Integrated Care System
Nottingham & Nottinghamshire

Acute, community and primary care services

Clinical & community services strategy

2019-2024

Nottingham City Council

Nottinghamshire County Council

NHS

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Executive summary

In Nottinghamshire we have made great progress in improving people's health and wellbeing. Today, we can treat diseases and conditions we once thought untreatable: cancer survival rates, for instance, have increased dramatically in just twenty years.

However, with great improvements come new challenges. While we now live longer, for many these additional years are not lived in good health. The growing prevalence of long-term health conditions, for instance, places new strains on our health and care services. There is inequality evident in both the location of challenges and in access to services. In some areas, it is easier to access a GP than in others, or to find things to do to keep you active and fit.

As the challenges our health and care system faces change, so must our services. In this endeavour, we start with a simple goal: to ensure everyone in Nottinghamshire has the best possible health and wellbeing they can. This means more people able to live full and independent lives in their homes, more care provided for them near those homes, better local access to health and care services, and a greater focus on the prevention of illnesses, not just their treatment.

Our vision for the ICS is ambitious

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

The Need for an ICS Clinical & Community Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical and Community Services Strategy does not sit in isolation, it is an integral part of the components that will be necessary to make our new system function effectively and deliver the desired outcomes.

The strategy provides the framework for future service model development and to help understand what services will be delivered where.

The Case for Change

We have made great strides in improving the health and care of our population, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

Delivering the NHS Five Year Forward View Triple Aims is a major driver of our case for change. The Triple Aims are:

Improving Health & Well-being

There are currently 1.1m people in the Nottingham and Nottinghamshire ICS area, which is set to increase by 3% by 2024 and by 10% by 2039. Depending on where you live in Nottinghamshire, people have different overall life expectancy and healthy life expectancy (i.e. the number of years a person lives in 'good health'). This variation is significant and is a key outcome that the ICS wishes to make improvements in to close the gap.

Deprivation and socio-economic factors are key drivers of this inequality - unemployment, lower qualifications and less healthy lifestyle choices (healthy eating, smoking, overweight/obesity, low physical exercise) consistently result in poorer health and wellbeing outcomes.

Transforming the Quality of Care

Our citizens want to be able to receive services in a very different way to that which their parents and grandparents did. They have told us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective all modes of service delivery have increased year on year such that A&E attendances have seen a 4% increase in the last 3 years with a 17% increase in those aged 70+. Inpatient episodes have also increased by 7% over the last 3 years.

Circulatory disease (including stroke, coronary heart disease), cancers and respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise. Evidence has confirmed that these diseases can be prevented by improving lifestyle choices.

The pressures on our current services are unsustainable and require a significant transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Workforce Challenges

Workforce is a key driver for change within our system. We employ a wide range of talented and dedicated staff across our services who provide excellent care and support to our populations.

However, it is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as high sickness and turnover rates; high reliance on agency staff and high vacancy rates. Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken for us to address this significant workforce challenge.

These are aligned to four strategic workforce objectives;

1. Recruitment & retention supporting our current workforce
2. Supporting and retaining our students
3. Developing and supporting new roles
4. Preparing the workforce for new ways of working.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives from the Government. Without change, the situation will get worse.

Key challenges are growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

We can only spend the money that the Government has allocated to us – to do otherwise is unfair on other areas and other parts of the public sector. But this isn't simply about reducing spend – by doing things differently, we can change the way that we deliver services that mean people get treatment when it is needed and are supported to stay well whilst spending less money.

Developing the Clinical Model

We have held a series of clinically led workshops attended by over 200 clinicians and health and care professionals from a wide range of disciplines. All parts of our system were represented at these workshops and together developed the following set of design principles, which have been signed off by the Programme Board:

- Principle 1 – Care and support 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 maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being will be considered alongside physical health and well-being
- 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
- 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 – They will be designed in partnership with local people 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.

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

Our clinical model is based around a life continuum – recognising that people will move both up and down the continuum in terms of the support and intervention that they need. This model is supported by some key cross cutting aspects such as population health management and 100% risk stratification, prevention being everybody's responsibility and a focus on personalisation and self-care.

A recognised progression of care needs has therefore been utilised within the development of this strategy. These include:

- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal personalised care
  - Living with a Long-term health or care need (including mental ill health)
- **Care in a Crisis**
  - Care that is needed on an emergency or same day/urgent basis
- **Managing Illness**
  - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well
- **End of Life**
  - Patient centred with joint decision making.

Delivering Our New Models of Care

To support this clinical model there is an ongoing process of clinically and professionally led service reviews. These reviews are utilising a systemic approach to consider where and how we currently deliver services and compare these against benchmarking data, national and international models of best practice and ongoing developments in technology and infrastructure. This will enable us to determine;

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models.

Our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire.

Conclusion

This Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision. This will continue to be developed further during the next stage of the strategy development. However, its success is dependent on the 3 levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures. We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

Foreword

We are delighted to present this Clinical and Community Services Strategy for Nottingham and Nottinghamshire. Our strategy, which will make a huge contribution to improving the health of our population, has been developed alongside our staff, clinicians, and members of the public.

It reflects not only the challenges across our health and care system that we know we need to address, but also what local people have told us matters to them in their own health and wellbeing and how they access support.

We know that we have challenges we need to address. We have a growing population, rising demand for health services, increasing numbers of people with long-term health problems and significant health inequalities. We also know that by working together across health and care organisations we can address these challenges. We are excited to launch this strategy, which sets our how we will go about making sure our health and care system is designed in the right way to provide the care that people need, when they need it.

This Clinical and Community Services Strategy signals an important step-change in our work as a system. We are working closer together across organisations to make sure we provide more care for people outside of hospital and do more to support people to live healthy, happy and independent lives. More than ever before we are working as a single system with a shared goal – to improve the health and wellbeing of the people living in Nottingham and Nottinghamshire.

Our strategy, developed on behalf of the Nottingham and Nottinghamshire Integrated Care System, sets out how we will transform our services for the future so that they can meet the needs of our population and help people to stay healthy for longer. It has galvanised the local health system to focus on building clinical and community services that improve the health of our citizens, supporting people across their whole lives to stay healthy and providing the right support for them when they need it.

We know that we have much to do but we are also excited about what we know we can achieve, and proud to launch this strategy as a key part of our journey to achieve lasting change in our health and care system to help people live longer and healthier lives.

Tracy Taylor
Chief Executive
Nottingham University Hospitals NHS Trust

Dr Nicole Atkinson
Clinical Chair
Nottingham West Clinical Commissioning Group

Introduction

The Need for an ICS Clinical Strategy

The NHS Long Term Plan is clear that to meet the challenges that face the NHS it will increasingly need to be:

- More joined up and coordinated in its care
- More proactive in the services it provides
- More differentiated in its support offer to its individuals.

At the heart of this approach is working as an integrated health and care system to achieve the best outcomes for our citizens. Explicit within this is the recognition that some of the service changes necessary may not be in the interests of individual organisations but are required to maximise what can be achieved for the individual patient and the whole system.

As such, the vision for the ICS is to deliver sustainable joined up, quality health and social care and broader community services that maximise the health and well-being of the people of Nottingham and Nottinghamshire.

Each individual partner in the Integrated Care System (ICS) has their own Service Strategies in relation to the delivery of their core services. This ICS Clinical and Community Services Strategy provides a long term (five year plus) overarching vision for our health and care delivery system and provides a strategic direction and framework for which future service development and reconfiguration will be considered against.

Nottingham and Nottinghamshire has the benefit of long established relationships and partnerships and these are the basis on which our new models of care and clinical strategy are being developed.

A separate, but inter-related mental health strategy has also been developed across the ICS. There are inevitably a considerable number of overlapping and integrated outcomes and actions that need to be taken to deliver the holistic needs of our population. Therefore, the ICS Board will ensure that there are single, integrated implementation plans where appropriate.

The Strategy Development Process

This Strategy has been developed through an open and inclusive process which weaves together the expertise of both clinicians and care experts with citizens in determining the future shape of services across the system.

This Clinical and Community Services Strategy does not sit in isolation, it is an integral part of the components that will be necessary to make our new system function effectively and deliver the desired outcomes. The strategy provides the framework for future service model development and to help understand what services will be delivered where.

This will be informed by a greater understanding of the needs of our population through Population Health Management data.

Stakeholder Engagement

As part of the development process there has been a wide range of stakeholder engagement events and opportunities for input. These include:

- 3 design workshops including over 200 local clinicians, care professionals and system leaders from across statutory, voluntary, and commissioning organisations
- A Technology and Innovation workshop with 35 experts from a range of fields
- The involvement of citizen representatives in the strategy design workshops and the involvement of a number of citizen and patient groups in the development of the strategy
- Citizens are now involved in each of our service reviews (see section 7) through attendance at workshops and through specific focus groups for the different areas of care. Voluntary sector organisations are also involved in each of the reviews. The numbers of citizens involved in the work will grow as the service reviews are extended.

The System level Outcomes Framework

This Clinical and Community Services Strategy has been developed alongside other key workstreams across the ICS. The need to align the strategy with the emerging system-level outcomes framework is essential. The ICS Board recently confirmed that the ICS outcomes framework is being based on the triple aims (improved health and wellbeing, transformed quality of care, and sustainable finances) whilst increasing healthy life expectancy remains the overarching system outcome.

The purpose of the framework is to provide a clear view of our success as an ICS in improving the health, wellbeing and independence of our citizens and transforming the way the health and care system operates. The Framework sets out short, medium and long term outcomes the whole ICS will work together to achieve based on eight ambitions. These remain in draft but are currently outlined as follows:

Outcome Ambitions	
1	Our people live longer, healthier lives
2	Our children have a good start in life
3	Our people and families are resilient and have good health and wellbeing
4	Our people enjoy healthy and independent ageing for longer, at home or in their community
5	Our people have equitable access to the right care at the right time in the right place
6	Our services meet the needs of our people in a positive way
7	Our system is in financial balance and achieves maximum benefit against investment
8	Our system has a sustainable infrastructure

This Clinical and Community Services Strategy focuses on what future services will look like to deliver this outcomes framework over the long term.

The case for change

The populations of Nottingham and Nottinghamshire require health and care services that are of the highest quality and delivered as locally as possible. Our citizens have told us that they want to be supported to take more responsibility for their own health and that if they become ill they want to be cared for at home wherever possible with a proactive support system wrapping services around them.

We have made great strides in improving the health and care that our population receive, but to continue to improve outcomes and stay within the funding allocated by the Government we recognise we need a major transformation programme which will require all sectors – NHS, social care, local authority, private and voluntary to work collaboratively with our citizens to radically redesign the way we deliver our services.

There are a number of reasons why our services need to be radically re-focused to ensure we can maximise the health and well-being of our population and deliver the triple aims identified in the Five Year Forward View and the NHS Long Term Plan.

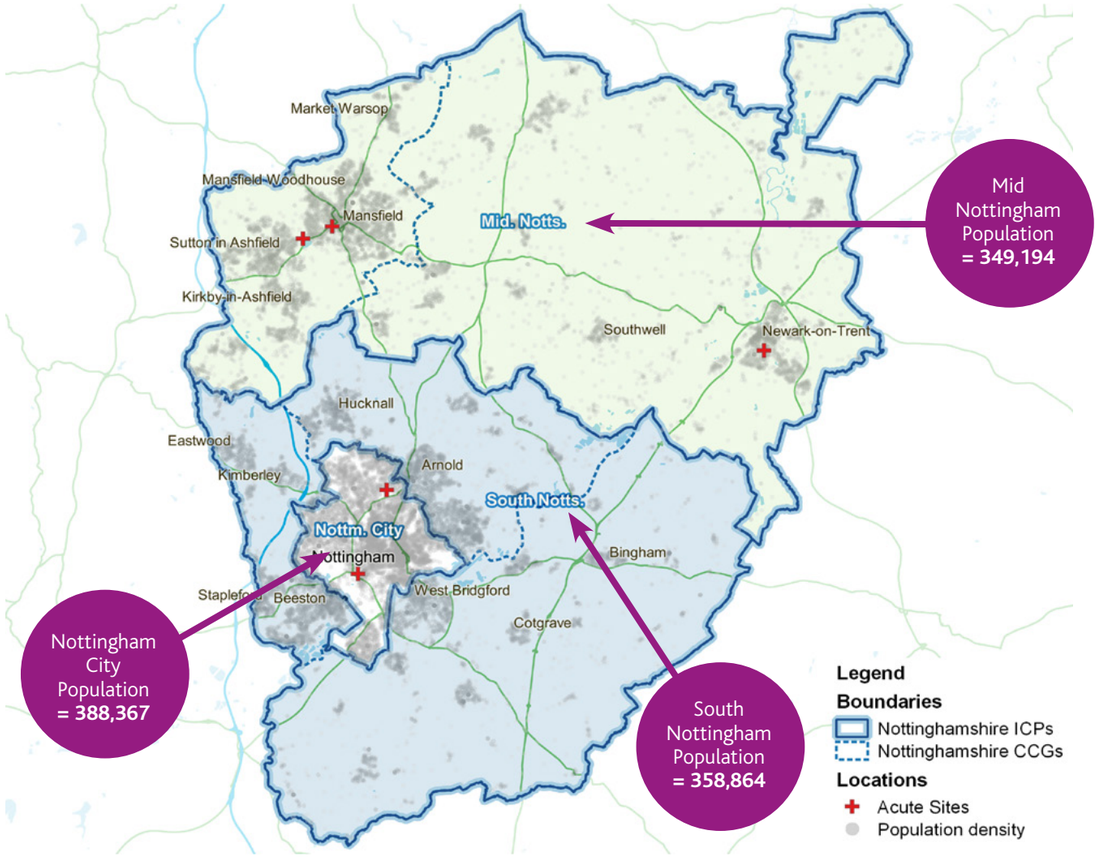
Improving Health & Well-being

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

The age profile of our populations in Mid Notts and South Notts 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 when we discount for its large student population. People are also 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 at 318th is one of the least deprived in the country.

Deprivation and socio-economic factors significantly affect a person's life expectancy. Nottingham City and Mansfield & Ashfield are affected by higher 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') of our population also shows a pattern of inequality. 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.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

Therefore improving healthy life expectancy is essential to creating a sustainable system and securing this improvement requires change in every part of the system.

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.

At the age of 4-5yrs Nottingham City children are already significantly less likely to be a healthy weight than 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.

Transforming the Quality of Care

Changing Public Expectations

We have a growing population with increasingly complex care needs that are placing different demands on our health and care services. People also want to be able to receive services in a very different way to that which their parents and grandparents did. Our citizens tell us they want easier access to services closer to home, increased use of technology, such as options of web based consultations and other ways that enable them to take greater control of their health and well-being whilst still being able to see a doctor face-to-face when it's really needed.

Many of our health facilities were established over 50 years ago to meet a very different health need. Our health and care services need to adapt and change to provide high quality care for people at home or in the community (where clinically appropriate) and to ensure everyone can benefit from modern day medicine and technological advances.

Clinical Sustainability

The current healthcare system is clinically unsustainable driven by demand pressures, insufficient levels of out of hospital services and staff shortages.

From an activity perspective we have seen:

- **Outpatient appointments** have increased by 15% in the last 3 years (17/18 vs 14/15) with a 20% increase in age 70+ Outpatient appointments
- **A&E attendances** have seen a 4% increase in the last 3 years (17/18 vs 14/15) with a 17% increase in age 70+ A&E attendances in last 3 years
- **Inpatient episodes** have increased by 7% over the last 3 years but we have seen a corresponding decrease in bed days by 9% and an increase in daycase activity of 10%. There has been a 17% increase in inpatient episodes in those aged 75+.

Currently 13% of the ICS population is aged 70+ and this population accounts for:

- **20%** A&E attendances
- **27%** outpatient appointments
- **31%** of emergency inpatients
- **33%** of elective and **33%** of daycases.

Circulatory disease (including stroke, coronary heart disease), Cancers and Respiratory diseases currently account for 60% of the diseases that cause the gap in life expectancy between the most and least deprived areas in Nottinghamshire and these are set to rise.

For example over the next 20 years Stroke will increase to 84%, respiratory diseases to 101% and Cancer to 179%.

Evidence has confirmed that these diseases can be prevented by improving lifestyle choices. For example;

- 9 out of 10 strokes are caused by risk factors that can be modified
- 40 - 45% of Cancers are caused by risk factors that can be modified.

Current data suggests that we still have significant areas of unhealthy lifestyle choices as demonstrated below;

Smoking	• Mansfield & Ashfield > 1 in 5 people • Rushcliffe 1 in 12 people
Exercised for 30 mins for 12 out of 28 days	• Nottingham City/ Mansfield and Ashfield - 1 in 3 people • Rushcliffe - 1 in 2 people

With the population growing, ageing and spending a higher proportion of time in poor health, there will be an ever increasing need for carers. Informal carers need more support - they are 2.5 times more likely to experience psychological distress than non-carers and working carers are two to three times more likely to suffer poor health than those without caregiving responsibilities. Carers of people with dementia particularly struggle and dementia is due to increase 86% in the next 10 years.

The pressures on our current services are unsustainable and require a significant transformation in not only how and where services are delivered, but also how we shift to a more proactive model of care that focuses on preventing the population developing the disease burden in the first place.

Clinical sustainability also requires us to review and consider how and where we deliver services from. Treatments are becoming increasingly specialised offering the potential to improve quality of care further by enabling access to the latest treatments and techniques. However, this does require more specialised services to be based around larger centres.

This will enable specialist staff to build their skills and capabilities, and to ensure all patients have access to specialist skills and equipment.

Workforce Challenges

Workforce is a key driver for change within our system. It is becoming increasingly difficult to recruit staff with the right skills and expertise in the right locations as there are national shortages of staff entering training places or wanting to join these professions. We know that measures such as trying to recruit more staff or increasing wages alone are not going to solve this issue so we need to consider different options of how we recruit and retain the necessary workforce.

The ICS has developed a 10 year People and Culture Strategy which will fully articulate the challenge and put forward some of the mitigations in terms of recruiting and retaining high quality staff to deliver the care needs of our population. We employ a wide range of talented and dedicated staff across our system who provide excellent care and services to our populations. The profile of staff is as follows:

- 35,436 full time equivalent members of staff are employed across the Nottinghamshire system
- 18,318 of our staff are based in our hospitals
- 11,949 of our staff are based within a community setting
- 2,171 of our staff are based out of hospital but work system wide
- 2,965 of our staff are based out of the ICS.

We face a number of challenges across our ICS in relation to workforce related issues. These include aspects such as:

- We have a system wide reliance on agency staff which is both a financial issue and a clinical risk. The three NHS providers in Nottinghamshire spent approximately £40m on agency staff in 2018/19.
- There is a requirement in the GP Forward View and the Mental Health Forward View to increase the numbers of staff in these areas, e.g. 77 more GPs by 2020, 30 Children & Young People MH workers, and 23 Mental Health crisis workers
- Sickness absence is higher than the national NHS average
- Vacancy rates higher than the national NHS average (12.1% vs 9.1%) and we have a high turnover rate at 11.4%
- Nursing vacancy rates are also extremely high – 18.9%, which equates to a vacancy figure of 1,412 FTE.

Our local estimates indicate that based on current demand trajectories we will have a shortage of at least 1500 clinical staff over the next five years. This is exacerbated by a reduced supply of graduates and an ageing workforce with a significant number of staff reaching retirement age.

Some of the key staffing impacts on the delivery of our strategy include a shortage of General Practitioners (77 FTE short by 2020) along with a general shortage of primary care based staff. Certain hospital based specialities including Health Care of the Elderly, Stroke, Paediatrics, Emergency Medicine and Radiology are all struggling to meet the growing demand.

Additionally, there are 2000 (9%) social care/ residential care vacancies with turnover in Nottingham in line with the England average for this sector of 30.1%.

Our People and Culture strategy outlines a range of initiatives and actions that need to be taken forward for us to address this significant workforce challenge. These are aligned to four strategic workforce objectives:

1. Recruitment & retention supporting our current workforce
2. Supporting and retaining our students;
3. Developing and supporting new roles
4. Preparing the workforce for new ways of working.

Staff engagement is a key enabler to the delivery of both our People and Culture Strategy and to this Clinical and Community Services Strategy. It is essential that we listen and respond to our workforce to shape the delivery of our priorities. Evidence tells us that an engaged and committed workforce leads to improved patient outcomes and increased staff satisfaction which will assist with recruitment and retention challenges.

Developing our Clinical and Community Services Strategy will also identify where we will deliver services differently and how we can use enablers such as technological advances to mitigate some of the workforce challenges. We need to ensure that staff are empowered to work at the top of their licence and that we maximise their valuable contribution by developing new and innovative roles where appropriate to ensure we continue to focus on high quality patient outcomes.

Additionally, we recognise that the current roles and workforce structures are not fit for purpose. We need to develop a flexible workforce that is not constrained by organisational or professional boundaries. In order to achieve this we will need to link with education providers and review the approach to training our future workforce to focus on the skills we need rather than the roles themselves.

Sustainable Finances

The ICS currently spends £3.2bn annually on health and care services and for a number of years has been spending more money than it receives. Without change, the situation will get worse. In 2018/19 the financial position of the system deteriorated, with a forecast in-year deficit of £87 million, this is £19 million worse than the position agreed with national NHS leaders. Key challenges are growth in activity/demand (health and social care), provider pay pressures and non-delivery of efficiency programmes.

The system faces a gap of £159.6m in 2019/20 representing 4.9% of the total system resources – this gap is expected to increase to in excess of £500m by 2023/24 for NHS services alone if we do not change the way in which we design services and work with our populations to improve their health and well-being to prevent them entering ill-health in the first place.

The improved NHS Long Term Plan funding settlement will result in system resources increasing by circa 20% over the next five years but this will not keep pace with cost increases which are projected at 35% for the same period if we don't do anything differently. To a large extent these cost increases are driven by projected increases in demand for healthcare services. If there was no projected increase in demand for services the financial gap would actually narrow to £50m due to the funding increases expected.

The NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding. However, for 2019/20 control totals remain in place, for individual organisations and ICSs.

Current services are not set up to enable our staff to work as efficiently or as effectively as they could or to deliver as much health care as could be provided if services were better organised. It is therefore imperative that we drive forward our transformational change in order that we will be able to deliver services and meet the needs of our local populations within the available resources.

These features of the financial position of the ICS show that while it is unrealistic to expect no increase in demand for services, improving the health of the population with better prevention, earlier intervention and more developed self-care, is at least as important to a sustainable healthcare system as the improving the efficiency of service provision.

National Drivers

There are a range of national policy drivers that we remain committed to as a wider system that this strategy has taken account of. In particular:

- The Five Year Forward View and the refreshed guidance in February 2018 reaffirmed national priorities and set out five challenges for the NHS and social care system to respond to
- The General Practice Forward View in April 2016 which was supplemented by Investment and Evolution; a five year framework for GP Contract reform to implement The NHS Long Term Plan
- Prevention is Better than Cure – Our vision to help you live well for longer - Department of Health & Social Care (Nov 2018)
- Universal personalised care: Implementing the comprehensive model – NHSE (Jan 2019)
- Our understanding of the implications of the imminent 'Green Paper' on social care.

Local Drivers - Fixed Points in the System

Given the challenges and expectations of the people of Nottingham and Nottinghamshire we are being ambitious in our proposed changes. But there are some things that we are not proposing to change in order to create a small number of fixed reference points to support service and capital planning. These are set around core areas of urgent access and interdependency of services in those locations. These have been confirmed as;

Agreed Fixed Points of Delivery	
Kingsmill Hospital	**Accident & Emergency for all patients; and** **Antenatal and postnatal obstetrician led services;**
QMC Nottingham	**Accident & Emergency for all patients;** **Major Trauma & associated services;** **Antenatal and postnatal obstetrician led services;** **Neonatal Intensive Care;** **Nottingham Children's Hospital**
Newark Hospital	**Designated range of Commissioner Requested Services which includes high volume/low complexity elective care and diagnostics plus Urgent Care services**
Rampton Hospital	**High secure mental health facilities**
Wells Road Centre Nottingham	**Low secure adult mental health facilities**
Highbury Hospital	**Inpatient mental health services**
Hopewood Hospital	**Inpatient mental health services for children and young people**
LIFT and PFI Facilities	**All the LIFT and PFI healthcare facilities will be effectively used**

These fixed points are important as they set the foundations to construct where future service provision will be delivered from across the system. They will be used to build other services around and enable the focus to be on how these are maintained in the future rather than whether they are required. While many services not on this list will not change location, their future planning will be undertaken by reference to these fixed points through the service review process and engaging with patients and the public.

Estates & Infrastructure

A further key constraint and opportunity is the quality of the estate and infrastructure of current service provision. There is £168m of backlog maintenance required across the key NHS provider organisations much of it critical for ongoing service delivery. The healthcare estate infrastructure in the ICS costs circa £172m p/a of which £78m p/a is Private Finance (PFI) or LIFT payments.

It is also the case that there is significant opportunity to better use estate capacity in the system either through effective reuse or disposal. Some areas for improvement include:

- 33% of the acute hospital estate is used for non-clinical purposes and 2.55% of the estate is unoccupied
- Across the health community there are 316 healthcare buildings including 115 owned by GPs
- The ICS has been set a land disposal target for Nottinghamshire of £12.2m to support the reinvestment in modern facilities

It is therefore essential that the future clinical services models enable:

- Improved use of our quality estate, especially PFI and LIFT building where we are tied into a long term contractual commitment
- Reduction in the acute service estate footprint, currently envisaged to be predominantly at the City Hospital campus, to enable investment in better quality estate both on that site and elsewhere
- Use the estate more effectively for the whole health and care system looking beyond traditional organisational boundaries.

Conclusion

We have a compelling need for change, driven by the changing needs of our local population and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

We are faced with a current health and care system that has a number of challenges ranging from an inability to recruit and retain the key skills and personnel that we require to deliver care and rising costs that mean that our current services are costing more than the income we receive.

These issues are very real and we need to address them in a way that will improve outcomes for individuals, our communities and all our staff working across the system.

Figure 1 overleaf provides a summary of how the development of the Clinical and Community Services strategy will support the ICS to deliver the NHS Long Term Plan 'Triple Aims':

Driving change across the ICS 'triple aims'

Improved Health and Wellbeing

- The clinical and community services strategy will support people to live longer, healthier lives
- Our children will have a good start in life
- Reduce avoidable admissions and managing conditions amenable to healthcare
- Reducing outcomes gap so that our populations enjoy healthier and independent ageing for longer
- Improving workplace health and reducing long term unemployment

Transforming Care and Quality

- Shifting from a reactive hospital based treatment model to pro-active approaches of prevention and early intervention
- Variation in primary care access and outcomes will be reduced
- Inconsistent clinical pathways and outcomes removed
- Improve self-care and management
- Developing new models of care in priority pathways
- Our populations will have equitable access to the right care at the right time in the right place

Sustainable Finances

- Nottinghamshire currently spends £3.2bn on health and social care services
- Health and Care system faces a £156.9m Do Nothing gap in 2019/20 representing 4.9% of system resources
- Projected gap of £500m for NHS alone by 2023/24
- System resources expected to increase by 20% over next five years but this will be outstripped by cost increases of 35% if we don't do anything different
- New Clinical Service Models will be a key contributor to bridging this gap alongside increasing efficiency and reducing waste

NB – Figures currently exclude Nottingham City Council

Figure 1

Our shared vision

Our vision

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

The aim of our strategy is to support the system to achieve this by shifting the focus of our health and care delivery from reactive, hospital based treatment models to a pro-active approach of prevention and early intervention, delivered in people's homes or in community locations where this is appropriate.

By working in partnership across our different providers of care and all our sectors of care – acute, community, general practice, local authorities and wider community services including voluntary and private providers, we aim to ensure our citizens' experience is less fragmented and is integrated via a single patient record.

This requires a high level of trust both at an organisational level and individual clinician level to enable the necessary culture change that will support positive risk taking to become the norm.

The NHS Long Term Plan articulated the gap around delivery of the 'triple aims' and identified five major practical changes necessary to achieve closure of these gaps. The ICS has undertaken a process to align our system priorities to the Long Term Plan and confirmed five priorities that must be delivered. This strategy will make a step change in supporting the delivery of these priorities which include:

- Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting
- Improve the care of people with single and multiple long term conditions through greater proactive management and self-management to reduce crises
- Reduce waste and improve efficiency and value across the system (including estates)
- More action on and improvements in the upstream prevention of avoidable illness and its exacerbations.

Re-shape and transform services and other interventions so that they better respond to the health and care needs of our population

Approach to strategy development

Our clinical strategy fully recognises that we cannot continue with the current 'illness' models of healthcare that the NHS has traditionally delivered.

Tangible benefits can be achieved if we fully embrace the opportunities provided by utilising population health management data to risk stratify the population. This will allow us to identify who is most at risk of developing preventable conditions or whose health may deteriorate and then identifying the 'what and where' health and care services will be delivered to pro-actively target those most at risk.

The Clinical Design Principles

Through engagement at the workshop events the following set of design principles have been agreed with the CSS Programme Board to build on the vision and system challenges:

- Principle 1 – Care and support 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 maximise the health of the population at every level and be supported through a system commitment to 'make every contact count'
- Principle 3 – Mental health and well-being 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
- 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 un-necessary duplication.
- Principle 6 – They will be designed in partnership with local people 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.

Public Engagement

Nottingham and Nottinghamshire have a long history of service transformation and throughout each of these programmes of work there have been numerous consultation and engagement events with patients, carers and the public. These were then supplemented by public engagement at the outset and during the development of the Strategic Transformation Partnership work.

The output from this wide range of engagement events has created an overwhelming case for change in terms of the way that health and care services have been traditionally delivered across Nottingham and Nottinghamshire and have been the foundation of the case for change for the Clinical and Community Services Strategy.

The Clinical Services Strategy Programme Board acknowledged that this work remains valid and demonstrates a strong consensus as to what the public would like to see from our clinical and community services. The following key factors from the feedback were considered during the strategy development:

- Joined up health and care to enable a seamless approach for the individual
- Prevention and self-care are essential components
- Less reliance and demand on acute hospitals – and ultimately smaller facilities
- Strengthened and integrated primary and community care services with new models of care able to meet the needs of individuals in their own homes where ever possible
- Evidence based planning and streamlining to reduce inefficiency and unwarranted clinical variation.

The Clinical Model Framework

Our aspiration is that we want people to live healthy and fulfilling lives. However, we also recognise that at times throughout their life, people will become unwell and that they will need different services at different points in their lives.

It is also acknowledged that people will move both up and down the continuum in terms of the support and intervention that they need. For example, an individual's life may suddenly be impacted by a significant trauma that has life changing consequences or a family may have a child born with extremely complex health and care needs that will stay with them throughout their lives. Others may have complex needs that following intervention allow them to live independently with support from their GP or community team.

A recognised progression of care needs has therefore been utilised within the development of this clinical strategy. These include:

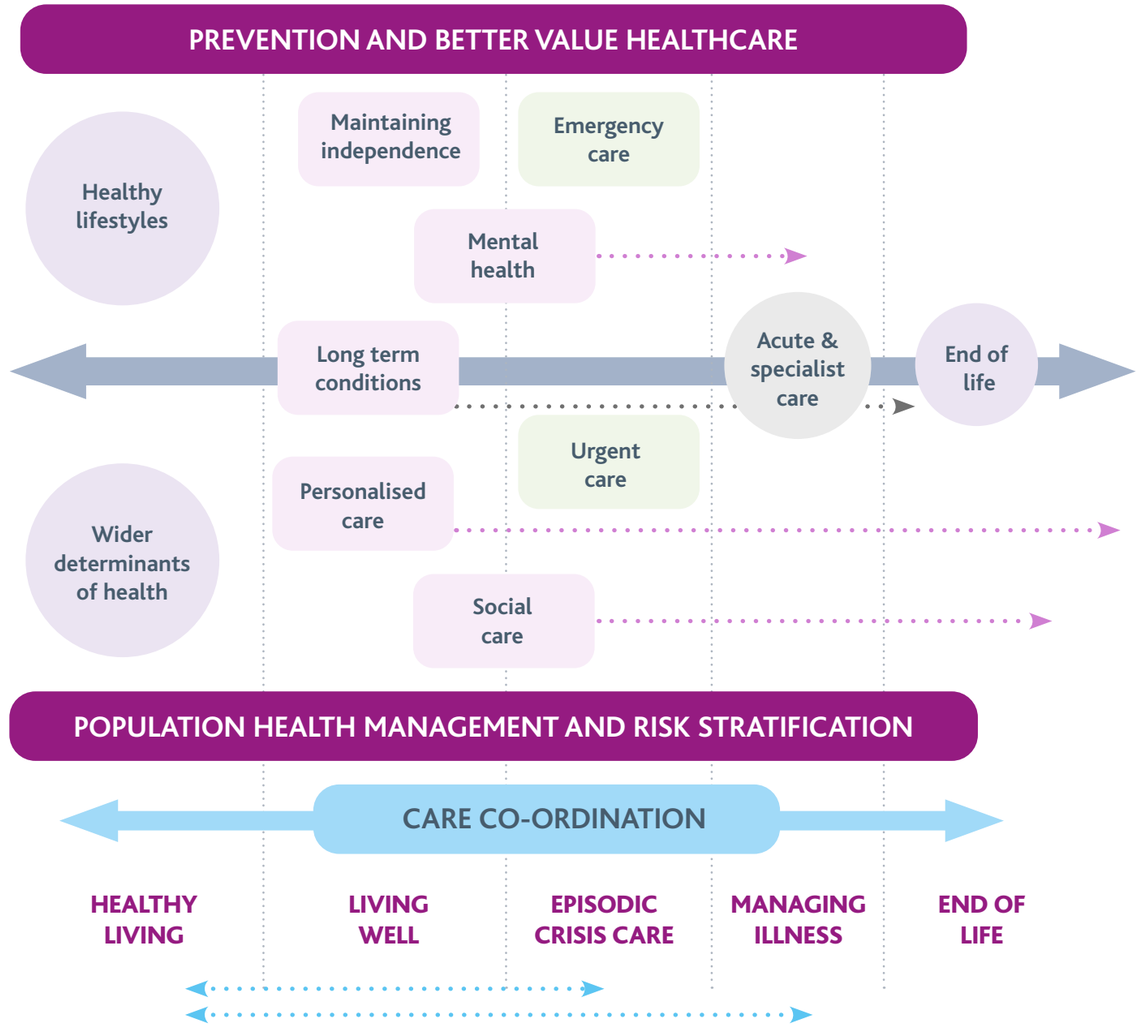
- **Staying Healthy**
  - Primary Prevention & Education
  - Wider determinants of health
- **Living well**
  - Primary & secondary prevention
  - Maternity and Children's Services
  - Universal personalised care
  - Living with a Long-term health or care need including mental ill health
- **Care in a Crisis**
  - Care that is needed on an emergency or same day/ urgent basis
- **Managing Illness**
  - Planned acute or specialist care (including cancer care) and support with the aim to return back to living well.
- **End of Life**
  - Patient centred with joint decision making.

Using this consistent approach across our service reviews will enable the aggregate changes and impact to be determined for:

- Size and configuration of future estate
- Shared and inter-connected IT systems
- Skills, configuration and requirements for our future workforce models
- Ongoing organisational development and culture changes.

Overleaf provides a schematic representation of our approach to developing the Clinical and Community Services Strategy whilst the next section explores the dimensions of care for the high level clinical model in more depth.

The schematic demonstrates that some aspects of our care model are needed throughout a person's life, for example we would see that there are opportunities for prevention and promotion of maximising the value from our health services pertain to all parts of our continuum whilst in other aspects, people will move through various stages for example, they may be in need of support in an emergency but then return back to healthy living.



1

Healthy living

Why prevention & education?

Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention activities are key to keeping people independent and well at home and to avoid the escalation of needs that can result in crisis interventions. Prevention is important at all ages throughout life.

Around 20% of our lives are spent in poor health, and evidence suggests that the past gains in life expectancy may be becoming harder to achieve. We are now living with more complex illnesses for longer. This trend is set to continue as the proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third of these people having a mental health problem.

The case for change has clearly identified that we can make a positive difference in our population's health if we focus on prevention as well as educating and supporting our populations to choose healthier lifestyle choices. In Nottingham and Nottinghamshire, the leading risks attributable to years of life lost due to premature mortality are tobacco, alcohol, dietary risks and high blood pressure.

It is estimated that currently only 3-5% of health spending is on public health activities, yet population health initiatives when evaluated usually have a far greater return on investment for every £1 spent.

For example, we know that 9 out of 10 strokes are caused by behaviours that could be modified. A key health intervention that would support this change is the NHS Health Check Programme. However, only 44% of those people who were invited to participate across our ICS during 2013-2018 for a coronary vascular disease check actually attended.

The case for change articulated the growing problem relating to LTCs resulting from obesity, especially obesity arising in childhood.

Obese children and adolescents suffer from both short-term and long-term health consequences. The most significant health consequences often do not become apparent until adulthood and these include cardiovascular diseases (mainly heart disease and stroke); diabetes; musculoskeletal disorders, especially osteoarthritis; and certain types of cancer (endometrial, breast and colon).

It is estimated around 50% of GP appointments, 64% of outpatient appointments, and 70% of hospital bed days are due to preventable ill health. Overall 40% of the burden on health services in England may be avoidable through preventable action.

The evidence around smoking cessation is overwhelming. The World Health Organisation has clearly outlined the health benefits of quitting smoking. Within 2-12 weeks of quitting, circulation improves and lung function increases and within a year coronary heart disease is about half that of a smoker and within 5 years stroke risk has reduced to half that of a smoker.

Across Nottingham and Nottinghamshire, the move towards a smoke free generation would annually save lives (c. 1,823 early deaths are 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.

Another key area is the impact of alcohol on a wide range of conditions such as cancer, cardiovascular and alcohol related injuries. Alcohol related hospital admissions account for 1.1million admissions a year nationally.

The benefits that can be achieved from a focused reduction on preventable conditions such as tobacco and alcohol are significant. As such, a key part of our Clinical and Community Services Strategy will be that prevention and maximising future health is something that all partners are responsible for and will be considered throughout every stage of our clinical model.

As a system, we have a responsibility to make the environment and culture within which people live, work and play more supportive of enabling good health. We need to incentivise people to want to lead an active lifestyle and to have the knowledge, skills and confidence to take full control of their lives and making healthy choices as easy as possible.

We need open conversations at a population and individual level on how the health and social care system works jointly with the public to collectively support health and well-being. One such mechanism will be health promotion activities and a wide range of media need to be utilised to maximise public awareness and uptake. Technology will play an important and evolving role in preventative activity as well as a focus on factors such as housing and air pollution.

There is a growing body of evidence that health and care interventions are only able to address 10% of overall health benefit in terms of access to care and it is only by addressing the wider determinants of health that a real step change can be made in people's lives.

Understanding the wider determinants of health

Contributors to health outcomes

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

We need to:

- Ensure prevention activity is considered for all ages and takes a conception to grave approach that enables us to 'make every contact count' (MECC)
- Systematically tackle Nottingham and Nottinghamshire leading risks factors which impact on premature mortality - namely tobacco, dietary risks including obesity, alcohol, lack of exercise and high blood pressure
- Prevent or delay long term health and social care needs by identifying early risk factors that could impact on people's independence, health and well-being
- See a systematic culture change – moving to a system that takes a longer-term view and thinks about prevention rather than simply treatment
- Establish virtual clinics to access information, advice and guidance to prevent ill-health
- Establish links with education providers to pro-actively support children and their families to have the best start in life
- Ensure housing plans for the future support all communities that can meet the needs of people with all age disabilities and an ageing population
- Increase social prescribing for leisure activities to increase levels of physical activity at all ages.

Key Outcomes

- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- The overall demand for services is reduced as a result of work on prevention and the wider determinants of health
- In the longer term see a significant reduction in premature death from the main attributable risk factors
- Prevention activities are pro-actively and systematically funded and a longer-term view is taken to return on investment.
- Risk factors are identified and addressed at an earlier stage
- The interventions applied will be universal in their reach, but targeted according to need.
- An increasing number of people are supported in their own homes and local communities for longer.

2

Living well

We want to increase the amount of years that people live in good health. To do this we need to support people to have a good start in life and then enable them to live independent, fulfilling lives where they feel able to reach their full potential. This is a key outcome that the ICS wants to achieve.

We know that the number of people living with multi-morbidity prevalence will rise dramatically across our population over the coming years. The numbers of people with 4+ diseases will more than double in the next 20 years and this is significantly increasing the complexity of those people who do need health and care support.

Our current system is overly reliant on beds and care isn't provided in the right place. Our data suggests that in point prevalence studies, during the study period in 2017 50% of the patients in a hospital bed at Nottingham University Hospital could have been cared for more appropriately in a different setting and then when we reviewed CityCare beds in 2018 we found 60% of patients could have been cared for elsewhere.

In 2017/18, 335 elderly people aged over 65 were admitted to care homes in Nottingham (887/1,000 pop = 12th highest nationally out of 152 Local Authorities), and 987 in Nottinghamshire County (590/1,000 pop = 78th).

The evidence base for Personalised Care continues to grow – current statistics suggest that people who are confident to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts and 38% fewer emergency admissions than people with the least confidence.

It is estimated that if we can provide greater proactive management and increase self - care activities then there is the opportunity to reduce our spend on Long Term Condition management by £12m in 2019/20 across the ICS. This would be achieved by reducing demand on acute hospital care and through re-investment of potential savings allow additional services to be developed in community based supporting infrastructure.

Community pharmacies could play a significant role in supporting people to live well and reduce the need for urgent assistance. Expansion of services such as supervision of medication compliance, medicines support including adjustments and prescribing support along with wider offers such as advice on minor ailments has shown that there are significant benefits to the NHS of cost efficiencies worth £1.1 billion and avoided treatment costs worth £242 million. In addition patients report time savings in reduced travel time and saved GP appointments.

Understanding the changing needs of our population and local communities is essential and will be informed by the use of population health management data. This work brings together health and social care factors and uses predictive analysis to help target interventions on a personalised basis.

Maternity, children & families

There has been a focus on transforming maternity care across our ICS for some time and we now need to increase the pace and focus on delivery.

We know that there is still a great deal to do to ensure that our children and their families have a great start in life. For example, we have high proportion of mothers who smoke at the time of delivery (14.7% compared to England average at 10.8%) and in addition there is a high still birth rate in Mansfield and Ashfield (5.1%) and in Nottingham City (5.2%) compared to the national average at (4.3%). With the right targeted interventions we can make a dramatic improvement in this area.

Maternity and family health will take a preconception-to-adulthood approach with the focus on 'teams around the family' operating largely through a community hub-based model, working to avoid cycles of poor health outcomes. This approach will work to deliver the best start in life and make the best use of all contacts to prevent poor health outcomes for the whole family.

Families will have a care navigator through their Primary Care Network who will pro-actively help to access the right support at the right time in the right place. This single point of contact is vital for providing a family with consistency throughout the early years.

Most services will operate best from a community hub where specialists can be co-located, rather than in the home, although home visiting will be an option where appropriate for the patient.

This pathway will be supported by consultant-led maternity services operating from the ICS' two acute trusts. Birth setting will be determined by patient choice, and the option of home birth (where clinically appropriate) will be presented alongside other options.

Due to the breadth of the reviews for both Maternity and Children & Young People further pathway work is ongoing in the next phase of service reviews and it has been agreed that the two aspects will initially be separated to enable a detailed understanding of the emerging models of care and challenges for each element of service provision.

Personalised care

Personalised care will mean that our citizens have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual preferences. Personalised care is central to our new service models. Working through the Primary Care Networks we will ensure that people have more options, better support, and properly joined-up care at the right time in the optimal care setting.

Less than half of people in Nottinghamshire with a long term condition have had a conversation with a primary care health care professional to discuss what is important to them, and a third don't have an agreed care plan.

This shift in focus therefore represents a new relationship between people, professionals and the health and care system. It provides a positive change in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

Managing long term conditions (LTC)

People with long term health and care needs want to live as normally and independently as they can. Despite the diversity of the range of conditions in terms of diagnosis and disease, people with a LTC progress through the same stages of intervention as other conditions.

An ever increasing proportion of the population are living with a multiple range of health and care needs. Whilst traditionally we may assume that this is isolated to older people, this is not the case. Older adults (65+) with functional needs i.e. Frailty are a major user of care services and have increasing risk of hospitalisation, increased length of stay and ultimately increased risk of needing long term care. However, there is an increasing proportion of children, young people and adults living with multiple long term conditions who require access to multiple services and specialities.

An individual's care needs will be met in the most appropriate place that their level of acuity dictates, but wherever possible the default will be to provide holistic support services into a person's home.

Personalised health and care plans will be in place for every person who has a LTC and will be fully co-produced recognising that the patient and their carers are often experts in their own condition and care needs.

Loneliness and social isolation are often associated with those with complex health care needs. 11% of people over 75 report feeling isolation and 21% report feeling lonely. Strategies that enable people to be socially engaged, remain in employment where appropriate and continue with activities that give their life meaning also need to be integral within our clinical and community models.

A key component of our Clinical and Community Strategy therefore needs to be a radical redesign of our approach to drive a proactive approach focusing on wellness and 'what matters to me' rather than an illness model of 'what is wrong with me'.

Mental health

An increasing number of people are now living with both physical LTCs such as respiratory or heart disease and mental health LTC's such as dementia and alzheimers. We need to clearly align our work in managing complex health needs with those contained with the mental health strategy to ensure system wide, integrated interventions that meet the needs of the whole person.

Social care

County, City and District Councils provide a wide range of community support to people, including preventative, housing, leisure and social care services. They are therefore integral to achieving the objectives of the ICS and key partners across the system.

Social care provides information and advice, short term reablement and long term support to enable the promotion of independence and well-being and to ensure that people understand the choices about how and where their ongoing care needs might be best met.

Both the City and County Council partners in the ICS have their own adult social care strategies and transformation programmes and this Clinical and Community Services Strategy fully acknowledges the essential interface between this strategy and those developed with a focus on the provision of social care

We Need to:

- Ensure a single health and care record is available that is ultimately held by the patient and shared across all organisations
- Ensure an empowering, patient centred culture is in place that enables the conversations to be around 'what matters to me as a person'
- Change the skills of our workforce with a continued focus on multi-skilled practitioners able to deliver first line interventions with knowledge of when to refer to specialised staff
- Support the community and voluntary sector to further extend its impact on outcomes through initiatives such as ending social isolation and self-care hubs
- Link with the Population Health Management work to ensure 100% of the population can be risk stratified by each PCN to proactively case manage those at risk of exacerbating LTC's and losing independence and wellbeing
- Ensure that care co-ordination is implemented in a standardised manner across all our PCNs to deliver clear support and sign-posting initially focusing on those with multiple co-morbidities
- Review the benefits to be achieved from telehealth and remote monitoring technologies in accordance with the Assistive Technologies Strategy

- Confirm our approach to developing a single point of access (SPA) model across both an ICS or if more appropriate in each ICP footprint and whether this is to be multi-agency and how it aligns with the Integrated Urgent Care roll out
- Ensure systematic medication reviews for all people with multiple co-morbidities
- Complete the Better Births maternity review and implement the recommendations across our system
- Develop our community hub model for maternity and family health services
- Use assessment tools such as the Patient Activation Measure to build knowledge, skills and confidence with the person to self-manage and provide personalised solutions that meaningful to the individual
- Use person centred conversations to understand where adjustments to the individual's lifestyle could impact on their health, wellbeing and independence.

Key Outcomes

- We will be systematically using readily accessible population level data to support segmentation and risk stratification
- A narrowing in the life expectancy gap and the healthy life years gap across our populations
- Local Community Pharmacies will be a key first point of contact with appropriate local and national payment mechanisms in place to support this
- Increased numbers of people have a single care co-ordinator to support them navigate and sign-post them to appropriate services
- Increased proportion of people are able to access Personal Health Budgets
- Those accessing services reporting:
  - Feeling more empowered to manage their condition and are able to access the right additional support when required
  - Receiving integrated, wrap around locally delivered care and support to meet their physical and mental health needs
- Ensure we have outcome measures in place that measure the whole system of care for people with complex needs
- A reduction in the number of people entering long term residential or nursing home care.

Social Prescribers are in every Primary Care Network and are able to appropriately direct patients to a wide range of resources across their local community

3

Care in a crisis

At different times in an individual's life they may require access to crisis care to manage a sudden onset of illness or a traumatic event. Our current models of managing these episodes are often predicated on patients themselves deciding whether their need is urgent or indeed an emergency or can be managed in a routine way through their GP.

As a system we are facing a number of operational challenges in terms of achieving the required levels of service delivery for A&E. This includes the 4 hour performance target. For example, NUH has consistently underperformed with an average of 64.4% achieved in March 2019, but Sherwood Forest has also seen deteriorating performance at 91.7% in Q4. Ambulance response times across our ICS are also longer than the required standards in all categories of response.

At least 8,500 (11.6%) of emergency admissions per year are for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension – many of which we have already identified are preventable conditions. Over 75s make up less than 10% of the ICS population, but account for a 1/3rd of emergency admissions and a half of emergency bed days. Two thirds of emergency inpatient beds are occupied by the over 65s (c. 1,000 beds/day).

Spending time in hospital when it could be avoided can be detrimental to a individual's overall health - 35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65% therefore we should do everything possible to ensure we avoid any unnecessary hospital admissions or delays to a person's discharge.

It is estimated that there is a significant financial saving opportunity if we could radically redesign the urgent and emergency care system with an opportunity potential of circa £14m across the ICS in 2019/20.

An individual's perception of an emergency or urgent need may at times be somewhat different from the clinical opinion. This disconnect may be due to a lack of knowledge, fear and anxiety or simply a desire for the convenience of getting a need met in a convenient and immediate manner.

Therefore, a focus for this strategy is in defining urgent, same day care in a way that is relevant to society and setting clear parameters for what a patient can consistently expect from different settings and how they will meet their individual needs.

This will clarify for citizens what they should expect from emergency and urgent care settings as well as the different range of access to General Practice services both in and out of hours.

Emergency Care

Emergency care is defined as being required immediately or within 4 hours of the injury or symptom commencement.

Access to the emergency department will be triaged via the emergency ambulance or single front door to ensure people are directed to the appropriate level of service provision.

Ambulance services are at the heart of the urgent and emergency care system and we need to ensure that our paramedics and ambulance crews have the skills and resources to enable more care to be delivered at home or settings outside of hospital, whilst at the same time working to reduce delays in hospital handovers. We will increasingly support ambulance decision making with technology and appropriate algorithms to support the correct management and care for a patient.

Urgent Care

Urgent care is defined as being required within a 4 - 24 hour period after the commencement of symptoms or diagnosis.

The model of urgent care is still to be fully determined and will need to link into the developing Urgent Treatment Centres and to the Primary Care Networks (PCNs). The latter will have a key role to play in meeting the urgent/same day demand elements of the clinical model for those who have primary health care needs.

The developing PCNs will ensure that 100% of practices are covered by extended hours access at evenings and weekends seven days a week and will support the delivery of a combined access offer including the NHS App and on-line booking options.

In addition, PCNs will continue to develop innovative solutions to increase 'streaming' of patients so that they are able to offer convenient same day urgent appointments whilst preserving continuity of care for patients with more complex long-term conditions.

Models to actively support people with worsening conditions to prevent a hospital admission are well developed in parts of the ICS. Our Clinical and Community Services Strategy assumes that models such as 'Call for Care' will be available routinely for all of our population. This will enable the emergency ambulance service and both in-hours and out-of-hours General Practice to access a dedicated team to provide urgent, home based assessment and intervention within 2-4 hours. This will enable people to safely stay in their own homes and prevent a hospital admission.

We will aim for a consistent model of Emergency and Urgent care access across all parts of the ICS that is clearly communicated and understood by the public. Our aim is that this will encourage appropriate usage of Emergency Department, Urgent Treatment Centres, General Practice and wider primary care services rather than the ongoing high levels of usage at hospital based emergency services.

We need to:

- Confirm our overall approach for accessing urgent levels of care to ensure appropriate signposting and consistency of offer to local alternatives such as Community Pharmacy
- Develop a clear and coherent long term communication campaign in conjunction with the public to support ongoing behaviour change and align the public and clinicians expectations over service offers
- Provide a web based, trustworthy source of localised information regarding self-help, advice and sign-posting
- Provide a single point of telephone access via NHS111 and the Clinical Assessment Service (CAS) that will intelligently triage all requests for care and signpost patients to the right point of care, including the capacity to make GP appointments in line with the requirements of the new GP Contract.
- Develop the offer from each of our PCNs to enable appropriate on the day access balanced with the ability to preserve continuity of care
- Develop a consistent model for a community hub and determine the locations for these across the ICS
- Ensure a model that meets the key components of 'Call for Care' is available in all areas of Nottingham and Nottinghamshire
- Ensure alignment of this model with the approach to support people who experience a mental health crisis.

Key Outcomes

- Seamless integration across acute, community, primary and local authority crisis services. This could include co-location of a broad range of services within single sites or locality hubs to provide a 'one stop shop' approach. These should include physical, mental health, housing and social care and where appropriate wider community and voluntary sector services
- A standardised, consistent emergency and urgent care offer across all the whole of the ICS
- Reduced demand on the hospital emergency department and the ambulance service
- The public reporting increased confidence in being able to access emergency department alternatives in the wider community
- Delivery of the ED performance targets and an improved outcome and experience of care for those who need to use crisis services
- Parity of service offer whether the crisis is related to a mental health or physical health care need.

4

Managing illness

There is an expectation that most people at some point in their lives will require support to manage an episode of illness. Again, the aim here is to agree with the person what it is they want to achieve and provide specific support and intervention that meets those needs and enables them to return back to living a healthy and fulfilling life.

We recognise that our previous systems and processes have created services that are confusing and inequitable across our whole ICS. Nationally it's been estimated that up to 50% of patients attending General Practice have conditions that may not need a GP and could be treated by less qualified staff.

Previous work across the ICS has demonstrated that most of the elective or planned care activity currently takes place in hospitals resulting in people travelling to a main hospital site for care that could equally be delivered closer to home. Phase 2 of outpatient transformation work has the potential to release £5.6m of costs in 2019/20 if we develop different models of delivering planned care services.

We are not consistently delivering the required performance targets and some of these contacts are not always valuable e.g. Procedures of Limited Clinical Value (PLCV) and some outpatient appointments.

Our Clinical and Community Services Strategy and the ongoing service reviews will therefore focus on the fundamental principle to reduce variation and drive standardisation in outcomes for the whole population. This will require common pathways across primary, secondary and tertiary care and with social care to ensure there is consistency in entry and exit points when people find themselves needing care and support to manage episodes of illness.

Planned Care

Planned care is defined as care that is non-urgent, for which the patient receives a pre-arranged appointment and is either a self-referral or via a clinical referral.

A key principle in reviewing our planned care services is to ensure we reduce variation and drive standardisation where appropriate in order to reduce duplication and improve equity of service delivery and outcomes.

Considerable work has already been undertaken across the ICS to improve the pathways of planned care, from developing standard referral guidelines in a number of specialities to redesigning some clinical pathways such as Musculo-Skeletal services (MSK) and gynaecology.

The Clinical and Community Services Strategy development is therefore working alongside these ongoing programmes of work and assumes that as we move forward all pathway reviews for planned care will take on a whole patient journey perspective and cover all aspects of care from referral to discharge with ongoing care in a person's place of residence where appropriate.

A key assumption of the clinical and community strategy is that increasingly a greater proportion of planned care will take place in a community setting. This will include the delivery of first and follow-up outpatient appointments on both a face-to-face basis and via the use of telephone or video technology.

It also assumes that the level of surgical intervention will decrease for an increasing proportion of patients who, through being full chose not to have an active surgical intervention but are managed through alternative means such as ongoing physiotherapy and support.

Perioperative care will increasingly take place out of hospital settings, in community locations, utilising a range of near patient diagnostics and outreach services supported by technology.

The utilisation of designated planned care facilities will support the system to enable consistent delivery of planned care, irrelevant of pressures on emergency services.

Acute and specialist care

Although care at home is the preferable option wherever possible, the model accepts that home may not at times to be able to provide the level of support, expertise or environment required. Hospital beds will be provided where these are the appropriate option agreed by the patient and care team.

We will build on the national direction of travel towards the centralisation of specialised services being provided in larger centres where this is appropriate to do so and it is based on associated improved clinical outcomes and the development of network models of delivery.

Nottingham and Nottinghamshire has a significant range of specialised services provided in both physical and mental health care and we will concentrate our expertise on developing these services and being at the forefront of innovation.

Specialist care can also extend to our expertise in specialised diagnostic areas (e.g. PET CT, Medical Genetics) and we will continue to work with key partners locally and nationally to ensure that the citizens of Nottingham and Nottinghamshire have appropriate and timely access to the latest technologies.

Cancer Care

Prevention of cancer is equally as important as the diagnosis and treatment and we recognise the importance of national screening programmes and maximising uptake into these via Primary Care Networks and communication campaigns at both a national and local level. To date our ICS screening rates for bowel, breast and cervical cancer across Nottinghamshire are all above the national average rates although they are below the national average in the Nottingham City population.

We have a good track record of achieving the targets for seeing people within 14 days if they are referred for a suspected cancer and 5,600 people were newly diagnosed with cancer in 2016/17 which is roughly in line with the national incidence rate. However, we have difficulties in meeting the 62 day wait standards and are failing to meet the surgical treatment of cancer within 31 days.

Diagnosing cancer will continue to take place in acute hospital settings for the foreseeable future, but it's anticipated over the life of this strategy that this will shift increasingly into community-based settings as technological advances support different diagnostic approaches. Referral processes will be a combination of GP direct access and patient self-referral if clear and obvious cancer symptoms are present.

We envisage that an increasing number of treatments will be undertaken closer to home through mobile chemotherapy and immunotherapy services. Treatment should be supported by an MDT, attached to a Primary Care Network and will be the key mechanism to link the patient with other support e.g. mental health outside of the defined cancer treatment.

Post-discharge care will increasingly shift to community or home settings, delivered either in primary care or by an expanded community cancer workforce who are able to undertake better assessment of need and reduce the requirement for crisis management.

We need to:

- Ensure we develop standard referral guidelines and planned care pathways that reduce variation and improve equity of outcomes for our population
- Ensure specialist care and cancer service developments deliver the appropriate models of centralisation and ensure outreach services are in place
- Continue to scope the required community infrastructure and capacity to support the shift to out of hospital models of community care.

Key Outcomes

- Consistency of offer and delivery at all levels of care
- Timely access to care in the right location with reduced delays in transfers of care
- Care co-ordinated across defined pathways underpinned by integrated technology and health care record.
- Improved outcomes in early diagnosis and cancer survival rates.

5

End of life

End of life care is the part of palliative care which follows from the diagnosis of a terminal illness where cure is no longer possible and the patient is entering the process of dying.

There is increasing acknowledgement of the growing palliative and end of life care needs for people with non-cancer diagnosis, and our emerging new care models around end of life care support the growing national policy direction.

End of life care national statistics indicate that currently:

- 1% of the population dies each year in the UK
- Only 25% of deaths are from cancer
- 46.9% die in hospital and 46% in their usual place of residence
- 70% of people do not die where they choose.

Increasingly people are using a Preferred Priorities for Care document to write down what their wishes and preferences are during the last year or months of their life. It includes their individual views on what is important to them and where they would like to die.

Across our ICS 48.8% of deaths occur in hospital compared to the national average. There is also a differential across our system with 53.1% in Nottingham City compared to 44.4% in Rushcliffe.

The term 'end of life care' is used by different people to mean different things, since this phase could vary between months, weeks, days or hours in the context of different disease trajectories. This Clinical and Community Services Strategy assumes that End of Life services will be based on the needs of the individual rather than a predetermined period of time. It is however anticipated that it will include people who are likely to die within the next 12 months who have:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events.

Palliative care is an approach that improves the quality of life of patients and their families through the prevention and relief of suffering by means of early identification, assessment and treatment of pain and other problems, physical, psychological and spiritual. It is based on the following palliative care principles:

- A focus on quality of life which includes good symptom control
- A whole person approach which takes into account the person and those that matter to them
- Respect for patient autonomy and choice
- Emphasis on open and sensitive communication.

Our system has already undertaken considerable work in the Mid Nottinghamshire locality to develop an integrated service specification around a 'community hub' model of care to enable patients to be cared for as close to home as possible. These will be fully aligned with the ongoing clinical strategy work.

When end of life decisions are required, the lead clinical role should come from the Primary Care Network Multi-Disciplinary Team (MDT) regardless of clinical setting. This may be supported by living wills which can be shared with clinicians as required.

Specialist palliative care will be available to support the MDT team for those people with more complex palliative care needs. Specialist palliative care is provided by specially trained multi-professionals and can be accessed in any care setting. Advice regarding symptoms and medications, or a wider discussion of the patient's current situation including the appropriate provision of in-patient, community, day care or hospice and out-patient services is a key feature of the emerging model.

The specialist team is complemented by chaplaincy, therapists and psychology services working alongside a wider team of nursing staff to deliver the care required across the different aspects of the service.

We need to:

- Ensure conversations regarding end of life are based around the wishes of the person and those that matter to them and that these are clearly documented and shared across the MDT
- Ensure Primary Care is able to take a lead role in managing the end of life needs of their local population
- Develop partnership working across the system (PCNs and Specialist Palliative Care teams) to ensure the appropriate support is available to enable people to die at their preferred location
- Ensure end of life care is appropriately developed for all people who are dying, and extends beyond those dying from cancer
- Extend the use of enhanced summary care records and the use of a portal so that people's end of life wishes are readily available for all service providers irrelevant of care setting.

Key Outcomes

- An increase in the number of people dying in their preferred location
- An increase in the number of people with a living will that clearly outlines their wishes that has been shared with their clinical teams.

An increase in the number of families and carers reporting feeling supported and aware of where to seek help and support in times of crisis

Delivering our new models of care

In order to ensure that our delivery models develop in a coherent and systematic approach our system is developing across 3 levels of collaboration;

- Primary Care Networks (PCNs) consisting of integrated health and care teams linking with wider local authority housing and community services across neighbourhood localities
- Integrated Care Providers (ICPs) facilitating the integrated provision and delivery of outcomes for the population. Three ICPs have been agreed - Mid Notts, South Notts and Nottingham City
- Integrated Care System (ICS) for the whole of Nottingham and Nottinghamshire.

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the 3 levels of the system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Integrated Place Based Care

The notion of 'place' and 'neighbourhoods' have become increasingly important in health and care policy. Alongside the development of this clinical services strategy there has been a significant amount of work to develop the vision and model for delivery at a place level in our ICPs and at a neighbourhood level in our PCNs.

Primary Care Networks

General Practice accounts for nine out of ten patient contacts within the NHS and plays a crucial role in providing urgent care, coordinating and providing chronic disease management, health promotion and early intervention and in supporting people to manage their own care.

PCNs will work together with other local health and care providers around natural local communities to provided coordinated care through the development of integrated neighbourhood teams. 'Primary Care' is defined as first line services such as; general practice, community services, mental health, voluntary sector and social care etc.

The PCNs will utilise Population Health Management (PHM) intelligence and 100% population risk stratification to proactively identify and co-ordinate the care management of their neighbourhood population.

Our aim that PCNs will work collaboratively to focus on prevention and personalised care, supporting patients to make informed decisions about their care and look after their own health by connecting them with the full range of statutory and voluntary services. To achieve this we aim to have a core consistent "community hub" offer across the ICS so that the range of services is understood by professionals and public alike. This will increase confidence in access of these services and over time enable ongoing reductions in hospital based provision.

The new models of care will incorporate the provision for local pharmacies to provide consistent low acuity urgent care services dealing with minor conditions and accurately signposting people with higher levels of need to the appropriate services.

The ability for pharmacies to support the self-care agenda should not be underestimated as part of both the management of long-term conditions and for those with an urgent care need.

Integrated Care Partnerships

Our three ICPs will undertake integrated provision and coordination of care, holding a clear contract value for what the providers are commissioned to deliver. This may result in ultimately moving towards capitated budgets in accordance with national policy intentions.

Our ICPs are an aggregation of the relevant Primary Care Networks (PCNs) and all other services that support health and wellbeing within their defined place. They will observe the overriding principle of equity of access to universal and targeted services to address health and wellbeing.

They will collaborate with other ICPs in the ICS to ensure consistency of entry and exit points for patients using the services of providers who are partners with more than one ICP.

Integrated Care System

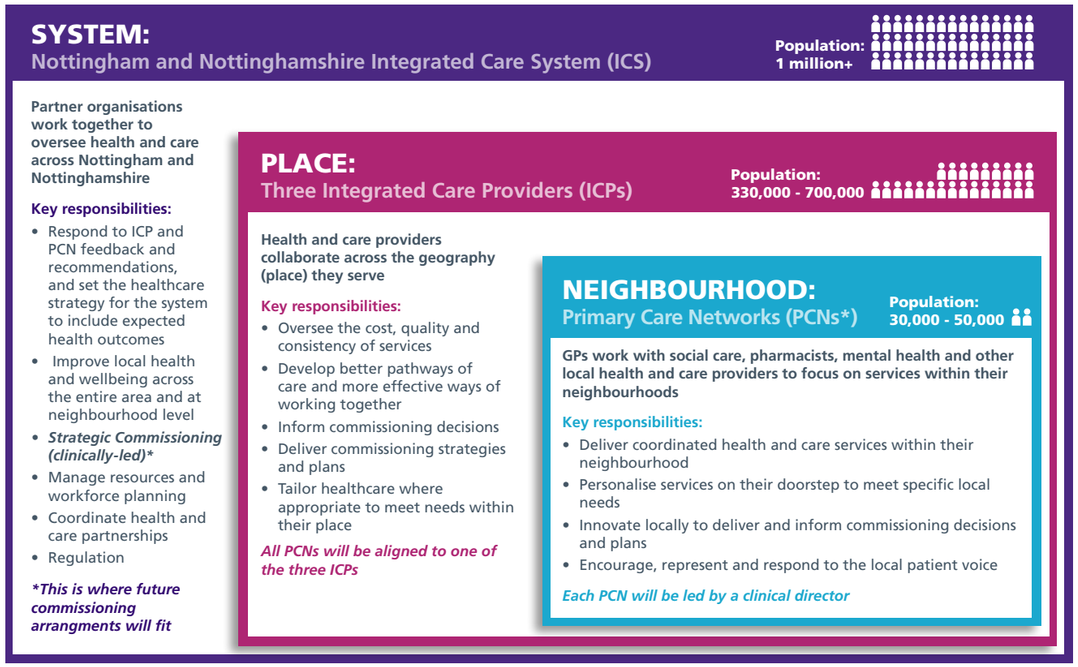
The ICS is a collaboration of equal partners working to system wide objectives. The ICS is responsible for ensuring that appropriate strategies are in place to invest our resources in what we know works and to ensure culture change through removing blocks to integrated care.

The aim of the ICS is to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age.

The ICS will work through the three ICPs and PCNs to ensure a comprehensive health and care offer is equitably available to all of our citizens. This strategy clearly articulates the need to blur the organisational boundaries between all sectors of health and care provision. This will inevitably require strong organisational leadership and a balance of the necessary trade-offs that will be required to support the transition periods as we move from the old to the new models of care with associated activity, income and workforce consequences.

This strategy outlines the agreed facilities that will be significant for service provision into the future and our ICS will be working collaboratively with the main service providers and through the ICPs to ensure that patients who require hospital based care can access this swiftly and safely. When a person's medical care requirements have been met then their discharge or transfer of care to the PCN teams needs to be smooth and seamless.

Working at system, place neighbourhood population levels: what should happen where (right task for the right population level)



This strategy provides a framework and agreed direction against which future service reviews will be undertaken. The aggregate impacts of the ongoing service reviews will provide key requirements for the future development of other supporting areas in the ICS including;

Informatics and Technology Strategy

The delivery of an integrated shared care record cannot be under-emphasised if our strategic intent is to be met. We have made significant progress in system inter-operability and development of the Care Centric Portal but the aspirations around the development of a single health and care record need to be clarified and remain a system priority.

Estates Strategy

This strategy and the output of the ongoing service reviews will be essential in guiding decisions about where individual services are located and the consequential investment in estates and infrastructure that is required.

The system has already outlined a number of estate priorities in terms of acute services infrastructure and the outputs from the ongoing service reviews will clearly identify the associated community infrastructure necessary.

Workforce Strategy

The ICS has developed a People and Culture strategy. There is an urgent need to continue to review the range of skills needed and develop different types of roles that will enable us to have workforce that is agile and fit for the future.

Where necessary, consolidation of workforce and integration of provision will allow specialists to offer more effective support within a single setting and then provide a hub and spoke model to other locations to ensure economies of scale, maximise expertise and improve outcomes.

Hospital based activity will reduce in the new models of care and the specialist workforce necessary to support our acute hospitals will increasingly support outreach models of care to support generalist care in the community.

Demand & Capacity Modelling

Shifts in activity from acute hospital settings to a community facing delivery models are fully anticipated as a consequence of this clinical and community strategy. It is also anticipated that there may be some relocation of services as a consequence of the service reviews that will require closer consideration and potentially public consultation.

There is a clear need for a system wide demand and capacity modelling approach to enable us to better understand the size and volume of activities that will take place in each sector as a consequence of the new pathways of care and service models. The current approach of each organisation modelling individual elements of impact is not sustainable and needs to be fully reviewed.

Next phase of strategy development

New models of care, workforce and commissioning must reflect whole patient journeys and providers within our ICS have already recognised that they will need to adapt, integrate and collaborate to accommodate this approach.

Our clinical models distinguish between the imperative of developing sustainable services designed around entire patient journeys that cross organisational boundaries and at this stage we have not assessed the impact on individual providers who will play a part in delivering care for part of those journeys.

The development of this Clinical and Community Services Strategy has not been undertaken in isolation. There are already a number of well-established groups exploring new service models for certain patient cohorts and taking forward evidence based care across the system. A number of these were explored as part of the first phase of workshops for the clinical strategy and these have not been duplicated, but we will complement and learn from each other as the systematic reviews move forward.

There is a need to ensure continual alignment with various other plans and system wide initiatives including the ICS Five Year Strategic Plan, the mental health strategy delivery plan and the implementation of the Urgent Treatment Centre requirements.

Ongoing service reviews

This Clinical and Community Services Strategy is only one component of the whole system review that is required. We are also taking forward a systematic review process of our 'end to end' pathways of care – from a patient first noticing they have a symptom or need through diagnosis, treatment and discharge to the management of ongoing care needs or end of life care.

This is an extensive system wide piece of work which will ultimately take place across a minimum of 20 services. The CSS Programme Board have reviewed these services against a range of quantitative and qualitative criteria and agreed the prioritisation of six service reviews, which are ongoing. These include:

- Cardio Vascular Disease – Stroke
- Respiratory – COPD and Asthma
- Frailty
- Children and Young People
- Maternity and Neonates.

These reviews will enable the long term ICS programme of change to be developed to deliver these New Care Models and to inform what the future requirements are for estate and workforce in particular but also technology.

Conclusion

The Clinical and Community Services Strategy starts to define what needs to be delivered and to some extent, where and when that care needs to be delivered in our future vision.

This will continue to be developed further during the next stage of the strategy development. However, its success is to some extent entirely dependent on the three levels of our system continuing to collaborate, develop and mature into effective commissioning and integrated delivery structures.

Fundamental within our new service models is the principle that more care will be delivered closer to people's homes rather than in a central hospital based location. Prevention and population health management will drive a pro-active model of care that will target interventions and reduce the overall burden of ill-health.

In order for this to be achieved there needs to be a significant review of the infrastructure that is currently available to enable this shift in focus to take place.

Whilst providing convenient services close to home is important, patient choice and 'what matters to me' is equally as important as clinical expertise in terms of assessment of need. However, both the timeliness of the response and the level of care required will be the key determining factors in deciding upon the location that care is delivered.

We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens.

Taking forward the key recommendations in this clinical and community services strategy will offer the system a strategic framework within which it can aim to achieve its aspirations and vision for improving the health and well-being of the population of Nottingham and Nottinghamshire.

We have a compelling need for change, driven by the changing needs of our local population, financial and workforce drivers and by the need to ensure we are consistently offering the best evidence based services for all of our citizens

This strategy is published on behalf of:

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Rushcliffe Clinical Commissioning Group

The ICS Office
Riverside Suite
County Hall
West Bridgford
Nottingham
NG2 7QP

Email: ics@nottscc.gov.uk