Nottingham and Nottinghamshire Clinical Commissioning Group

Commissioning Strategy 2020-2022

PLEASE NOTE: Whilst this document is largely complete, this version is still being shared to seek further comment and input.

VERSION CONTROL			
Version Number	**Date**	**Author**	**Details of Update**
0.1	21.6.2019	Andrea Brown	Early draft collating pre-existing material
0.2	21.6.2019	Lucy Dadge	Second draft - Inclusion of narrative on moving toward a single system wide approach to U&E Care
0.3	2.7.19	Andrea Brown	Third Draft - Alignment with Primary Care, Finance and Quality strategies
0.4	09.7.19	Andrea Brown	Fourth Draft – NHSE Feedback and CCG Strategic Commissioning group feedback

AUTHORISATION		
Date	**Name**	**Position**

Contents

Foreword

Nottingham and Nottinghamshire Clinical Commissioning Group has developed this commissioning strategy to describe our approaches to effect a change in the configuration of services, seeking to improve care delivery and meet the needs of our whole population. It is a plan that details the actions we will take to make the most impact, as leaders within the Integrated Care System within Nottingham and Nottinghamshire.

Our strategy has been developed in alignment with national and local policy:

- Nottingham and Nottinghamshire Integrated Care System
- Five Year Forward View
- General Practice Five Year Forward View
- Mental Health Forward View
- Transforming Care Programme
- National Cancer Strategy
- Nottinghamshire Health and Wellbeing Strategy
- Nottingham City Health and Wellbeing Strategy
- NHS Long Term Plan

Our strategy sets out our commissioning journey for the next two years detailing the next steps towards achieving the Integrated Care System priorities:

- Better outcomes
- Better experience for our staff and citizens
- Better use of resource

Our effectiveness and success is dependent upon robust commissioning approaches, system collaboration, brave and resilient leadership, clinical engagement, drive, ambition and transformation, sound financial strategy and excellent and transparent governance. We will be further developing and improving our approaches to these important underpinning characteristics over the next two years.

Our staff and membership are key to our success. Creating an environment that recognises good work, energy and effort will ensure that staff and our membership feel able and empowered to contribute to the transformation that is required to achieve our ambitions.

Our Vision

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

Section 1 – Purpose

This document sets out the commissioning strategy for delivery of health services working in partnership with local government for the population of Nottingham and Nottinghamshire for the period 2019- 2021. This strategy describes our ambitious journey to ensure that our residents receive care, treatment and support that is person centred, designed around their own strengths and needs and that of their families and carers. This strategy will be developed further to align with the development of the Long Term Care Plan. This will be based on full engagement with stakeholders and the public on how we achieve the outcomes to meet our ambition for healthier, stronger and resilient communities in Nottinghamshire.

It is recognised that commissioning needs to change with stronger strategic commissioning at a system level, better coordinated and integrated delivery at a local level and with services being personalised.

Through strong strategic commissioning their will be robust management of the financial resources, acknowledging that system savings need to be realised year on year. It will also require clarity on other financial aspects such as capital investment required to support care delivery.

There will also be a requirement to work with partners outside of Nottinghamshire where commissioning operates on a regional footprint. It will be the case that we will need to work with other CCGs that we border to manage specific service delivery. As part of our strategic alignments with local authority there will be partners that operate in different ICS systems which will require strong management that in achieving economies of scale we do not lose local responsive delivery of services. This change in commissioning will be explained within this strategy.

A key focus of the strategy is to support a managed shift towards health and care that is increasingly preventive and delivered at community level, rather than in acute

- enabled to prevent avoidable illness
- able to stay healthy and independent
- Living in strong communities that can share responsibility
- Signposted to good advice and information
- Able to benefit from a strengthened primary, community, social and carer services

Fig 1. Diagram representing the focus in commissioning to support a managed shift in what and where care is provided

What is strategic commissioning?

Commissioning has traditionally been delivered through detailed contract specification, negotiation and monitoring or the routine use of tendering. National payment regimes reward increased activity and encourage income generation. Strategic commissioning is quite different.

The focus on defining and measuring outcomes, putting in place capitated budgets with appropriate incentives for providers to deliver these outcomes, and using longer-term contracts extending over five to ten years. Overtime this will reduce transaction costs and free up resources to invest in improving health and care. Strategic planning will be undertaken with partners across the ICS and will increasingly seek to address or prevent health prtoblems more proactively. The commissioner will increasingly drive and support the development of provider collabortions who are able to deliver high quality care within an overall affordability envelope.

Strategic commissioning has four key elements - analyse, plan, do and review - which are sequential and of equal importance, i.e. we have spent equal time, energy and attention on all four elements. These elements are described in Figure 2 in the commissioning cycle.

Fig 2. The Commissioning Cycle Source:

In carrying out these activities we will consider the perspective of

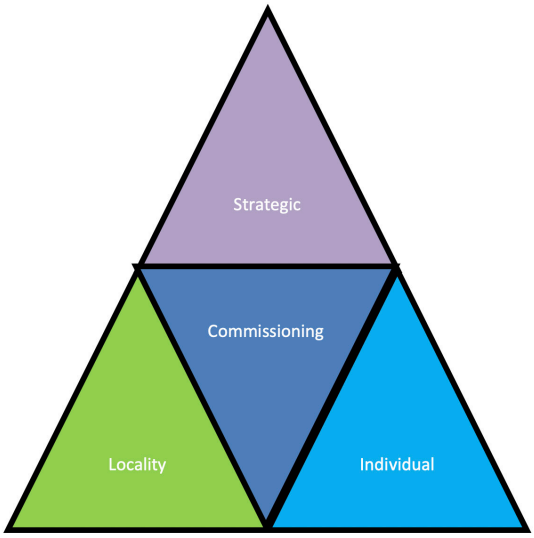
- different stakeholders, including providers and potential providers
- in the context of personalisation, clear mechanisms for service users, carers, and their representative organisations

Our analysis has been informed by population needs assessment: a joint activity completed with strategic partners, along with service reviews and an understanding of the resources needed and risks involved in implementing change and/or continuing with the status quo.

Our planning approach is described in this strategy having taken into account the gaps between what is needed and what is available, and describes how these gaps will be addressed within available resources.

We also explain how we will ensure that the services needed are delivered as planned, in ways which efficiently and effectively deliver the priorities and targets set out in our commissioning strategy.

Fig 3 describes the definitions of commissioning



Commissioning comprises a range of activities, including:

- assessing needs
- planning services
- procuring services
- monitoring quality

Strategic Commissioning takes place over longer time frames.
It is also expected that Strategic commissioning will set the framework and standards for commissioning activity at other levels.

Locality commissioning is working with common principles including delivery of outcomes to determine the delivery of care at a local level
Organisations should work together to govern the common resources available for improving health and care in their area.

Individual Commissioning is done by the individual, a career, an independent broker, a staff member or a combination of these. It is important that individuals have the tools to identify and access the right services; to do so safely, cost effectively

What does Joint Commissioning mean for Nottingham and Nottinghamshire?

As a strategic commissioner it is our responsibility to plan and commission with our partners, clinicians and communities safe, high quality and accessible services that meets the needs of our population within our available resources. As we further determine, with our strategic partners, our common priorities we will identify opportunities to further align and increasingly integrate commissioning. This will enable seamless services and better management of our financial resource. This means maintaining a strong influence on the nature of services delivered in both the place and local settings.

To achieve this cohesive and connected approach to clinically led commissioning we will adopt appropriate commissioning approaches. Figure 4 details the spectrum that exists around commissioning approaches that we will agree with our strategic partners with an ambition that we move toward an increase in integrated commissioning.

As we establish strategic commissioning we recognise that we need to enhance our skills, create the capacity and capability to deliver this changed commissioning focus.

Key areas of analytical capacity to support our population health management approach, ability to capture and simplify the complex system into clear delivery interventions that are understood by all partners.

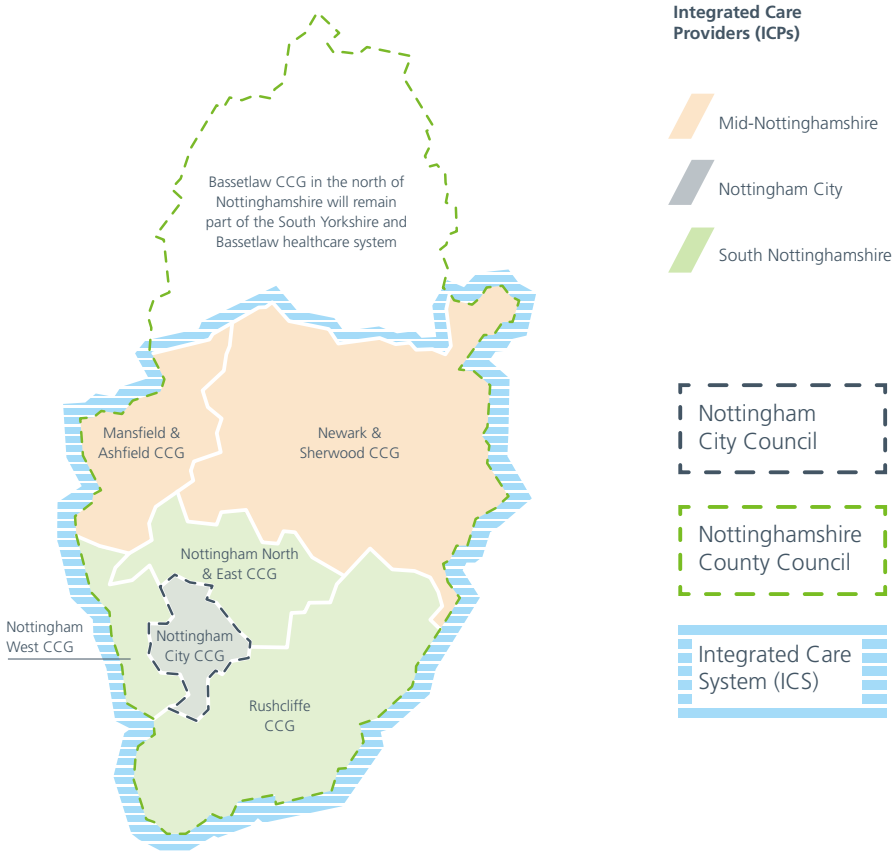
CO - ORDINATED COMMISSIONING	LEAD COMMISSIONER	JOINT COMMISSIONING	INTEGRATED COMMISSIONING
It is imperative that all Health and social care organisations work closely to align commissioning intentions and contract requirements the ICS will provide the vehicle for this where appropriate	One commissioner takes the lead responsibility to develop commissioning intentions and contract with a provider. Contract associates can work either to the main contract or require separate Key Performance Indicators	Commissioners across health and social care work together to define joint commissioning intentions, supported by shared values, objectives and a pooled budget. Ultimately one contract and one service specification for providers. Teams not necessarily located together but can be supported by an agreement to work together	Fully integrated commissioning team across health and social care. Located together, working as an independent commissioning unit

Fig 4. Spectrum of commissioning

Our key strategic commissioning partners are our local authorities of Nottingham City and Nottinghamshire County Councils. Each has a Health and Wellbeing Strategy with key priorities that reflect the population they serve. Although there are commonalities around need there are diverse populations. This means that it is not always going to be the case that full alignment and therefore fully integrated commissioning across the three partners is achievable. However, as the system architecture becomes more established, recognition of the geography or place has been made with Nottingham City an explicit place where local delivery will be executed. As all three strategic partners are members of the Nottingham and Nottinghamshire Integrated Care System, the opportunity to develop and refine through monitoring at a system leadership will exist.

We currently have agreements in place where the CCG and local authority pool resources or where a lead commissioner approach has been applied. In section 2 we describe the changing environment in which we will commission a place based approach. We will, therefore, review our existing arrangements to ensure that they best serve the population need and are efficiently delivered. Within the place and neighbourhood levels of delivery we will also look at our partnership working with district councils and how services can be better aligned and in time integrated to achieve proactive responses to citizen's needs. This will be achieved in bringing together our understanding of wider determinants of health and increasingly implementing preventative measures. As a strategic commissioner we will create the framework and governance of system level commissioning providing a standard and consistent approach as well as economies that allows for local delivery. It is the case that the development of each of the ICPs (place) is moving at a different pace; Nottingham City ICP are already looking at existing joint commissioning intentions that we intend to build on whilst in Mid and South Nottinghamshire ICPs there is work to develop these with both the county and district councils.

Nottingham and Nottinghamshire Integrated Care System (ICS)



NOTTINGHAM & NOTTINGHAMSHIRE INTEGRATED CARE SYSTEM	NOTTINGHAM CITY COUNCIL	NOTTINGHAM COUNTY COUNCIL
Improved health and wellbeing	Children and adults in Nottingham adopt and maintain healthy lifestyles	To give everyone a **good start in life**
Increased independence, care and quality	Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	To have **healthy and sustainable places**
Effective resource utilisation	There will be a healthy culture in Nottingham in which children and adults are supported and empowered to live healthy lives and manage ill health well	To enable **healthier decision making**
	Nottingham's environment will be sustainable; supporting and enabling its citizens to have good health and wellbeing	To **work together to improve health and care services**

Table 1: Comparison of strategic ambitions

National Policy Context

In 2015, the Local Government Association published the 'Commissioning for Better Outcomes' Framework. This framework was revised in 2017, in partnership with NHS Clinical Commissioners and published in 2018 as the 'Integrated Commissioning for Better Outcomes: a Commissioning Framework' (ICBO). It sets out the standards to support local health and care systems to strengthen and progress their integrated commissioning arrangements.

As a partner within the Nottingham and Nottinghamshire Integrated Care System the CCG will continue to drive the system ambition of integration. However, it is recognised that the frameworks by which the CCG works and those of our strategic partners offer challenges in bringing together our resources and delivering against our regulatory requirements respectively.

The NHS Long Term Plan, published in December 2018, signalled the direction for health and care services over the next ten years. It aims to give everyone the best start in life, deliver world-class care for major health problems, such as cancer and heart disease, and help people to age well.

The NHS Long Term Plan also sets out how the challenges that the NHS faces, such as staff shortages and growing demand for services, can be overcome by:

1. Doing things differently: giving people more control over their own health and the care they receive
2. Preventing illness and tackling health inequalities: increasing the focus on some of the most significant causes of ill health, such as smoking, drinking problems and avoid Type 2 diabetes
3. Backing the workforce: increasing the NHS workforce, training and recruiting more professionals
4. Making better use of data and digital technology
5. Getting the most out of taxpayers' investment in the NHS: through identifying ways to reduce duplication in how clinical services are delivered

Local Context

Our strategy has been informed by the analysis available around our population health needs. CCGs have a duty to promote equalities and to work in partnership with local authorities, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the wellbeing of local populations. This population information is provided in a Joint Strategic Needs Assessment (JSNA). This is described in detail in section 3.

Section 2 – The changed delivery environment

The CCG as a strategic commissioner has a responsibility to create the best environment for delivery of optimum care. In addressing the population health needs the CCG will support establishing a system architecture for delivery which enables providers to deliver care at the earliest opportunity and in the most local setting that is appropriate.

As commissioning operates at a system level care delivery will operate at a place (ICP) and neighbourhood (PCN). The place and neighbourhood levels will operate increasingly through co-location, collaboration and integration across all providers and will include both statutory organisations as well as the voluntary sector.

As part of the move to the new system architecture, Nottingham and Nottinghamshire have established three Integrated Care Partnerships (ICPs) and 20 Primary Care Networks (PCNs). Figure 5 below provides an illustration of responsibilities in relation to working as a system.

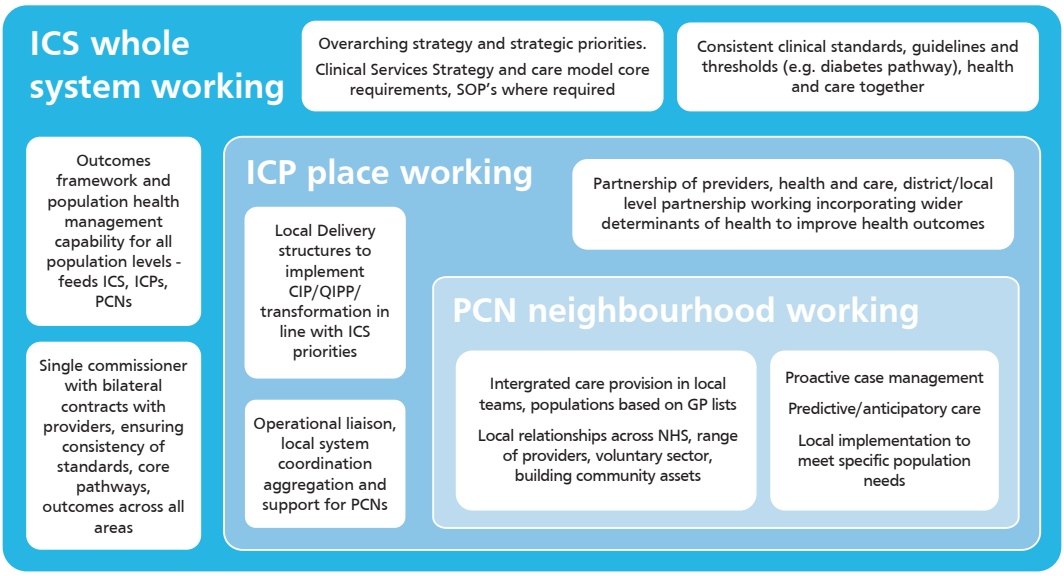
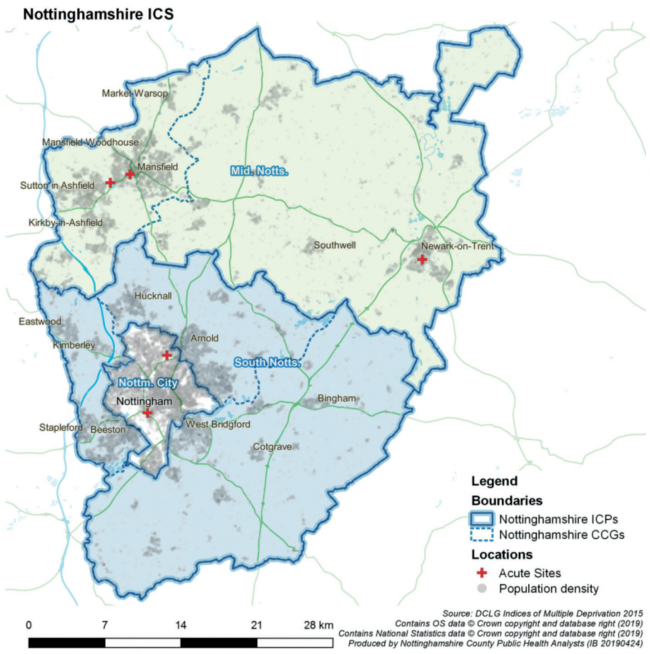
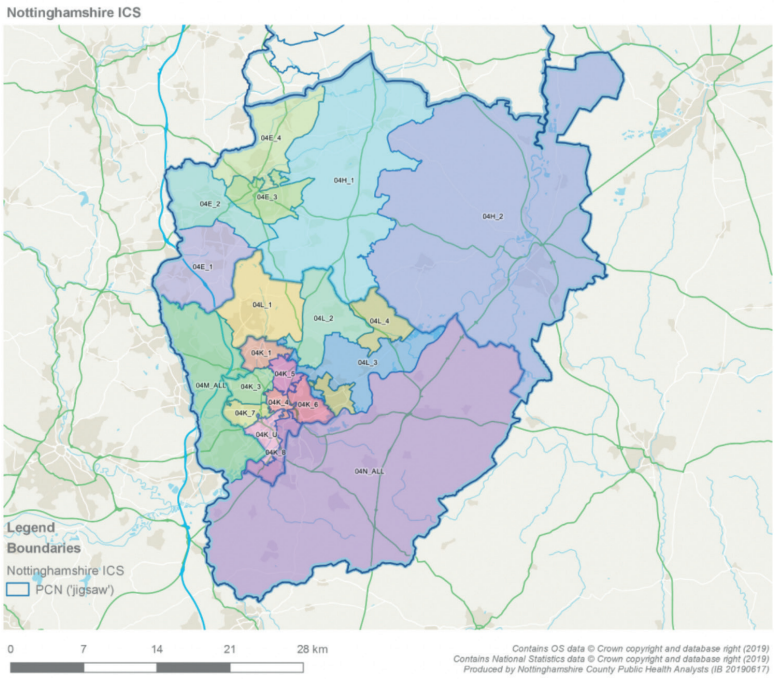


Fig 5. Delivery of care model for Nottingham and Nottinghamshire

In map 1 and map 2 below the detail of the geography covered in both ICP and PCN structures demonstrates the shift to local



Map 1. Delivery of care model for Nottingham and Nottinghamshire



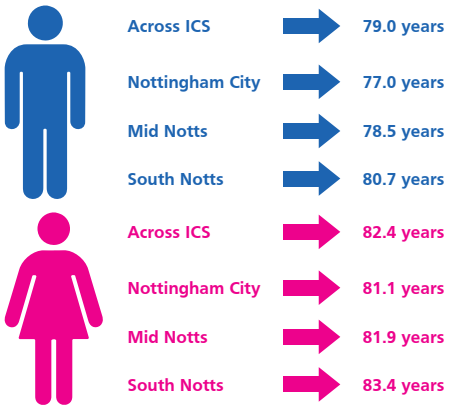
Map 2. Delivery of care model for Nottingham and Nottinghamshire

Section 3 – Population Health Needs

Changing Demographics

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS. This is set to increase by 3% by 2024 and by 10% by 2039.

The age profile of our populations in Nottingham and Nottinghamshire are relatively similar to that of the England average, whilst our Nottingham City population has a smaller proportion of those aged 50+ and a higher proportion of younger people even without its large student population. People are living far longer with 13% of the ICS population currently aged 70+, which is set to rise to 18% by 2039. Deprivation is a strong driver of illness and poor levels of health. Our ICS has large variations in the levels of deprivation, for example Nottingham City and Mansfield and Ashfield are some of the most deprived districts in England compared to Rushcliffe which has significantly lower levels of deprivation.



Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher levels of unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) resulting in poorer health and wellbeing outcomes. Across the ICS we have a differential pattern in overall life expectancy with male life expectancy ranging between 77yrs – 80.7yrs and females ranging between 81.1yrs – 83.4yrs.

The healthy life expectancy, i.e. the number of years a person lives in 'good health', also shows a pattern of inequity – a male in Nottingham City lives 57 years in good health compared to a male in the rest of Nottinghamshire who lives 62.5 years. The pattern is similar for females with 53.3 years compared to 61.6 years.

The number of people living with multi-morbidity prevalence will also rise dramatically across our population significantly increasing the complexity of those people who do need health and care support. The numbers of people with 4+ diseases will more than double in the next 20 years and 2/3 of these will have mental ill-health as well as physical ill-health. By 2039 moderate frailty will increase by 96% and severe frailty by 117%.

Childhood obesity is a further key indicator of the impact our lifestyle choices have on the health of our population. It is associated with a higher chance of premature death and disability in adulthood. Overweight and obese children are more likely to stay obese into adulthood and to develop long term health (LTC) conditions such as diabetes and cardiovascular diseases at a younger age.

For most LTCs resulting from obesity, the risks depend partly on the age of onset and on the duration of obesity. Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences of childhood overweight and obesity, that often do not become apparent until adulthood, include cardiovascular diseases (mainly heart disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

At the age of 4-5yrs, Nottingham City children are already significantly less likely to be a healthy weight that those in Nottinghamshire and the rest of England. By age 10-11yrs the gap has grown further with only 57.8% of Nottingham City children being a healthy weight compared to 64.3% in England as a whole. By 10-11yrs 2 in 5 children and 1 in 15 children in Nottingham City are severely obese and this is increasing year on year for both age categories.

The JSNA covers specific areas of care as well as wider determinants of health and wellbeing. Chapters are regularly reviewed to ensure they reflect the most current understanding of need. The table in Appendix 1 provides the summary of both Nottinghamshire City and Nottinghamshire County population demographics. It is the intention that this commissioning strategy identifies those services that we need to commission to deliver improvements in outcome, to reduce inequalities and improve life expectancy.

Our Population

	England		Nottingham and Nottinghamshire ICS		Index Nottingham and Nottinghamshire vs England	
	59,759,638		1,096,640		1,096,640	
	Female	Male	Female	Male	Female	Male
Age	**29,909,960**	**29,849,678**	**544,681**	**551,959**	**544,681**	**551,959**
95+	0.1	0.1	0.1	0.0	91	88
90-94	0.4	0.2	0.4	0.2	100	92
85-89	0.9	0.6	0.9	0.6	97	97
80-84	1.3	1.1	1.3	1.1	98	97
75-79	1.7	1.5	1.7	1.5	98	98
70-74	2.4	2.3	2.4	2.2	98	98
65-69	2.4	2.3	2.4	2.3	97	100
60-64	2.7	2.7	2.6	2.6	97	96
55-59	3.2	3.3	3.1	3.2	99	98
50-54	3.4	3.6	3.3	3.5	98	97
45-49	3.3	3.5	3.1	3.3	95	96
40-44	3.1	3.3	2.8	3.0	92	92
35-39	3.5	3.7	3.2	3.5	92	96
30-34	3.7	3.7	3.5	3.9	94	104
25-29	3.6	3.6	3.5	3.9	97	111
20-24	3.2	3.1	4.3	4.1	133	131
15-19	2.7	2.8	2.9	2.9	110	106
10-14	2.8	2.9	2.7	2.8	96	95
5-9	2.9	3.1	2.9	3.0	98	99
0-4	2.7	2.8	2.6	2.7	97	98

Table 2

Health Outcomes and Health Inequalities

The three ICPs across the System reflect this variation – with the City ICP having a significantly younger population, with the other two ICPs conversely showing a skew to older populations.

The population of Nottingham and Nottinghamshire is 88% White ethnic against 85% for England overall. Within that, the City ICP is 28% Asian, Black, Mixed and Other ethnic groups compared with England at 15%. The converse applies in the two other ICPs: there are relatively more White ethnic group residents compared to England with Mid Notts at almost 98% and South Notts over 93%. Levels of education in the system are again broadly similar to England overall with 25% of residents with no qualifications and 25% with Level 4+ (first degree or higher) qualifications. This again varies across the patch with City residents over-indexing in Level 3 (A-Levels) and under-indexing in degree qualifications (implies graduation retention rates are low). Almost 30% of residents in Mid Notts have no qualifications.

In terms of employment, the residents of Nottingham and Nottinghamshire are mostly employed in Lower Managerial (18%), Semi-Routine (15%) and Routine (14%) occupations. Nottingham and Nottinghamshire has relatively fewer people in managerial, intermediate and self-employed occupations and relatively more in relatively more in technical, routine and semi-routine occupations.

Across Nottinghamshire and Nottingham, the move towards a smoke free generation would annually save lives (c. 1,823 early deaths due to smoking), reduce hospital admissions for smoking related and directly attributable conditions (c. 10,992), reduce health inequalities and provide societal cost savings of £153m.

Circulatory, Cancer and Respiratory are the broad causes of death contributing most to inequalities in male and female life expectancy in Nottingham and Nottinghamshire. For males, these top three causes of death contribute to 71% in Nottingham and 61% in Nottinghamshire of the life expectancy gap between the most and least deprived populations. For females the figures are 54% in Nottingham and 60% in Nottinghamshire.

In Nottinghamshire tobacco is the highest risk impacting on years lived with disability and years of life lost due to premature mortality. Nottinghamshire has a higher rate of years lived with disability attributable to smoking and dietary risks than Nottingham (this is higher in males than females for both). Tobacco use is by far the biggest cause of preventable cancer in Nottinghamshire.

In Nottingham, alcohol is the biggest single risk factor for early death and illness in those aged 15-49. Nottingham has some of the worst outcomes for alcohol related harm in England, impacting across the wider health and social care system. In Nottingham, high BMI is the leading attributable risk to years lived with disability. High BMI increases the burden of MSK conditions which are the leading cause of disability in England. In Nottingham 72% of the MSK burden is due to low back and neck pain. Major depressive disorder and years lived with disability is higher in Nottingham than Nottinghamshire and in females versus males. Nottingham is higher than the England average.

More information on the demographics of Nottingham and Nottinghamshire can be seen in the Primary Care Strategy.

	Nottingham City	Nottingham North & East	Nottingham West	Mansfield and Ashfield	Newark and Sherwood	Rushcliffe
Population registered with GP practices	388,378	141,257	106,542	195,710	136,229	128,524
Population key facts (compared with England average)	Significantly more young people – 1 in 8 people is a full-time university student Growing population - significant international migration particularly from Eastern Europe, and more births than deaths Adults more likely to live in ill health than elsewhere	Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Comparatively good health outcomes 19.5% registered disabled compared with 17.6% England average	Growing population Age profile similar to England average Health outcomes are similar or better	Growing population Age profile similar to England average Many health outcomes worse than England	Growing population Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Similar health outcomes to England	Lower proportion of young adults aged 20 to 40 Higher proportion aged 50 and older Health outcomes similar to, or significantly better than England
Healthy life expectancy compared with the England rate	Significantly lower		Similar	Significantly lower	Similar	Similar to, or better
Biggest health issues	Circulatory diseases, cancer, respiratory and digestive disease	Incidence rate for new cancers and mortality for all cancers higher than the England average	High number of patients with a limiting long term illness or disability (18.8% compared with 17.6% England average)	All cancers – especially lung cancer, circulatory disease and respiratory disease		
Major health determinants	Deprivation, smoking prevalence and alcohol-related harm	Lower levels of deprivation		Some of the most deprived areas in Nottinghamshire		Some of the least deprived populations in Nottinghamshire

Table 3

Population Health Management

As a strategic commissioner the approach of Population Health Management (PHM) will be adopted. PHM seeks to improve the health outcomes across Nottingham/ Nottinghamshire by monitoring and identifying individual patients within PCN's. Utilising current business intelligence to cohort, segment and risk stratify patients by aggregating data to provide a comprehensive holistic picture of patients across the system will allow for different commissioning strategies to be applied to suit the specific needs of the neighbourhood populations. Using and building upon current data sources from public health, primary care, secondary care, social care and mental health to achieve and improve patients outcomes, reducing unwarranted variation, making the best use of the resources available while lowering costs to meet the ICS system level outcomes framework and align with the 'triple aim' objectives.

Building upon the evaluations undertaken across Nottingham/Nottinghamshire and with support from the ICS Leadership Board and Clinical Reference Group, an Expert Advisory Group has been established to focus on a specific population cohort (initially LTC) cradle to grave with the aim of:-

- Understanding the current baseline, agreeing the scope, inclusive of all health, care and socio economic factors to segment the population within the (LTC) cohort.
- Segmentation to be informed by the utilisation, needs and desired outcomes of the population with consideration of national and local requirements
- Baselining the activity on the population once segmented.
- Baselining the spend on the population once segmented.
- To identifying true variation based on the segmentation and develop an infrastructure, intelligence and interventions that supports the mitigation of unwarranted variation.
- Agree and recommend system standard cohort outcomes (health and care), ensuring these align and meet the system outcomes framework and best practice guidance.
- To develop and agree risk stratification/ algorithms (low, medium and high) criterion that can be adopted to meet the whole LTC's population health's system outcomes framework.
- To identify and recommend system level, measurable indicators.
- Ultimately, to develop and agree a fully informed blue print prototype LTC framework approach which the whole system will follow going forward.

Expected outcomes

Delivering Population Health Management within Nottinghamshire will require a combined system implementing the following elements:

1. Segmenting the population
2. Selecting the interventions to deliver
3. Stratifying the delivery of outcomes based on need and impact
4. Defining outcomes
5. Sharing data and analytical infrastructure

Segmenting the population and stratifying based on need

The first PHM step taken in Nottingham and Nottinghamshire is to understand the population. This is particularly important in a system with finite resources which will, at times, be required to re-allocate resources across organisations quickly and efficiently to areas with the greatest need and opportunity, ensuring care is not compromised. The ICS seeks to improve the health and wellbeing of the population as a whole and to do that there must be population segments, age/sex bands, and other differentiating criteria established up front to evaluate and compare like for like going forward. Consistent and well-defined segmentation and stratification will give ICPs the tools to: identify and manage the population; align care coordination and other system resources; inform provider decision making, and other areas of the system in a more targeted and data-driven manner; and support measurement of specific outcomes across varied cohorts and demographics.

The proposal is that the Nottingham and Nottinghamshire segmentation strategy will undertake a hybrid approach to segmentation, forged mainly around the bridges to health framework and will segment the population at three levels:

- Level 1 - Whole population
- Level 2 - Sub-population
- Level 3 - High Risk population

Level 1: Segmentation – Whole Population

The aim of whole population segmentation is to ensure that;

- Each segment is broadly homogeneous, with common health prospects and priorities that can be addressed through careful system planning.
- Each segment is sufficiently distinct, with unique health and care delivery needs.
- Each segment includes every person, acknowledging that individuals will move between segments, as their health needs change
- Each segment's definitions should be sufficiently precise to allow a baseline population number to be determined, assuming access to the appropriate dataset.

Level 2: Segmentation – Sub-population

Once segmented into population cohorts, the population will then be divided into sub populations and stratified based on high, medium and low risk levels. The table below (fig 6) presents the proposed sub population stratification categories. These were recommended by Outcomes Based Healthcare, who are working with NHS England to develop their national PHM outcomes framework, therefore local experts agreed that this approach would enable the system to strategically align to the national direction, but enable a more tailored approach.

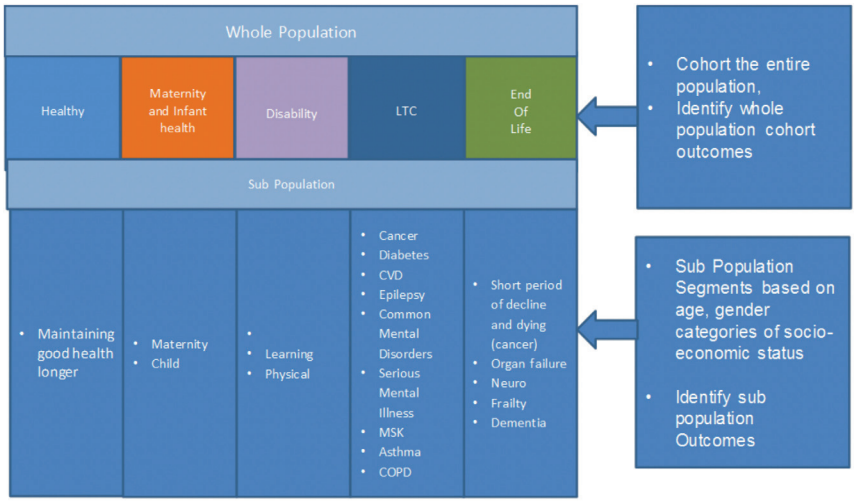


Fig 6

Level 3: Segmentation – High risk population

Currently the CCG is focussing on individuals deemed at high risk, such as an unplanned hospitalisation, as part of the modernised Devon risk stratification approach covering 2% of the system's population. However, this does not include social care or mental health data. This approach mainly focusses on frailty and urgent care attendance. It is proposed that this methodology is continued, becoming more inclusive. However the systematic outcome is to focus on reducing unplanned admissions across Nottingham and Nottinghamshire.

Set, Measures and monitor outcomes

In order to measure outcomes, we need to understand the current patient populations through population profiling; (risk stratify patients into cohorts, set their budgets taking into consideration the morbidity burden of their populations, and set equitable outcomes targets).

Going forward, the proposal is that the CCG will align outcomes to the whole population within each cohort, and sub population categories. These outcomes will be based around core health and care needs and take into consideration the socio economic impact on an individual's health and care needs. Current outcomes are to be fully identified, with further work to align future intended outcomes to National, local and regulatory frameworks and be co-ordinated and agreed via an expert panel supported by financial and analytical partners.

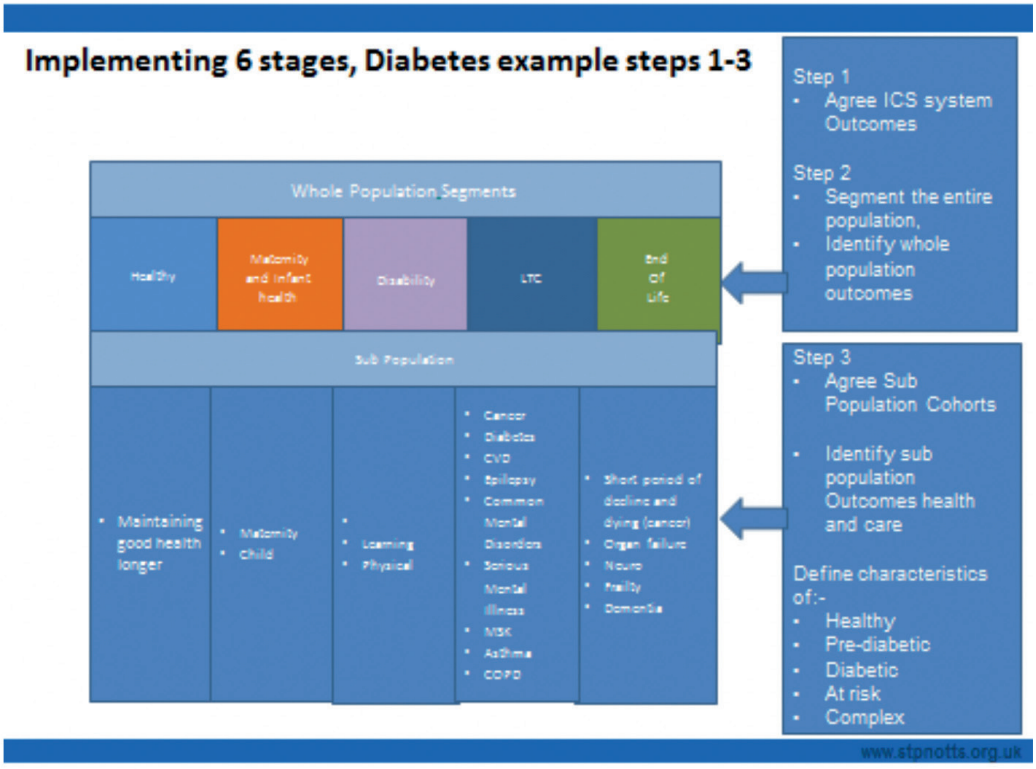
As a system, our intention is to produce an outcomes system in which each whole population cohort, and sub-population category will support the CCG and ICS to achieve its outcomes. A pyramid approach to outcomes, will ensure that we are delivering defined outcomes across our system.

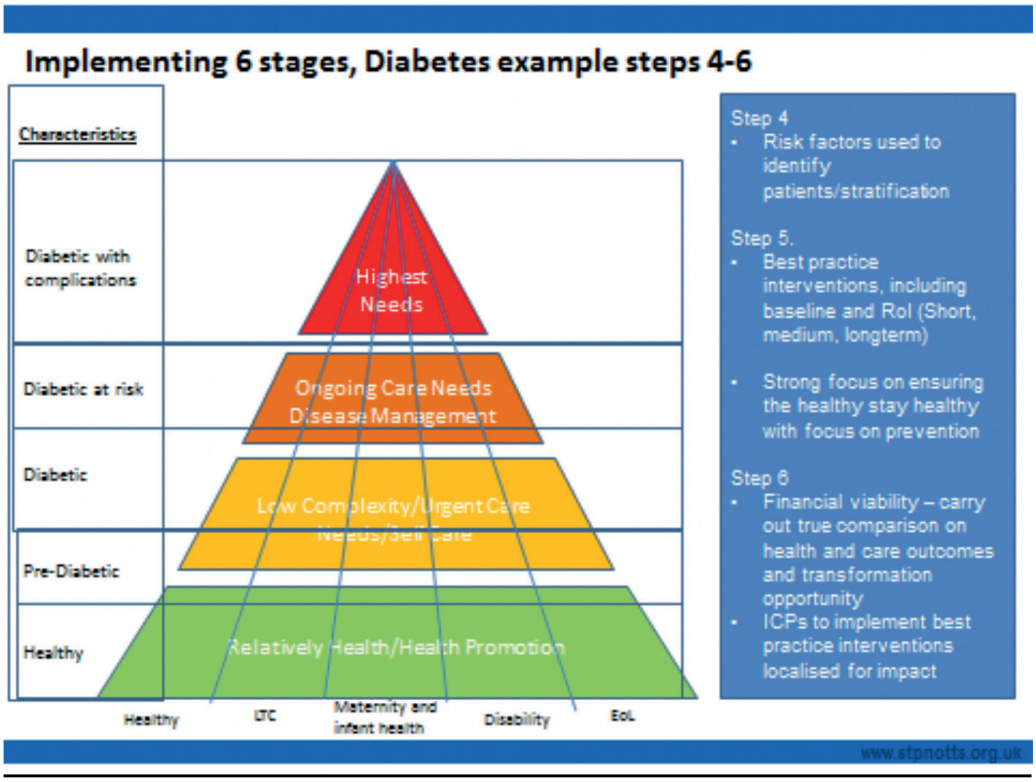
We will partner with Imperial College which will enable development of localised interventions across the PCN's demography (Nottingham/Nottinghamshire), consideration of to all aspects of the health and care economy, based on the agreed outcomes framework and aligned locally to patient need. This approach will enable:

- Effective (personal) value – each patient in the health economy receiving interventions that addresses their personal preferences
- Preference-sensitive conditions (e.g. back pain, prostate cancer)
- Patients offered decision support to help them make a joint decision with their clinician
- Efficient (technical) value
- Services delivered as efficiently as possible
- Improving the outcomes it achieves for the same or lower cost
- Economic (allocative) value
- The right mix of services to address the needs of its population between services and within services.

The key to understanding and realise opportunities which population health management can address across Nottingham/Nottinghamshire will be high quality analysis of local and National information aggregated from individual patient-level data, and the insight that this can provide. This will enable evidence-based interventions to be identified, designed and implemented at an appropriate scale, and tailored and targeted to specific cohorts of the segmented population. It will also allow ongoing regular monitoring and evaluation of the achievement of outcomes. Fig 7 details the six step approach of population health management applied to Diabetes

Fig 7: 6 step approach to PHM – Diabetes





This six step approach will initially be applied to our priority service areas of Diabetes, Frailty and COPD. These services have been determined as our priorities based upon information around demographic need and current evidence around outcomes described earlier in this section.

Each of these service areas are being taken forward to provide Primary Care Networks with robust information to base their operational planning priorities as practices, across Primary Care Networks and within Integrated Care Partnerships. As a strategic commissioner, we will expect delivery to meet our expectations as outlined in our outcomes framework.

Alignment with the development of our Clinical Services Strategy

In earlier sections of this strategy we have looked at the 'why' we need to change what we commission; meeting the needs of our population and we have described 'how' the environment is changing to enable different operating models to develop. We are also looking to change the 'what' and 'where' our care will be in the form of new clinical models. We are developing a single clinical services strategy across the ICS that will deliver consistent, high quality and efficient clinical care, offering seamless care pathways across Nottinghamshire.

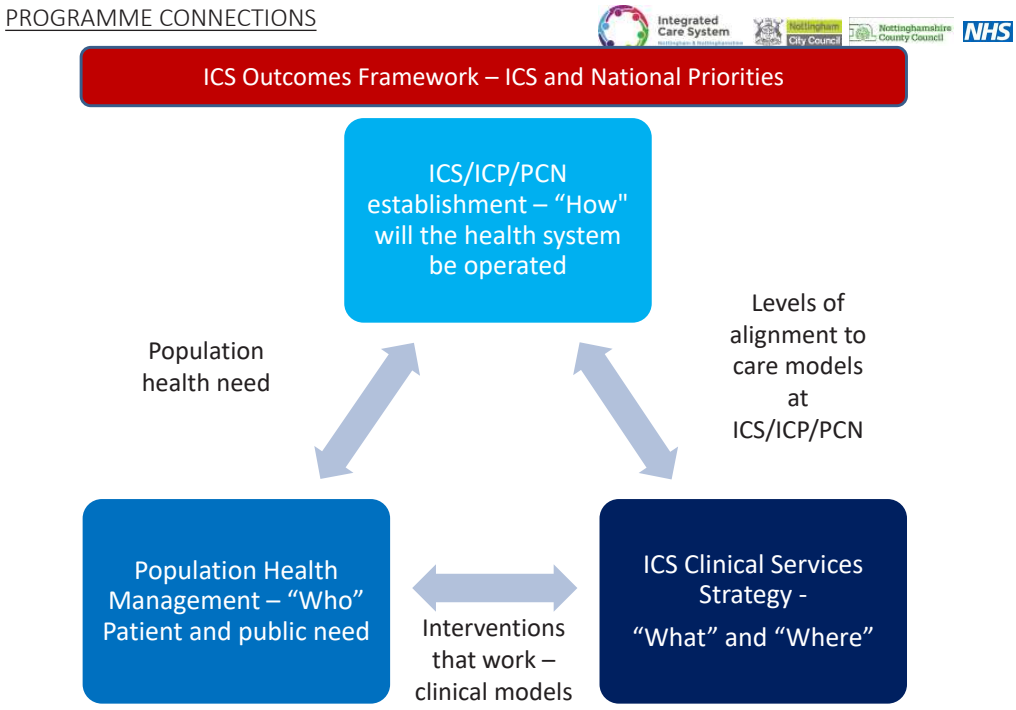


Fig 8 Relationship of the Clinical Service Strategy to the Population Health Management and system operating models

Figure 8 depicts the connection of our work to establish the system for strategic commissioning which recognises that some changes need to happen as a whole system rather than changing individual elements of the care pathway, still acknowledging the place, but with a level of standardisation expected around care.

- Principle 1 - Care will be provided as close to home as is both clinically effective and most appropriate for the patient, whilst promoting equality of access;
- Principle 2 - Prevention and early intervention will be supported through a system commitment to 'make every contact count';
- Principle 3 - Mental health and wellbeing will be considered alongside physical health and wellbeing;
- Principle 4 – The model will require a high level of engagement and collaboration both across the various levels of the ICS and with neighbouring ICSs; and
- Principle 5 - The models of care to be developed will be based on evidence and best practice, will ensure that pathways are aligned, and will avoid unnecessary duplication.
- Principle 6 – The models will be designed in partnership with patients and the public, and will operate across the whole healthcare system to deliver consistent outcomes for patients through standardised models of care, except where variation is clinically justified.

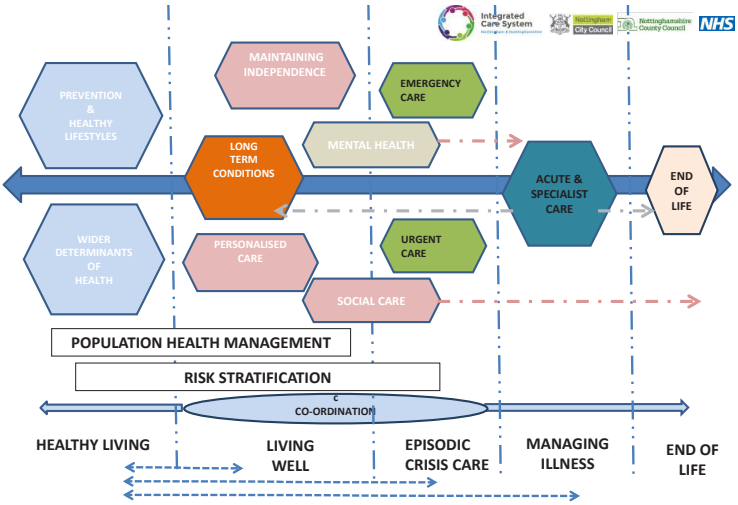


Fig 9: Care Model

The care model depicted in figure 9 describes the changed focus to healthy living, with each service being taken through a structured development using the following steps as a 'flight path 'to achieving changed care that is clinically led and co-designed with our citizens:

Step 1: Form core Steering Groups by disease/service group.

Step 2: Development of an Information Pack and Best Practice review by disease/ service group and disseminate to workshop delegate.

group and disseminate to workshop delegate.

Step 3: Using the information pack, horizon scan, technological advances & 'key' principles, consider these in-line with current service provision looking at local issues and challenges.

Step 4: Using further analysis of the identified core opportunities the group will co-design the new clinical model with patient representatives

Step 5: Present a summary of the outputs from workshop 1 & 2 to the ICS Clinical Design Group to test and confirm the model

Step 6: Model refined with patient and public feedback

Step 7: Final disease/service group future model and plan of change

Step 8: Steering Group present a summary of the workshops to the Programme Board

Section 4 – How we will address our population health needs

In the previous sections we have explained the commissioning approaches, the environment in which we intend to operate and the approach of population health management to target the triple aims and deliver improved outcomes. In this section, we detail how we are going to use those commissioning approaches to deliver care against identified needs.

We will commission in a way that builds on the strong history of joint working in Nottingham and Nottinghamshire.

The six Clinical Commissioning Groups that have come together as a single strategic commissioner have contributed significantly over recent years to the development of integrated care, place based delivery and local community innovations through Vanguard programmes; testing and developing new care models in the following areas:

- Integrated Primary and Acute Services – (Mansfield, Ashfield, Newark & Sherwood)
- Multispecialty Community Providers – (Rushcliffe)
- Enhanced Care Homes – (City)
- Urgent & Emergency Care: System Resilience Group – (Greater Nottingham)

All CCGs aligned in developing a common set of commissioning intentions for 2019-20 that sought to provide a more cohesive framework of service change. These intentions also began to create the opportunities acting as a single commissioner to describe to providers services being delivered within the different delivery environments of integrated care partnerships and primary care networks.

The following plans outline delivery expectations for our key service areas of:

- Prevention
- Personalisation
- Primary Care – PCNs
- Maternity
- Planned Care
- Cancer
- Mental Health
- Care Homes
- Learning Disabilites & Autism
- Urgent & Emergency Care

Prevention

Our Ambition:

Our vision is to maximise independence, good health and well-being throughout our lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

Our vision is to develop a system which is focused on delivering improvements in the health, wellbeing and independence of our population, based on the '4 Pillars' identified by the Kings Fund. This means making connections between the following areas:

- Wider determinants of health and well-being
- Our health behaviours and lifestyles
- Communities, health and well-being
- Integrated care and relationships with communities.

Our Approach:

Primary Prevention:

- Reduce the impact of smoking
- Reduce the impact of alcohol
- Increase immunisation against infectious diseases

Secondary Prevention:

- Reduce the impact of Cancer
- Reduce the impact of Diabetes
- Reduce the impact of Cardiovascular disease

What have we done?

- Gained approval for and implementation of Prevention Framework
- Alcohol agreed as the short term prevention priority for the ICS
- Alcohol 8 point action plan agreed and implemented
- Prevention priorities agreed
- Embedding prevention at an organisational level by aligning a Public Health Registrar to the Trusts

What will we do?

- Establishing alcohol champion in organisations across health, care and partner organisations, including a work programme
- Embedding IBA into workforce policies and practices across the system
- Effective case management and IBA through ED departments
- Agreeing and implementing ICS level plan for tobacco
- Further embedding prevention in ICS workstreams
- Consistently applied system wide approach to the detection of and diagnosis of Atrial Fibrillation
- Implementing relevant public facing campaigns to support primary and secondary prevention initiatives
- Progress Children and Young People's prevention plan focusing on childhood healthy weight, school readiness, resilience, imms and vacs coverage

Personalised Care

Our Ambition:

Our vision is to maximise independence, good health, and wellbeing throughout our lives, shifting the focus from 'what is wrong with you' to 'what matters to you'.

Our ambition and overall objective is to continue to be a leader in Personalised Care and deliver universal implementation of the Comprehensive Model of personalised care: making it a golden thread through everything we do, making it business as usual and an everyday reality for people by delivering the following objectives:

- Embedding of Shared decision making in 30 high-value clinical situations in primary care, secondary care and at the primary/secondary interface where it will have the greatest impact on experience, outcomes and cost – to be achieved by 2029

- For Nottinghamshire, by March 2020, a minimum of 20,869 people will have benefitted from Personalised care and support plans, across both specialist and targeted tiers of the Comprehensive Model.
- Around 5% of the population (50,000 people) will benefit from social prescribing every year
- Additional link workers in place across the system. National target is that "30,000 people with long-term conditions who also have low levels of knowledge, skills and confidence will have an assessment of their knowledge, skills and confidence (activation level),with 1 million benefitting from supported self-management approaches". For Nottingham, this means a minimum of 9,663 people in 2019/20
- Expand Personal Health Budgets to people with long term conditions or complex needs to 4% of the population, with 50% of the budgets being achieved through provider led services. For Nottingham, this means a minimum of 2,900 people will benefit from a PHB or integrated budget during 2019/20.
- From April 2020, everyone eligible for an assessment under the Care Act will experience an integrated and personalised approach, through joined up assessments, support plans and budgets across the 20 Primary Care Networks

Our Approach:

- Deliver an Integrated Accelerator Project
- Develop Personalised Support and Care Planning
- Increase Personal Health Budgets and integrated personal budgets
- Embedding Workforce Training
- Deliver Implementation of Social Prescribing
- Supported self-help and volunteering
- Support to citizens through Health Coaching, Self-management education, peer support and PAM
- Implementing Shared Decision Making

What have we done?

- Signed an MOU with NHSE to be a demonstrator site for the Comprehensive Model of Personalised Care
- Established of Integrated Accelerator Sites to deliver integrated assessments of peoples' needs in a personalised way
- Established Delivery Groups across the ICPs that will oversee the design of best model / approach to delivering social prescribing and community connectivity across the place geographies.
- Developed a better understanding of the incident of community based approaches and extent to which people are benefitting from these approaches through greater engagement and ongoing links with the VCSE and existing community assets.
- Increased access to self-management support, health coaching and community based approaches

What will we do?

- Build on the work of the delivery groups,
- Increase the numbers of link workers and health coaches within the ICPs, supporting LTC aspirations around the role,
- Implement system-wide plan for increasing the use of PAM and other relevant
- Establish Evaluation Framework for measuring Community Centred Approaches
- Increase the number of people with LTC and complex needs who receive a PHB to 2,900 people. (2018/19 target was 2,060)

- Continue to exceed national targets, reaching 20,869 person centred care and support plans by 2020, working collaboratively to ensure people in health and social care have one joined up plan that starts with an 'All About Me'

Primary Care Networks

Our Ambition:

Our vision is to an integrated care approach, focusing on place based care. Key characteristics are:

- A more integrated and collaborative primary care workforce, with a strong focus on partnerships – 'primary care' defined as first line services such as; general practice, public health, community providers, secondary care, mental health, voluntary sector and social care etc.
- A supported and integrated workforce with a combined focus on prevention and personalisation of care with shared and improved qualitative health and care outcomes utilising population health management data;
- Strong voice from partners working collectively to describe how clinical, social and financial drivers are aligned and focused through the ICP provider forums;
- Provision of care aligned to population of circa 30,000 and 50,000, working collectively to deliver localised care, with the ability of at scale working; maximising the economies of scale
- Patient Activation and strengthened local communities including social prescribing and self care initiatives

Our overarching aim is that Primary Care Networks will be at the heart of directing and providing health and care provision; improving the wellbeing of our local populations through proactive, accessible, coordinated and integrated health and care services.

Our Approach:

- Extended Access to Care – Deliverables of the GPF5YFV
- Population Health Management
- Integrated working
- Workforce sustainability

What have we done?

- Delivered GP Access with contracts in place across Nottingham and Nottinghamshire
- Primary Care Networks in place
- System Population Health Management Team in place
- System Primary Care Strategy developed
- PHM Expert Panels delivered with a focus on LTC
- Delivery plan for key priorities aligned to the new GP contract in place

What will we do?

- Agree a PCN/PHM/Interventions framework
- Estates review to take place as part of clinical strategy to define the "where"
- Workforce review to take place
- Implement the new GP contract
- Develop a prevention and health outcomes local delivery plan focussed on the key areas such as CVD, diabetes, stroke and cancer
- Creation of PCN specification to be adopted across the system

Phase 1:

- Adult community services – general health and mental health (those services covered in the NHCT contract)
- Enhanced primary care services
- Medicines management
- Prescribing
- Referral Support Service

- Population health management and tactical commissioning

Phase 2

- Children and young people's health services
- Adult social care

Phase 3

- Third sector commissioning

Maternity

Our Ambition:

The Nottingham & Nottinghamshire LMS vision is that Maternity services should be safe, personalised, kind, professional and family friendly. Every woman should have access to information to make informed decisions and access support centred on their individual needs and circumstances.

This will be achieved by:

- Improving choice and personalisation of maternity services so that all pregnant women have a personalised care plan and are able to make choices about their maternity care; during pregnancy, birth and postnatally.
- Most women receiving continuity of the person caring for them throughout their whole pregnancy pathway whilst identifying digital opportunities to improve access and involvement.
- Reducing the rates of stillbirth, neonatal death, maternal death and brain injury during birth by 20% by 2020/21; creating a system which is committed to learning from incidents across the ICS and with others.

Our Approach:

- Continuity of Care
- Personalised Care
- Safer carer
- Improve access to specialist Services

What have we done?

- System-wide Programme Board with workstreams established.
- Recent establishment of a PMO with new Executive Lead and Programme SRO identified. Full review of programme governance underway.
- Engagement with system wide workforce modelling (Whole Systems Partnership) alongside the Derbyshire STP.
- Close working with Connected Nottinghamshire around digital access to maternity records and improvements to current processes across both Trusts.
- Agreement of an IAPT pathway for perinatal mental health.

What will we do?

- Implementation of agreed IAPT pathway for perinatal mental health
- Delivery of national and regional trajectories, including:
- Piloting of Continuity of Carer models
- Piloting a single co-produced personalised care plan for all women across the LMS
- Co-production with women - choices information for the LMS supporting women to make unbiased choices about their care and from three settings of birth
- Start to explore potential pilot models for Continuity of Carer targeted towards women from BAME groups and those living in deprived areas.
- Responding to the recommendations of the Neonatal Critical Care Review and working with the Clinical Services Strategy work stream to determine best governance and oversight
- Implementation of maternity smoking cessation pathway (Nottingham City) and LMS wide smoking campaign

- Piloting a community hub model – separate pilots in Mid-Notts and Greater Notts with services available to meet the needs of the local population
- Review of postnatal care offer
- Continued engagement with public and staff to ensure co-production of all LMS initiatives Scoping for an LMS wide Single Point of Contact for All women and Families

Planned Care

Our Ambition:

Our ambition is that people get fast access to advice and support, self-management information, and, where needed, gets to see the right health professional as quickly as possible. We want to ensure care is delivered in a responsive and person-centred manner, and, critically, as close to home as possible.

Our objectives are:

- Deliver a 33% reduction in face to face outpatient appointments
- Deliver consistency and standardisation across planned care pathways
- Further opportunities being considered include specialty level transformation schemes, patient initiated follow ups, virtual clinics, one stop shops, specialist nurse led follow ups and shifting activity to alternative settings.

Our Approach:

- Managing Elective activity
- Pathway and model of care redesign
- Surgical Care transformation

What have we done?

- Standardised system wide community based gynaecology model and 6 most common pathways in Gynaecology agreed
- Single MSK model agreed
- Single Service Restriction Policy agreed with common prior approval system in place
- System wide Consultant to Consultant referral policy agreed.
- Health optimisation has gone live in 4 specialities in GN. Best practice surgical optimisation pathway agreed. Patient information leaflets have been updated in further languages to support health optimisation.
- Increased standardisation within diabetes with ICS wide standard approach to diabetes patient structured education in place, ICS wide Gestational diabetes pathway agreed with mobilisation underway.; high level service model drafted Ophthalmology transformation action plans submitted to NHSE in place to deliver high impact interventions
- reduce outpatient attendances and contacts which do not add patient benefit; Patient Initiated Follow Ups(PIFU) being introduced by Providers Continued to support and ensure use of standardised templates

What will we do?

- Implement MSKN pathway across whole ICS
- Commence work to realise opportunities identified by Rightcare in MSKN – Procedures
- Implement community gynaecology across whole ICS
- Identify and develop referral guidelines in an agreed number of specialties
- Implement 1 diabetic pathway across ICS
- Implement standardised advice and guidance specifications
- Implement virtual clinics in specialties not undergoing whole pathway redesign

- Implement neurology virtual clinics for chronic headaches
- Commence work in Urology and ENT pathway redesign
- Reduce 52 week waiters and reduce waiting list

Cancer

Our Ambition:

Our overarching vision is to deliver the key Cancer Taskforce Report recommendations as set out in the NHS England Cancer Strategy Implementation plan 'Achieving World-Class Cancer Outcomes Taking the Strategy Forward'

- Our aims are to:
- Increase prevention;
- Speed up diagnosis;
- Improve the experience of patients; and
- Help people living with and beyond the disease

Our objectives are:

- All NHS providers in the ICS are compliant with NICE Guidance PH48 Smoking acute, maternity and mental health services
- Improve 1 year survival rates, achieving 75% target by 20/21
- Improve early diagnosis rates to 62% by 20/21 and 75% by 28/29
- Deliver all NHS constitutional cancer waiting time standards including new 28 day referral to diagnosis target being introduced in 2019
- Ensure all elements of the Recovery Package are commissioned.
- Improve patient experience and satisfaction of services, pathways, measured via the annual National Cancer Patient Experience Survey.

Our Approach:

- Prevention
- Earlier Diagnosis
- Improving Cancer Treatment and Care

What have we done?

Prevention

- Smoking cessation service now permanently based at NUH, SFHFT and Healthcare Trust to support staff and patients quit smoking.

Early diagnosis:

- Non-specific / vague symptoms pathway piloted (as per 10 yr Plan).
- Lung MOT Service piloted in Nottingham City (as per 10 yr plan). Being expanded to Mansfield and Ashfield CCG as part of national programme.
- Good progress in implementing Direct Access Diagnostics for Primary Care, including FIT for Colorectal Cancer (one first in country).
- CCG and GP Practice cancer profiles produced highlighting variation in practice. Outliers identified.

Improving Cancer Treatment and Care:

- Improved 62 day cancer performance. Good progress in implemented National Timed Pathways for Lung, Prostate and Colorectal.
- Good progress implementing all stages of Recovery Package across ICS. Community Cancer Service piloted. Integrated IAPT service being piloted.

What will we do?

Prevention

- Expand smoking cessation service based at NUH, SFHFT and Healthcare Trust (pending funding via NHS Plan)

Early diagnosis

- Roll out Non-specific / vague symptoms pathway across ICS (as per 10yr Plan).
- Continue to roll out Lung MOT Service across City CCG and expand into Mansfield and Ashfield CCG (as per 10yr plan).
- Continue to implement Direct Access Diagnostics for Primary Care, Continue to reduce variation in CCG and GP Practice cancer metrics.

Improving Cancer Treatment and Care

- Achieve and sustain 62 day cancer performance targets partly through continued implementation of National Timed Pathways for Lung, Prostate and Colorectal.
- Monitor performance against new 28 day diagnosis target and implement plans where appropriate.
- Continue to implement all stages of Recovery Package across ICS.
- Community Cancer Service to be expanded across each ICP

Mental Health

Our Ambition:

Our aims are to:

- Reduce inequalities and narrow the gap between Severe Mental Illness life expectancy and the rest of the population by 3 years
- Increase healthy life expectancy by 3 years against the baseline
- Deliver constitutional and transformation assurance standards
- Ensure everyone can access mental health services in the right place at the right time
- Create one integrated strategic commissioning function that harmonises approaches, whilst responding to local need
- Have the workforce to deliver mental health services and ensure we have a mentally health aware workforce

Our Approach:

We have identified a set of five key strategic objectives (or 'pillars') that will frame our work:

- Establish an integrated system infrastructure
- Increase support for prevention, self-care and the wider determinates of health
- Implement a person centred approach to mental health
- Improve access to specialist services
- Achievement of the 5YFV workforce

What have we done?

- All age mental health strategy developed and approved
- Established a mental health and social care partnership board to support implementation of the strategy
- Set up task force for Out of Area Placements and Urgent Care
- Held 2 patient/carer engagement events to establish how they may contribute to the strategy going forwards.
- Held a workshop focusing on delays in transferring/discharging from inpatient mental health facilities
- Held a workshop with voluntary services in identifying how they can be best engaged in mitigating crisis.
- Group set up to focus on personal health budgets for people with personality disorder
- Feeding in mental health into the PHM/ Expert panel group – Programme Director member of this group
- Developed business case to expand IPS into Mid-Notts

- Developed a business case to expand street triage and introduce tri-triage approach with EMAS to be presented to GN and MN March 19.

What will we do?

Integrated system infrastructure

- Align Local Authority strategic commissioning resource
- meet the Mental Health Investment Standard (MHIS). Full information is in section 3.6 of the NHS Operational Planning and Contracting Guidance 2019/20.
- Commissioners develop a comprehensive picture of current activity and spend on MH cohort

Prevention, self-care and the wider determinants of health

- Link with PHM workstream with regards to risk stratification of MH population cohort incl. quantification and characterisation of cohorts
- Map staff training offer and uptake; prioritise training; provide training
- Link with prevention, person and community centred workstream to implement social prescribing (picking up debt, loneliness and low level anxiety/ depression), PHBs to be introduced in personality disorders and expand shared decision making, alcohol prevention and making every contact count
- Liaise with Suicide Prevention Partnership to identify priority areas for supprt working towards a 10% reduction in suicides by 20/21
- Each CCG, as part of an STP footprint, should ensure increased access to NICE concordant community-based specialist perinatal mental health services (in secondary care settings) for at least 4.5% of their population birth rate, equating to an additional 20,000 women nationally.
- Link with homelessness group to develop and implement action plan for homeless citizens
- Expand programme of individual placement support into Mid Notts
- Begin to scope out work being undertaken across county and city for adverse childhood experiences.

Person centred approach to MH

- Identify services in place to deliver annual physical health checks and follow up care for people living with SMI
- Link with primary care workstream in the development of place based multidisciplinary teams, sharing responsibility for monitoring and managing the physical health of people with SMI between primary and specialist mental health services
- Undertake actions identified in IAPT access recovery plans to achieve current IAPT standard. Action plan required for delivery of IAPT LTC and IAPT 22% access rates by end 19/20 – Please see attached document for further detail
- Target cognitive behavioural treatments and social interventions for those at risk due to their long term physical condition
- Link with primary care workstream in the development of Integrate mental health support with primary care and chronic disease management programmes
- Scope appropriate pathways for patients with co-existing mental health and substance misuse
- Scope feasibility of expanding current Time to Change activity into County

Improve access to specialist services

- Implement crisis/liaison and OAP/urgent care action plan this includes actions identified below:

- Transfer 16 spot purchased beds into a sub-contract in order to achieve better value and ensure care is closer to home, commence development/implement Red2Green and continuity of care
- Develop a full business case for NHT inpatient provision which is informed by other urgent mental health care pathway transformation to deliver appropriate adequate local bed provision
- Complete review and reconfiguration of current Crisis and Home Treatment Teams and mobilise new care model to ensure services meet the minimum functions of:

  (i) urgent and emergency community mental health assessment, and

  (ii) intensive home treatment as an alternative to inpatient admission, 24 hours a day, and 7 days per week
- Spread coverage of liaison mental health teams through sustained commissioning of Core24 teams by 2020/21. Progress plans for acute hospitals to have mental health liaison services that can meet the specific needs of people of all ages, including children and young people and older adults by 2020/21
- Work to ensure crisis teams meet core fidelity standards by 20/21
- Develop new care model for Local Mental Health Teams and local multi-agency urgent response
- Implement improvement plan for the Nottinghamshire Crisis House
- Implement findings of the Liaison Psychiatry Service models, ensuring continued Core 24 compliance
- CYP – undertake actions articulated in CYP recovery plan. Develop actions to support the 19/20 requirement of increasing access to 34% of estimated 2004 CYP prevalence.
- CYP – CCGs should ensure there is a crisis response 24/7 which combine crisis, liaison and intensive community support functions that meets the needs of under 18 year olds.
- CYP – Deliver against regional implementation plans to ensure that by 2020/21, inpatient stays for children and young people will only take place where clinically appropriate, will have the minimum possible length of stay, and will be as close to home as possible to avoid inappropriate out of area placements, within a context of 150-180 additional beds by 2020/21
- EIP – CCGs to ensure the 2018/19 commitment for NICE concordance for EIP from the implementation plan is met; then deliver against the further ambition for 50% of services to be graded at level 3 by the end of 2019/20

Care Homes

Our Ambition:

Our aims are to:

- Support and develop the care homes sector to deliver high quality person centred care.

To have a high quality home care provision that supports people to stay at home

Our Approach:

- Enhance primary care support
- Multi-disciplinary team support including coocrdinated health & social care
- Reablement and Rehabilitation
- High quality End of Life care and dementia care
- Workforce development
- Data, IT and technology

What will we do?

Enhanced primary care support

- Strengthen to links between GP practices and Care Homes by increasing alignment.
- Continue to work with NHSE national team to implement Medicines Optimisation in Care Homes (MOCH) to facilitate timely and structured medication reviews.
- Continue to promote the use of proactive care and extend services to reduce demand on urgent, emergency and out of hours care.
- Continue to spread vanguard recommendations such as 'Red Bags' and trusted assessor roles to facilitate prompt and efficient transfers of care.

MDT in-reach support

- Work with partners to embed proactive allocation of MDT support and resource to care home population using risk stratification indicators to focus attention and resource on those who are frail or at risk of admission to hospital and those with the greatest potential to benefit

Reablement and rehabilitation

- Work with the ICS community centred approaches team to develop community assets and mapping

High quality end of life care and dementia care

- Work with the EOL service established in MN and share learning in commissioning a GN service
- Increase use of the Electronic Palliative Care Co-ordination System (EPaCCS) to support individuals to die in their preferred place of care
- Use of advances care planning to support end of life care needs
- Work to establish an approach to identify those with dementia in care homes.
- Promote the use of 'This is Me' tool in care homes.**Joined up commissioning between health and social care**
- Work with providers of care homes services using care home forums and provider engagement events to collectively deal with issues and provide opportunities for 2-way feedback.
- Work to increase engagement from mental health, learning disability and younger adult care home and home care services.
- Articulate links between the EHCH and wider whole system initiatives such as transformation, QIPP,
- CQUIN and STP/ICS work priorities
- Scope opportunities to work with Nottinghamshire County Council to introduce a single -shared care home contract based on a similar model to the current shared care home contract with Nottingham City

Workforce development

- Understand the training and ongoing learning support options available to care home staff.
- Continue to promote engagement with recognised organisations such as Optimum Workforce Leadership, Health Education England, Skills for Care, Academic Health Science Network, East Midlands Patient Safety Collaborative and colleges and universities to support continuing professional development, career pathways and training. We will continue to encourage and promote leadership development opportunities available.
- Increase the number of nursing associates and continue to progress and enhance engagement with the 'Holistic Worker' programme.

Data, IT and Technology

- Work to understand opportunities available to advance technology in care homes to deliver technology enabled care.
- Increase the numbers of care services compliant with the Data Security and Protection Toolkit (DSPT)

Learning Disability & Autism

Our Ambition:

The Transforming Care Programme aims to transform care and support for people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition.

'Building the Right Support' is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.

As part of Building the Right Support Nottinghamshire has an established Transforming Care Partnership (TCP) with a joint ambition to reduce reliance on inpatient care through planning to reach a significantly reduced inpatient rate by March 2021. The TCP is committed to ensuring people with learning disability and/or autism get better support, whilst improving care quality and outcomes.

Across Nottinghamshire we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives.

Our Approach:

- Activity – admissions prevention
- Increased support for prevention. Self-care and the wider determinants of health
- Integrated care support & finance
- Workforce planning and development
- Communications, engagement and co-production

What have we done?

Activity – admissions and prevention

- New unplanned care model and expanded ICATT team, has successfully reduced numbers of acute admissions
- Previous inpatient provider de-registered an inpatient unit and registered as a community based service
- Successful bids for non-recurrent funding to kick start new model and absorb double running costs

Strategic and operational commissioning

- System-wide TC Programme Board with work-streams established.
- PMO with new Executive Lead and Programme SRO identified.
- Successful transfer of funding from specialised commissioning hub, distributed across the partnership using pooled budget principles.

What will we do?

Activity – admissions and prevention

- Second inpatient provider is opening a new community based service in June 19
- Increased focus on secure inpatients with forensic needs to ensure robust packages of support are available and that early discharge planning commences to reduce the overall number of NHSE inpatients

Increase Support for prevention, self-care and the wider determinants of ill health

- Increase the number of annual health checks
- Review the ATU/Locked Rehab model of care
- Evaluation of enhanced Services – ICATT, Forensics, Unplanned Care

Strategic and operational commissioning

- Strengthening alignment to the ICS
- Strengthening alignment to the Mental Health work-stream
- Delivery of national and regional trajectories/targets
- Working towards an agreed pooled budget
- Strengthen commissioning integration

Integrated Care Support and Finance

- Responding to the recommendations of the Learning Disability Mortality Reviews

Urgent & Emergency Care

Our Ambition:

There is currently a variation in the delivery of urgent and emergency care across Nottingham and Nottinghamshire. Our ambition is to achieve the same standard across the place geography. This section describes that journey from the perspective of the transformation footprints determined by the main acute providers of Nottingham University Hospitals in Greater Nottinghamshire including Nottingham city and Sherwood Forest Hospital in Mid Nottinghamshire

Greater Nottinghamshire:

Deliver urgent care system change committed to improving A&E performance to meet the national requirements and. respond to the existing and growing need from our population

- integrated planning for community, primary and acute response to urgent care need across work streams and organisations
- ensure patients get the care they need fast and in most appropriate setting; improve waits for A&E and hospital admission
- Respond to capacity challenge on acute beds by delivering key projects to improve the pathways
- Focus on workforce solutions with a whole system approach

Mid Nottinghamshire

To ensure patients access the most appropriate services to meet their health and care needs including self-care, primary care and community services. A&E will be for emergencies only. This will be achieved by:

- Primary Care led proactive identification and care planning for patients at risk of admission to hospital
- integration of resources currently spanning secondary and community services which will result in an integrated rapid response service.
- a single point of access (SPA) as well as community and A&E based rapid assessment for patients at immediate risk of acute admission with interventions including intensive home based care and / or step up community bed based care.
- proactive management of discharges into the Home First integrated discharge pathways delivering a discharge to assess approach.
- There will be a single provider for community beds with access for 'step up' and 'step down' through a SPA.
- Community bed based intensive support will be provided for 14 days with a further 14 days of home based care as required
- Implementation of the nationally mandated Integrated Urgent Care (IUC) pathway

Our Approach:

Greater Nottinghamshire:

- System wide leadership
- Admission Avoidance and pre hospital
- Improvement to length of stay and acute flow
- Improved discharge pathways

Mid Nottinghamshire:

Transformation of the end to end Urgent Care Pathway incorporating:

- A new integrated rapid response service specification with the aim to deliver a two hour community based urgent care service to prevent admission and facilitate discharge.
- More prevention, self-care and proactive care and crisis planning particularly for the frail, elderly and those living with long term conditions.
- Enhanced urgent access into general practice (primary care at scale optimisation) and further development of the Acute Home Visiting Service.
- Re-specification of A&E front door triage and streaming to facilitate discharge including signposting and direct booking into Primary Care appointments.
- Implementation of the Urgent Treatment Centre model as per the national specification at PC24 and Newark.
- Procurement of a clinical assessment service (CAS) to provide additional clinical assessment of 111 calls, supporting delivery of a safe reduction in ambulance conveyance to A&E.

Enhanced Community Services access and provision including:

- A new integrated rapid response service specification with the aim to deliver a two hour community based urgent care service to prevent admission and facilitate discharge.
- Re-specification of the community bed base to ensure an ANP led model that incorporates the HFID pathways.

Greater Nottinghamshire:

What have we done?

- Establishment of A&E delivery board to provide assurance point oversee the implementation of recovery plans, ensuring the following:
- Proactive care based on risk stratification of population
- Responsive care navigation
- Multi-disciplinary teams, based around community and Primary Care Hubs
- Intensive Recovery Model (step up/step down)
- Population access to urgent care services with 24/7 single front door services
- Full implementation of the Urgent Treatment Centre model

What will we do?

Build on the 19/20 approach to operational planning, discussing the activity modelling and challenge not just between GN CCP and NUH, but across local authority and community providers

- Confirm a detailed system wide knowledge of pathways, flow and capacity across primary, community and acute care
- Through the leadership of the A&E Delivery Board, confirm system-wide agreement to the urgent and emergency care target operating model and pathways and robust joint planning around each of the changes and monitoring of the anticipated benefit. This should include the impact of proactive care initiatives to ensure a truly integrated approach to delivering against the capacity challenge.
- To achieve the national ambition of 30% of patients receiving Same Day Emergency care which will include all diagnostic texts, treatment and care that are required being delivered in a single day to avoid unnecessary overnight hospital stays.

- A single system footprint approach for integrated urgent care, care navigation and respiratory including the procurement of a Clinical Assessment Service (CAS) and Urgent Treatment Centres (UTCs) in line with national guidance. The CAS will provide a 'consult and complete' model for patients calling 111, reducing onward referrals to other services including ambulances and A&E. It will also facilitate health and social care professionals to navigate the system. UTCs will provide face to face treatment for patients with minor injuries and illnesses. The service will be GP led and option at least 12 hours a day.

Mid Nottinghamshire

What have we done?

- Ensuring that effective risk stratification was completed across Primary Care, with a particular focus on identifying those with moderate and severe frailty
- Providing an enhanced care homes service to the homes who have the most non elective admissions to hospital
- Increasing the number of ambulatory care pathways available at PC24
- Ensuring intensive home support services available in the community are provided across all of mid Notts
- Integrating clinical navigation and intensive home support services
- Holding MDTs for those individuals who are high intensity users of services to create care plans to reduce dependency
- Commissioning and mobilising an integrated EOL service
- To increase activity through the ambulatory care unit at SFHFT
- To reduce EMAS conveyance rates to A&E
- To re-specify a number of community services

What will we do?

- Ensuring that MDTs across Primary Care are proactively reviewing those most at risk of admission (including the frail and those with long term conditions) with support from newly appointed navigators
- Providing training to care home staff so that they can proactively manage residents before they deteriorate (significant 7 project)
- Re-specifying the services provided at PC24 and Newark UCC in line with the national UTC specification
- Commissioning an integrated rapid response service across mid Notts to proactively prevent admission to and facilitate discharge from hospital
- To expand the role of the HVSU post to include a focus on alcohol dependency
- To commission a clinical assessment service to support 111 and ensure patients receive the right care first time, reducing activity at A&E
- Re-specifying community bed provision to support the HFID workstream and reduce length of stay at SFHFT
- To ensure that community services specifications are aligned across mid Notts and greater Notts

Section 5 – Financial resources

The financial allocations for the Nottingham and Nottinghamshire CCGs for the five years to 2023/24 have been confirmed as part of the NHS Long Term Plan. This means that for the first time in a number of years we have the certainty over the CCGs' collective resources that we need to allow us to set out a comprehensive medium term Financial Strategy which not only meets our short-term and longer-term financial requirements, but which also enables the CCGs to deliver their commissioning strategy, and the local health and social care system to deliver both its emerging clinical strategy, and also the vision and objectives of the NHS Long Term Plan.

To achieve all of these objectives will be very challenging, and we will need to move at pace and scale in order to do so successfully, but the high level opportunities and priorities have been identified and agreed, and we are resolved to working with system partners to ensure that we meet both our own financial targets, and also those of the wider system, whilst at the same time ensuring that the standard and quality of care for patients, and the performance of our clinical services, not only does not deteriorate, but actually improves, over this five year period.

In order to do this there are five key objectives that this Financial Strategy seeks to achieve:

1. Over the next five years, we will ensure that investment in primary care and community services will grow faster than our allocation. There will be a financial benefit from this investment as demand for emergency care will be reduced – a planned return on investment of approximately 3:1. We will ensure these investments represent value-for money, and that these services are productive and outcomes-focussed.
2. We will invest in mental health services to ensure that they grow faster than the overall CCG allocation, to enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people.
3. We will ensure that the funding is available to increase the number of planned operations and cut long waits. A digital model of outpatient services will increase productivity and efficiency whilst improving the experience for patients.
4. We will realise the financial benefits of merging six CCGs together as one, and the efficiencies that can be made both directly through more streamlined structures which avoid duplication of efforts, but also the indirect benefits of the merger – commissioning at scale and being able to direct resources in a focussed way at the CCGs' priorities in order to deliver real transformational change. Merging our six CCG's financial allocations into one also allows additional flexibility and resilience which reduces the financial risk compared to having six individual organisations each with its own control total and statutory requirement to make a surplus each year.
5. We will work with provider colleagues to ensure the system is affordable and sustainable. Without this, we will not solve the problems, and merely move the financial challenge around different parts of the system. This is not our aim, and we will adopt a collaborative approach in the delivery of this strategy.

For more information view the financial strategy.

Section 6 – How we will measure our success

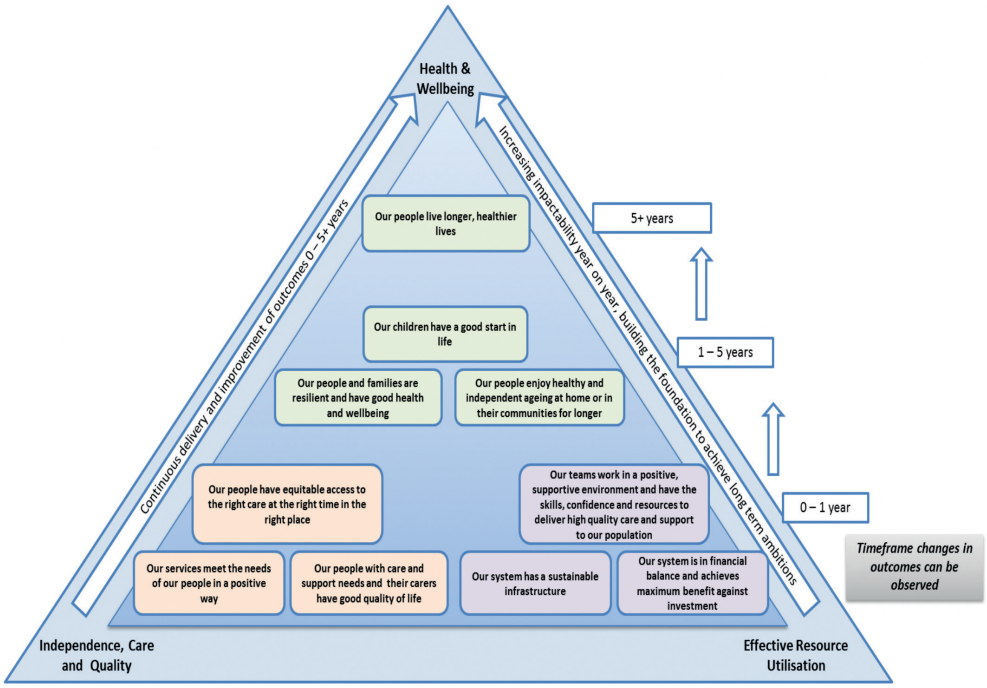
In section 3 we described our approach to population health management and the pyramid of outcomes which would support our delivery of the ICS three aims of:

- effective resource utilisation
- independence, care and quality
- health and wellbeing.

A framework has been created that defines each of the aims with ambitions we want to achieve for our population and related outcome measures. These are described in the outcomes pyramid in Figure X with the relationship of these elements detailed in table X

For more information view the quality strategy.

Fig x: Outcomes Pyramid



HEALTH & WELLBEING	
Ambitions	**System Level Outcomes**
Our people live longer, healthier lives	■ Increase in life expectancy ■ Increase in healthy life expectancy ■ Increase in life expectancy at birth in lower deprivation quintiles
Our children have a good start in life	■ Reduction in infant mortality ■ Increase in school readiness ■ Reduction in smoking prevalence at time of delivery
Our people and families are resilient and have good health and wellbeing	■ Reduction in illness and disease prevalence ■ Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population ■ Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing
Our people will enjoy healthy and independent ageing at home or in their communities for longer	■ Reduction in premature mortality ■ Reduction in potential years of life lost ■ Increase in early identification and early diagnosis

November 2019

Develop the ICS 5 year implementation plan

Ongoing

Support and facilitate the development of our ICPs(Place)and PCNs (Neighbourhood

April 2020

Establish appropriate governance between the CCG and ICPs

April 2020

Complete the analysis of population health in the initial priority areas and agree use by ICP/PCNs

April 2020

Review our existing joint agreements and evaluate effectiveness and value for money

June 2020

Use evaluation to determine what additional capability and capacity is required with strategic partners to deliver joint commissioning – joint development plan

April 2020 - ongoing

Develop a communication and engagement plan around strategic commissioning plans and delivery

April 2020

Further develop our existing working relationships with strategic partners and establish a formal joint commissioning Board

September 2020

Identify or refresh our common priorities and agree appropriate commissioning approaches

September 2020

Develop our commissioning intentions

INDEPENDENCE CARE & QUALITY	
Ambitions	**System Level Outcomes**
Our people will have equitable access to the right care at the right time in the right place	■ Reduction in avoidable and unplanned admissions to hospital and care homes ■ Increase in appropriate access to primary and community based health and care services ■ Increase in the number of people being cared for in an appropriate care settings
Our services meet the needs of our people in a positive way	■ Increase in the proportion of people reporting high satisfaction with the services they receive ■ Increase in the proportion of people reporting their needs are met ■ Increase in the number of people that report having choice, control and dignity over their care and support
Our people with care and support needs and their carers have good quality of life	■ Increase in quality of life for people with care needs ■ Increase in appropriate and effective care for people who coming to an end of their lives

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

Section 7 – How will the strategy be used

This joint commissioning strategy sets a number of challenges:

- To work in different ways with our communities
- To work together, in a much more joined-up way as commissioning organisations
- To encourage our providers to work differently with regards to the services delivered – both how and where they are delivered

In order to achieve this, the commissioning strategy must be used as a live document. We have a number of prerequisites which we must continue to develop across our system and then adopt as business as usual. We have broad ranging strategic delivery plans which need to be supported by operational delivery plans and we are seeking to achieve this in a challenging financial environment.

Appendix 1

Nottinghamshire City	Nottinghamshire County
The latest estimate of the City's resident population is 329,200 (Mid-Year Estimates 2017), having risen by 4,400 since 2016.	The latest estimate of the County's resident population is 817,900 (ONS mid-year estimate 2017).
The City continues to see a large amount of population 'churn', with 30,600 people arriving from elsewhere within the UK and 31,800 leaving.	The number of people living in Nottinghamshire increased by 5% between the Census of 2001 and 2011 to 785,800 and is expected to increase by a further 6% to 836,000 by 2021 (ONS 2016-based Resident Population Projections)
Population projections suggest that this may rise to around 344,300 by 2027. International migration (recently from Eastern Europe) and an increase in student numbers are the main reasons for the population growth since 2001, together with the excess of births over deaths.	The main reasons for the population increase from 2016 to 2017 are primarily an increase in net migration of people from both other areas of the UK (internal migration – additional 4,400 persons) and abroad (international migration – additional 1,600 persons), and an increase in life expectancy due to natural change (births minus deaths – additional 391 persons) in the population.
29.6% of the population are aged 18 to 29 – full-time university students comprise about 1 in 8 of the population.	Our population is predicted to continue to age over the next 5 years to 2021, with the population aged over 65 expected to increase from 167,400 in 2017 to 178,400 in 2021 (a 6.6% increase). Similarly the population aged over 85 in the county is expected to increase from 20,900 in 2017 to 22,500 in 2021 (an 8% increase) (source: ONS 2016-based Subnational Population Projections).
In the short to medium term, the City is unlikely to follow the national trend of seeing large increases in the number of people over retirement age, although the number aged 85+ is projected to increase.	Older people are more likely to experience disability and limiting long-term illnesses, particularly if they provide unpaid care for 50 or more hours per week (JSNA chapter: Carers).
The number of births has risen in recent years until 2011 but the numbers have slowly declined since then.	More older people in Nottinghamshire are anticipated to live alone; increasing by 41% between 2015 and 2030 (POPPI).
The 2011 Census shows 35% of the population as being from BME groups; an increase from 19% in 2001.	Black and minority ethnic (BME) populations are relatively low in Nottinghamshire, 4% compared with 15% nationally. BME populations in Nottinghamshire generally have a younger age profile than the general population (Census 2011).

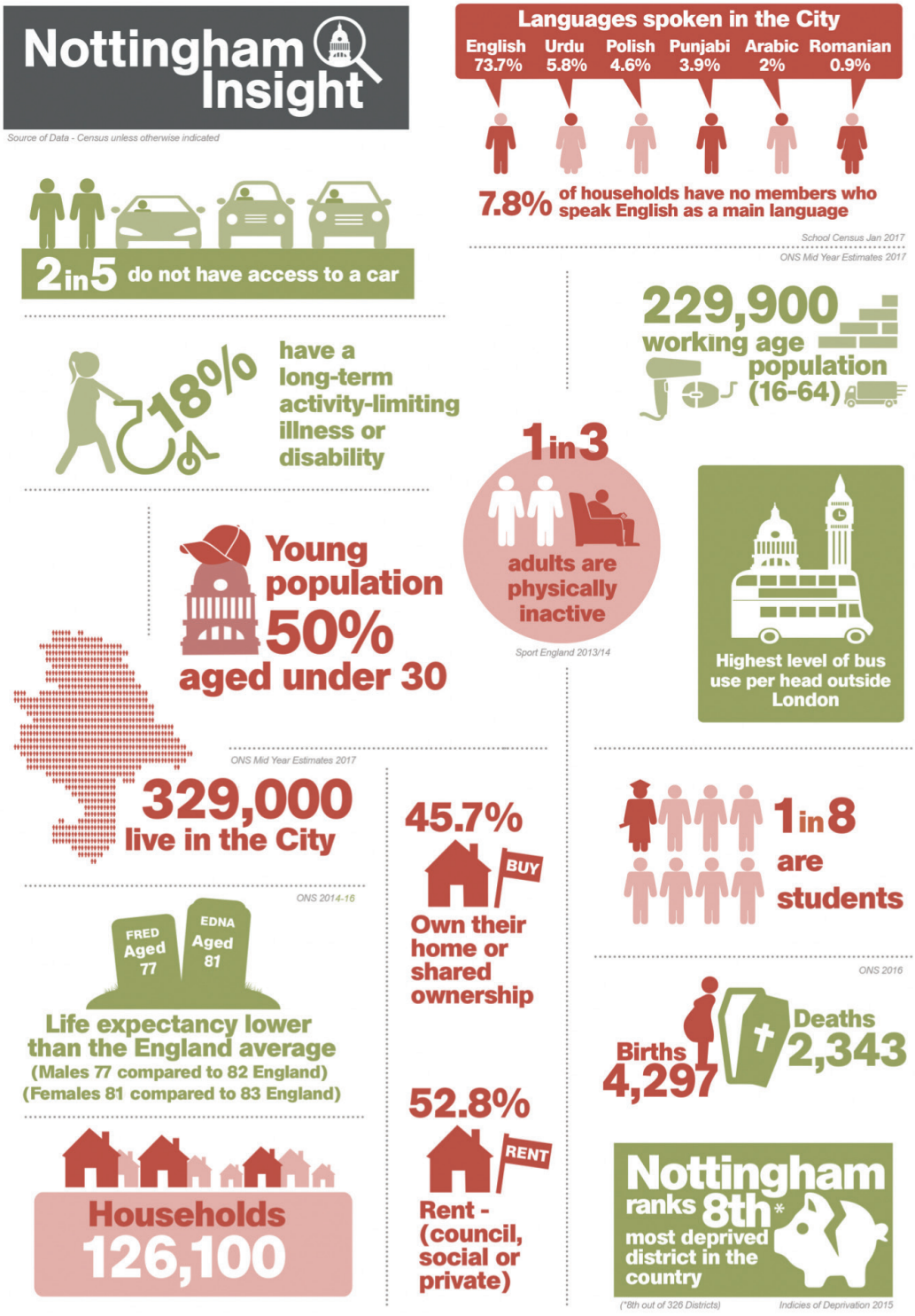
Appendix 1

Nottinghamshire City	Nottinghamshire County
Despite its young age-structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability.	Job Seekers Allowance claimant rate in Nottinghamshire is historically lower than national levels, but in May 2018 it is 1.1% which is the same as the national figure (NOMIS).
White ethnic groups have higher rates of long term health problems or disability overall, although this varies with age, with some BME groups having higher rates in the older age-groups.	For those aged 18-24 years, unemployment rates have been higher than national levels for 8 of the past 9 years and were 1.3% in May 2018, compared with 1.0% nationally (NOMIS).
The City gains young adults due to migration, both international and within Britain, whilst losing all other age groups - this includes a net loss of families with children mostly through moves to the surrounding districts.	Dominant mosaic groups which make up over half of all households include: E Suburban Stability, H Aspiring Homemakers, F Senior Security, K Modest Traditions, L Transient Renters (Customer Insight).
There is a high turnover of population – 21% of people changed address in the year before the 2011 Census.	Deprivation levels for Nottinghamshire as a whole are comparable with England. However, within Nottinghamshire there are communities with both some of the highest levels of deprivation in the country and some of the lowest levels of deprivation (IMD 2015).
Nottingham is ranked 8th most deprived district in England in the 2015 Indices of Multiple Deprivation (IMD), a relative fall from 20th in the 2010 IMD.	In Nottinghamshire there are 25 areas, known as LSOAs, in the 10% most deprived areas in England. The most deprived areas are concentrated in the districts of Ashfield (9), Mansfield (6), Bassetlaw (6) and Newark & Sherwood (3).
Around a third of super output areas in the City are in the worst 10% nationally (IMD 2015).	People living within the more deprived areas of Nottinghamshire have higher levels of unemployment, lower levels of qualifications, less healthy lifestyle choices and poorer health and wellbeing outcomes compared with those in less deprived areas (JSNA chapter: The People of Nottinghamshire).
34.2% of children and 25.8% of people aged 60 and over are affected by income deprivation.	
Health and Disability is the Indices of Deprivation domain on which Nottingham does worst, followed by Education, Skills & Training and Crime.	

Appendix 1

Nottinghamshire City	Nottinghamshire County
The dominant Mosaic groups in Nottingham are Groups J, L, M, O and N. (See the Mosaic and customer insight pages)	
A higher proportion of people aged 16-64 in Nottingham claim some form of benefit than regionally and nationally. See the latest Quarterly Benefits Bulletin.	
The unemployment rate is lower than the recent peak in March 2012, but remains higher than the regional and national average. See the latest Monthly Unemployment Note.	
Residents who live in the City have a lower average income than people who work in the City. See the latest Summary of the Annual Survey of Hours and Earnings.	
Despite large numbers of students, Nottingham has a higher proportion of people of working age with no qualifications, compared with the national average. See the latest Quarterly Indicators summary.	
There are high levels of child poverty in the City with around a third of children and young people living in workless households. See the latest Child Poverty note.	
Rates of car ownership are low, particularly amongst pensioners living alone and lone parents. See the 2011 Census data page.	

Appendix 2


Nottingham Insight
Source of Data - Census unless otherwise indicated
Languages spoken in the City
English 73.7%
Urdu 5.8%
Polish 4.6%
Punjabi 3.9%
Arabic 2%
Romanian 0.9%
7.8% of households have no members who speak English as a main language
School Census Jan 2017
ONS Mid Year Estimates 2017
2 in 5 do not have access to a car
229,900 working age population (16-64)
18% have a long-term activity-limiting illness or disability
1 in 3 adults are physically inactive
Sport England 2013/14
Young population 50% aged under 30
Highest level of bus use per head outside London
ONS Mid Year Estimates 2017
329,000 live in the City
45.7% BUY Own their home or shared ownership
1 in 8 are students
ONS 2014-16
FRED Aged 77
EDNA Aged 81
Life expectancy lower than the England average
(Males 77 compared to 82 England)
(Females 81 compared to 83 England)
ONS 2016
Births 4,297
Deaths 2,343
52.8% RENT Rent - (council, social or private)
Households 126,100
Nottingham ranks 8th* most deprived district in the country
(*8th out of 326 Districts)
Indicies of Deprivation 2015