keep our communities safe and healthy	1. Support people who are marginalised in our communities to ensure they are safe from harm and their needs are met.	√	√	√
	Mental Health 2. Address inequalities in mental health with a particular focus on vulnerable communities, for example BAME communities, asylum seekers and LGBTQ+ communities. 3. Improve the life expectancy and healthy life expectancy of people living with poor mental health 4. Promote parity of esteem – so that mental health is placed on a par with physical health. 5. Ensure people at risk of suicide are identified earlier and provided access to evidence-based interventions, paying particular attention to:	√ √ √	√ √ √	√ √ √

	a) Men, including men in contact with or in transition through the criminal justice system, b) Children and young people, including university students, c) Self-harm as a risk factor.			
	<u>Homelessness</u> 6. Strengthen prevention and early intervention approaches as part of the broader Homelessness Reduction Strategy. 7. Develop an integrated strategic approach to people needing supported accommodation. 8. Improve options for people with accommodation needs who are marginalised, ensuring they are safe from harm. 9. Develop pathways for recovery and independence, supporting individuals to build on their strengths to achieve the outcomes that matter to them.	√ √ √ √	√ √	√ √ √ √
	<u>Domestic Abuse</u> 10. The setting up and subsequent running of the Domestic Abuse Partnership Board will ensure a commitment to working together and sharing accountability for delivery through linked governance structures producing improved cross- sector and whole system integrated partnership working, leading to unity of purpose, joined up workstreams, effective feedback loops and elimination of gaps and duplication in achieving objectives for Domestic Abuse. 11. Address the wider determinants behind domestic violence, noting the increased risk arising from intergenerational issues, adverse childhood events and use of alcohol and substance misuse. Ensuring joined up working with related work programmes will enable a more integrated approach to tackling this level of complexity. More systemic issues associated with poverty, discrimination and lack of opportunity can be targeted through strategic focus on place based programmes for adult mental health, and children and families. 12. Ensure equity of access to bespoke support and service provision for those with protected characteristics and also male survivors. 13. Improve outcomes for victims in recovering from harm and coping with everyday life. 14. Raise awareness of hidden harm, ensuring that residents and professionals have the information they need to spot the signs of slavery, abuse and exploitation and report concerns or respond to victims where appropriate. 15. Refresh and deliver Nottinghamshire's Violence Against Women and Girls Strategy, securing funding to sustain joined up, high quality services across public and third sector organisations.	√ √ √ √	√ √ √ √ √	√ √ √ √ √

5. How Are We Going to Get There? System and Framework for Action

5.1 Summary of Evaluation of Strategy 2018-2022

It is also important to learn lessons from the development and implementation of the previous strategy (a full evaluation is provided in Appendix 4). One to avoid making the same mistakes but also to build on any particular areas of success. Key successes were identified from work presented to the Board since 2018 and these included;

- Development and Publication of the Best Start Strategy 2021 – 2025 and establishment of the Best Start Partnership Steering Group in 2021.
- The Childhood Obesity Trailblazer Programme, establishment of the Food Insecurity Network and Food Clubs across Nottinghamshire and the approval of a Food Charter.
- The publication of the Nottinghamshire Tobacco Declaration and Air Quality Strategy 2020 – 2030 with Nottingham City Council.
- Workshops on mental health, resilient communities and whole family approach, local area coordination and harm from alcohol.
- Publication of a number of JSNA chapters covering:
  - 1001 Days: From Conception to age 2 & Early Years and School Readiness (2019)
  - Tobacco Control (2020)
  - Self-harm (2019)
  - Mental Health and Emotional Health of Children and Young People JSNA (2021)
  - Health & Homelessness (2019)
  - Domestic Abuse (2019)
  - Substance Misuse and Young People and Adults (2018)
  - Autism (2019)
  - Learning Disabilities (2019)
  - Sexual Health and HIV (2019)

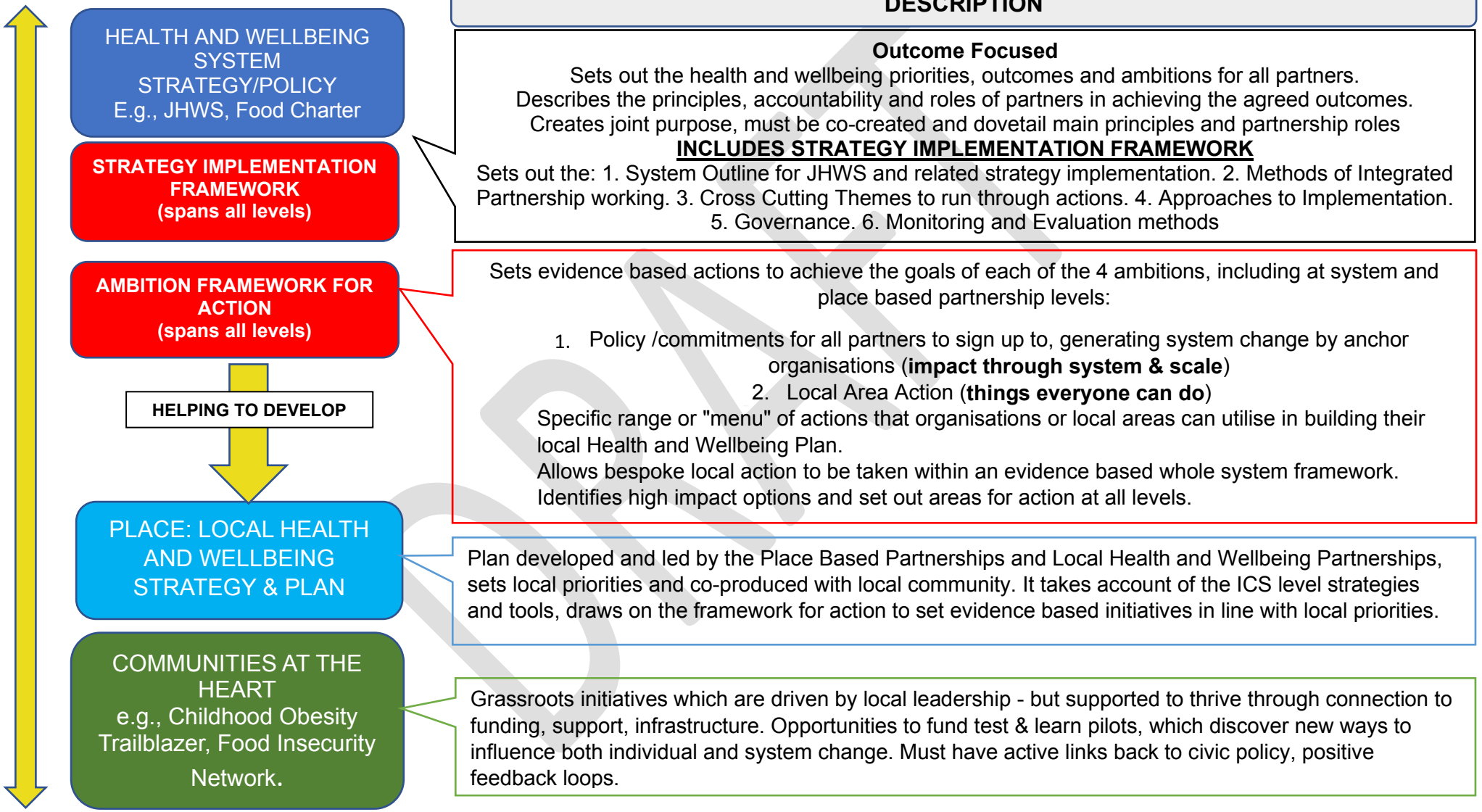
Key challenges and limitations of the strategy were identified from the findings of the survey circulated and these included:

- Too many disparate areas of work under the ambition for healthy and sustainable places was not effective, and may have impacted the effectiveness of other ambitions such as healthier decision-making;
- There needed to be a tighter and clearer focus on health inequalities;
- Delivery of the strategy had been constrained by demands due to COVID-19;
- Delivery of parts of the strategy was largely achieved outside the Board, and that although members may agree to actions at Board, it was not always clear whether this was then driven forward in their organisations.

Considering suggestions for ways the Board could “add value”, multiple respondents to the survey suggested the Board should focus on a limited number of priorities, targeting funding to these and ensuring action across all relevant partners and sectors, not just one lead organisation for a particular topic. Holding partners in the Board accountable for delivering and reporting on their organisation’s contribution was also seen as important. Taking an asset-based approach with places and communities and supporting local decision-making was suggested, and ensuring a focus on the environment in which people live which shapes health behaviours.

5.2 System Outline

5.2.1 System Outline Description



5.3 Strategy Implementation Framework

5.3.1 Mindset

As part of the framework, partners are encouraged to shift their mindset for the implementation of this strategy, from the current system to a more place-based health approach.

CURRENT SYSTEM	PLACE-BASED HEALTH
Closed	**Open**
Separate service silos/individual isolated activities	**Whole system approach**
Vertical top down model	**Horizontal model across places**
Institution led	**Person centred**
Largely reactive	**Largely preventative**
Focussed on treating ill health	**Focussed on promoting well being**
Health in a clinical setting	**Wider determinants of health in Communities**
Services "done to" citizens	**Balance of rights and responsibilities**
Linear causes and effects	**Dynamic Feedback Loops**

5.3.2 Organisational Roles

These are for guidance as to the knowledge and expertise each organisation can bring to the JHWS overall.

Organisation	Role in Delivering JHWS	Main Related Strategies and Plans
Nottinghamshire Health and Wellbeing Board	• Provides oversight and scrutiny of interlinked JHWS Ambitions • Mutual accountability and alignment with ICB • Mainly Civic and Community Level Intervention policy and expertise at a system level	Joint Health and Wellbeing Strategy Joint Strategic Needs Assessment
Nottingham & Nottinghamshire Integrated Care Board (ICB)	• Mutual accountability and alignment with HWB • Mainly Service and Community Level policy and expertise at a system level	Health Inequalities Strategy 2020 - 2024
Nottinghamshire County Council (NCC)	• HWB Member responsibilities • Service, civic and community policy and expertise at a system level	Nottinghamshire Plan 2021-2031
Nottinghamshire Police and Crime Commissioners Office	• HWB Member responsibilities • Individual and community safety policy and expertise	Nottinghamshire Police and Crime Plan 2021 - 2025

Place Based Partnerships (Mid Notts, South Notts and Bassetlaw)	• Main conduit for delivery and communication regarding the JHWS • Place knowledge and expertise	Local Health and Wellbeing Plans
District and Borough Councils	• HWB Member responsibilities • Place and neighbourhood knowledge and expertise	Ashfield District Council: Corporate Plan 2019 – 2023 Ashfield Health and Wellbeing Partnership: Be Healthy, Be Happy 2021 - 2025. Mansfield District Council: Making Mansfield – Towards 2030 (delivery plan for wellbeing) Newark and Sherwood District Council: Community Plan 2020 - 2023 Newark and Sherwood Health and Wellbeing Partnership: Plan 2019 - 2022 Gedling Borough Council: Gedling Plan 2020-2023 Broxtowe Borough Council: Corporate Plan 2020 - 2024 (Health Business Plan 2021 – 2024) Health Action Plan 2021 – 2023 Rushcliffe Borough Council: Corporate Strategy 2019 - 2023 Bassetlaw District Council: Investing in Bassetlaw - Council Plan 2019 – 2023
Voluntary Sector	• Community Initiatives • Voice for Lived Experience at all levels • Grassroots initiatives • Local and Neighbourhood knowledge	
Communities	• Base for Community level co-design, co-production and grassroots initiatives • Voice for Lived Experience	

Individuals	• Voice for Lived Experience • Empowerment for self-care of health and wellbeing	

5.3.3 Cross Cutting Themes

These themes must cut across all of our actions for implementing this strategy. Please see Glossary for definitions.

Equity and Fairness

- Health Inequalities
- Inclusion Health
- Social Justice

Prevention

- Primary, secondary and tertiary prevention
- Wider determinants

Environmental Sustainability

- The responsibility to conserve natural resources and protect global ecosystems to support health and wellbeing, now and in the future.

Cross Cutting Themes		Further Description
Equity and Fairness	Health Inequalities	There are many ways of intervening to reduce health inequalities. For example: • intervening at different levels of risk • intervening for impact over time • intervening across the life course
	Inclusion Health	People belonging to inclusion health groups frequently suffer from multiple health issues, which can include mental and physical ill health and substance dependence issues. This leads to extremely poor health outcomes, often much worse than the general population, lower average age of death, and it contributes considerably to increasing health inequalities. Inclusion health includes any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups. There will be differences in needs within socially excluded groups (for example between men and women) and these differences must be understood and responded to appropriately (PHE, 2021).
	Social Justice	• **Access** (greater equality of access to goods and services) • **Equity** (overcoming unfairness caused by unequal access to economic resources and power)

		• **Rights** (equal effective legal, industrial and political rights) • **Participation** (expanded opportunities for real participation in the decisions which govern their lives).	
Prevention	Types of prevention	Primary prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
		Secondary prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop – for example breast screening
		Tertiary prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g., chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy (LGA, 2022).
	Wider Determinants	This can include: Poverty, employment, housing, community cohesion, environment, transport, amenities, green space….	
Environmental Sustainability	1. Ensure that plans to address climate change explicitly include actions to reduce health inequalities and negative impacts on the most deprived. 2. Identify high impact actions which maximise benefits to health and environment, informed by the detailed recommendations of the report Sustainable Health Equity: Achieving a Net-Zero UK. 3. Ensure all actions taken in delivery of the JHWS must take environmental sustainability into account. 4. Recognise that prevention is also an integral part of climate action, by avoiding future carbon footprint of health and care services. 5. Support the integration of system efforts to tackle climate change through existing partner plans 6. Use of Procurement levers to improve service sustainability		

5.3.4 Implementation Approach

5.3.4.1 Principles for Integrated Partnership Working

We will achieve our vision by:

- Empowering individuals, families and communities by removing barriers to health and wellbeing, such as lack of tasty and affordable food.
- Recognising which actions are beneficial for the whole county through to those that are very important for local work.
- Focusing on preventing ill-health and reducing health inequalities.
- Fully utilising the strengths of each organisation.
- Encouraging grassroots initiatives and innovation.
- Evolving our approach as we learn and evaluate our actions.

Working together in a system and a culture of partner organisations with shared values, common goals and agreed priorities to bring about change for the better in reducing health inequalities in Nottinghamshire.

The principles serve as a foundation for our reasoning, decision making and integrated partnership working throughout the four years of this strategy.

5.3.4.2 Test Learn Build

This is a new and innovative approach to partnership working and programme delivery developed by the national Childhood Obesity Trailblazer Project, of which Nottinghamshire is one of 5 partners. The approach centres around developing ideas and learning through implementing them in order to build on successful work. It is closely connected with the Strengths Based Approach outlined in section 5.3.1.

A number of 'conditions' that need to be in place to enable areas to embrace the test and learn approach and the principles within it. These are: permission to "fail"; viewing failure as a "ladder to success"; and being clear what "success" looks like.

'Permission to fail'

It is important to create the conditions in which people feel they have been given 'permission to fail'. This means reinforcing the value of learning from when things don't work in the way they were expected to the first time. It is therefore acceptable, indeed inevitable, that some initiatives will "fail".

Embedded within this are two further factors:

1) There should be a 'no blame' culture. Indeed, honourable failures should be celebrated, providing a space for everyone involved to view the journey objectively and learn from it.
2) There is a need to accept when to change direction and adapt the project in a timely fashion.

Viewing failure as a ladder to success

There is a need to re-think what is meant by 'failure'. Failure should be seen as a valuable experience for learning about what doesn't work and therefore what else could work in achieving a goal. It should therefore be more widely accepted that 'failing' is a step on the ladder to success. It is an important part of a journey, not the end of one.

Being clear on what is success

It is important to develop a shared understanding of what exactly the programme is aiming to achieve, and therefore what will be classed as success. Will success be based on the outcomes the programme achieves? Will success be the extent to which the system has embedded change? Or is success perhaps the way in which change is happening?

This understanding of success should then inform the way in which it is measured. For interventions such as those at the heart of the five trailblazer projects, success cannot solely be measured quantitatively. Furthermore, system change takes time and therefore 'success' in this sense may not be revealed until years after the programmes has ended.

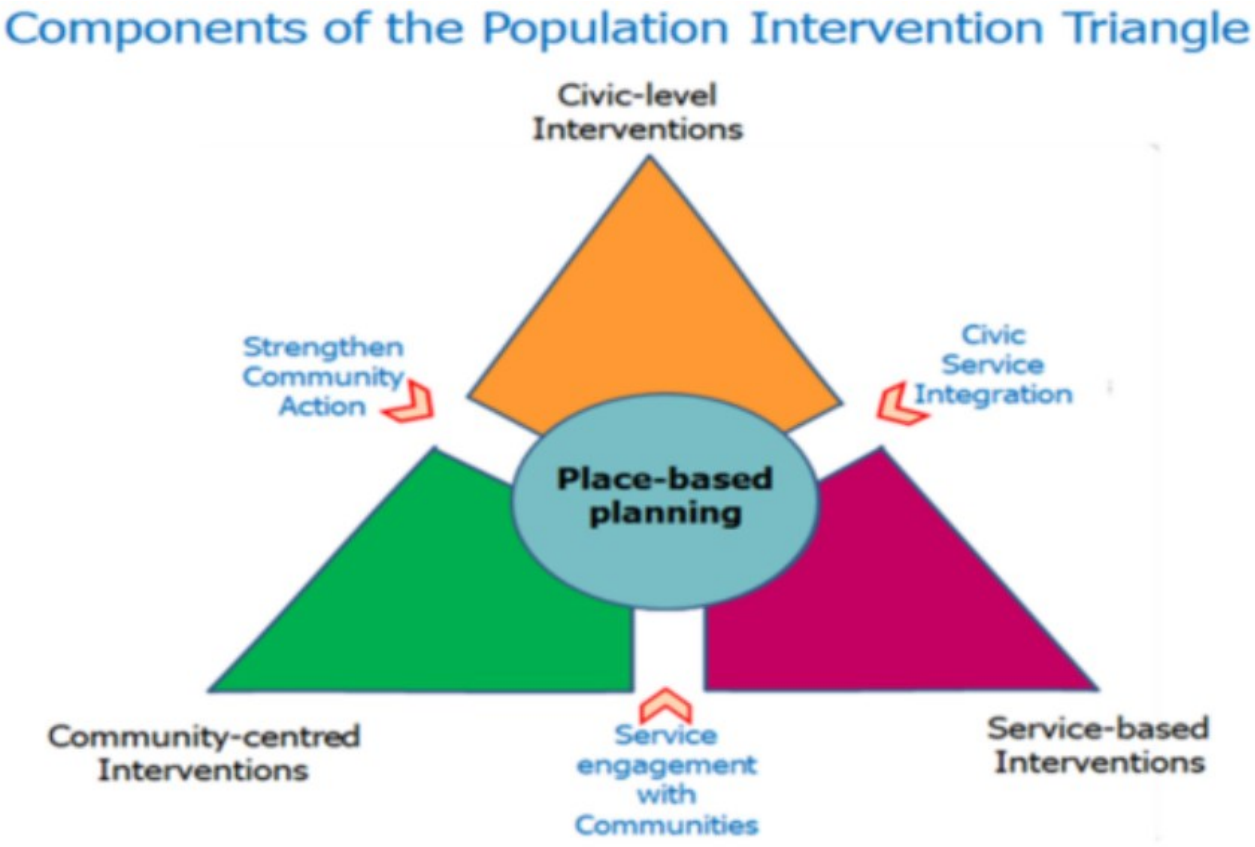
It has been, however, often challenging to adopt this approach in practice, as it is contrary to what we are often conditioned to do. However, an important aspect of the JHWS is the integrated partnership working which goes beyond quantitative indicators and targets and is fundamental to effective system functioning.

5.3.4.3 Civic-Level, Service-Based and Community Centred Interventions

Addressing health inequalities works better with the **combined input of service, civic and community interventions**.

The JHWS has a focus on civic-level interventions and community-centred interventions, and complements the Nottingham and Nottinghamshire Integrated Care System (ICS) Health Inequalities Strategy whose focus is more on service-based interventions as well as community-centred ones (Nottingham and Nottinghamshire Integrated Care System (2020).

Please see appendix 6 for further information.



Source: UK Government (2021)

TARGET THE MOST VULNERABLE FIRST AS WELL AS THE WHOLE POPULATION			
IMPORTANT TO INTERACT BETWEEN THE THREE SEGMENTS			
Intervention	**CIVIC**	**COMMUNITY**	**SERVICE**
Short description	*What are the barriers that prevent people having good health and wellbeing? Inform-support-enforce*	*How can communities be empowered to take control of their own health and wellbeing? Empowering-collaborative-self managing*	*What support can be put in place for people who need specific help? Targeted- Sustainable*

<table>
<tr><td rowspan="4">Approaches to intervention and some examples</td><td rowspan="2"><u>Inform:</u>
Let Communities know about subsidies or new legislature

Communities to highlight legislature or bureaucracy that is hampering community grassroots work and growth</td><td>Co-Production:
Developing services together | Nottinghamshire County Council</td><td>Strength-based approach:
Strengths-based approaches | SCIE</td></tr>
<tr><td>Left Behind Neighbourhoods:
'Left behind' neighbourhoods - Local Trust</td><td>Population Outcome Through Services Framework (POTS):
Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk).</td></tr>
<tr><td><u>Support:</u>
Reduce hire or rental charges for buildings or rooms
Remove bureaucracy</td><td>Local Area Coordination:

Big investment for Local Area Co-ordinators in Notts | Nottinghamshire County Council

ICS Community Prevention Project:</td><td>All Our Health:

All Our Health: personalised care and population health - GOV.UK (www.gov.uk)</td></tr>
<tr><td><u>Enforce:</u>
Air Quality regulations
Alcohol taxation</td><td>Grassroots initiatives:

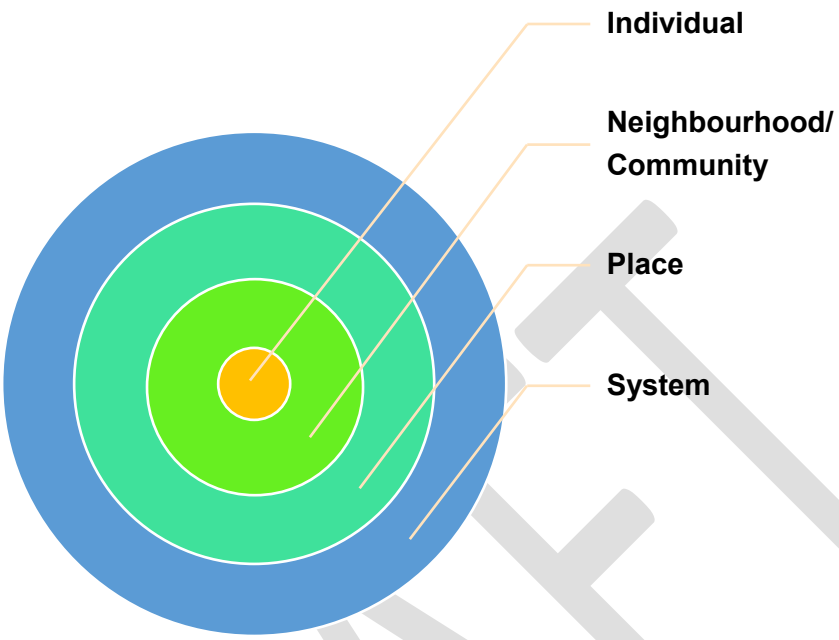
https://www.unhcr.org/innovation/grassroots-organizations-are-just-as-important-as-seed-money-for-innovation/

Community Organising Approach:
Introduction to community organising - Community Organisers (corganisers.org.uk)</td><td>Works best in conjunction with civic and community based services- moving away from automatically putting in a service because of need</td></tr>
<tr><td>Other guidance</td><td>Health in All Policies Approach (see below)</td><td>NICE Guidance on Community Engagement</td><td>Services need to be:

• evidence-based
• outcomes orientated
• systematically applied
• scaled-up appropriately
• appropriately resourced
• sustainable</td></tr>
<tr><td></td><td colspan="3">PHE (2017), Reducing Health Inequalities: System, Scale and Sustainability, available at: Reducing health inequalities: system, scale and sustainability (publishing.service.gov.uk).
UK Gov (2021), Place Based Approaches for Reducing Health Inequalities: Main Report, available at: https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report.</td></tr>
<tr><td></td><td colspan="3">THE 4 FRAMEWORKS FOR ACTION WILL HAVE MORE INFORMATION FOR SPECIFIC TOPICS</td></tr>
</table>

5.3.5 Levels of Intervention

There are a number of levels at which there can be actions taken (civic, community and service) that can have a beneficial effect. Careful planning is required to decide which level will have the most impact.



Level	Example of Intervention
Individual	Strengths- based approach: Strengths-based (or asset-based) approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing. It is outcomes led and not services led. More information: https://www.scie.org.uk/strengths-based-approaches
Neighbourhood/ Community	Northfield Avenue Community Allotments in Mansfield: Led by a local champion who manages long term health conditions herself, people are encouraged to get involved "out of the house and in a safe environment" (Downey and Kirkham, 2021).
Place	Bassetlaw Clinical Commissioning Group has recently announced a series of grants to support organisations working with citizens in the area. The awards were made to 12 local groups carrying out a range of activities to improve the health of people in Bassetlaw. They included; • A Place to Call Our Own (APTCOO) – who provide support to individuals with attention deficit hyperactivity disorder (ADHD) / DHD/ autism spectrum disorder (ASD) and their parents/carers. • Aurora – who provide Holistic support for those people with Cancer and their families. • Bassetlaw Action Centre – providing transport for those that cannot get to a health related appointment and Staying Well Courses.

	• Barnsley Premier Leisure – an exercise referral scheme including cardiac rehab and stroke and neuro patients. (Bassetlaw ICP, 2022)
System/County	Nottinghamshire Food Charter (2022) - sets out a shared vision and priorities to improve the local food system over the next four years, focusing on social, environmental and economic outcomes.

5.3.6 Climate Change

It is now well recognised and understood that climate change presents the greatest health threat of our generation.

5.3.6.1 Joint Health and Wellbeing Strategy Actions

It is important to recognise that actions to tackle carbon emissions also represent significant opportunities to improve health and reduce health inequalities. This is commonly referred to as the co-benefits of action on climate change. For example, active travel has both significant health benefits, and is an important contributor to reducing carbon emissions from transport.

The areas for action identified by Marmot to achieve health equity through environment strategy align directly with many of the priorities already identified within Nottinghamshire for this health and wellbeing strategy, as summarised in the table below.

Policy Recommendation	**Policy Detail**	**Local Health and Wellbeing Priority**
1. Support a just energy transition that minimises air pollution from all sources	Continue to reduce dependence on fossil fuels and accelerate the transition to clean energy sources with decarbonisation of power generation, industrial, commercial and domestic energy.	Air quality, housing
2. Design and retrofit homes to be energy efficient, climate resilient and healthy	Build and retrofit healthy & climate resilient homes, adapted to local environmental needs, with passive cooling measures to address exposure to urban heat.	Housing & homelessness Mental Health
3. Build a sustainable, resilient and healthy food system	Enable a wider range of national and local powers to shape food systems and combine these with the resources and statutory duties to support the transition to healthier and more sustainable diets. Policymaking should be led by an objective to reduce rates of diet-related disease via substitution of unhealthy and carbon intensive food products with fruit, vegetable and wholegrains.	Food insecurity & nutrition
4. Develop a transport system that promotes active travel and road safety, and which minimises pollution	A transport system that is accessible to all and which maximises the physical and mental health benefits of active and decarbonised transport.	Obesity, physical activity, Air Quality, mental health.
5. Develop healthy and sustainable models of work	Support more inclusive local economic growth and shift towards circular economy principles.	Healthy & Sustainable Places ways of working.

5.3.6.2 Role of the Health and Wellbeing Board

Health Inequalities
In line with the statutory role of the HWB and to hold the system to account, it is important to ensure that plans address climate change explicitly and include actions to reduce health inequalities and negative impacts on the most deprived.

1. **High impact action on Healthy & Sustainable Places**
   Through the Healthy & Sustainable Places theme, identify high impact actions which maximise benefits to health and environment, informed by the detailed recommendations of the report: Sustainable Health Equity: Achieving a Net-Zero UK (Munro et al, 2021).

2. **Climate change impacts on health**
   Improve understanding of likely climate change impacts on health in Nottinghamshire, and necessary mitigations, through a JSNA rapid review.

3. **Environmental Sustainability is a cross cutting theme underpinning all aspects of delivery of the JHWS**
   In order to safeguard the future health and wellbeing of our population, all actions taken now in delivery of the JHWS must take environmental sustainability into account.

4. **Prevention**
   Recognise that prevention is also an integral part of climate action, by avoiding future carbon footprint of health and care services. Hold the system to account for embedding prevention within all sectors.

5. **Support the integration of system efforts to tackle climate change through existing partner plans**
   Whilst the member organisations of the health and wellbeing board, and wider anchor institutions are all pursuing action plans to tackle climate change and reduce carbon emissions individually, coordination between organisations in order to maximise civic impact is less well developed. Organisations also vary in their recognition of health and health inequalities as an important aspect of delivering sustainable environmental change. The Health and Wellbeing Board occupies a unique position as a statutory board, convening health, social care, local authorities and wider partners. The board can provide a forum to bring system partners together in a workshop, to improve visibility and collaboration, through the lens of the health of our population.

6. **Use of Procurement levers to improve service sustainability**
   Show civic system leadership by promoting good practice in use of social value act etc. to secure improvements to both health & environment through our collective procurement power.

5.3.7 Community Networks And Pilots

Community initiatives by members of the public are extremely important to address very local problems that are impacting on health and wellbeing. Populations (including local businesses) need to be empowered and resourced to set up these projects, but also communities need to be linked in with current health and wellbeing work such as that being undertaken for this strategy.

5.3.7.1 Current Routes for Communities to Link into Health and Wellbeing Work

Current examples of routes to link community projects and members of the public to more official health and wellbeing work:

Route	Organisation(s) involved	Description
Childhood Obesity Trailblazer	Multiple	Working with Nottinghamshire Community to improve childhood obesity- including setting up 30 Food Clubs
Our Voice	Nottinghamshire County Council (NCC)	To be inserted
Nottingham & Nottinghamshire Integrated Care System Co-Production Strategy	Nottingham and Nottinghamshire Integrated Care System (N&N ICS)	To be inserted
Community Development Forums	Primary Care Networks (PCNs) – report to Place Based Partnerships (PBP)	To be inserted
District and Borough Health Partnership Groups	Nottinghamshire Districts and Boroughs	Members of the public and local grassroots initiatives can be members of the groups but also can present their work at meetings
Community Support Hub	NCC	Initiative set up during the COVID-19 pandemic
Single Point of Coordination for Communities	NCC	Currently in development. Seeks to link Community practitioners such as Local Area Coordinators and Community Prescribers
Citizens Advice Bureau Citizen's Panel	Citizens Advice Bureau (CAB)	For clients who use the CAB service
Community Network Meeting	Community and Voluntary Sector (CVS)	

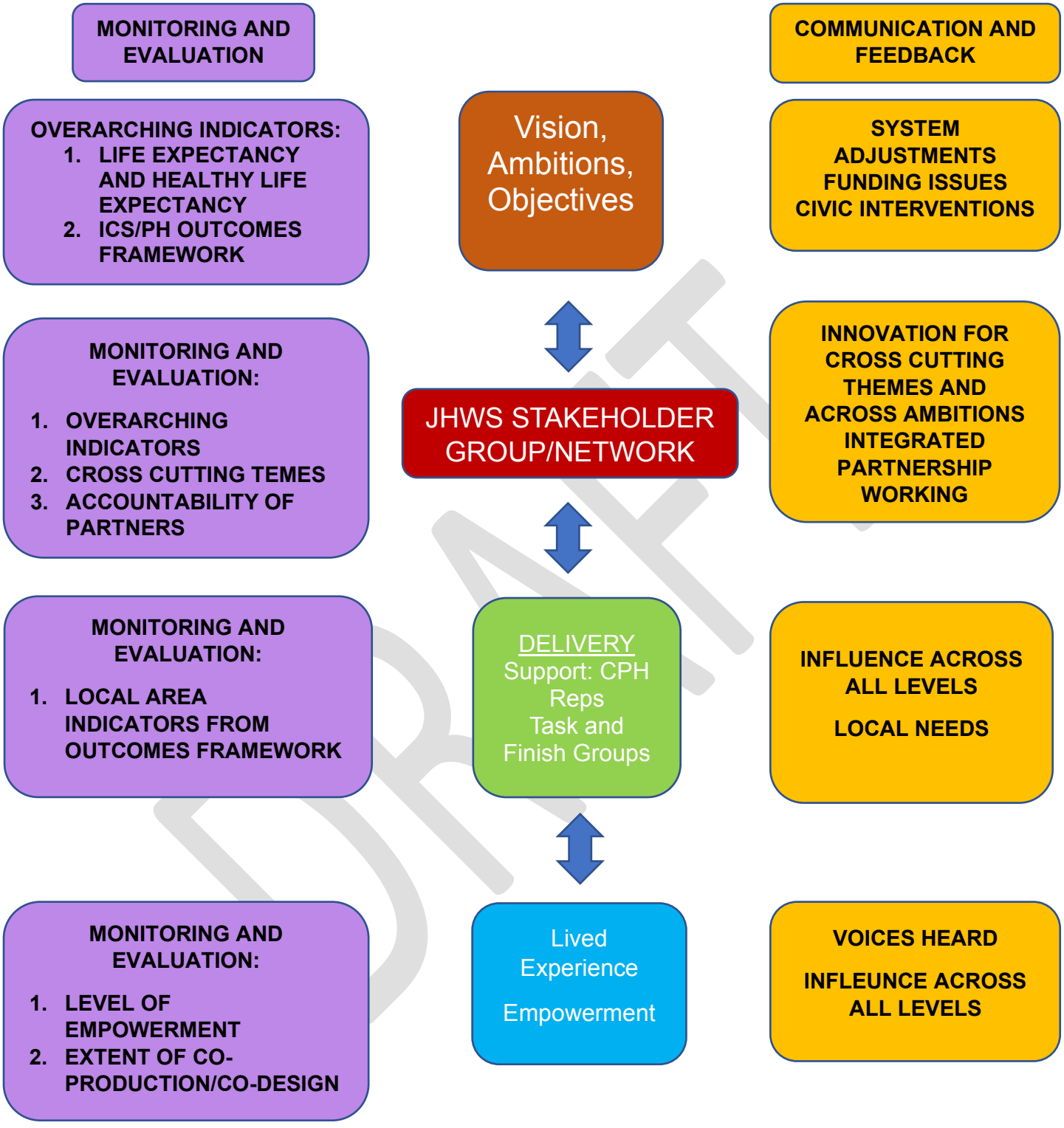
5.3.7.2 Current Barriers to Optimal Community Networks

In our engagement with partners and members of communities, 3 main barriers to optimal community network initiation and empowerment were found:

Barrier	Explanation	Possible Solutions
1. Resources	Resources such as personnel but also capabilities such as printing,	Expand work in partnerships to share resources
2. Funding	Funding tends to be short term, with short deadlines for applications. This makes it difficult to plan or sustain projects. It has also been pointed out that a lot is only for digital projects, whereas a lot of the most vulnerable people require face to face meetings.	Funding needs to take into account the requirements for population interventions stated in section 5.3.4.3 • evidence-based • outcomes orientated • systematically applied • *scaled up appropriately* • *appropriately resourced* • *sustainable* Generational change > long term investment in funding, with measurables and strategy.
3. Communication	Communication in terms of getting people's voices heard was cited as a difficulty Organisations need to avoid jargon and be mindful of the language used so as not to alienate those from outside the organisation.	Maximise routes to link communities and health and wellbeing work listed above and expand options. Improve and embed co-production work by NCC and ICS. Also use the JHWS Stakeholder Group/Network as a conduit for community voices and lived experience. Use the Voluntary and Community Sector already establish networks to establish communication at neighbourhood level. Ensure all communication is fully accessible - language, QR codes, relay UK.

The third column cites initial possible solutions, but this needs to be taken forward as an action.

5.3.8 Integrated Partnership Working



5.3.8.1 What is Integrated Partnership Working?

For the purposes of this strategy, this is defined as:

"a system and a culture of partner organisations working together with shared values, common goals and agreed priorities to bring about change for the better in reducing health inequalities in Nottinghamshire"

(adapted from Brigend County, 2011)

5.3.8.2 Communication and Feedback

To facilitate integrated partnership working, a JHWS Stakeholder Group/Network will be established.

Purpose and aim: To provide a platform for maximising integrated partnership working in implementing the JHWS

Objectives: To enable factors such as:

- System Adjustments
- Funding Issues
- Civic Interventions
- Innovation For Cross Cutting Themes And Across Ambitions
- Integrated Partnership Working Opportunities
- Influence Across All Levels
- Local Need
- Community voices heard
- Influence Across All Levels

To be effectively communicated and either resolved or implemented as appropriate across the ambitions

Process:

1. MS Teams shared page for JHWS Stakeholder Group/Network to be set up
2. Access given to JHWS programme group leads
3. Information such as the factors above relevant to JHWS implementation to be brought to the shared page for shared learning

5.4 Frameworks For Action

There will be a Framework for Action for each ambition (to be inserted): **give every child the best chance of maximising their potential**, **create healthy and sustainable places**, **access the right support to improve your health** and **keep our communities safe and healthy**.

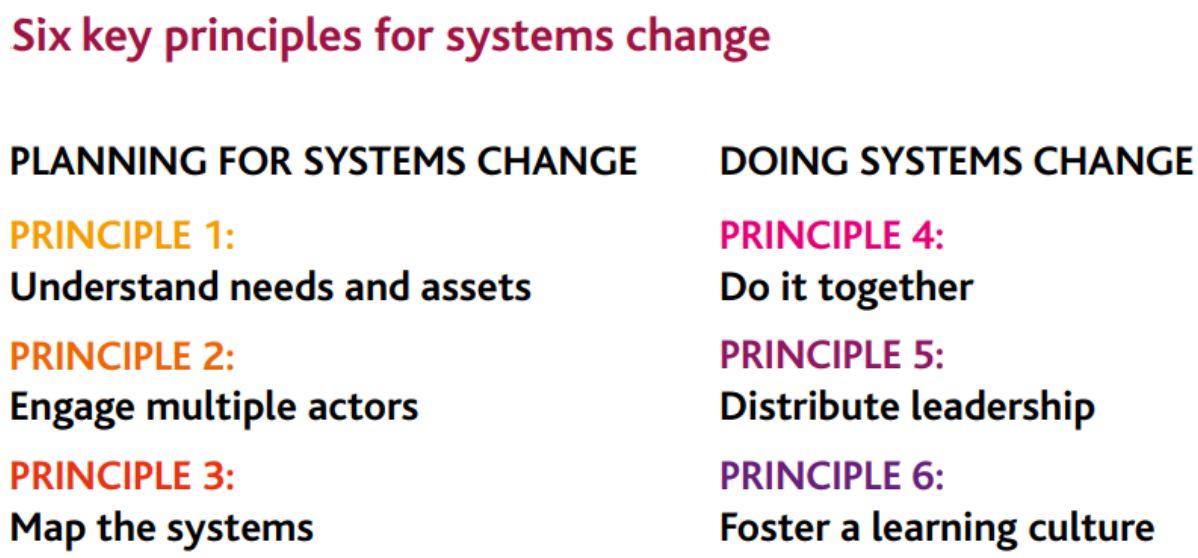
These will set out evidence based actions to achieve the goals of each of the 4 ambitions, including at system and place based partnership levels:

1. Policy /commitments for all partners to sign up to, generating system change by anchor organisations (**impact through system & scale**)
2. Local Area Action (**things everyone can do**)

Specific range or "menu" of actions that organisations or local areas can utilise in building their local Health and Wellbeing Plan. It will allow bespoke local action to be taken within an evidence based whole system framework, and identifies high impact options and may set out areas for action at all levels in the system.

5.5 Approach to Implementing System Change

As described, this approach to implementing the JHWS will require a shift in mindset by all partners, organisations and individuals involved. We will therefore have 6 key principles for systems change:



Source: NPC (2015)

Principle	How It Will Be Followed
1. Understand needs and assets	Use JSNA and other data analysis as a baseline but use continual process of engagement and feedback to understand current system
2. Engage multiple actors	Use continual process of engagement and keep looking to widen scope of partners and actors
3. Map the systems	Understand what the system consists of and how it currently works together
4. Do it together	Use of engagement and other methods such as co-production.
5. Distribute leadership	Emphasise need for multiple organisations to take the lead in areas, even if not their usual line of expertise
6. Foster a learning culture	JHWS Stakeholder Group/Network will foster a learning culture among operational officers and bring this to the strategic level

5.6 Approach to Communication

5.6.1 Public Facing Strategy

A draft copy can be found online, and once approved the public facing JHWS will be promoted with residents as part of our approach to communication. Hard copies will also be available.

5.6.2 Public JHWS Website

As part of our communication strategy, a new website for the Joint Health and Wellbeing Strategy 2022 – 2026 will be developed to promote the board and its work on health and wellbeing.

5.7 Delivery Plan

To be inserted following the workshop planned on 23 March 2022.

6. How Do We Know When We've Got There? Monitoring and Evaluation

6.1 Measurements of Success

As stated in the evaluation of the 2018-2022 JHWS, care needs to be taken to avoid simply using a large number of quantitative indicators to show if our objectives and ambitions have been met. A variety of measurements need to be used but also when they are used is important.

Ambition	Objectives	Method of Measurement
1: Give every child the best chance of maximising their potential	<u>Best Start</u> 1. Prospective parents are well prepared for parenthood- c) Empower a wide range of partner organisations to prepare prospective parents for parenthood d) Children are ready for nursery and school and demonstrate a good level of overall development 2. Work in partnership to ensure all children, particularly Looked After Children, children eligible for free school meals, children with Special Educational Needs and/or Disabilities (SEND), and children for whom English is an additional language achieve a good level of development. 3. Support the most vulnerable children and families to access the right support at the right time whether it be access to childcare or 1-2-1 family support. 4. Narrow the health inequalities gap for low income groups and their peers by commissioning and delivering services and interventions which target localities and groups with poorer health and wellbeing outcomes.	To be inserted
2: Create Healthy and Sustainable Places	1. Ensure that the environments in which people grow, live, work and age promote good health and wellbeing.	
	<u>Air Quality</u> 2. Ensure that outdoor air quality supports healthier lives in all communities.	
	<u>Food Insecurity/Nutrition</u>	

	3. Enable residents to be able to access to healthy, tasty, affordable food which should also be positive for the environment and the local economy. 4. Tackle food insecurity and make sure that vulnerable residents have access to good food.	
	<u>Wider Determinants</u> 5. Ensure our plans for economic recovery, jobs and growth are positive for health and wellbeing and the environment.	
3: Support to Improve Health	1. Health, care and community services will work together to strengthen their focus on promoting good health & wellbeing and preventing illness, by building on people's strengths.	
	2. Coordination of schemes to support people to make informed decisions about their health (such as 3 Lines of Conversation, Make Every Contact Count, Health Literacy and Strength- Based Approach) to maximise community engagement and impact, especially in least advantaged areas.	
	<u>Mental Health:</u> 3. Commit to further improving the knowledge, competencies and skills of the workforce in relation to mental health promotion and suicide prevention. 4. Sign up to the Prevention Concordat and develop a place based approach to mental health promotion. 5. Work with partners (inc. business and industry and voluntary sector) to promote mental resilience and wellbeing. 6. Increase access to low level, responsive support to prevent needs escalating, including self-harm and suicide.	
	<u>Tobacco Control</u>[4]: 7. Create a smoke free generation in Nottinghamshire County by 2030 with a specific focus on reducing inequalities and ensuring tobacco control measures are embedded in the most deprived areas.	

[4] To note this is still in draft form and to be agreed with partners.

	8. Embed the treatment of tobacco dependency throughout the NHS. 9. Re-invigorate tobacco declaration and use of the toolkit.	
	Healthy Weight/Physical Activity 10. Address inequality and empower everyone to be physically active in a way that works for them. 11. Take a whole system approach to address the causes of obesity.	
	Alcohol[5] 12. Increase population level understanding of risk and harm. 13. Preventing alcohol harm through wider related local/national policy 14. A systematic approach to Alcohol Identification and Brief Advice (IBA). 15. Identification of 'alcohol champions' in key organisations across the system. 16. Including alcohol as a priority for employee health and wellbeing. 17. Agreeing and embedding pathways for service users with co-existing mental health and substance misuse issues.	
4: Keep our communities safe and healthy	1. Support people who are marginalised in our communities to ensure they are safe from harm and their needs are met.	
	Mental Health 2. Address inequalities in mental health with a particular focus on vulnerable communities, for example BAME communities, asylum seekers and LGBTQ+ communities. 3. Improve the life expectancy and healthy life expectancy of people living with poor mental health 4. Promote parity of esteem – so that mental health is placed on a par with physical health.	

[5] To note the approach and final objectives are to be determined.

	5. Ensure people at risk of suicide are identified earlier and provided access to evidence-based interventions, paying particular attention to: d) Men, including men in contact with or in transition through the criminal justice system, e) Children and young people, including university students, f) Self-harm as a risk factor.	
	<u>Homelessness</u>[6] 6. Strengthen prevention and early intervention approaches as part of the broader Homelessness Reduction Strategy. 7. Develop an integrated strategic approach to people needing supported accommodation. 8. Improve options for people with accommodation needs who are marginalised, ensuring they are safe from harm. 9. Develop pathways for recovery and independence, supporting individuals to build on their strengths to achieve the outcomes that matter to them.	
	<u>Domestic Abuse</u>[7] 10. The setting up and subsequent running of the Domestic Abuse Partnership Board will ensure a commitment to working together and sharing accountability for delivery through linked governance structures producing improved cross- sector and whole system integrated partnership working, leading to unity of purpose, joined up workstreams, effective feedback loops and elimination of gaps and duplication in achieving objectives for Domestic Abuse. 11. Address the wider determinants behind domestic violence, noting the increased risk arising from intergenerational issues, adverse childhood events and use of alcohol and substance misuse. Ensuring joined up working with related work programmes will enable a more integrated approach to tackling this level of complexity. More systemic issues associated with poverty, discrimination and lack of opportunity	

[6] To note this is still in draft form and to be agreed with partners.
[7] To note the objectives for Domestic Abuse Partnership Board are still to be determined (due April 2022).

	can be targeted through strategic focus on place based programmes for adult mental health, and children and families. 12. Ensure equity of access to bespoke support and service provision for those with protected characteristics and also male survivors. 13. Improve outcomes for victims in recovering from harm and coping with everyday life. 14. Raise awareness of hidden harm, ensuring that residents and professionals have the information they need to spot the signs of slavery, abuse and exploitation and report concerns or respond to victims where appropriate. 15. Refresh and deliver Nottinghamshire's Violence Against Women and Girls Strategy, securing funding to sustain joined up, high quality services across public and third sector organisations.	

6.2 Quantitative Indicators

For all quantitative indicators, attempts will be made to show whether inequalities in the particular indicator are decreasing.

6.2.1 Headline Indictors

Indicator	Source	Monitoring Mechanism	Responsibility	Reporting
Life expectancy at birth (male)	PHOF	PHOF Report	PH Intel	HWB Annually
Life expectancy at birth (female)	PHOF	PHOF Report	PH Intel	HWB Annually
Healthy life expectancy at birth (male)	PHOF	PHOF Report	PH Intel	HWB Annually
Healthy life expectancy at birth (female)	PHOF	PHOF Report	PH Intel	HWB Annually
Slope of inequality	PHOF	PHOF Report	PH Intel	HWB Annually
E03 Mortality rate from causes considered preventable ** (NHSOF 1a)	PHOF/NHSOF		PH Intel	HWB Annually

6.2.2 Underlying Indicators

Nottingham & Nottinghamshire Integrated Care System Outcomes:

- Key indicators are healthy life expectancy (HLE) and main contributors to HLE:
    - Smoking Prevalence in adults
    - Admission episodes for alcohol-related conditions (Narrow)
    - Adults consuming '5-a-day' on a 'usual day'
    - Percentage of physically inactive adults
    - Percentage of adults overweight or obese
    - Year 6: Prevalence of healthy weight (10/11 year olds)

Ambition or Priority	Indicator	Source	Monitoring Mechanism	Responsibility	Reporting
Best Start	C08 Child development at 2 – 2 ½ years (segmented into age, sex and deprivation deciles so to further focus which sub populations to monitor and target interventions)	PHOF			
Alcohol	C21 Alcohol-related admissions to hospital Monitoring how much overall is being drank across Nottinghamshire What percentage of people are drinking within the recommended limits? Number of alcohol related motor accidents is reducing	PHOF			
Tobacco control	C13 Smoking prevalence – 15 year olds C18 Smoking prevalence – adults (over 18s)				
Domestic Violence	B11 Domestic Abuse Related Incidents and Crimes[8]	PHOF			

[8] Care must be taken that this not an under report which could be a challenge as it might not be possible to do a representative sample due to access and ability to disclose information around suffering domestic abuse.

	Referral rate from health service to domestic abuse support services and the percentage of patients currently accessing domestic abuse services that are also accessing appropriate health support.				
	Securing a downward trend in the prevalence of domestic abuse related crime	Numbers, rates and trends from the Crime Survey for England and Wales For Nottinghamshire (by extrapolation) • in total, • by Borough • by age, • gender, • ethnicity, • disability • sexual and gender identity.			
	Improving the balance between capacity and need in delivering services and support	There are no national standards for capacity needed but unmet need can be estimated by comparing current provision with the Council of Europe Standard or by modelling. A number of data sources can be used. *Supply of refuge and support* The Council of Europe Standard for refuge accommodation (all) is 1 unit per 1000 population. The JSNA for Nottinghamshire (2019) suggests that to meet this target, Nottinghamshire would have to increase provision to 83 units Currently, supply of refuge accommodation in Nottinghamshire stands at 40 units offering 206 beds. While this is a lower proportion per head of population (0.48 per 1000) than in England and Wales overall (0.7 per 1000) each unit can accommodate families to a level higher than that seen in other parts of the country. *Need* for refuge accommodation can be estimated by			

		• Numbers and trends in domestic abuse related crime • Child Protection Plans: trends in the % of referrals, initial assessment and child protection plans where domestic abuse is a factor. (Annual returns of Child Protection Plans) • Trends in the numbers (proportion of households made homeless) because of domestic abuse (Homeless Watch Survey) • Refuge provision per head of population locally compared with national data • Trends in rates of referrals to multi-agency risk assessment conference (MARAC) • Trends in attendance at A&E for domestic violence related incidents			
	Early intervention: delivering models of care that enable confident disclosure in health and social care settings with referral for advice and support	• Rates of referral from primary care and maternity services via domestic abuse, stalking and honour based violence (DASH) and Humiliation, Afraid, Rape and Kick (HARK) models. • Rates of referral from services (probation, drug and substance misuse, other) • An increase in the numbers of settings providing specialist advice and support for example children and family centres • An increase in calls to Helplines for advice and support			
	Delivering models of care that reduce disruption to individuals affected by domestic abuse and their children	• An increase in the rate of sanctuary provision • An increase in numbers and % of those moving directly from emergency accommodation to secured tenancies			
	Ensuring equity of access to services and support for all those at risk or affected by domestic abuse	• The total number of survivors accessing the commissioned services (separated into the three categories of men, women and children) (each quarter). • Equality Impact Assessment (EIA)			

		Establish routine monitoring of equity of access for all those at risk of or affected by domestic abuse and/or covered by the Domestic Abuse Act.			
	Improving the identification and reporting of domestic abuse related crime including rates of conviction	Numbers, trends and rates in outcomes from 'Police Reported Crime Outcomes' (baseline March 2020 to most recent year) for Nottinghamshire and by borough: • Proportion resolved • Proportion unresolved (suspect identified) • Proportion unresolved (suspect identified) • Proportion unresolved (suspect not known) • Information is also available to identify reasons for attrition: numbers charge; out of court disposal; not in public interest to continue; evidential difficulties; survivor withdraws support			
	Ensuring that service development and delivery is reflective and responsive, informed by the lived experience of survivors	• Surveys and interviews with survivors and victims • Contract monitoring of service providers • The number of survivors accessing wider non-commissioned domestic abuse services (e.g., NIDAS, Broxtowe Women's project, Midlands Women's Aid and Newark Women's Aid).			
Food Insecurity and Nutrition	Proportion of the population meeting the recommended '5-a-day'				
Homelessness	B15 Homelessness 9 Indicators Number of rough sleepers in the yearly snapshot Reduction in the rate of emergency and A+E attendances. Percentage of homeless people having their annual long term conditions review.	PHOF			

Healthy Weight	Percentage of adults (aged 18+) classified as overweight or obese Obesity in early pregnancy Percentage reporting a long term Musculoskeletal (MSK) problem % reporting at least two long-term conditions, at least one of which is MSK related	PHOF			
Mental Health	B18 Social isolation † (ASCOF 1I) B19 Loneliness C28 Self-reported well-being E09 Excess under 75 mortality rate in adults with serious mental illness * (NHSOF 1.5) E10 Suicide rate ** (NHSOF 1.5.iii) : 'Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Persons)' 'Successful completion of drug treatment - opiate users ' Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate' This gives a range of indicators to assess if the strategic interventions identified are making a difference and if not gives a basis for evaluation and review of the strategy going forward.	PHOF			
Air Quality	D01 Fraction of mortality attributable to particulate air pollution Some other indicators to monitor if we going to achieve the goal of reduce pollution could be number of miles travelled by car and the percentage of journey made by car.				

6.3 Qualitative Indicators

To be inserted

6.4 Summary of Monitoring and Evaluation Process

To be inserted

Appendix 1 Current Health in Nottinghamshire: Data Analysis

A1.1 National

In 2020, Michael Marmot produced an update to his 2010 report on health inequalities "Fair Society, Healthy Lives" followed by a second update analysing the effect of the COVID-19 pandemic (Marmot, 2021). He found that nationally:

- Life Expectancy and Healthy Life Expectancy is getting worse;
- Health inequalities are increasing;
- There is not enough recognition of the impact of wider or social determinants of health and upstream prevention on the burden of ill health;
- There has been no sign of a decrease in mortality for people under 50;
- Additional impact of the climate crisis;
- Funding and resources need to be more focussed on wider determinants and prevention.

He states that we can't go back to "business as usual" because the situation regarding health inequalities was not acceptable then, so it's even less acceptable now (Marmot, 2021).

A1.2 Local

An overview of Nottinghamshire in relation to the Public Health Outcomes Framework is available online (undertaken in December 2021). The Public Health Outcomes Framework (PHOF) comprises a nationally determined set of indicators which help us to understand long term trends in the health of the population.

The majority of indicators within PHOF show Nottinghamshire as 'better than' or 'similar to' England. However, it should be noted that a number of indicators do not yet have data from the time period of the COVID-19 pandemic, and therefore will not reflect any worsening or inequalities this may have brought about. A report on the impact of COVID-19 on the population of Nottinghamshire is being developed – Please refer to Appendix 2 for further information.

The following table highlights a number of PHOF indicators where Nottinghamshire has high inequalities, it provides data on:

Nottinghamshire compared to England - This is based on local health data and judges is Nottinghamshire better, similar or worse than the average for England in this area?

Inequality Gap in Nottinghamshire – This is the relative inequality gap within Nottinghamshire for a particular area, with a higher % indicating a higher level of inequality.

Comparison of inequality gap to all upper tier local authorities in England – This the relative inequality gap in Nottinghamshire ranked in deciles within England (scoring 1 indicates authorities with the lowest inequality gap in that area compared to the rest of England, to 10 the highest inequality gap).

Indicator	Notts Value Compared to England	Notts Inequality Gap	RSII Decile: Upper Tier Local Authorities in England
Our Community			
Long Term unemployment	Similar	184%	6

Unemployment (% of the working age population claiming out of work benefit)	Better	159%	6
Households with overcrowding based on overall room occupancy levels	Better	108%	5
Child Poverty	Better	179%	9
Percentage aged 65 or older in poverty	Better	139%	6
Older people living alone	Better	34%	5
Estimated % of households that experience fuel poverty		30%	5
Maternal & Child Health			
Deliveries to teenage mothers	Similar	283%	7
General fertility rate: live births per 1,000 women aged 15-44 years	Similar	6%	1
Emergency hospital admissions for injuries in 15-24 years old	Similar	78%	9
Emergency hospital admissions for injuries in under 15 year olds	Better	63%	10
Emergency hospital admissions for injuries in under 5 year olds	Better	51%	10
Emergency hospital admissions in under 5 years old	Better	34%	8
A&E attendances aged under 5 years old	Better	6%	1
Year 6: Prevalence of obesity (including severe obesity)	Better	76%	9
Reception: Prevalence of obesity (including severe obesity)	Better	68%	9
Year 6: Prevalence of overweight (including obesity)	Better	46%	8
Reception: Prevalence of overweight (including obesity)	Similar	44%	9
Disease and poor health (all age / adults)			
Emergency Hospital admissions for all causes	Better	68%	9
Emergency Hospital admissions for Chronic Obstructive Pulmonary Disease (COPD)	Better	178%	9
Emergency Hospital admissions for coronary heart disease	Better	70%	8
Emergency Hospital admissions for heart attacks	Better	47%	4
Emergency Hospital admissions for stroke	Better	32%	4
Emergency Hospital admissions for hip fracture in persons aged 65 and over	Similar	45%	8
Hospital Stays for Self-Harm	Worse	111%	8
Percentage of people who reported having a limiting long term illness or disability	Worse	47%	8
Causes of death and life expectancy			
Deaths from causes considered preventable (under age 75)	Similar	120%	8
Deaths from circulatory disease (under age 75)	Better	101%	6
Deaths from all causes (under age 75)	Similar	89%	7
Deaths from respiratory disease (all age)	Similar	86%	8
Deaths from all cancer (under age 75)	Similar	59%	7
Deaths from coronary heart disease (all age)	Similar	54%	4

Deaths from all causes (all age)	Worse	52%	7
Deaths from circulatory disease (all age)	Similar	46%	5
Deaths from all cancer (all age)	Worse	40%	7
Deaths from stroke (all age)	Similar	10%	4
Life expectancy at birth – Male	Similar	10%	4
Life expectancy at birth – female	Worse	10%	4

(OHID, Fingertips, 2021)

Summary

The largest health inequality observed within Nottinghamshire is the **proportion of births to women aged under 18**, with a relative inequality gap of 283% and more than a third of local authorities having a gap higher than this.

Within Nottinghamshire, inequalities for **serious injury** (requiring a hospital admission) are high for all age groups of children and young people - These inequality gaps are high compared to other upper tier local authorities; only 3% of authorities have a higher gap for under 15s, only one-in-ten have a gap higher for aged 5 and under. The Nottinghamshire gap for ages 15 to 24 is in the top 80% observed nationally.

There are high inequalities in the **prevalence of obesity** for 5/6 year olds (Reception year) and 10/11 year olds (year 6) within Nottinghamshire and these gaps are high compared to other local authorities; for both age groups the inequality gap in Nottinghamshire is in the highest 20% of local authorities nationally.

The inequality gap within the County is similar for **overweight children** in reception year and year 6. Theses inequality gaps are high compared to other authorities; for overweight, the relative gap in Nottinghamshire is in the highest 25% in England for both reception year and year 6.

There is also a high level of inequalities within Nottinghamshire observed for the rate of **emergency hospital admissions for chronic chest disease**. This inequality gap is also high when compared to other authorities in England; only 17% have a higher relative gap.

Appendix 2 Scoping for Nottinghamshire COVID-19 Impact Assessment

To be inserted

Appendix 3 Report on Public and Partner Engagement

A3.1 Key Points

We spent over 3 months speaking and listening to members of the public and hearing from organisations involved in health, care and community and voluntary services on what they think matters most.

Our ambitions and areas of focus cover the whole population from conception to end of life care, and particularly those community groups who can feel excluded.

Feedback from residents (adults, children, young people) and partners has identified many other important concerns. They included poverty, and loneliness, substance misuse and support for families. Climate change and improving access to services (including GPs, dentists, and mental health services) were also important.

We have used this feedback to change and improve our priorities areas of focus and to shape the delivery plan. Some topics people raised (such as substance misuse) are the responsibility of other boards and strategies, so are not included in this strategy, but the Health and Wellbeing Board will continue to contribute to work in that area.

People wanted to see that the organisations on the Health and Wellbeing Board would work together effectively and acknowledged that the nine areas of focus are strongly interlinked and need to be tackled in a joined-up way.

A3.2 How we engaged with communities

In November and December 2021, we undertook an online survey which was available to all residents and organisations across Nottinghamshire. An “Easy Read” version of the survey was available, and residents were able to contact the council’s Customer Service Centre for support to complete the survey if needed. There were over 270 responses to the survey.

We invited residents to “roadshows” in each of the seven district council areas of Nottinghamshire. Five of these were held as planned in a face-to-face format in venues such as libraries and leisure centres, and two had to be held online following changes in COVID-19 guidance from the government. Approximately 90 people attended the roadshows in total.

We also aimed to gather the views of children and young people, through an additional online survey, by speaking to youth forums in different areas of Nottinghamshire and by looking at other surveys which have been conducted locally and nationally (the Big Notts Survey, the Children’s Commissioner’s Big Ask, and a youth survey undertaken by Gedling District Council). There were over 75 responses to our children and young people’s survey.

A3.3 How we engaged with partner organisations

Organisations involved in the health, care and community and voluntary sectors were invited to participate in the online survey and the district roadshows, together with residents. We additionally held an online roadshow specifically for these partner organisations. We attended meetings of district health partnerships, which are meetings led by district councils and bring together a wide range of organisations in each area with an interest in health and wellbeing. We also engaged with the Nottinghamshire Integrated Care System’s Health Inequalities Committee, a key partner for tackling the wider determinants of health and improving wellbeing for everyone in Nottinghamshire.

We heard from organisations of varying sizes, from grassroots initiatives such as community gardens and patient support groups, to NHS Trusts and district councils.

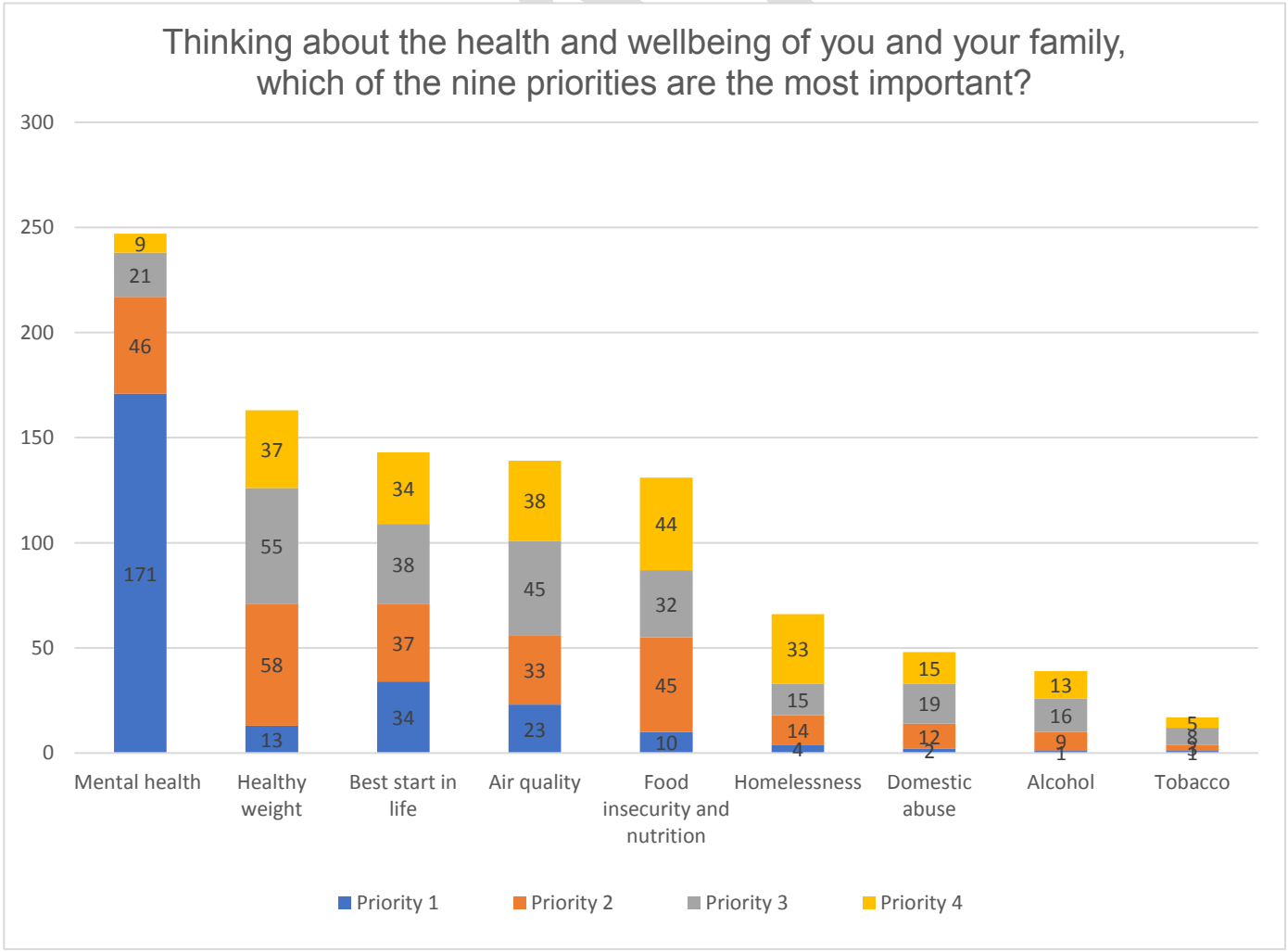
We are also planning to hear more from the community and voluntary sector specifically, by engaging in the focus groups of Nottinghamshire Together's "State of the Sector" project in the coming months.

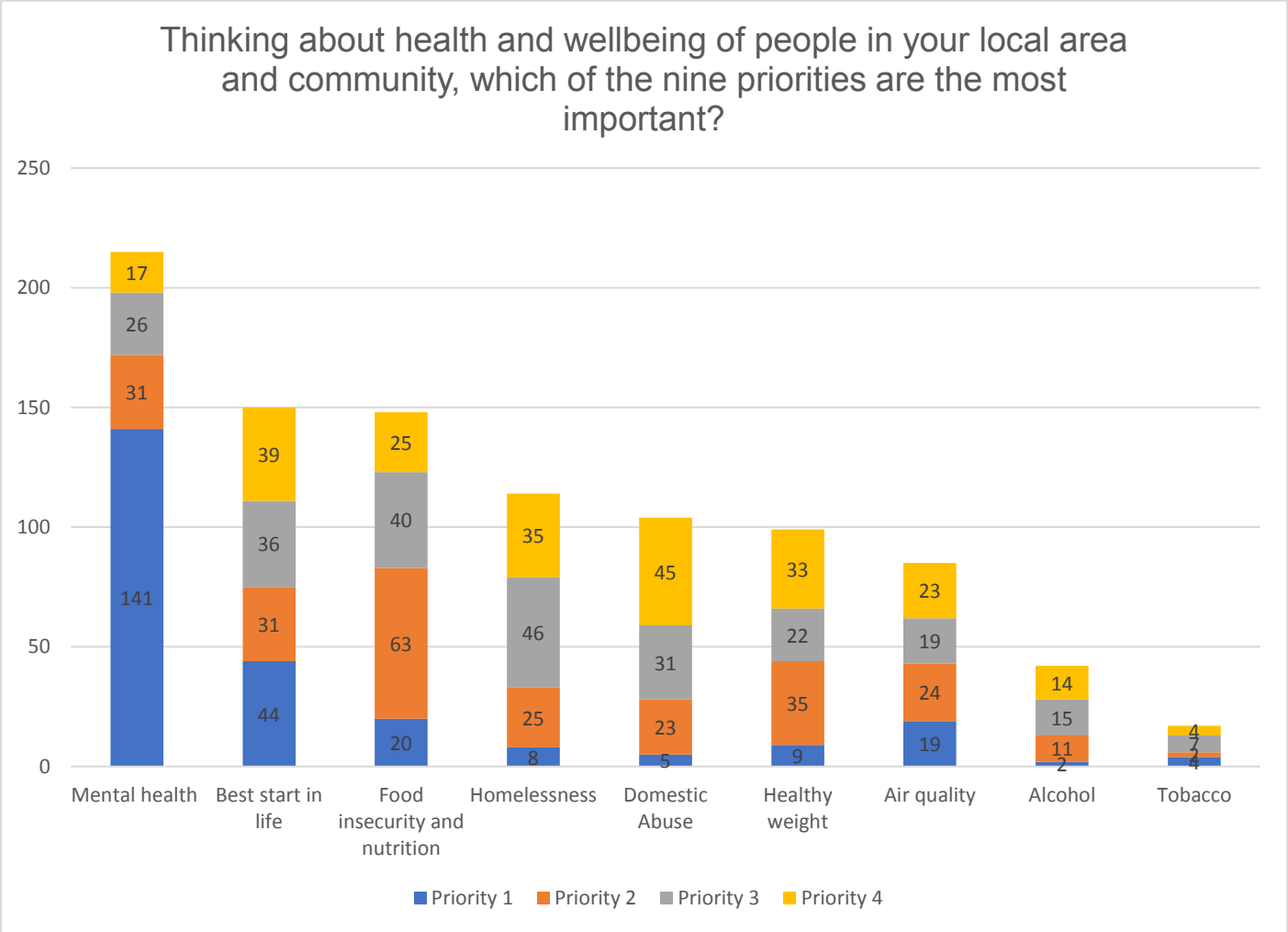
A3.4 What we heard

Some key findings from the survey were that:

- Nearly 90% of participants agreed or strongly agreed with the proposed vision for the strategy, with just over 3% disagreeing or strongly disagreeing;
- 92% of participants agreed or strongly agreed with the four proposed ambitions of the strategy, with around 4% disagreeing or strongly disagreeing;
- 80% of participants agreed or strongly agreed with the nine proposed priorities of the strategy, with just over 8% disagreeing or strongly disagreeing;

Over 90% of participants selected mental health as one of the top four priorities for them and their family, with 63% choosing it as their top priority (priority 1). Healthy weight, "best start in life", and air quality were each selected as one of the top four priorities for the participants and their family by over half of those completing the survey, with food insecurity also reaching nearly half. Mental health was also the top priority when participants were asked to consider their local area and community, with the next three priorities being "best start in life", food insecurity and homelessness.





Topics that people felt were missing included mental health, access to services (face-to-face GP appointments, dentists, specialist mental health services), services for those with disabilities including learning disabilities, physical activity, gambling and drug addiction, climate change and green spaces, housing, poverty, employment and education.

A3.5 Feedback on strategy delivery

Taking the responses to the survey and what we heard at the roadshows and other meetings we attended, some key themes emerged.

Some participants felt the strategy was too ambitious, but more commonly wanted to know how the Health and Wellbeing Board would work to make sure the strategy was delivered. People wanted to see that the organisations would work together effectively, and that individual organisations would be held responsible for delivering the ambitions and priorities in the strategy. Some participants had concerns about being able to deliver work on the strategy in the context of public service cuts.

It was also commonly noted that the priorities are strongly interlinked and need to be tackled in a joined-up way. Partner organisations highlighted the role of the community and voluntary sector in bringing local, place-based knowledge, building community assets and supporting individuals, but sustainable funding models are needed to support this.

A3.6 Feedback on strategy content

In terms of specific themes and topics that were raised:

- **Mental health** was one of the top areas discussed in responses to the survey, with lots of concern about access to specialist services including CAMHS (Child and Adolescent Mental Health Services) and learning disability services. People also felt education was important from an early age and throughout the life course, and proposed ideas about access to services via schools, pharmacies and community hubs.
- **Climate change and the environment** was a very common theme, which has not featured strongly in previous engagement exercises. Some mentioned the need for radical action. People were aware of the health benefits of improving air quality and protecting green spaces (via mental health, exercise and active travel), and suggested improving conditions for cycling, reducing vehicle emissions, retaining trees, preventing building on green spaces, active travel to school and banning woodburning stoves.
- **Communities** were seen as very important. All areas should be involved in decisions about them. It was important to build trust through honest communication and long-term commitment to work with communities, particularly those most in need. Building healthier communities and places through work on planning and other policy was also supported by partner organisations.
- Communities were also linked to **access to support**. Support for older people and those with health conditions would be best within their own communities, with enough provision for the needs of the community, particularly those that are more isolated or more deprived. Similarly, communities were linked to addressing the pandemic-related upsurge in social isolation and loneliness, and its impact on mental health.
- Rapid **access to services** including GPs, dentists and mental health services was very commonly raised. Signposting and coordinating access to services was important to stop people falling through gaps or struggling with form-filling and making appointments. Some mentioned the idea of community hubs or single points of access. Many wanted services located in local communities, which would understand local needs, bring communities together and avoid issues with poor transport links
- Many comments focused on **services for children, young people and families**, including poor performance of maternity services in Nottingham, cuts to early years services including Children's Centres, and support for vulnerable families. Other themes related to children and young people included the importance of education, the effect of domestic abuse and community and road safety. On the other hand, some felt that older people should be a priority similar to giving children the "best start in life".
- Various aspects of **poverty** were highlighted including fuel poverty, food insecurity and access to good employment. This was particularly highlighted in the most deprived areas of the county, but it was also felt that pockets of poverty can easily be overlooked in all areas. "Digital poverty" and poor transport links in rural areas were also mentioned, particularly as a barrier to accessing services.
- **Housing** was discussed as a basic human right which underpins health and wellbeing – not limited to homelessness, but taking a broader view including quality, affordability and catering for the needs of different groups. Access to emergency or refuge accommodation when needed was also mentioned, and reablement following hospital discharge.
- It was felt that some aspects of **physical health** were not emphasized in the strategy. Physical activity was particularly highlighted given its strong links to mental health and

healthy weight, and barriers in access either due to cost of gyms and pools or safety of walking and cycling. The food environment and sexual health were also raised.

- Some participants felt that **disabilities and long-term health conditions** were not given enough consideration in the strategy. Specific discussions with D/deaf community groups highlighted major barriers to accessing services, particularly telephone appointments, and lack of accessible health information in British Sign Language.
- Other themes included **substance misuse and gambling addiction**, with gambling mentioned as a growing problem, and many respondents felt these should be recognised in the strategy alongside mental health and alcohol use.
- **Crime**, and **keeping communities safe**, was mentioned by some.

A3.7 What we heard from children and young people

The survey for children and young people asked a smaller number of questions and used alternative wording for the vision and priorities to ensure these were clear to all age groups. Key findings from the survey were that:

- 93% thought the vision ("goal") was the right one;
- 79% thought the nine priorities ("issues") were the right ones to work one, but those that disagreed thought that personal safety (such as online safety, sexual assault at school and crime and drugs) should be considered, and others were concerned about climate change and loneliness;
- Mental health was the highest priority for the young people responding and their families, with domestic abuse, homelessness and healthy weight coming next;
- Mental health was again considered the highest priority for the local area and community, with homelessness, domestic abuse and best start in life ranked next
- Alcohol and tobacco were the lowest ranked priorities for both young people and their families and for their local areas and communities.

We also asked what we could do to make the biggest difference to young people's priorities. The youngest age group of 11 or under mentioned helping people with mental health issues, homelessness, and domestic abuse. Amongst 12- to 15-year-olds, boys felt their main issue was around being listened to and spoken to openly and honestly. Girls strongly focused on mental health issues, normalising talking about it and access to counselling. Other issues mentioned were domestic abuse, housing and the environment. In the 16 to 17 age group, the main comments were again around more support for mental health, as well as giving a bigger say to young people.

Over 18s picked up some similar themes around mental health, including better access to mental health services, support and more "positive messages" in schools and reducing waiting lists for CAMHS. However, support for young families and parents was also a clear concern in this group, including access to children's centres, improving maternity and health visiting services, and the cost of healthy eating. Some also had concerns about loneliness and mental health in the elderly, and about inequalities between areas, such as disparities in quality of play facilities and stigma around foodbanks.

Bringing the survey together with discussions at a youth forum, it was clear that mental health was a very high priority for young people. There were also concerns around vaping and that although many young people may not take up smoking cigarettes because they know the health risks, they may consider vaping as it is seen as 'cool' and safer. Young people also raised the issue of misuse of harmful substances.

Below are the results of a short engagement exercise undertaken at Bassetlaw Youth Forum.

A3.8 Other sources of information

The Big Notts Survey was undertaken in August and September 2021 to inform the development of Nottinghamshire County Council's Council Plan. Over 10,000 people responded, and additional work was undertaken to complete a "representative" survey with

people who reflected the make-up of the population of Nottinghamshire. Results from the general survey showed that health is a high priority for many, particularly looking back over the pandemic, when over 60% of people said their top concern had been the physical health of their friends, family and others, with mental health also an important concern for 41%. Looking forward over the next two years, health was one of the top three concerns, but came below concerns about a return to COVID-19 restrictions and climate change and the environment. Job security, financial security, mental health and children's education and life chances were also common concerns. Thinking about what would make Nottinghamshire a better place to live and work, access to health services, good job opportunities and less pollution/better air quality were the top responses. Amongst the representative survey, affordable housing was the top issue that would make Nottinghamshire a better place to live. Whilst priorities and concerns varied between areas of Nottinghamshire and groups of people, the results further emphasize the importance of many themes found in our engagement.

A survey of young people was undertaken at the same time, and again emphasized mental and physical health across age bands, particularly concern for the individual's own mental wellbeing. Female residents and those with long-term health needs and disabilities were more likely to cite mental health as a concern. Lower levels of crime and attractive local areas were seen as important priorities for local areas across all age bands. Affordable housing and good health services were important to older age bands, with improved schools more important amongst younger ages. Awareness of the climate crisis and the need to address it was also evident.

The Children's Commissioner for England undertook the "Big Ask", a survey of over half a million children nationally, in 2021. Whilst 80% of those who responded were happy or OK with their mental wellbeing, girls and older teens were more likely to be worried about their mental health. Social media, physical health and isolation during the pandemic were all seen as strongly influencing mental health, as well as exams and bullying. The importance of access to support through school, through online support and through specialist services was highlighted.

A recent survey of young people in Gedling identified bullying, exams, getting a job in the future and mental health as top concerns in their personal lives, and looking at wider issues, COVID-19 and the environment/climate change were concerns. Participants were also asked about where they felt safe; over 90% felt safe at home but less than 30% in the local area at night.

Appendix 4 Evaluation of Joint Health and Wellbeing Strategy 2018 – 2022

A4.1 Introduction

The second Joint Health and Wellbeing Strategy for Nottinghamshire was agreed in 2017 and was in place from 2018 to 2022. The vision of the strategy was:

"Working together to enable the people of Nottinghamshire, from the youngest to the oldest, to live happier and healthier lives in their communities, particularly where the need is greatest."

The four key strategic ambitions were:

- To give everyone a good start in life
- To have healthy and sustainable places
- To enable healthier decision making
- To work together to improve health and care services

This evaluation aims to give an overview of the strengths and limitations of the 2018-22 strategy development and implementation. It will not undertake a detailed evaluation of the programmes of work underneath each strategic ambition.

It will include:

- a summary of changes in the "headline" indicators of progress as envisioned in the 2018-22 strategy (i.e. outcomes);
- a summary of changes in the indicators from the Public Health Outcomes Framework for key "areas of focus" for the strategic priorities on healthy places and a good start in life (i.e. outcomes);
- a review of key successes and challenges in the implementation of the ambitions;
- a participatory exercise with members of the Joint Health and Wellbeing Board and other key stakeholders to assess the processes of strategy development and implementation;
- a brief review of national literature on the strengths and limitations of Joint Health and Wellbeing Strategies and Joint Health and Wellbeing Boards.
- a discussion summarising the findings and taking into account the wider national and global context in which the strategy was developed and implemented.

A4.2 Evaluation methods

A4.2.1 Outcome data

Data on outcomes was sourced from the Public Health Outcomes Framework (PHOF) via the Fingertips tool (OHID, 2022a). The outcomes identified for monitoring at the outset of the 2018-22 strategy were utilised. Data was extracted for the timepoint immediately before the introduction of the strategy (generally 2016/17) and for the most recent timepoint (generally 2019/20). Where indicators were no longer available or definition substantially changed the meaning, they were removed.

Colour coding for trends was taken from PHOF, calculated over last five valid timepoints, except where the PHOF tool states insufficient data. In this case, the confidence intervals at the two timepoints described above were compared – Please see **Table 2.**

A4.2.2 Key successes

Key successes were identified from work presented to the Board since 2018, with further information sought from officers involved in implementation. This is outlined in **Table 1.**

A4.2.3 Participatory exercise

Initially, a questionnaire was circulated to members of the Board in October 2020 to seek their views on the 2018-22 strategy. Nine responses were received. The questions were open and answers were free-text, aiming to gather views and opinions on the development and implementation of the strategy.

Following on from the survey, short (15-20 minute) semi-structured interviews will be undertaken in February and March 2022 to seek more detailed views from a wider group of board members and other key stakeholders. Question prompts were developed based on the NHS Confederation's self-assessment tool for Health and Wellbeing Strategies (2013), and refined to focus on topics highlighted by the answers from the survey and from public and partner engagement relating to development of the 2022-26 strategy.

Answers will be analysed thematically and summarised in the findings section.

A4.2.4 Literature review

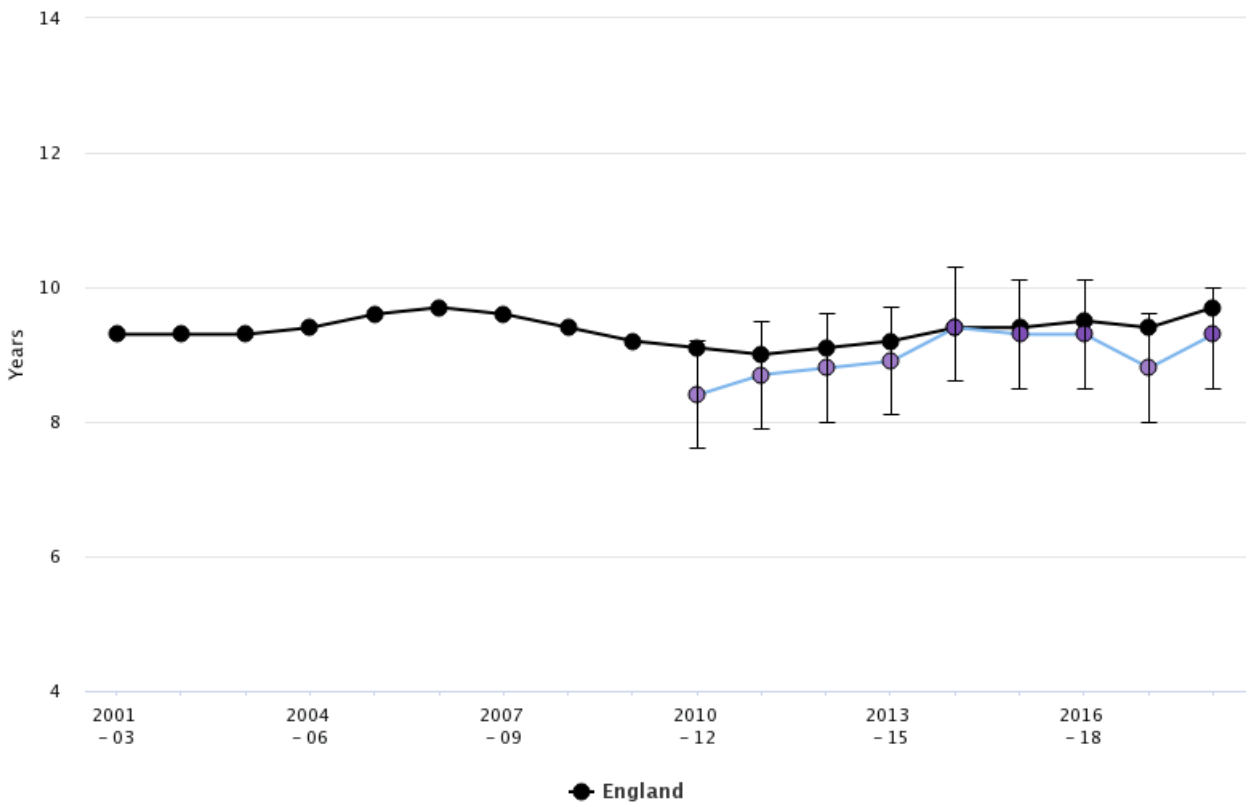
A rapid review was undertaken to identify and summarise literature evaluating the effectiveness of Health and Wellbeing Strategies at a national level. Relevant documents were identified by undertaking an internet search for "effectiveness" or "evaluation" and "Health and Wellbeing Strategy/ies" or "Health and Wellbeing Board/s", by reviewing the websites of relevant organisations such as the King's Fund, and by checking the reference list of the documents identified for further relevant literature.

A4.3 Evaluation findings

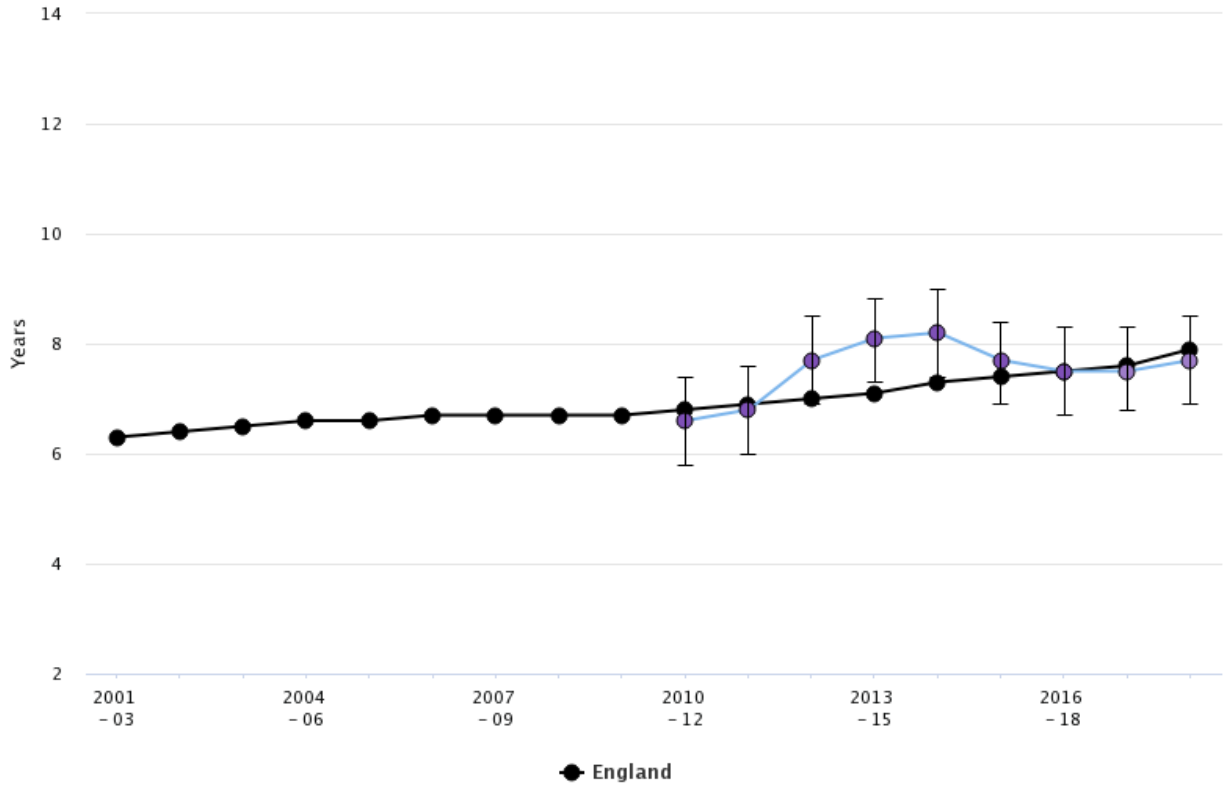
A4.3.1 Outcome data

At the outset of the strategy, life expectancy and healthy life expectancy were considered the "headline indicators" of progress, using the Slope Index of Inequality between the most and least deprived sections of the population. The figures below show how the Slope Index of Inequality has changed since 2001-03 for England (indicated by black dots) and since 2010-12 for Nottinghamshire (indicated by purple dots). The estimates for 2012-14 were used in the development of the last strategy. At that time, inequality in life expectancy for males was 8.8 years, whilst in the latest figures (2018-20) the figure was 9.3 years. The confidence intervals for the two timepoints overlap (i.e. the difference could be down to random variation). For females, inequality in life expectancy was 7.7 years at both time points (OHID, 2022a). Data for the more detailed indicators for each area of focus under two of the strategic priorities (healthy and sustainable places, and a good start in life) are shown in **Table 2.**

A02a – Inequality in life expectancy at birth (Male) for Nottinghamshire



A02a – Inequality in life expectancy at birth (Female) for Nottinghamshire



Source: OHID, 2022a

A4.3.2 Key successes under the Joint Health and Wellbeing Strategy 2018 – 2022

Table 1.

JHWS 2018 – 2022 Ambition	Key Successes
A good start in life "We want to improve the life chances of all of the children of Nottinghamshire. There is overwhelming evidence that making healthier decisions early, from pregnancy, can influence someone's health throughout their life. During the consultation we suggested potential priorities that the Board might focus on to achieve a good start in life: • Child poverty • Keeping children and young people safe • Making sure that children and young people are happy and healthy"	Development and Publication of 1001 Days: From Conception to age 2 JSNA Chapter (2019) and early years and school readiness JSNA Chapter (2019) Progress Update (2020) to the JSNA chapter on Child Poverty (2016) Development and Publication of the Best Start Strategy 2021 – 2025, which uses an early help approach and prioritises early childhood to improve outcomes for young children and their families. Establishment of the Best Start Partnership Steering Group in 2021, and associated action plans and sub-groups for each of its 10 ambitions: 1. prospective parents are well prepared for parenthood 2. mothers and babies have positive pregnancy outcomes 3. babies and parents/carers have good early relationships 4. parents are engaged and participate in home learning from birth 5. parents experiencing emotional, mental health and wellbeing challenges are identified early and supported 6. children and parents have good health outcomes 7. children and parents are supported with early language, speech, and communication 8. children are ready for nursery and school and demonstrate a good level of overall development 9. children have access to high quality early years provision 10. parents are in secure employment.
Healthy and Sustainable Places "We want to create places which maximise the health benefits for those people who live or work in those	**Food Environment:** The success of the Childhood Obesity Trailblazer Programme, establishment of the Food Insecurity Network and Food Clubs across Nottinghamshire, and the development of a Food Charter.

places. We know that our strength is in tackling the wider issues which affect health and wellbeing like housing, our environment, the food we eat, skills and education, transport and our friends, families and local communities. These are the issues we believe we can have the biggest impact on: • Food environment • Physical activity • Tobacco • Mental wellbeing including dementia • How we plan where we live – spatial planning • Warmer and safer homes • Stronger and resilient communities • Skills, jobs and employment • Domestic abuse and sexual violence • Compassionate communities supporting those at the end of life • Substance misuse (drugs and alcohol) • ASD/Asperger's • Carers • Sexual health"	**Physical Activity:** Nottinghamshire Health, Wellbeing and Physical Activity Work (e.g. Bellamy & Coxmoor) and endorsement of the Active Notts Making Our Move Strategy. **Tobacco:** The development and publication of the Nottinghamshire Tobacco Declaration and Tobacco Control JSNA Chapter (2020). **Mental Health:** 2 workshops held on mental health, increased number of local signatories to the Prevention Concordat and publication of Self-harm JSNA Chapter (2019) , Mental Health and Emotional Health of Children and Young People JSNA Chapter (2021). **Planning:** The development and publication of the Nottinghamshire Spatial Planning and Health Framework 2019 – 2022 and the Air quality Strategy for Nottingham and Nottinghamshire 2020 – 2030 **Homes:** The Warm Homes Fund and publication of Health & Homelessness JSNA Chapter (2019) **Stronger and Resilient Communities**: workshop held on Community Resilience and whole family approach (2019) and Local Area Coordination (2021). The latter has a pilot project being set up in 2022. **Skills, jobs and employment:** Publication of Health and Employment Strategy 2020 – 2030 and the director of Public Health's annual report on Health and Work (2019) **Domestic Abuse:** Publication of Domestic Abuse JSNA Chapter (2019), ongoing commissioning for the Domestic Abuse Duty and establishment of a Domestic Abuse Local Partnership Board and Domestic Abuse Strategy 2021 – 2024. **Compassionate communities supporting those at the end of life:** development and Publication on End of Life Care for Adults JSNA Chapter (2017) **Substance misuse (drugs and alcohol):** Development and publication on Substance Misuse and Young People and Adults JSNA Chapter (2018) and workshop held on harm from Alcohol (July 2019).

	ASD/Asperger's: Development and publication on Autism JSNA Chapter (2019), Learning Disabilities JSNA Chapter (2019) **Carers:** A JSNA chapter on this area is in development for 2022 and Nottinghamshire County Council are developing a Joint Carers Strategy for 2022 – 2027 **Sexual Health:** development and publication on Sexual Health and HIV JSNA Chapter (2019)
Healthier decision making "We want to make sure that we influence decisions where there is the potential to improve health and reduce health inequalities. We want all of the Board partners to think about the impact that every strategic decision might have on health. We will be working to implement the guidance in Health in all policies: a manual for local government and to extend the approach across the partnership. We know that the challenges to health and wellbeing are complex and that no single organisation or even one sector has the knowledge, skills or resources to address them. This approach starts with the policy issue rather than the health problem e.g., transport rather than obesity and encourages policy makers to think about what the impact of the policy would be on health and wellbeing. This would include all policies, for instance licensing, transport, waste management, and employment to name but a few."	The Health and Wellbeing Board continues to address health in all policies and examples of these include the Nottinghamshire Spatial Planning and Health Framework 2019 – 2022 and will look to further embed health at the heart of all decisions in the new Joint Health and Wellbeing Strategy for 2022 – 2026.
Working together to improve health and care services	The merging of 6 Clinical Commissioning Groups into Nottingham and Nottinghamshire Clinical Commissioning Group in April 2020.

“In December 2015, the NHS shared planning guidance ‘Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21’outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England has produced a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency. These plans have become Sustainability and Transformation Partnerships and are developing into Accountable Care Systems and are the main vehicles which are driving integration. The Board will oversee, challenge and support these and other change programmes. The residents of Nottinghamshire relate to 2 STPs. The Better Care Fund (BCF) incentivises service integration. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources accordingly.”	The Better Care Fund (BCF) programme supports the local system in Nottinghamshire to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Each year the Better Care Fund submits planning templates to the Health and Wellbeing Board for approval. Another success is the development of the Pharmaceutical Needs Assessment in 2018-2021. The aim of the Pharmaceutical Needs Assessment (PNA) is to enable understanding of the pharmaceutical needs of our local population and where necessary use this information to develop pharmaceutical services to meet any identified unmet needs. The PNA is used to inform the commissioning process in respect to pharmaceutical needs in Nottinghamshire. In Nottinghamshire we now have an Integrated Care System that the Health and Wellbeing Board works together with to improve health and care services.

A4.3.3 Findings of the questionnaire

Nine responses were received. Seven of the respondents had been involved in the development of the strategy for 2018-22.

In terms of the development of the strategy, numerous respondents identified the importance of engagement events and workshops in multiple locations and with a range of partners gathering a wide range of input. Online meetings for better attendance and participation were mentioned.

Possible improvements suggested for the development of future strategies included agreeing delivery plans, accountability and systems for monitoring and review with system partners before signing off the strategy. This was raised a number of times. Other suggestions included identifying what value the Board and strategy can add that is not delivered through other forums, adopting a more creative, flexible and empowering approach to community needs such as "test and learn", and using digital approaches to engaging and hearing residents' voices.

Reflections on the strengths and limitations of the strategy as written were that:

- taking a place-based approach engaged partners effectively and allowed a "joined-up" approach to interconnected issues;
- too many disparate areas of work under the ambition for healthy and sustainable places was not effective, and may have impacted the effectiveness of other ambitions such as healthier decision-making;
- the overarching vision needed to be "tighter" and ambitions around inequalities clearer.

Moving on to implementation of the strategy, most respondents felt they had a clear understanding of the role of the Health and Wellbeing Board, but there were mixed views on the effectiveness of the Board as a whole in delivering the strategy. It was very clear that the ability to deliver the strategy had been constrained by demands on partner organisations due to COVID-19. However, some also felt that delivery of parts of the strategy was largely achieved outside the Board, and that although members may agree to actions at Board, it was not always clear whether this was then driven forward in their organisations

Views on the effectiveness of subgroups in implementing the strategy also varied. Some had secured ongoing "buy-in" from partners and strong engagement. Others had struggled with ownership, or had not delivered actions as planned due to the capacity of partner organisations. It was also noted that the impact of COVID had eclipsed other work.

Key achievements identified included production of Joint Strategic Needs Assessments, generating shared understanding of priorities, engagement of partners, support for the Best Start strategy, development of the Tobacco Declaration and Food Charter, and advocacy for the importance of wider determinants and health inequalities in the developing Integrated Care System. Employment and health was also identified as an area of success.

Considering suggestions for ways the Board could "add value" in future, some focused on the Board's ways of working and others suggested areas of focus. Multiple respondents suggested the Board should focus on a limited number of priorities, targeting funding to these and ensuring action across all relevant partners and sectors, not just one lead organisation for a particular topic. Holding partners in the Board accountable for delivering and reporting on their organisation's contribution was also seen as important. Taking an asset-based approach with places and communities and supporting local decision-making was suggested, and ensuring a focus on the environment in which people live which shapes health behaviours.

A4.3.4 Findings of the semi-structured interviews

To be inserted

A4.3.5 National literature on health and wellbeing strategies and boards

A number of reports were identified which reviewed the effectiveness of Health and Wellbeing Strategies and/or Boards. These ranged from in-depth academic evaluations, to system reviews of specific issues which touched on Health and Wellbeing Boards, to opinion pieces from organisations with expertise in the health and care system.

A 2018 evaluation by the Universities of Durham and Sheffield, and the London School of Hygiene and Tropical Medicine included a literature review, a survey of Directors of Public Health and Health and Wellbeing Board chairs, and in-depth fieldwork in five local authorities (Hunter et al, 2018). It concluded that Health and Wellbeing Boards were the most important forum for "the system" to come together, and have great potential to drive the local agenda, given very senior representation from partner organisations and democratic accountability. However, this potential is unfulfilled and some Health and Wellbeing Strategies go undelivered, due to lack of power to make decisions and to hold organisations to account. In the context of Integrated Care Systems, Health and Wellbeing Boards could become effective, accountable bodies for place-based population health, or could become "talking shops… left to wither on the vine."

A further report in 2018 from the Care Quality Commission summarised their findings from reviews of 20 local health and care systems (Care Quality Commission, 2018). Whilst this was focused on the care of people over 65, it looked at how systems were working as a whole to achieve this. It noted the potential of Health and Wellbeing Boards for strong system leadership, particularly where there was a clear vision, wide representation and accountability between partners for shared goals. However, many were not fulfilling their potential, and some were forums for engagement or simply signing off proposals rather than providing scrutiny and challenge. This report formed the main evidence on Health and Wellbeing Boards in a 2018 National Audit Office report on the health and social care interface.

In 2019, the Local Government Association described the "achievements, challenges and learning" from 22 effective Health and Wellbeing Boards across the country, in the context of the health and care integration agenda (LGA, 2019). Nottinghamshire's Health and Wellbeing Board was included in this work. The report argued that Health and Wellbeing Boards are important "anchors of place", provide strategic leadership and help to navigate local challenges as the only forum bringing together political, community and health leaders, drive a place-based and preventative approach to integration, and particularly effective Health and Wellbeing Boards are supporting system change at scale to deal with variation in outcomes or "embedded" issues such as poverty. A key recommendation was that each Health and Wellbeing Board "should review its way of working and consider if its JSNA and JHWS are still fit for purpose in the new landscape of system, place and neighbourhood working."

An opinion piece by the King's Fund, also from 2019, reviewed the role and contribution of Health and Wellbeing Boards in the context of the emergence of Integrated Care Systems. It focuses on the complexity and evolving nature of relationships and governance, especially where there are multiple Health and Wellbeing Boards for one Integrated Care System, or vice versa, and notes examples where effective formal or informal arrangements have been made to mitigate this complexity and enable joined-up working (The Kings Fund, 2019).

The most recent report identified was a review by the Association of Directors of Adult Social Services (ADASS) and the Association of Directors of Public Health (ADPH) in the West Midlands, which looked at Health and Wellbeing Boards in the region in relation to Integrated

Care Systems and place-based partnerships (2021). From the perspective of leaders within local authorities, there was commitment to a model of place-based and partnership working, and the opportunity to work with Integrated Care Systems to reduce health inequalities. However, views of Health and Wellbeing Boards varied from being "talking shops" and "in search of a purpose" to being the "glue" holding a place-based approach together.

The Local Government Association has recently (late 2021) undertaken a "State of the Nation" survey on Health and Wellbeing Boards. Results are unfortunately not yet available.

Overall, common strengths of Health and Wellbeing Boards identified in the literature included commitment, engagement and the building of relationships between partners, and their potential to achieve real change for people and places was widely recognised. However, challenges included holding partners and the system to account, navigating complex geographies (particularly in the "new landscape" of Integrated Care Systems), and providing scrutiny and challenge.

A4.4 Discussion and conclusions

When the strategy was developed, a very large number of outcomes from the Public Health Outcomes Framework had been identified as indicators. Whilst these are presented in the Appendix to this report, it is difficult to draw conclusions as to the impact of the Joint Health and Wellbeing Strategy on these indicators. This is largely because of the very wide range of other factors at play, including the national policy context. In addition, the most recent data is always a year or two out of date and it is therefore difficult at this stage to assess changes over the whole period of the strategy (and in this case the effect of the COVID-19 pandemic is likely to add further difficulty in doing so). It is therefore suggested that for future strategies a smaller number of key indicators are selected to support the Board's understanding of the local picture and ongoing prioritisation of work.

Of note, a number of themes relating to strategy delivery were raised both in the participatory element of this evaluation and in the engagement undertaken regarding the development 2022-26 strategy, and in some cases also in the national literature on Health and Wellbeing Boards. It is therefore recommended that the following areas should be priorities for the Board in beginning to deliver the new strategy:

- **Accountability** of member organisations and **governance and monitoring** of the strategy;
- The importance of an **integrated, "joined up" approach**, both in terms of joining up areas of work and avoiding single-issue silos, and ensuring all partners in the Board contribute to identified priorities;
- Approaches for genuine **community engagement and co-production** in delivering the priorities of the strategy.

Table 2. Summary of changes in the indicators from the Public Health Outcomes Framework for key areas of focus for the Joint Health and Wellbeing Strategy 2018 – 2022.

Areas of focus (healthy and sustainable places)	Indicator	2016/17	2019/20
Food environment	Reduce child dental decay	20.1% (18%-22.4%)	19.9% (17.9%-22%) [2018/19]
	Percentage of adults (aged 18+) classified as overweight or obese	64.4% (62.6%-66.2%)	65.5% (63.8%-67.2%)
	Proportion of the population meeting recommended "5-a-day" on a "usual day" (adults)	58.7% (57.0%-60.3%)	56.3% (54.7%-58.0%)
	B01b - Children in relative low income families (under 16s)	17.2% (17%-17.4%)	15.3% (15.1%-15.4%)
Tobacco	Smoking Prevalence in adults (18+) - current smokers (APS)	17.3% (14.5%-20.2%)	11.4% (8.6%-14.1%) N.B. Change in definition
Mental wellbeing and dementia	C14b - Emergency Hospital Admissions for Intentional Self-Harm (per 100,000 population, directly age-standardised)	No data available	207.1 (197.1-217.5)
	C28c - Self-reported wellbeing - people with a low happiness score (APS)	9.4% (7.3%-11.6%)	8.7% (6.3%-11%)
	E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	407.5% (380.3%-436.3%) [2016-18]	515.8% (483.7%-549.6%) [2018-20]
	E10 - Suicide rate	7.6% (6.5%-8.8%) [2016-18]	8.6% (7.3%-9.8%) [2018-20]
Physical activity	Percentage of physically active adults	66.4% (64.8%-68%)	66.1% (64.5%-67.6%)
	C28c - Self-reported wellbeing - people with a low happiness score (APS)	9.4% (7.3%-11.6%)	8.7% (6.3%-11%)
	B10 - Killed and seriously injured (KSI) casualties on England's roads (per billion vehicle miles)	99.4 [2017]	94.8 [2019]
	D01 - Fraction of mortality attributable to particulate air pollution (30+ years)	5.0%	5.3%
Health and spatial planning	Percentage of physically active adults	66.4% (64.8%-68%)	66.1% (64.5%-67.6%)
	Percentage of adults (aged 18+) classified as overweight or obese	64.4% (62.6%-66.2%)	65.5% (63.8%-67.2%)
	C28c - Self-reported wellbeing - people with a low happiness score (APS)	9.4% (7.3%-11.6%)	8.7% (6.3%-11%)
	D01 - Fraction of mortality attributable to particulate air pollution (30+ years)	5.0%	5.3%
Warmer and safer homes	B17 – Fuel poverty (low income, high cost methodology)	8.8 [2017]	10.2 [2018] [Note change in methodology from 2019]
	Emergency hospital admissions due to falls in people aged 65 and over (per 100,000)	No data available	2221.2 (2150.7-2293.4)

	E14 - Excess winter deaths index	24.2% (18.9%-29.9%)	14.0% (9.0%-19.2%)
Vibrant and supportive communities	No indicators in strategy documentation		
Jobs and work	B08d - Percentage of people in employment	75.6% (73.1%-78.1%)	72.6% (69.8%-75.4%) [2020/21]
	B08a - Gap in the employment rate between those with a long-term health condition and the overall employment rate	14.1% (11.6%-16.6%)	11.1% (8.7%-13.5%)
	B09b - Sickness absence - the percentage of working days lost due to sickness absence	0.9% (0.6%-1.5%) [2016-18]	0.8% (0.5%-1.2%) [2017-19]
Domestic Violence and Abuse	B11 - Domestic abuse-related incidents and crimes (per 1000)	18.6	21.9
	B12b - Violent crime - violence offences per 1,000 population	16.2 (15.9-16.4)	24.5 (24.2-24.9)
Compassionate communities supporting those at the end of life	No specific indicator in outcomes framework. Indicator is proportion of deaths (all ages) across the settings of home, hospital, hospice or 'other places'		
Substance misuse	Successful completion of drug treatment - opiate users	7.1% (6.1%-8.3%) [2017]	4.2% (3.4%-5.2%) [2019]
	Successful completion of drug treatment – non-opiate users	33.9% (30.3%-37.8%) [2017]	32.7% (29.1%-36.5%) [2019]
	Successful completions of alcohol treatment	33.8% (31.3%-36.4%) [2017]	40.7% (38%-43.4%) [2019]
ASD/Asperger's	No indicators in strategy documentation		
Carers	B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	28.0% (23.7%-32.3%)	23.6% (20.1%-27.1%) [2018/19]
Sexual Health	Under 18 conceptions (per 1000)	16.4 (14.2-18.7) [2017]	16.1 (14.0-18.5) [2019]
	D02a - Chlamydia detection rate (per 100,000 aged 15 to 24)	1805.6 (1717.3-1897.3) [2017]	1518.4 (1436.9-1603.4) [2020]
	D07 - HIV late diagnosis (all CD4 less than 350) (%)	48.8% (37.4%-60.2%) [2016-18]	42.9% (28.8%-57.8%) [2018-20]
Areas of focus (A good start in life)	**Indicator**	**2016/17**	**2019/20**
Child poverty	A02a - Inequality in life expectancy at birth (slope index of inequality, years)	9.3 (8.5-10.1) [Male] 7.5 (6.7-8.3) [Female] [2016-18]	8.8 (8.0-9.6) [Male] 7.5 (6.8-8.3) [Female] [2017-19]
	B01b - Children in relative low income families (under 16s)	17.2% (17.0%-17.4%)	15.3% (15.1%-15.4%)

	B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	68.1% (67.2%-69.1%)	70.5% (69.6%-71.4%) [2018/19]
	Young People not in education, training or employment,1.05i	6.0% (5.7%-6.4%)	10.0% (9.6%-10.5%)
	B08a - Gap in the employment rate between those with a long-term health condition and the overall employment rate	14.1% (11.6%-16.6%)	11.1% (8.7%-13.5%)
	B15a - Homelessness - households owed a duty under the Homelessness Reduction Act	No data available	6.9% (6.6%-7.1%)
	Low birth weight of term babies	2.4% (2.1%-2.8%) [2017]	2.1% (1.8%-2.5%) [2019]
Children and young people are safe	B03 - Pupil absence	4.4% (4.3%-4.6%)	4.4% (4.3%-4.5%) [2018/19]
	B04 - First time entrants to the youth justice system (per 100,000)	321.2 (280.7-365.9)	121.0 (97.2-148.9)
	B07 - People in prison who have a mental illness or a significant mental illness	No data available	No data available
	B11 - Domestic abuse-related incidents and crimes (per 1000)	18.6	21.9
	B12b - Violent crime - violence offences per 1,000 population	16.2 (15.9-16.4)	24.5 (24.2-24.9)
	Emergency Hospital Admissions for Intentional Self-Harm (per 100,000 population, directly age-standardised)	No data available	207.1 (197.1-217.5)
Children and young people are happy and healthy	2.02ii - Breastfeeding prevalence at 6-8 weeks after birth	No data available	43.7% (42.6%-44.8%)
	C12 - Percentage of looked after children whose emotional wellbeing is a cause for concern	43.7% (38.7%-48.9%)	43.4% (39%-48%)
	C14b - Emergency Hospital Admissions for Intentional Self-Harm (per 100,000 population, directly age-standardised)	No data available	207.1 (197.1-217.5)
	C28c - Self-reported wellbeing - people with a low happiness score (APS)	9.4% (7.3%-11.6%)	8.7% (6.3%-11%)
	E10 - Suicide rate	7.6% (6.5%-8.8%) [2016-18]	8.6% (7.3%-9.8%) [2018-20]

Appendix 5 Data Analysis of 9 Priorities

There will be accompanying resource packs and infographics for each priority. Below provides a summary on the data analysis.

Priority	Summary
Best Start	• Number of key risk factors affecting vulnerability in childhood, a high number of which show health inequalities in Nottinghamshire. For example; Individual; Family; Community and wider physical and social environment • Poverty and inequality have an impact on health, wellbeing and life chances. • Children in higher IMD areas are more likely to be overweight, have lower vaccination rates, have more dental decay • There are differences among children in different ethnic groups, between males and females (males worse), looked after children and children with disabilities. • Childhood obesity is more prevalent in the north of the County. • School readiness is worse than England average
Mental Health	• Affected by many different risk factors covering areas such as individual, friends/peers, family, school, spirituality/religion, social media and community. • Early negative experiences in homes, schools, or digital spaces, such as exposure to violence, the mental illness of a parent or other caregiver, bullying and poverty, increase the risk of mental illness. • Physical health problems significantly increase the risk of poor mental health, and vice versa. Believed that approx. 30% of people with a long term condition have a mental health problem. • More deprived areas have a higher recorded prevalence of mental disorders for schizophrenia, bipolar affective disorder, and other psychoses. • There are health inequalities around mental health and ethnicity. If you are a female of Black, Asian or other ethnicity you are more likely to report experience a common mental health disorder in the past week. • Mental health risk factors for many common mental disorders are heavily associated with social inequalities highlighting the importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages, and through to older age. • Women in Nottinghamshire more likely to be admitted for intentional self-harm • There are higher contact rates with mental health services for BAME, unemployed, densely populated areas, and deprived area. • The county is performing well on the Risk Factors indicator but slightly worse on Quality & Outcomes and much worse Protective factors, Prevalence & Incidence and Services (the last two indictor areas could be impact by small indicator numbers). • There needs to be a balance between focusing on population level outcomes and a person-centred approach to care.
Alcohol	• It is hard to identify a single cause for alcohol addiction.

	• Binge drinking affects many aspects: physical health, accidents and injury, violence and antisocial behaviour, unsafe sex, employment issues and mental health. • Alcohol consumption is a risk factor for more than 60 chronic diseases and conditions. • Alcohol related death, cancer (worse for males in Nottinghamshire), admissions for alcohol-specific conditions and percentage of dependant drinkers tend to be highest in more deprived areas. • More risky alcohol consumption in white teenagers • Females under 18 more likely to be admitted for alcohol related conditions and have more risky alcohol behaviour, but males more likely at over 18. • Nottinghamshire worse than England for alcohol related traffic accidents (latest data from 2014-2016).
Tobacco Control	• Analysis has also shown that early teens whose main caregiver smoked were more than twice as likely to have tried cigarettes (26% v 11%) and 4 times as likely to be a regular smoker (4.9% v 1.2%). • Adults with depression are twice as likely to smoke as adults without depression. Most people start to smoke before showing signs of depression, so it's unclear whether smoking leads to depression or depression encourages people to start smoking. It's most likely that there is a complex relationship between the two. • People with schizophrenia are three times more likely to smoke than other people and tend to smoke more heavily. • Data shows that white people and people with mixed ethnicity are far more likely to be current smokers than other ethnicities • Data also shows people are far more likely to be current smokers if you are male, in manual occupation and aged 25 to 55 years. • Nottinghamshire has a higher percentage than England of mothers who are current smokers at time of delivery, and has been higher for more than decade
Domestic violence	• A study found that cumulative exposure to greater neighbourhood deprivation over the first 18 years of life was associated with women's increased risk of experiencing intimate partner violence in early adulthood. • Some research has shown that mixed ethnicity households were more likely to experience or report domestic abuse • In 75% of the domestic abuse-related crimes recorded by the police in the year ending March 2019, the victim was female. • Younger women (aged 20 to24) were more likely to be victims of domestic abuse than women over 25 • Women with a disability were also more likely to be a victim of domestic violence • In the year ending March 2021, there were 12 domestic abuse related crimes recorded by the police per 1000 of the population.
Food Insecurity and Nutrition	• In the 2016 United Kingdom survey, the following characteristics were associated with higher risk of any food insecurity (those in **bold** are associated with severe food insecurity). *Younger age groups (16 to 24 and 25 to 34) *Non-white identity *Children in the household *Low levels of education ***Unemployment**

	***Life-limiting health problems or disability** ***Incomes in the lowest income quartile**
Healthy Weight	• Wider determinant risk factors for non-healthy weight: *Social and psychological factors — the habits and customs of a person's social network can affect their diet. Some people with low self-esteem or depression may over-consume foods high in fat, sugar, and calories (so-called 'comfort foods'). *Prior pregnancy, although this association is confounded by contributing cultural, environmental, and socioeconomic factors. *Sleep deprivation. *Less formal education. *Low socioeconomic status. • People who are insufficiently active have a 20% to 30% increased risk of death compared to people who are sufficiently active. • Link between obesity and deprivation is much more pronounced in children • Link between ethnicity and obesity is a mixed picture, but those from ethnic groups are far less likely to be physically active. • Most at risk are poorly educated older men • Nottinghamshire has a higher percentage of adults classed as overweight or obese than England, including those in early pregnancy.
Homelessness	• Risk factors for homelessness: *Leaving home for the first time or leaving care *Pregnant with nowhere to stay when the baby comes *Struggling to live on benefits or a low income *From abroad without the right to claim benefits *An asylum seeker or refugee *Leaving prison *Being evicted *Domestic violence or abuse *Harassment by neighbours • It is a complex interaction between individual and wider factors • Research suggests that average age of death of someone who has experienced longer-term homelessness is 47 years (for women this is 43 years). • Mental ill health can be a cause and a consequence of homelessness. 45 per cent had a diagnosed mental health problem, compared with 25 per cent in the general population. • People from a black ethnic group are relatively much more likely to be homeless and white ethnic group relatively less likely to be homeless
Air Quality	• Physical activity reduced for those with heart and lung problems, asthma and older people in more polluted areas • Air and noise pollution have an adverse effect on mental health • Long term exposure reduces life expectancy • Worst air pollution levels seen in more ethnically diverse neighbourhoods, even accounting for deprivation • Stronger effects among women for air pollution, boys earlier in childhood, girls later in childhood • Nottinghamshire needs to improve the quality of its air as the air quality indicators 'Fraction of mortality attributable to particulate air pollution' and 'Air pollution: fine particulate' matter are worse than the England average.

Appendix 6 Civic-Level, Service-Based and Community-Centred Interventions

A6.1 Civic Level Interventions

Essentially, civic level interventions remove obstacles and barriers to good health and wellbeing and empowerment to achieve this. It comes from a different perspective- instead of asking what services would support you to have good health and wellbeing, civic interventions ask the question*: what are the barriers that prevent you having good health and wellbeing?*

Through healthy public policy, including legislation, taxation, welfare and campaigns, organisations can mitigate against the structural obstacles to good health. Adopting a Health in All Policies approach can support local authorities to embed action on health inequalities across their wide ranging functions (UK Gov, 2021).

Government guidance states there are 3 types of civic intervention: inform, support and enforce.

A number of civic interventions are addressed in the Nottinghamshire Council Plan for 2021 – 2031.

Underpinning all of this is a **Health in All Policies** (HiAP) approach. Nottinghamshire County Council approved a HiAP approach in 2018.

The WHO definition of this is:

> *"Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity."*
>
> (WHO, 2015).

Table 1. Examples of Civic Level Interventions

	Type of Civic Level Intervention		
System Level	Inform	Support	Enforce
	Health in All Policies Approach (e.g. Health Impact Assessments, Health Equality Assessments)		
System (County Council, ICP/ICB)	1. Communication- including information and campaigns 2. Community Safety 3. Statutory PH responsibilities	1. Policy and strategy development and review 2. Fiscal measures- incentives and disincentives 3. Economic development and job creation 4. Spatial and environmental planning 5. Welfare and social care 6. Community Safety 7. Impact as major local employer 8. Statutory PH responsibilities	1. Legislation- including regulation, licencing and by-laws 2. Community Safety
Place (PBP and District and Borough Councils)	1. Communication- including information and campaigns 2. Community Safety 3. Statutory PH responsibilities	1. Policy and strategy development and review 2. Fiscal measures- incentives and disincentives 3. Economic development and job creation 4. Spatial and environmental planning 5. Welfare and social care 6. Community Safety 7. Impact as major local employer 8. Statutory PH responsibilities	1. Legislation- including regulation, licencing and by-laws 2. Community Safety
Neighbourhood	1. Communication- including information and campaigns 2. Community Safety 3. Statutory PH responsibilities	1. Policy and strategy development and review	

A6.2 Community Centred Interventions

A6.2.1 Co-Production
To be inserted

A6.2.2 Local Area Coordination
To be inserted

A6.3 Service Level Interventions

A6.3.1 Inclusion Health
To be inserted

A6.3.2 Health Literacy
To be inserted

A6.3.3 Conversation Approach
To be inserted

A6.3.4 Make Every Contact Count (MECC)
To be inserted

Appendix 7 Other Related Strategies & Plans

A7.1 County Wide Strategies & Plans

Plan or Strategy	The Nottinghamshire Plan	ICS Health Inequalities Strategy 2020 to 2024	Nottingham and Nottinghamshire Police and Crime Plan
Main Ambitions or Aims	1. Helping our people live healthier and more independent lives 2. Supporting our communities and families 3. Keeping children, vulnerable adults and communities safe 4. Building skills that help people get good jobs 5. Strengthening businesses and creating more good-quality jobs 6. Making Nottinghamshire somewhere people love to live, work and visit 7. Attracting investment in infrastructure, the economy and green growth 8. Improving transport and digital connections 9. Protecting the environment and reducing our carbon footprint	**Health and Care Services:** 1. Protect the most vulnerable from COVID-19 2. Restore health and care services inclusively 3. Digitally enabled care which increase inclusion 4. Accelerate prevention programmes 5. Particularly support those who suffer mental health **Lifestyle Factors:** 6. Alcohol 7. Smoking 8. Diet and physical activity 9. Children and Young People **Living and Working Conditions:** 10. Environment 11. Economy/employment 12. Housing 13. Education/life learning	1. Preventing crime and protecting people from harm 2. Responding efficiently and effectively to community needs 3. Supporting victims and survivors, witnesses and communities
How it links to JHWS	Several interlinking objectives	Several interlinking objectives Objectives being progressed based on NHS Long Term Plan but also dependant on JHWS priorities	Several interlinking objectives
Link to document	https://plan.nottinghamshire.gov.uk/	https://healthandcarenotts.co.uk/wp-content/uploads/2020/10/Notts-ICS-HI-strategy-06-October-v1.8.pdf	Awaiting publication

A7. 2 Local Strategies & Plans

Plan or Strategy	Nottingham City	Mid Notts PBP	South Notts PBP	Bassetlaw PBP
Main Ambitions or Aims				
How it links to JHWS				
Link to document				

Appendix 8 Governance and Responsibilities of the Health and Wellbeing Board

A8.1 Terms of Reference

(as outlined in the Nottinghamshire County Council Constitution – pages 4-13).

To prepare, publish and maintain a joint strategic needs assessment.

To prepare, publish and maintain a Pharmaceutical Needs Assessment

To prepare and publish a joint health and wellbeing strategy based on the needs identified in the joint strategic needs assessment and to oversee the implementation of the strategy.

Discretion to give Nottinghamshire County Council an opinion on whether the Council is discharging its statutory duty to have due regard to the joint strategic needs assessment and the health and wellbeing strategy.

To promote and encourage integrated working including joint commissioning in order to deliver cost effective services and appropriate choice. This includes providing assistance and advice and other support as appropriate, and joint working with services that impact on wider health determinants.

To discuss all issues considered to be relevant to the overall responsibilities of the Health and Wellbeing Board, and to perform any specific duties allocated by the Department of Health.

The Board will be responsible for its own projects and may establish steering groups to consider projects. Where it considers appropriate, projects will be considered by a cross-committee project steering group that will report back to the Board or most appropriate Committee.

*It is important to note that Nottinghamshire County Council is considering moving to a Cabinet System and therefore its constitution will be updated in 2022.

A8.2 Statutory Responsibilities

A8.2.1 Health and Wellbeing Board

Health & Wellbeing Boards were established under the Health and Social Care Act 2012 with the duties to:

a) To improve the health and wellbeing of the people of Nottinghamshire.

b) To reduce health inequalities.

c) To promote the integration of services and integrated working.

d) To produce a Joint Strategic Needs Assessment, identifying current and future health needs.

e) To develop a health and wellbeing strategy which addresses the health needs identified in the Joint Strategic Needs Assessment.

A.8.2 Nottingham and Nottinghamshire Integrated Care Board

In relation to duties regarding the Health and Wellbeing Board, The Integrated Care Board in the future will produce:

a) Joint Forward Plan – It must involve the Health and Wellbeing Board in preparing or revising the plan and consult the Board on whether the draft takes proper account of the joint local health and wellbeing strategy.

b) Joint Capital Resource Use Plan - Before the start of each financial year, it must prepare a plan setting out their planned capital resource use and share a copy with the Health and Wellbeing Board.

c) Annual Report - An integrated care board must, in each financial year, prepare a report on how it has discharged its functions in the previous financial year. It must in particular review any steps that the board has taken to implement the joint local health and wellbeing strategy to which it was required to have regard. In undertaking the review, the integrated care board must consult the Health and Wellbeing Board.

d) Performance Assessment of Integrated Care Board - NHS England must conduct a performance assessment of each integrated care board in respect of each financial year, on how well the integrated care board has discharged its functions during that year. In conducting a performance assessment, NHS England must consult the Health and Wellbeing Board as to its views on any steps that the board has taken to implement the joint local health and wellbeing strategy.

(subject to and outlined in the Health and Social Care Bill (April 2022)

A8.2.3 Healthwatch

As outlined in the Health and Social Care Act, Healthwatch's duties regarding the Health and Wellbeing Board are;

a) Appointment of one person to represent Healthwatch on the Health and Wellbeing Board.

b) Involvement in preparing the Joint Strategic Needs Assessment and Strategy.

(Health and Social Care Act 2012)

A8.3 Sub-groups Structure

Sub-Group	Purpose	Chair	Plan for 2022-2026
1. The Joint Strategic Needs Assessment Steering Group	Purpose: To direct the Joint Strategic Needs Assessment process for Nottinghamshire on behalf of the Health and Wellbeing Board.	Chair: Amanda Fletcher, Consultant in Public Health	To be confirmed - JSNA review currently being undertaken.
2. Pharmaceutical Needs Assessment Steering Group (City & County)	Purpose: To drive and oversee the development and production of PNAs for Nottingham City and Nottinghamshire County for April 2022.	Chair: Amanda Fletcher and David Johns, Consultants in Public Health (County and City).	This group will continue for 2022 – 2026.
3. The Health Protection Strategy Group (City & County)	Purpose: To address the health protection needs in Nottinghamshire City and Nottinghamshire County.	Chair: Directors of Public Health (City & County).	This group will evolve into Health Protection Board and continue for 2022 – 2026.
4. Healthy and Sustainable Places Coordination Group	Purpose: To coordinate delivery of the Healthy & Sustainable Places ambition of the Joint Health and Wellbeing Strategy.	Chair: The Chair of the Health & Wellbeing Board	This group will continue for 2022 – 2026 with focus on Food Insecurity (?)
5. Substance Misuse Strategy Group	Purpose: To prevent and reduce substance misuse and related problems through partnership working and improve the quality of life for people who live, work and visit Nottinghamshire.	Chair: Amanda Fletcher, Consultant in Public Health	This group will continue for 2022 – 2026 with focus on alcohol (?)
6. The Children and Families Alliance	Purpose: The Children and Families Alliance is a partnership of organisations that commission and provide services for children, young people, and their families within Nottinghamshire and enable these partner services to meet their statutory duty to co-operate to improve the well-being of children.	Chair: Colin Pettigrew, Corporate Director, Children and Families	This group will continue for 2022 – 2026.

7. The Best Start Partnership Steering Group (established 2021)	Purpose: To champion and deliver effective and meaningful multi-agency planning and service delivery to give every child in Nottinghamshire the best start in life and deliver the Best Start Strategy.	Chair: Louise Lester, Consultant in Public Health	This group will continue for 2022 - 2026.
8. The Nottinghamshire Housing Partnership Board (proposed to be established)	Purpose: To provide leadership and oversight in relation to the delivery of housing services in Nottinghamshire to people with health and care needs, so that they can carry on living healthy and independent lives at home for as long as possible.	Chair: To be confirmed.	It has been agreed to not establish this board at this time.
9. The Nottinghamshire Integration Board (proposed to be established)	Purpose: To provide leadership and oversight in relation to the delivery of integrated health and care across the whole County of Nottinghamshire	Chair: To be confirmed.	It was agreed at Health and Wellbeing Board on 1/09/21 to not establish this Board at this time.

A8.4 Changes to Health and Wellbeing Landscape

A8.4.1 ICS Introduction

Since 2018, there have been a number of organisational changes within the health and wellbeing sphere, the main one being the introduction of Integrated Care Systems (ICSs).

ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups. They work to deepen the relationship in many areas between the NHS, local councils and other important strategic partners such as the voluntary, community and social enterprise sector. They have developed better and more convenient services, invested in keeping people healthy and out of hospital and set shared priorities for the future (NHS, 2021). To find out about Nottingham and Nottinghamshire ICS please visit: https://healthandcarenotts.co.uk/.

However, a constant in all this change has been the Health and Wellbeing Board.

A8.4.2 COVID-19 Impact and Health Inequalities

Obviously the COVID-19 pandemic has had (and continues to have) a massive impact not only on the health and wellbeing of the population of Nottinghamshire, but also on its' economy. It has caused the deaths of members of the population, but also unfortunately served to exacerbate health inequalities that were there before. It has also shown the close relationship between health and the wider determinants of health such as poverty, employment, air quality and access to healthcare.

However, the pandemic has enabled some positive developments and innovations such as online engagement and services and also closer partnership working across the County.

A8.4.3 Climate Change

Climate change is also major concern, and has been called the “the greatest threat to global public health” in a collective editorial of over 200 Public Health experts (Atwoli, et al, 2021). This concern only increased over the course of the last strategy.

A8.4.4 Place Based Delivery

The main delivery of the JHWS will be at place level. There are two primary delivery groups which function at this level, Place Based Partnerships (PBPs) (from April 2022) and Health Partnerships run by the District and Borough Councils.

Place Based Partnerships

South Notts PBP- 8 priority neighbourhoods

Mid Notts PBP- 2 priority neighbourhoods

Bassetlaw PBP- 4 priority neighbourhoods

District and Borough Health Partnerships

Each District and Borough in Nottinghamshire has a partnership that develops a plan to address the health and wellbeing needs of their local population.

Glossary

Term	Definition
Climate Change	A change of climate which can be attributed directly or indirectly to human activity, that alters the composition of the global atmosphere and which is in addition to natural climate variability observed over comparable time period (IPCC, 2018)
Health Inequalities	Avoidable, unfair and systematic differences in health between different groups of people (Kings Fund, 2020). These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing (UK Government, 2021).
Healthy Life Expectancy	The average number of years that an individual is expected to live in a state of self-assessed good or very good health, based on current mortality rates and prevalence of good or very good health (Insee, 2019).
Inclusion Health	Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases) (PHE, 2021)
Life Expectancy	This is the average number of years that a newborn is expected to live if current mortality rates continue to apply (WHO, 2006)
Neighbourhood Level	A smaller geography that in county areas might correspond to district council boundaries or could be covered by a primary care network (PCN) and the community services that link into it. (PCNs are newly established networks of GP practices that were announced in The NHS long term plan and set up in July 2019.) These areas tend to cover populations of around 30,000 to 50,000 people (Kings Fund, 2019)
Place Level	This is usually the area covered by a local authority. In parts of the country, CCGs and local authorities cover the same geography and can therefore work together to commission jointly at 'place level'. The integration of acute, primary and social care services can also occur at this level. These areas tend to cover populations of around 250,000 to 500,000 people (Kings Fund, 2019)
Social Justice	The objective of creating a fair and equal society in which each individual matters, their rights are recognized and protected, and decisions are made in ways that are fair and honest (Oxford Reference, 2021)
Social Value	Social value encompasses environmental, economic and social wellbeing and understands each of these in terms of their impact on the quality of life of people. What outcomes improve quality of life,

	and how to deliver them, will look very different depending on the context. (UK GBC, 2021)
System Level	The area covered by an Integrated care system (ICS). The size of these areas varies, but they typically cover populations of one to three million people (Kings Fund, 2019). The Nottinghamshire Health and Wellbeing Board operates at system level.
Wider Determinants	A diverse range of social, economic and environmental factors which impact on people's health. Such factors are influenced by the local, national and international distribution of power and resources which shape the conditions of daily life. They determine the extent to which different individuals have the physical, social and personal resources to identify and achieve goals, meet their needs and deal with changes to their circumstances (OHID, 2021).
Prevention	Prevention includes: • stopping health problems from developing in the first place (e.g., by helping people stop smoking), • detecting and treating disease early (e.g., screening for different types of cancer), • reducing the effects of disease and injury (e.g., supporting people with long-term health conditions).
Health Promotion	Health promotion is the process of enabling people to have control over and improve their health - It focuses on a wide range of social and environmental interventions.

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