Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Meeting of Integrated Care Board Board

Date: Thursday 16th January 2025
Time: 09:30 – 12:00
Location: Virtual, via Microsoft Teams

Agenda Number:	6.1	
Title:	Update on the new Integrated Care Board (ICB) committee – Strategic Health Inequalities, Prevention, and Population Health (SHIPPH)	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No
Purpose: For Information		
Key Points for Discussion:		
A brief summary of the key updates in the main paper. • Background to the new Strategic Health Inequalities, Prevention, and Population Health (SHIPPH) committee. • The purpose, scope, and membership of the committee. • Progress made so far – the inaugural meeting of the committee was held in October 2024, with a second meeting held in December 2024. • The priority areas that the committee will initially focus on. • Terms of Reference and next steps to establish the committee.		
Recommendations:	The board are asked to: • Note proposed changes to the Scheme of Reservation and Delegation to formalise the committee as a subcommittee at the ICB board.	

	• Consider and approve the SHIPPH Terms of Reference, which have now been finalised by the committee. These are included in Appendix 1. • Note that the ICB Board will now receive regular updates from the chair of the committee.
Previously Considered By and feedback:	The development of the committee has been discussed with various system groups. This includes: - System Executive Group (SEG) – 21st November 2024 - ICB Board development seminar on health inequalities – 7th November 2024 - The inaugural meeting of the SHIPPH committee – 8th October 2024 - Strategic Prevention Oversight Group (SPOG) – summer 2024 - Population Health Improvement Leadership Group – summer/autumn 2024 - Community Health and Care Improvement Group (HCIG) – session on Long Terms Conditions. July 2024.
Management of Declared Interest:	No potential or actual conflicts identified.
Risk and Assurance:	The developments described in this update are intended to strengthen assurance around prevention activities and work to tackle health inequalities. The risk of the new committee is that health inequalities and prevention are seen as separate issues, rather than relevant for all ICB board committees. This will be mitigated by the committee and the Terms of Reference being clear that they do not replace the wider duty on all committee and other system groups to consider health inequalities and prevention.
Financial / Resource Implications:	No financial implications are identified as part of this update. The running and co-ordination of the committee will be resourced by the ICB Health Inequalities and Prevention team.
Legal, Policy and Regulatory Requirements:	The progress described in this paper will help the ICB to fulfil both its equality and health inequalities legal duties and regulatory requirements.
How does this reduce Health Inequalities:	This update is focused on reducing health inequalities.

How does this impact on Equality & diversity	The committee membership has been designed with inclusivity and diversity as a priority. This will ensure a broad and wide-ranging discussion on any issues which impact on population equality and diversity.
Patient and Public Involvement:	There has been no public involvement in the development of this paper. However, as part of establishing the committee, we have appointed four public contributors who are part of the core membership of the group.
Communications and Engagement:	Work is underway with ICB Communications team to develop a plan for the committee's communication and engagement requirements.
Author(s):	Zoe Rice, ICB Programme Manager for Population Health and Dr Joanne Medhurst, ICB Chief Medical Officer
Sponsoring Director / Clinical Lead / Lay Member:	Dr Joanne Medhurst, ICB Chief Medical Officer

Agenda item: 6.1

Update on the new ICB Board committee – Strategic Health Inequalities, Prevention, and Population Health (SHIPPH)

1. Background

In March 2024, the Integrated Care Board (ICB) Board considered four questions about progress towards tackling health inequalities:

1. Are we content with evolution as a method of improvement?
2. Are we sufficiently focused on actions in the present?
3. As leaders are we ensuring that all proposed changes and service delivery are looked at through an inequality lens?
4. Are we doing enough to support staff?

The board agreed that further work was needed to strengthen and accelerate progress towards tackling health and healthcare inequalities. Without this, significant parts of our population may continue to struggle to start well, live well, age well, and die well, with the subsequent impact on key outcome measures such as mortality.

The board supported embedding a greater focus on health inequalities across the ICB.

In response to this, a new subcommittee of the ICB Board has been established to provide oversight and assurance in relation to health inequalities, prevention, and population health.

The committee held its inaugural meeting in October 2024.

This paper provides an update on the committee, building on discussions at the November ICB board seminar on health inequalities.

2. Purpose and scope

The purpose of the committee is to provide oversight, and assurance of the Integrated Care System's efforts towards tackling health inequalities and embedding preventative approaches.

Included within this scope are:

- Addressing health and healthcare inequalities
- Embedding a culture of prevention and preventative approaches
- Delivery of Long Term Plan commitments on healthy weight, treating tobacco dependency, and alcohol and other drugs

- Inclusion health[1], including migrant health
- Vaccinations and immunisations
- Long term conditions

It is recognised that there are already some specific health inequality-focused improvement programmes underway across our Integrated Care System (ICS) which have established oversight and assurance arrangements in place. For example: within the Local Maternity and Neonatal System; issues being dealt with through the Mental Health and Autism Health and Care Improvement Group (HCIG); the South West Advisory Group (SWAG) Cancer Alliance.

The committee will not look to replace these oversight and assurance arrangements. Instead, the committee will prioritise other areas of focus, where there is currently limited/no system oversight in place.

While the committee is primarily focused on assurance, it also holds responsibility for the delivery of ICS Strategy Commitments to:

- Develop an overarching approach to prevention
- Developing a whole system approach to healthy weight
- Develop a whole system approach to Smokefree BNSSG (focused on reducing the harms from tobacco)
- Develop a whole system approach to alcohol and drugs

3. Membership

The membership is designed to be representative of our system.

As part of establishing the committee, four public contributors have been recruited to act as critical friends, using their experiences and knowledge to bring an alternative perspective and voice to this committee.

The committee is chaired by the ICB Chair, with core membership as follows:

Role	**Organisation / Group if applicable**
Chair (Chair of committee)	BNSSG Integrated Care Board (ICB)

[1] Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence, and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma, and Traveller communities, sex workers, people in contact with the justice system, and victims of modern slavery. NHS England » Inclusion health groups

ICB Executive lead (*Chief Medical Officer / Chief Transformation and Digital Information Officer)	BNSSG Integrated Care Board (ICB)
Chief Nursing Officer	BNSSG Integrated Care Board (ICB)
Head of Quality and Clinical Excellence	BNSSG Integrated Care Board (ICB)
Public Contributors – 4 roles	N/A
VCSE Chief Officer members x 4	For All Healthy Living Wellspring Settlement The Care Forum Wesport
Chair	ICB Independent Advisory Group on Race Equality
Director of Public Health	Bristol City Council
Director of Public Health	North Somerset Council
Director of Public Health	South Gloucestershire Council
Consultant in Public Health Medicine – Population Health	BNSSG Integrated Care Board / System
Medical Director	General Practice Collaborative Board
Chief Officer	Local Pharmaceutical Committee
Chief Nurse and Allied Health Officer	Sirona Care and Health representative
Associate Director of Strategy	North Bristol NHS Trust
Deputy Medical Director	University Hospitals Bristol and West NHS Foundation Trust
Director of Business Development and Improvement	University Hospitals Bristol and West NHS Foundation Trust
To be confirmed	Mental health representation
Vice Chair	Avon Local Optical Committee
Locality Director	Locality Partnership representative
Clinical Informatics Cabinet Chair Intelligence Centre Clinical Co-lead	System roles

4. Progress so far and initial areas of focus

The committee has now met on two occasions. At the inaugural meeting the group focused on:

- The rationale behind, and the aims and ambitions of the committee.
- Priorities for the committee in the context of national legislation, police and guidance.
- Agreeing ways of working.

Figure 1: Sketch note of discussions from the inaugural committee meeting, October 2024

Initial areas of focus

A forward planner for the committee has been developed, setting out the initial areas of priority focus:

- Approving the Joint Forward Plan submissions for the overarching approach to prevention, healthy weight, Smokefree BNSSG, and alcohol and drugs.
- Healthy Weight – Healthy Weight Declaration and pathway scoping and potential redesign.
- Cardiovascular disease – through an inequalities lens. This will include approving an Equality Objective focused on Cardiovascular disease.
- Developing use of the outcomes framework to track progress with long term conditions, health inequalities and embedding preventative approaches.
- Review of NHS England - The insightful ICB board and consideration of how the committee incorporates this new guidance into ways of working.

5. Next steps

1. The ICB board are asked to note the proposed changes to the Scheme of Reservation and Delegation to formalise the SHIPPH as a subcommittee at the ICB board.
2. The Terms of Reference have now been finalised by the committee. The board are asked to approve these.
3. ICB Board to receive regular updates from the chair of the committee.

Appendices

Appendix 1 – Terms of Reference for the SHIPPH Committee

Glossary of terms and abbreviations

Integrated Care Board (ICB)	The NHS organisation responsible for planning health services for their population.
Integrated Care System (ICS)	Integrated Care Systems bring together a range of partner organisations to help people stay happy, healthy and well for longer. Integrated Care Systems are designed to ensure that health and care services join up around individual needs – breaking down the boundaries between physical health, mental health and social care services. Integrated Care Systems have four key aims: • Improving outcomes in population health and healthcare • Tackling inequalities in outcomes, experience and access • Enhancing productivity and value for money • Helping the NHS to support broader social and economic development.
Health and Care Improvement Group (HCIG)	One of the types of groups in BNSSG that brings together partners to improve outcomes for our population. There are four of them: improving outcomes through effective and efficient hospitals; improving the lives of people living in our communities; improving the lives of people with mental health, learning disabilities and autism; improving the lives of our children.
Health inequalities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.
NHS Long Term Plan	The NHS Long Term Plan is a plan to improve and reform the NHS. It was published in January 2019 by NHS England.

Voluntary, Community, and Social Enterprise (VCSE)	A broad range of organisations that work for a social purpose, including charitable organisations, community-based groups, and community interest companies.

Strategic Health Inequalities, Prevention and Population Health (SHIPPH) Committee

Terms of Reference – 12.12.24

1. Introduction

Constitution
The Strategic Health Inequalities, Prevention, and Population Health Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the ICB website, set out the membership, the remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the Board. The Committee is a non-executive chaired committee of the Board and its members are bound by the Standing Orders and other policies of the ICB.

Purpose
The aims of the ICB are to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The purpose of the SHIPPH committee is to provide oversight, assurance and support for the ICS's efforts towards tackling health inequalities and embedding preventative approaches.

Included within this scope is:

- Addressing health and healthcare inequalities
- Embedding a culture of prevention and preventative approaches
- Delivery of Long Term Plan commitments on healthy weight, treating tobacco dependence, and alcohol and other drugs
- Inclusion health[1], including migrant health
- Vaccinations and immunisations
- Long term conditions

[1] Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery. NHS England » Inclusion health groups

From here on, when referring to tackling health inequalities and prevention, this will include all the above areas.

While the committee is primarily focused on assurance, it also holds responsibility for the delivery of ICS Strategy Commitments to:

- Develop an overarching approach to prevention
- Developing a whole system approach to healthy weight
- Develop a whole system approach to Smokefree BNSSG (focused on reducing the harms from tobacco)
- Develop a whole system approach to alcohol and drugs

The ICB Chief Medical Officer is the accountable officer for the delivery of these programmes, and the chair of the committee will lead the assurance around this.

It is recognised that there are already some specific health inequality-focused improvement programmes underway across our Integrated Care System (ICS) which have established oversight and assurance arrangements in place. For example: within the Local Maternity and Neonatal System; issues being dealt with through the Mental Health and Autism Health and Care Improvement Group (HCIG); the South West Advisory Group (SWAG) Cancer Alliance.

The committee will not look to replace these oversight and assurance arrangements. Instead, the committee will prioritise other areas of focus, where there is currently limited/no system oversight in place.

2. Delegated authority

The SHIPPH Committee is a formal committee of the ICB. The Board has delegated authority to the Committee as set out in the Scheme of Reservation and Delegation and may be amended from time to time. The SHIPPH Committee holds only those powers as delegated in these Terms of Reference as determined by the ICB Board.

3. Membership

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

The Board will appoint no fewer than four members of the Committee including one who is a Non Executive Member of the Board (from the ICB) and will act as Chair.

Other attendees of the Committee need not be members of the Board, but they may be, and will be drawn from ICB Partner or Other members (as outlined in the Constitution). When determining the membership of the Committee, active consideration will be made to equality, diversity and inclusion. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Chair

If a Chair has a conflict of interest another member of the Committee will be responsible for deciding the appropriate course of action. In the absence of the Chair, the remaining members present shall elect one of their number Chair the meeting.

The core membership will be as follows:

Role	**Organisation / Group if applicable**
Chair (Chair of committee)	BNSSG Integrated Care Board (ICB)
ICB Executive lead (*Chief Medical Officer / Chief Transformation and Digital Information Officer)	BNSSG Integrated Care Board (ICB)
Chief Nursing Officer	BNSSG Integrated Care Board (ICB)
Head of Quality and Clinical Excellence	BNSSG Integrated Care Board (ICB)
Public Contributors – 4 roles	N/A
VCSE Chief Officer members x 4	For All Healthy Living Wellspring Settlement The Care Forum Wesport
Chair	ICB Independent Advisory Group on Race Equality
Director of Public Health	Bristol City Council
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Director of Business Development and Improvement	University Hospitals Bristol and West NHS Foundation Trust
To be confirmed	Mental health representation
Vice Chair	Avon Local Optical Committee
Locality Director	Locality Partnerships
Clinical Informatics Cabinet Chair Intelligence Centre Clinical Co-lead	System roles

4. Administration

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

Each meeting will focus on a specific topic, enabling a deep dive. According to the topic being discussed, additional people will be invited to attend the meeting.

A forward planner will be developed to set out the topics of focus for SHIPPH over a 12 month cycle.

5. Decision making and quoracy

The quoracy needed for decision making is the following (who may nominate a deputy to attend in their absence): Non-Executive Director, Chief Medical Officer, Chief Nursing Officer/Chief Transformation and Digital Information Officer, one Director of Public Health, one public contributor, one provider representative, and VCSE representative.

Decision making and voting

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote. The result of the vote will be recorded in the minutes.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6. Frequency of meetings

The SHIPPH Committee will meet every two months. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

Of the six meetings per year, four of these will take place in person, two will take place on online.

7. Remit and responsibilities

The SHIPPH Committee will be responsible for:

Oversight

- Overseeing delivery of national requirements and strategy commitments related to health inequalities and prevention. This includes overseeing delivery of Joint Forward Plan. See Appendix 1 for summary of national legislation and policy requirements.
- Defining and agreeing the scope, at macro level, of the ICS's work to address health inequalities and embed prevention.
- Flagging how the HCIGs and other system groups are making progress towards the health inequality and prevention strategy commitments within that macro scope including wider obligations, such as Core20Plus5 adults and children and young people. The group will do this through supporting a cycle of continuous learning and improvement, as shown in the ICS governance arrangements in figure 1. Reviews will include recommendations for actions. Reviews will be shared with the Health and Care Professional Executive (HCPE) who will have this as a standing agenda item. The HCPE members will discuss the review and the outputs of that discussion will be fed into the HCIGs through either the Chief Medical Officer or Chief Nursing Officer.
- Annual review of Migrant Health service performance reports and plans for following year.

Decision making

- The SHIPPH committee does not hold a budget. However, the committee will offer a system view to inform decision making on any health inequalities and prevention monies held by the Chief Medical Officer.

Leadership, navigation, supporting learning and cultural change

- Holding the ICS to account in relation to its work to tackle health inequalities and improve prevention activities.
- Supporting the ICS in its strategic prioritisation of health inequalities and prevention improvement activities.
- Using its members to help enable progress where appropriate
- Offering support and guidance to the HCIGs and other improvement groups. The Population Health Improvement (PHI) Group will be available as a system asset to support this.
- Helping to align partners' efforts, e.g. by identifying opportunities for more collaboration
- Encouraging system decision-making and improvement groups to share work that has been successful / is being tried. Also, to share what they have tried that hasn't worked as well as they hoped.
- Sharing and promoting learning, good practice, and new publications/guidance.
- Identifying, through various sources of information including members of the group's own experiences and reflections, where changes may need to be made to increase the impact of health inequalities improvement work
- Supporting cultural change towards everyone involved in health and social care understanding the part they can play in supporting the population to live well and reducing health inequalities.
- Supporting the development of our workforce focused on prevention and health inequalities.
- Offering support and guidance to system decision-making and improvement groups in their work to address health inequalities

Delivery

- Delivery of the NHS Long Term Plan prevention programmes – whole system approaches to harmful alcohol use, healthy weight, tobacco control.

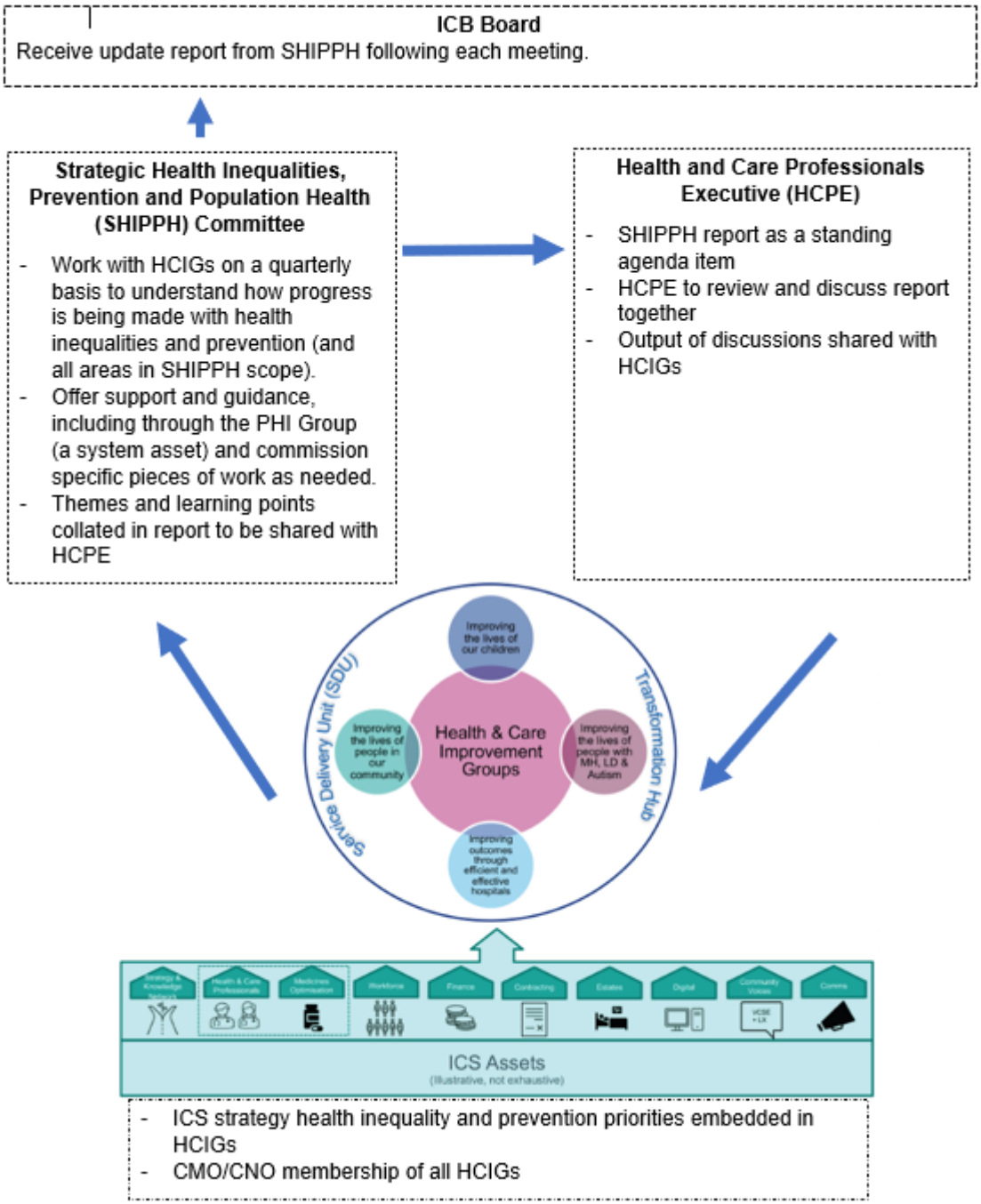


Figure 1: Proposed continuous learning approach for overseeing Health and Care Improvement Groups (HCIGs) progress with health inequalities and prevention

To track progress, the SHIPPH will identify and monitor a set of key outcomes using the BNSSG System Outcomes Framework, the Public Health Outcomes Framework and any other relevant outcomes framework.

8. Approach – individual and collective

Population health approach

The SHIPPH Committee will take a population health approach, recognising that there are a wide range of determinants of health and wellbeing, many of which lie beyond the reach of health and care services (The King's Fund). An emphasis on reducing inequalities in health as well as improving health overall is core to population health approaches.

> An approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people within and across a defined local, regional or national population, while reducing health inequalities. It includes action to reduce the occurrence of ill health, action to deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.
>
> Buck et al 2018, p 18

Figure 2: The King's Fund definition of Population Health

A population health approach recognises that to improve health and wellbeing, action is required across the following four pillars and in particular the interfaces and overlaps between them (see figure 3):

- An integrated health and care system
- The places and communities we live in, and with
- Our health behaviours and lifestyles
- The wider determinants of health, including housing, employment, environment

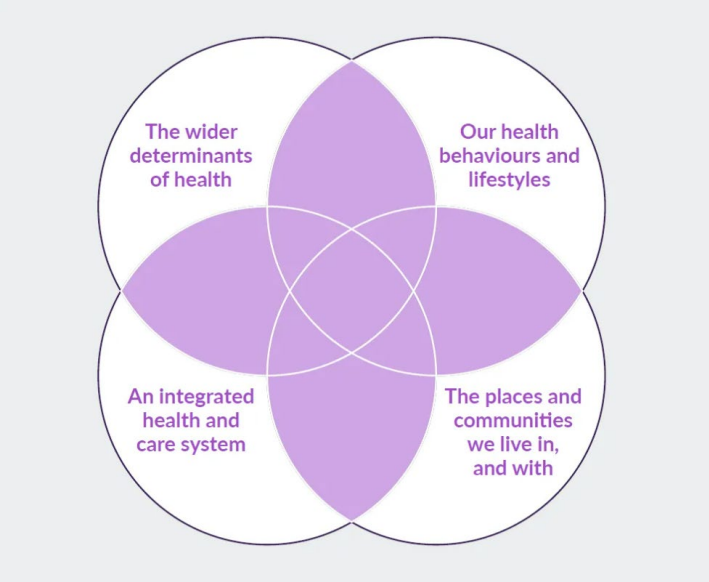


Figure 3: A Population health system

Within the context of an Integrated Care System, when working on health inequalities and prevention, it is recognised that partners will have different roles, including acting as lead, partner, contributor, and advocate. This is shown below for the NHS's role in prevention.

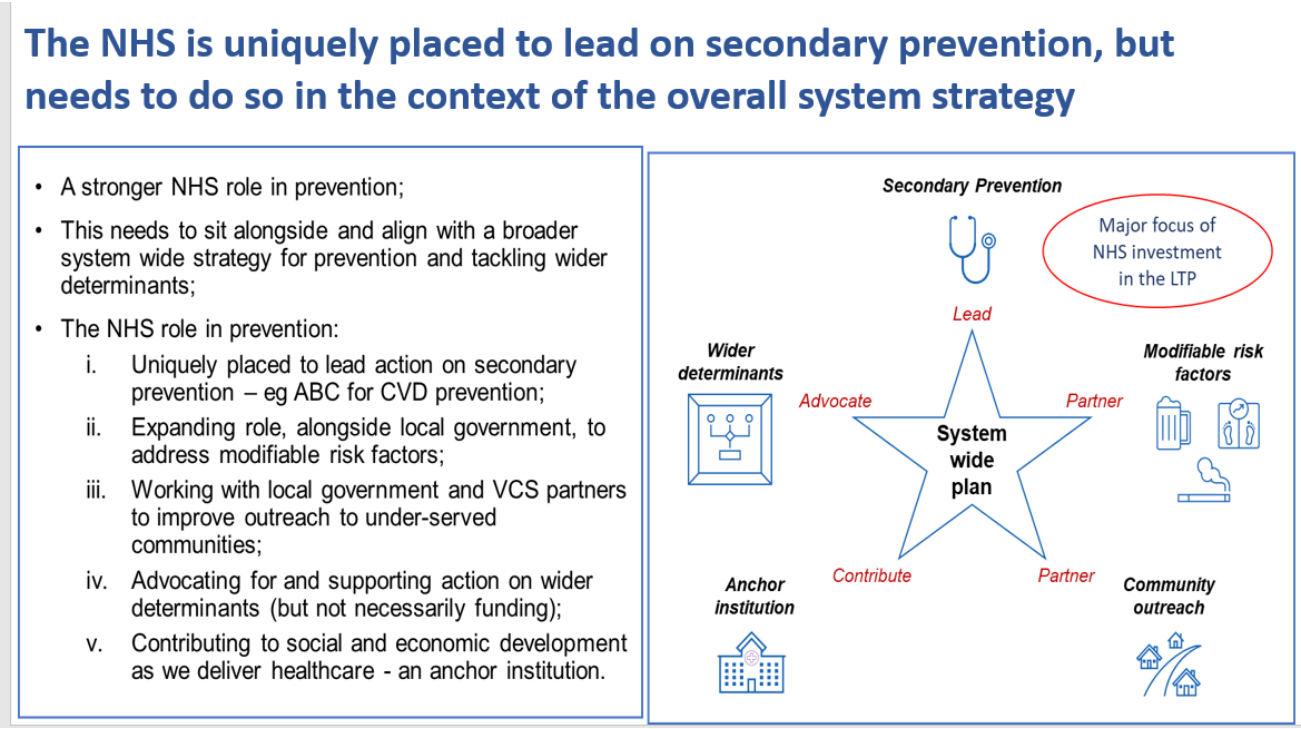


Figure 4: NHS role in prevention (Sarah Price, Director of Public Health, NHS England)

Continuous improvement

The SHIPPH Committee will adopt a consistent approach to improvement, using the FOCUS-ON method shown in Figure 5. This approach is aligned to Population Health Management and combines co-creation with our communities with a continuous improvement and learning approach.

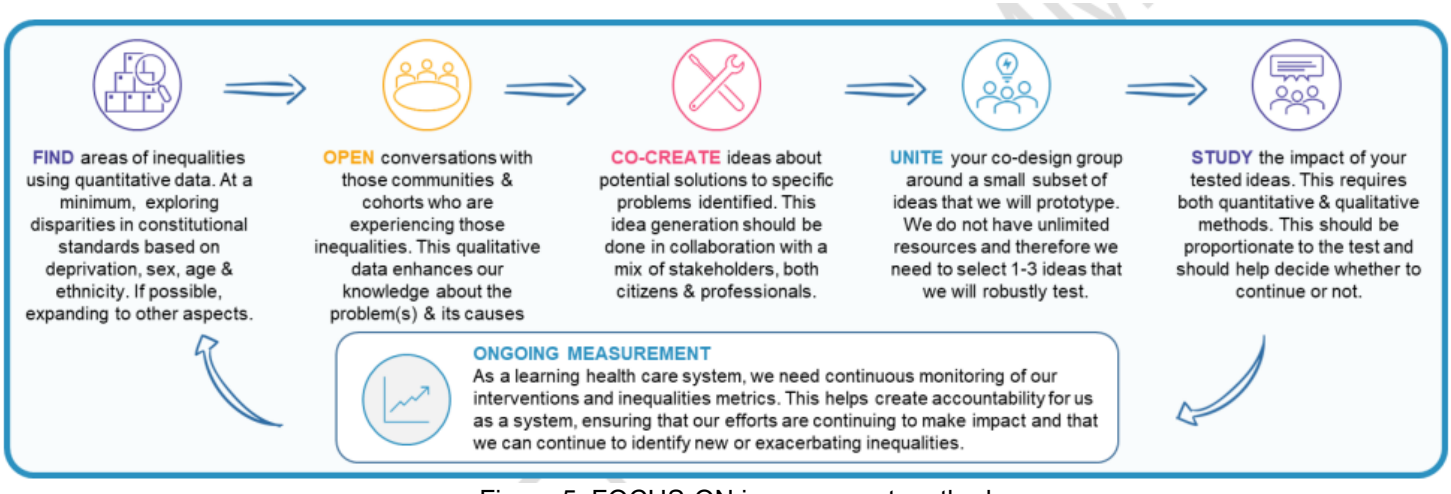


Figure 5: FOCUS-ON improvement method

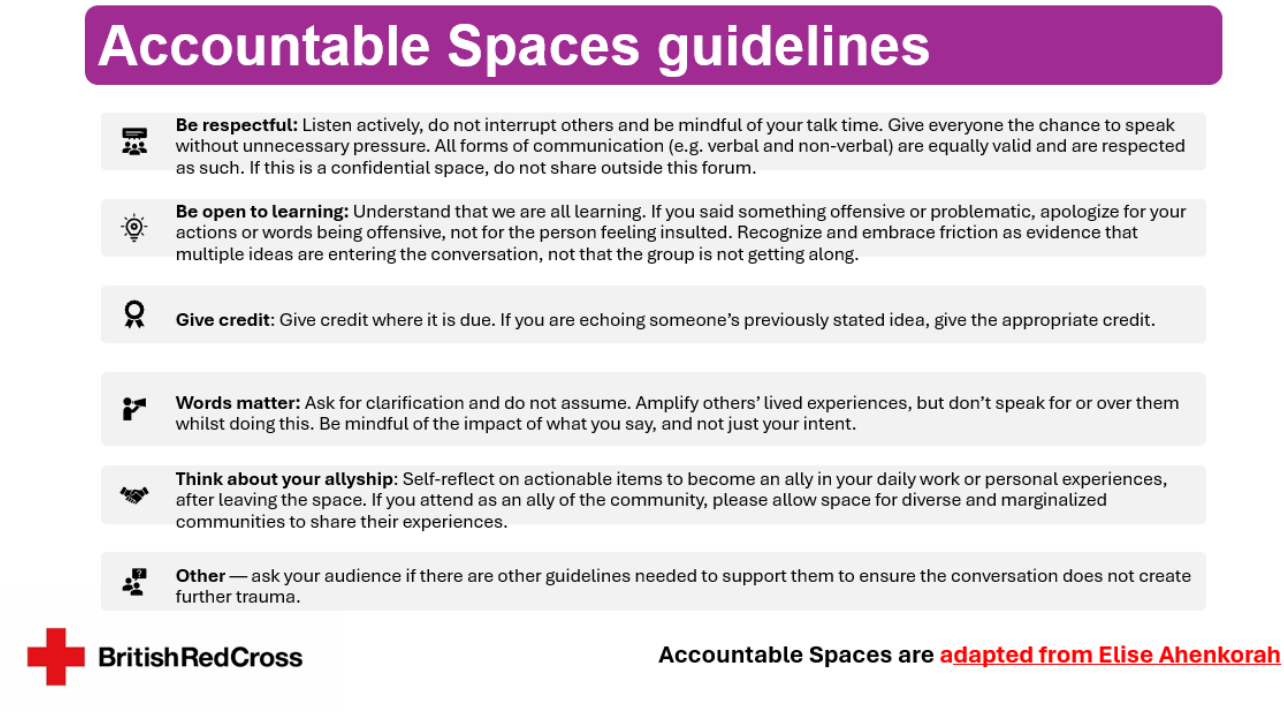
Trauma informed

Understanding the impact of trauma, its impact on people's health and wellbeing and how we can shift towards a trauma-informed approach is crucial to reducing health inequalities and embedding prevention. The SHIPH will utilise the BNSSG Trauma-Informed Practice Framework to support this approach.

9. Working together

The SHIPPH Committee will adopt the Accountable Spaces[2] guidelines as principles for how we work together.

> "Accountability means being responsible for yourself, your intentions, words, and actions. It means entering a space with good intentions but understanding that aligning your intent with action is the true test of commitment."
>
> *Elise Ahenkorah "Safe and Brave Spaces Don't Work (and What You Can Do Instead)"*



[2] "Safe and Brave Spaces Don't Work (and What You Can Do Instead)" | by Elise Ahenkorah (she/her) | Medium

10. Reporting Requirements

The SHIPPH Committee is directly accountable to the ICB Board.

The minutes of meetings shall be formally recorded. The Chair of the Committee shall report to the Board (public session) after each meeting.

Following each meeting, a briefing will be produced to support sharing key points/outputs across the ICS.

Figure 6 below shows how the SHIPPH Committee will connect with ICB and ICS operating, decision making and oversight arrangements.

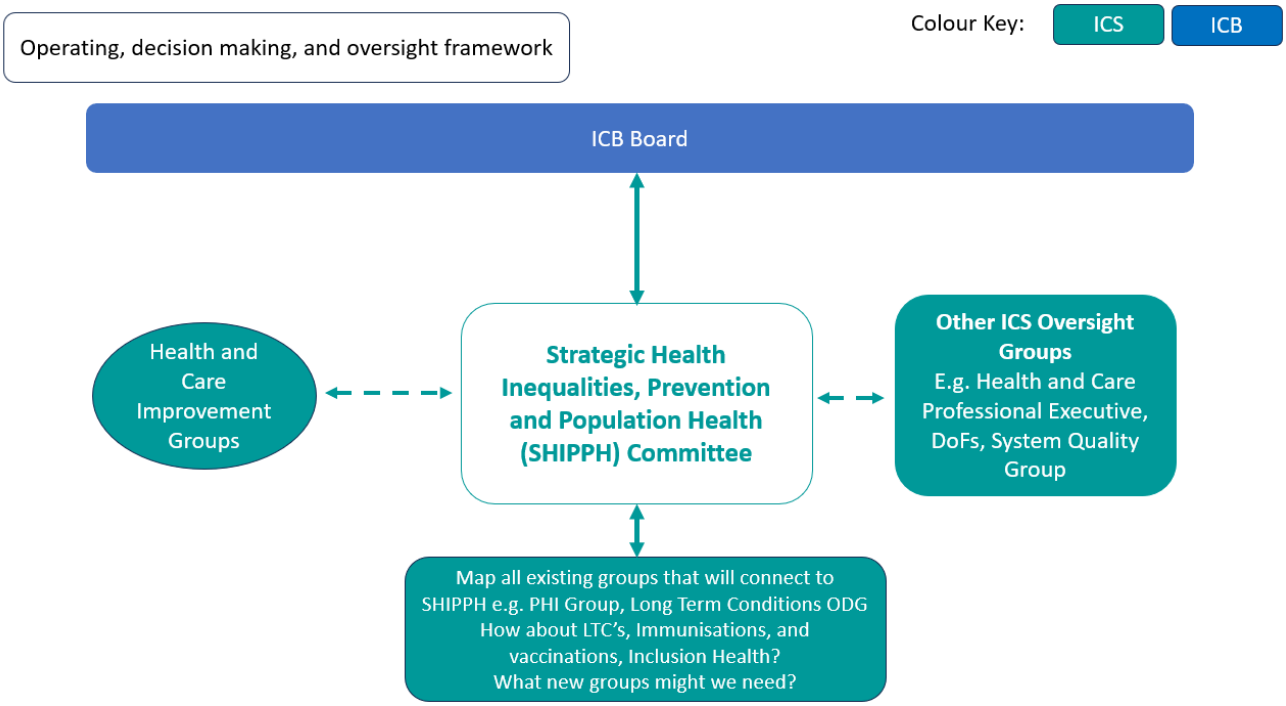


Figure 6: How SHIPPH Committee connects with ICB and ICS operating, decision making and oversight arrangements.

11. Review of Terms of Reference

The Committee will review its effectiveness at least annually and complete an annual report submitted to the Board. These terms of reference will be reviewed after six months and at least annually thereafter.

Any proposed amendments to the terms of reference will be submitted to the Board for approval.

The Committee will utilise a continuous improvement approach in its delegation and all members will be encouraged to review the effectiveness of the meeting at each sitting.

Appendix list:

Appendix 1: Summary of national legislation, policy and guidance relating to health inequalities and prevention.

Appendix 1:

Legislation, policy, guidance	Key duties/requirements
Public Sector Equality Duty *Public Sector Equality Duty: guidance for public authorities - GOV.UK (www.gov.uk)*	The duty is a statutory duty on listed public authorities and other bodies carrying out public functions. It ensures that those organisations consider how their functions will affect people with different protected characteristics. These functions include their policies, programmes, and services. The duty supports good decision-making by helping decision-makers understand how their activities affect different people. It also requires public bodies to monitor the actual impact of the things they do. For example, to keep under review how different groups of pupils are performing at school and to identify and take action if some pupils with protected characteristics need more support than others.
Health and Care Act 2022 *Health and Social Care Act 2022 - CF (carnallfarrar.com)*	NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas: • health and wellbeing for people, including its effects in relation to inequalities. • quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services. • the sustainable use of NHS resources.
NHS Operating guidance	NHS England ask systems to focus on five priority areas. Priority 1: Restore NHS services inclusively-It is critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic. Priority 2: Mitigate against digital exclusion Systems are asked to ensure that: • providers offer face-to-face care to patients who cannot use remote services • more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken

	down by relevant protected characteristic and health inclusion groups • they take account of their assessment of the impact of digital consultation channels on patient access. Priority 3: Ensure datasets are complete and timely. Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome. Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement). Priority 4 - Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes, including: • Ongoing management of long-term conditions • Annual health checks for people with a learning disability This example from Herefordshire and Worcestershire CCG. shows an approach tailored to the local population. • Annual health checks for people with serious mental illness, learning from proven delivery models such as the approach taken by City and Hackney CCG. •In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population. Priority 5: Strengthen leadership and accountability. Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme.
24/25 NHS operating guidance *NHS England 2024/25 Priorities and Operational Planning Guidance - CF (carnallfarrar.com)*	Key actions for systems are: Increase vaccination uptake for children. ICBs are expected to demonstrate how they are using this HI funding to target areas of highest need and premature morbidity and mortality in line with the Core20PLUS5 approach and in collaboration with primary care and VCSE colleagues.

	Update plans for the prevention of ill-health and incorporate them in JFPs, with a particular focus on improving outcomes for the Core20PLUS5 populations and NHS England's high impact interventions for secondary prevention. NHS England » High impact interventions. Plans should include a focus on: − continuing to provide a suite of lifestyle programmes and behavioural interventions to address inequalities in • cardiovascular disease (CVD) prevention. • smoking and alcohol cessation. • diabetes prevention; weight management. • and diabetes remission, with improved participation rates in the most deprived quintiles of the population. • supporting people to stop smoking, including through implementing opt-out treatment for patients in hospital and as part of maternity pathways 2024/25 priorities and operational planning guidance. • collaborating with local authorities and family hubs to support the Healthy Child Programme framework and stronger parent–infant relationships.
NHS Long Term plan *The NHS Long Term Plan - CF (carnallfarrar.com)*	Seeks to strengthen the NHS's contribution in areas such as prevention, population health and health inequalities. Also makes clear that real progress in these areas will also rely on action elsewhere.