Integrated Care Partnership Meeting Agenda (Open Session)

Friday 17 March 2023 14:00 – 15:30

The Council Chamber, County Hall, West Bridgford, Nottingham, NG2 7QP

"We will enable each and every person to enjoy their best possible health and wellbeing."

Principles:

- We will work with, and put the needs of, our **people** at the heart of the ICS.
- We will be **ambitious** for the health and wellbeing of our local population.
- We will work to the principle of **system by default**, moving from operational silos to a system wide perspective.

Values:

- We will be **open** and **honest** with each other.
- We will be **respectful** in working together
- We will be **accountable**, doing what we say we will do and following through on agreed actions.

	Item	Presenter	Type	Time
Introductory items				
1.	Welcome, introductions and apologies	Kathy McLean	Verbal	14:00
2.	Confirmation of quoracy	Kathy McLean	Verbal	-
3.	Declaration and management of interests	Kathy McLean	Paper	-
4.	Minutes from the meeting that took place on the 16 December 2022	Kathy McLean	Paper	-
5.	Action log and matters arising from the meeting that took place on the 16 December 2022	Kathy McLean	Verbal	-
Items for approval				
6.	Integrated Care Strategy for Nottingham and Nottinghamshire 2023 to 2027	Lucy Dadge	Paper	14:10
7.	Integrated Care Partnership 2023/24 Annual Work Programme	Lucy Branson	Paper	15:10
Closing items				
8.	Questions from the public relating to items on the agenda	Kathy McLean	Verbal	15:20
9.	Any other business	Kathy McLean	Verbal	-

Date and time of next meeting held in public: To be confirmed

Meeting Title:	Integrated Care Partnership
Meeting Date:	17/03/2023
Paper Title:	**Declaration and management of interests**
Paper Reference:	ICP 22 019
Report Author:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Report Sponsor:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Presenter:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair)
Recommendation(s):	The Integrated Care Partnership is asked to **note** this item.

Summary:

The Integrated Care Partnership (ICP) is required to implement and demonstrate robust arrangements for the identification and management of conflicts of interest. These arrangements should support good judgement about how any interests should be approached and managed; safeguarding the ICP from any perception of inappropriateness in its decision-making and assuring the public that the use of taxpayers' money is free from undue influence.

ICP members must ensure that they always comply with their organisational/ professional codes of conduct and details of the declared interests for members of the ICP are attached at Appendix A. Members are reminded of their individual responsibility to highlight any interests not already declared should a conflict (or potential conflict) become apparent in discussions during the meeting.

A protocol for managing conflicts of interest at meetings of the ICP is attached at Appendix B.

An assessment of members' interests has been performed against the meeting agenda and the outcome is recorded in the section below on conflicts of interest management.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	It is essential that the Integrated Care Partnership (ICP) establishes effective arrangements for managing conflicts and potential conflicts of interest to ensure that they do not, and do not appear to, affect the integrity of the ICP's decision-making processes towards the achievement of the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:
Appendix A: Register of Declared Interests for members of the ICP. Appendix B: Protocol for managing conflicts of interests at meetings of the ICP.

Report Previously Received By:
Not applicable to this report.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Register of Declared Interests

• The ICP has made arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the ICP will be taken and seen to be taken without being unduly influenced by external or private interests.

• The register is reviewed in advance of the meeting to ensure the consideration of any known interests in relation to the meeting agenda. Where necessary (for example, where there is a direct financial interest), members may be fully excluded from participating in an item and this will include them not receiving the paper(s) in advance of the meeting.

• Members and attendees are reminded that they can raise an interest at the beginning of, or during discussion of, an item if they realise that they do have a (potential) interest that hasn't already been declared.

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Nottingham West Primary Care Integrated Community Services (PICS) GP federation	Practice is a member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Primary Integrated Community Services (PICS) Ltd	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
ATKINSON, Dr Nicole	Clinical Director, South Nottinghamshire Place Based Partnership	Eastwood Primary Care Centre	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
BRIGGS, David	Medical Director, NHS Nottingham and Nottinghamshire ICB	British Medical Associaton	Member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Mid Nottinghamshire and Greater Nottingham Lift Co (public sector)	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Nottingham Schools Trust	Chair and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Care Workers Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DADGE, Lucy	Director of Integration, NHS Nottingham and Nottinghamshire ICB	Cleaners Union	Director (not remunerated)			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Hickings Lane Medical Centre	General Medical Practitioner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Nowenigma Ltd	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
DODDY, Cllr John	Chair of the Nottinghamshire Health and Wellbeing Board	Clayfields House Secure Unit	Employed to provide medical care	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Cornerstone Chuch	Director			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
GRIBBIN, Jonathan	Director of Public Health, Nottinghamshire County Council	Nottingham University Hospitals NHS Trust	Spouse is a Consultant in Obstetrics				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
HUBBER, Lucy	Director of Public Health, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Active Partners Trust	Director/Trustee (not remunerated)		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
LAUGHTON, Jane	Chief Exectuive Officer, Healthwatch Nottingham and Nottinghamshire	Nottingham University Hospitals NHS Trust	Spouse is employed as a Consultant				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MAY, Anthony	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
MCGREGOR-RILEY, Dr Victoria	Locality Director, Bassetlaw Place Based Partnership	Sheffield Teaching Hospitals NHS Foundation Trust	Spouse employed as a consultant surgeon				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCGREGOR-RILEY, Dr Victoria	Locality Director, Bassetlaw Place Based Partnership	Doncaster Bassetlaw Hospitals NHS Foundation Trust	Partner Governor on the Trust Board		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	University Hospitals of Derby and Burton NHS Foundation Trust	Trust Chair	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Treetops Hospice	Spouse is a trustee of Treetops Hospice				✓	01/07/2022	30/06/2022	Interest expired - no action required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Kathy McLean Limited- Private limited company to offer health related advice	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Barts Health NHS Trust (London)	Non-Executive Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NHS Employers	Chair of the national negotiation committee for Staff and Associate Specialists on behalf of NHS Employers		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Care Quality Commission (CQC)	Occasional Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	Public Sector Consultancy	Senior Clinical Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NHS England	Lay Advisor	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NEMS Healthcare Ltd	Spouse is shareholder				✓	01/07/2022	30/06/2022	Interest expired - no action required.
MCLEAN, Kathy	Chair, NHS Nottingham and Nottinghamshire ICB	NHS Providers Board	Trustee		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Nottingham City GP Alliance	The University of Nottingham Health Service is a member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	The University of Nottingham Health Service (UNHS), which provides primary care services under a GMS contract, is	Executive Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	UNICOM Healthcare LLP, which provide non-GMS primary care services	Director	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	NEMS Healthcare Ltd	Shareholder	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	NEMS Healthcare Ltd	Wife is shareholder				✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	The University of Nottingham Health Service (Cripps Health Centre)	Partner	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Local Authority	Cripps Practice provide contraceptive and sexual health services under national agreements	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Overdale and Breaston Practice in Derbyshire	Wife is GP partner	✓			✓	01/07/2022	Present	This interest will be kept under review and specific actions determined as required.

Name	ICP Membership Role	Declared Interest (Name of the organisation and nature of business)	Nature of Interest	Financial Interest	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interest	Date the interest became relevant to the ICB	Date To:	Action taken to mitigate risk
PORTER, Dr Hugh	Clinical Director, Nottingham City Place Based Partnership	Unity Primary Care Network	The University of Nottingham Health Service (Cripps Health Centre) is a member		✓			01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
REDFERN, Andrew	Chief Exexutive, Framework Housing Association	Derbyshire County Cricket League	Executive Committee Member			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
REDFERN, Andrew	Chief Exexutive, Framework Housing Association	Christian Projects Development Trust	Treasurer and Trustee			✓		01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
SACCO, Volt	Chief Executive Officer, Fosse Healthcare	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
SEBELIN, Jules	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
SHERRATT,Donna	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership	Nottingham CityCare Partnership	Employee	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
UNDERWOOD, Catherine	Corporate Director for People Services, Nottingham City Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Co-operative Party	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Sherwood Ward	Councillor, Deputy Leader and Portfolio Holder for Finance	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Labour Party	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	D2N2 Infrastructure and Investment Board	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Foresight Group LLP	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Cllr Adele	Chair of the Nottingham City Health and Wellbeing Board	Greater Nottinghamshire Rapid Transit Limited	Member	✓				01/07/2022	Present	This interest will be kept under review and specific actions determined as required.
WILLIAMS, Melanie	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council	No relevant interests declared	Not applicable					Not applicable	Not applicable	Not applicable

Appendix B: Protocol for managing conflicts of interest at meetings of the Nottingham and Nottinghamshire Integrated Care Partnership

1. A conflict of interest is defined as a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act is, or could be, impaired or influenced by another interest they hold.

2. An individual does not need to exploit their position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur. In fact, a perception of wrongdoing, impaired judgement, or undue influence can be as detrimental as any of them actually occurring. It is important to manage these perceived conflicts in order to maintain public trust.

3. Conflicts of interest include:

    - Financial interests: where an individual may get direct financial benefits from the consequences of a decision.
    - Non-financial professional interests: where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their reputation or status or promoting their professional career.
    - Non-financial personal interests: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit.
    - Indirect interests: where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision.
    - Loyalty interests: where decision making is influenced subjectively through association with colleagues or organisations out of loyalty to the relationship they have, rather than through an objective process.

    The above categories are not exhaustive, and each situation must be considered on a case-by-case basis.

4. In advance of any formal meeting, consideration will be given as to whether conflicts of interest are likely to arise in relation to any agenda item and how they should be managed.

5. At the beginning of each formal meeting, members and others attending the meeting will be required to declare any interests that relate specifically to a particular issue under consideration. If the existence of an interest becomes apparent during a meeting, then this must be declared at the point at which it arises. Any such declaration will be formally recorded in the minutes for the meeting.

6. The Chair of the meeting will determine how declared interests should be managed, which is likely to involve one the following actions:

   - Requiring the individual to withdraw from the meeting for that part of the discussion if the conflict could be seen as detrimental to decision-making arrangements.
   - Allowing the individual to participate in the discussion, but not the decision-making process.
   - Allowing full participation in discussion and the decision-making process, as the potential conflict is not perceived to be material or detrimental to decision-making arrangements.
   - Excluding the conflicted individual and securing technical or local expertise from an alternative, unconflicted source.

Integrated Care Partnership (Open Session)
Unratified minutes of the meeting held on:
Friday 16 December 2022 14:00 – 15:30
Committee Room, Loxley House

Members present:

Kathy McLean (Chair)	Chair of NHS Nottingham and Nottinghamshire ICB
Fiona Callaghan	Locality Director, South Nottinghamshire Place-Based Partnership (on behalf of Dr Nicole Atkinson)
Sarah Collis	Chair, Healthwatch Nottingham and Nottinghamshire (on behalf of Jane Laughton)
Lucy Dadge	Director of Integration, NHS Nottingham and Nottinghamshire ICB
Cllr. John Doddy (Joint Vice-Chair)	Chair of the Nottinghamshire Health and Wellbeing Board
Jonathan Gribbin	Director of Public Health, Nottinghamshire County Council
Lucy Hubber	Director of Public Health, Nottingham City Council
Victoria McGregor-Riley	Locality Director, Bassetlaw Place-Based Partnership and Mid-Nottinghamshire Place-Based Partnership
Anthony May	Chief Executive, Nottingham University Hospitals NHS Trust (Representative of the Nottingham and Nottinghamshire Provider Collaborative at Scale)
Dr Hugh Porter	Clinical Director, Nottingham City Place-Based Partnership
Andrew Redfern	Chief Executive, Framework Housing Association (partner member nominated by Nottinghamshire County Council)
Jules Sebelin	Chair of the Nottingham and Nottinghamshire Voluntary, Community and Social Enterprise Alliance
Donna Sherratt	Race Health Inequalities Programme Lead, Nottingham City Place-Based Partnership (partner member nominated by Nottingham City Council)
Amanda Sullivan	Chief Executive, NHS Nottingham and Nottinghamshire ICB
Catherine Underwood	Corporate Director for People Services, Nottingham City Council
Cllr. Adele Williams (Joint Vice-Chair)	Chair of the Nottingham City Health and Wellbeing Board

In attendance:

Alex Ball	Director of Communications and Engagement, NHS Nottingham and Nottinghamshire ICB
Lucy Branson	Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Joanna Cooper	Assistant Director, NHS Nottingham and Nottinghamshire ICB
Mark Wightman	Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire ICB
Sue Wass	Corporate Governance Officer, NHS Nottingham and Nottinghamshire ICB

Apologies:

Dr Nicole Atkinson	Clinical Director, South Nottinghamshire Place-Based Partnership
Dr Dave Briggs	Medical Director, NHS Nottingham and Nottinghamshire ICB
Jane Laughton	Chief Executive Officer, Healthwatch Nottingham and Nottinghamshire

Volt Sacco	Chief Executive Officer, Fosse Healthcare (partner member nominated by Nottinghamshire County Council)
Melanie Williams	Corporate Director for Adult Social Care and Health, Nottinghamshire County Council

Introductory items

ICP 22 008 Welcome, introductions and apologies

Kathy McLean welcomed members to the meeting of the Integrated Care Partnership. A round of introductions was undertaken and apologies were noted as above.

Regarding membership, the Chair asked members to note the following:

a) Victoria McGregor-Riley will continue to represent Mid-Nottinghamshire Place Based Partnership, in addition to representing Bassetlaw Place-Based Partnership, until such time as the outcome of the process to identify a representative for Mid-Nottinghamshire concludes.

b) Dr Nicole Atkinson will soon be leaving her role as Clinical Director for the South Nottinghamshire Place-Based Partnership. As such, Fiona Callaghan will attend meetings as South Nottinghamshire's representative until Nicole's replacement is appointed.

c) The final partner nomination from Nottingham City Council had been made; Emma Howard, Head Teacher at Nottingham University Samworth Academy, would join meetings from March onward. Emma had been nominated to bring a perspective of children and young people.

ICP 22 009 Confirmation of quoracy

The meeting was confirmed as quorate.

ICP 22 010 Declaration and management of interests

No interests were declared in relation to any item on the agenda. The Chair reminded members of their responsibility to highlight any interests should they transpire as a result of discussions during the meeting.

ICP 22 011 Minutes from the meeting that took place on the 13 October 2022

The minutes were agreed as an accurate record of the discussions held.

ICP 22 012 Action log and matters arising from the meeting that took place on the 13 October 2022

The actions from the last meeting were confirmed as complete.

Items for discussion

ICP 22 013 Initial Integrated Care Strategy for Nottingham and Nottinghamshire

Kathy McLean introduced the item and highlighted the following points:

a) The primary objective of the meeting was to review and approve the initial Integrated Care Strategy for Nottingham and Nottinghamshire. It was important to note that this was an initial strategy, as it had been an enormous ask to develop the strategy in such a short timeframe to meet the nationally

set deadline; and whilst presented for approval, this initial strategy could be built upon over the next three months, as partners came together to consider how the strategy would be implemented. Thanks were given to the team of colleagues, who had worked hard to meet the deadline.

b) The initial strategy built upon, and complemented, the existing Joint Local Health and Wellbeing Strategies and Joint Strategic Needs Assessments for Nottingham City and Nottinghamshire County.

Cllr Jon Doddy and Cllr Adele Williams made the following points:

c) The integration of services and a proactive approach to prevention are needed to bring about positive change in the health and social care system. As such, a bold strategy is needed to improve the health and wellbeing of the Nottingham and Nottinghamshire populace.

d) The strategy needs to ensure that people experience a seamless journey through the health and social care system, ensuring they receive the right level of support from the right service.

e) The inclusion of support for broader local social and economic development was welcomed.

f) It was also felt that addressing social care staffing levels would be fundamental to the success of the strategy.

Lucy Dadge presented the item and highlighted the following points:

g) The initial Integrated Care Strategy had been produced in partnership, with representatives from across the Integrated Care System involved in its development. This approach had garnered much more of a shared understanding of different parts of the system and a shared sense of purpose.

h) The strategy had benefitted from the involvement of people and communities, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives. The Integrated Care System (ICS) Partners Assembly had bought together 161 system stakeholders, carers, service users, patients and citizens. The annual Nottinghamshire County Council shadow event had been attended by over 250 children and young people. Two virtual public events had been attended by 48 individuals and a survey for people to provide their views on the emerging strategy had received 206 responses.

i) Feedback had been incorporated into the development of the strategy, including notably, the need for the strategy to be bolder in its ambitions, stating quantifiable health benefits; to use ‘Place’ and ‘Neighbourhood’ as the agents for change; to work in partnership with the voluntary and community sector; and to use co-production to achieve the ambitions of the strategy.

j) The three principles of prevention is better than cure; equity in everything; and integration by default were the foundation of the strategy and would guide all actions to implement it.

k) The achievement of these principles would necessitate a significant cultural change, with difficult decisions needing to be made, for example, in the re-allocation of resources to support people in greatest need; and the need to

address productivity, value for money considerations, and gaps in current services.

l) Members were asked to give consideration to the design options for the strategy, as enclosed in the report.

A wide-ranging discussion ensued, which included the following points:

m) The importance of engaging with borough and district councils at place level to take forward the prevention agenda was discussed.

n) Members recognised the diversity of the Nottingham and Nottinghamshire population, which was reflected within the existing Joint Local Health and Wellbeing Strategies.

o) It was recognised that the local health and care system was under significant financial pressure, which could necessitate the reallocation of resources to areas of greatest need. However, it was agreed that not all changes required funding; progress could be made by making pathways more efficient by working differently.

p) Concern was raised regarding the parity of resource between social care and health and greater detail of this issue in the next iteration of the Strategy would be welcomed, particularly around the expansion of the Better Care Fund.

q) Members felt that clarity was needed on how the wider population: citizens, schools, employers, housing associations, could play a part in working towards the aims of the Strategy. The potential opportunity created by the current devolution proposals for local authorities and Nottinghamshire and Derbyshire were noted.

r) There needed to be more detail in support of aim four regarding broader social and economic development. It was felt this should include, for example, greater embedment of social value in procurement practice.

s) To ensure commitment from current providers the Strategy needed to recognise and acknowledge the current pressure and issues and describe how they were being addressed.

t) Members discussed how to ensure the engagement of all health and social care workforce, and it was noted that planning was underway to use various tools to facilitate this, with leadership behaviours being key to bringing staff behind the aims of the Strategy. It was also noted that communications needed to be mindful of the morale of staff at this time.

u) It was recognised that the Strategy would need to speak to different audiences and its design needed to take this into account. The use of case studies and descriptions of what a healthy place looked like were proposed.

v) The need for continuous engagement with people and communities was noted.

w) Members welcomed and supported the principles and the ambition within the strategy and noted that the feedback provided would be considered and taken forward into the drafting of the final iteration of the strategy.

x) Members noted endorsed the next steps to develop implementation plans, which would take into account the plans in place within the Health and Wellbeing Strategies and the NHS Joint Forward Plan.

The Integrated Care Partnership:

- **Approved** the initial Integrated Care Strategy for Nottingham and Nottinghamshire.

ICP 22 014 Revised terms of reference for Nottingham and Nottinghamshire Integrated Care Partnership

As discussed at the last meeting, at the time of approving the Integrated Care Partnership's initial terms of reference, it was recognised that these would need further refinement following the receipt of guidance and advice, particularly in relation to decision-making arrangements as a joint committee in the context of the new legislation.

This had now been received and a small number of amendments to the terms of reference had been approved at meetings of the Nottingham City Council on 31 October 2022, the Integrated Care Board on 10 November 2022 and the Nottinghamshire County Council on 24 November 2022.

The Integrated Care Partnership **received** the revised terms of reference for the Nottingham and Nottinghamshire Integrated Care Partnership for information.

Closing items

ICP 22 015 Questions from the public relating to items on the agenda

At this point, the Chair noted that no questions had been received in advance of the meeting from members of the public. Members of the public in attendance at the meeting were then given the opportunity to ask any questions they may have, having observed the meeting.

In response, one member of the public noted the need for the Integrated Care Strategy to address the cultural change required by all staff to ensure that its ambitions were achieved. This insight was welcomed and supported by members.

ICP 22 016 Any other business

The Chair asked members to note that colleagues from the East Midlands Ambulance Service NHS Trust (EMAS) had written to advise that they were initiating the development of a new Trust Strategy, and that this work would be completed in collaboration with the five health and care systems in which the Trust operated. The revised Trust Strategy required approval by April 2023 and to this end, EMAS representatives would be attending the ICB's Board meeting in January to discuss the strategy development in line with the ICB's work to develop its Joint Forward Plan with NHS Trust Partners.

It was also noted that the Secretary of State for Health and Social Care had asked Patricia Hewitt to conduct an independent review of how to enable Integrated Care Systems to succeed. A call for evidence had been issued in support of the review, with responses due by 9 January. Members were encouraged to respond.

Date and time of next meeting held in public: 17 March 2023 at 14:00 (The Council Chamber, County Hall, Nottingham)

Meeting Title:	Integrated Care Partnership
Meeting Date:	17/03/2023
Paper Title:	**Integrated Care Strategy for Nottingham and Nottinghamshire 2023 to 2027**
Paper Reference:	ICB 22 022
Report Author:	Joanna Cooper, Assistant Director of Strategy, NHS Nottingham and Nottinghamshire Integrated Care Board
Report Sponsor(s):	Lucy Dadge, Executive Director of Integration, NHS Nottingham and Nottinghamshire Integrated Care Board
Presenter(s):	Mark Wightman, Director of Strategy and Reconfiguration, NHS Nottingham and Nottinghamshire Integrated Care Board Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council
Recommendation(s):	The Integrated Care Partnership is asked to: • Review and approve the Integrated Care Strategy for Nottingham and Nottinghamshire • Endorse the strategy launch plan Members are also asked to use their influence to communicate and engage with staff, stakeholders and the public to embed the strategy within their own organisations.

Summary:
At the Integrated Care Partnership (ICP) meeting on 16 December 2022, the initial Integrated Care Strategy was presented and approved. Following feedback from the ICP, work has continued to finalise the strategy which has been co-produced with a wide range of partners. The strategy has also been informed by the legislative requirements, statutory guidance and policy This paper sets out the work to date on confirming specific, ambitious metrics and targets and development plans for the launch of the final Integrated Care Strategy. The final designed strategy is appended to this report. The strategy is presented for the Integrated Care Partnership to review and approve.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The Integrated Care Strategy is fundamental to meeting the four core aims.

How does this paper support the Integrated Care System's core aims to:	
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:
Appendix A provides the finalised Integrated Care Strategy for Nottingham and Nottinghamshire. Appendix B provides a summary version of the Integrated Care Strategy Appendix C provides a set of guiding principles which supported the work of the Strategy Metrics Task and Finish Group. Appendix D provides details of the strategy launch plan

Report Previously Received By:
The Integrated Care Strategy set out within this paper has been shared with ICS partner organisations for their thoughts and comments throughout its development.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Care Strategy for Nottingham and Nottinghamshire 2023 to 2027

Introduction and context

1. In line with guidance from the Department of Health and Social Care, the Nottingham and Nottinghamshire Integrated Care Partnership (ICP) generated an initial Integrated Care Strategy to improve health and care outcomes and experiences for its populations, for which all partners will be accountable.
2. At its 16 December 2022 meeting, the ICP approved the Nottingham and Nottinghamshire's initial Integrated Care Strategy. For reference, the meeting papers can be found here: ICP-16.12.22.pdf (healthandcarenotts.co.uk).
3. Since the ICP meeting on in December, the Integrated Care Strategy Steering Group has overseen work to develop the strategy including to:
    a) Reflect narrative changes following feedback from the ICP.
    b) Design the strategy in line with the agreed style.
    c) Confirm specific and ambitious metrics and targets.
    d) Finalise the launch plan.

Finalising the Integrated Care Strategy

4. The Integrated Care Strategy is appended in Appendix A and summarised in Appendix B. These documents reflect the agreed design for the strategy and the narrative changes proposed by the ICP. For ease, these changes include:
    a) Ensuring that the principles stand out in the presentation of the strategy.
    b) Emphasising culture change – ensuring that the strategy recognises the current pressures for front line staff and then provides hope and ambition.
    c) Highlighting the role of social value.
    d) Prioritisation of ambitions ensuring that they are specific and tangible.
    e) Highlighting areas that we could go further on.
    f) Elaborating on Severe Multiple Disadvantage i.e. what does this look like in practice and how do we define this locally.
    g) Considering the role of anchor institutions in their widest sense.
    h) Ensuring parity between health and social care.
    i) Having a greater focus on children and young people and end of life.
5. Throughout this process the strategy has been circulated with ICS partners and organisations to shape, as appropriate.

Metrics Task and Finish Group

6. Recognising the desire to have ambitious defined metrics, the Steering Group established a Metrics Task and Finish Group to oversee this work. The Task and Finish Group was chaired by the Deputy Director of Public Health at Nottinghamshire County Council. Membership included representation from Local Authorities, the ICB, including the System Analytical Intelligence Unit (SAIU), NHS providers and Place Based Partnerships.

7. A set of objectives and guiding principles were developed to support the Metrics Task and Finish Group, which was supported by the ICP Chair and shared with the Joint Vice Chairs. Further details on this approach are appended to this report in Appendix C.

8. The Metrics Task and Finish Group held a workshop on 13 February to commence the work. Task and Finish Group leads were asked to liaise with key stakeholders to:

    a) Agree a set of strategic outcomes for the Nottingham and Nottinghamshire health and care system and its population.

    b) Agree quantifiable ambitions for each of the above.

9. The Task and Finish Group has concluded its work and the outputs are summarised in this paper as well as being included in the updated strategy document. The metrics included in the strategy have been collectively identified to reflect the ambitions of the system.

10. The ICP is asked to note the following:

    a) For some metrics, there is not an agreed ambition across the ICS. This may be due to the complexity of the metric and short timescales to meaningfully develop a system ambition, or in some cases it is simply not possible. Metrics affected by this are presented with the appropriate split e.g. by City and County.

    b) The metrics presented are collated from a number of sources across different time periods. The five-year ambition for each metric is expressed in the most appropriate way for that metric be that calendar year or financial year.

    c) Some metrics are updated annually through national targets. Therefore, these metrics will aspire to meet the national annual ambition e.g. healthcare associated infection, some adult social care targets.

11. The ICP is asked to consider and approve the following proposals for inclusion in the strategy, which have been endorsed by the Steering Group. For ease, these have been incorporated into the strategy presented in Appendix A:

a) It is proposed that a number of suggested metrics are presented instead as milestones in the strategy, e.g. completed review of the Better Care Fund Programme by March 2023.

b) For some metrics, the direction of travel is not consistent across the ICS or it is a particular area of challenge. In these cases, it is proposed to meet the national trajectory or average as a stretch target to enable any inequities to be addressed e.g. a reduction in the proportion of women smoking at time of delivery to close the gap between the local and England average so that the ICS matches the England average by March 2028.

12. Once this approach is confirmed, further work will take place to confirm ambitions and trajectories for each metric at an Upper Tier Local Authority, Place, and Lower Tier Local Authority level wherever possible.

13. A number of other proposals were endorsed for ICP consideration:

a) That work on the system Healthy Life Expectancy and Life Expectancy targets be revisited and refreshed. In the first instance it is proposed that a Task and Finish Group develop proposals for ICP consideration.

b) That further work take place to understand and identify health inequalities within each specific metric.

c) A paper is presented to the ICP under item 7 on the ICP's work programme for 2023/24. Under this item, the ICP is asked to give consideration to the impact of the strategy and ensuring that the conditions for success are established and embedded.

d) Alongside the strategic system ambition metrics, it is proposed that the ICP endorses the acceleration of work to implement and embed a population health management (PHM) outcomes framework consisting of a wider set of metrics based on local population data. Further details are set out in paragraphs 14 to 18 below.

Developing a Population Health Management (PHM) Outcomes Framework

14. One of the actions arising from the strategy is to develop a collaborative virtual intelligence system across the ICS. The development of this will enable a PHM outcomes framework to be developed.

15. Segmentation involves grouping the population into cohorts of people with similar relevant characteristics, e.g. age, the presence of long-term medical conditions, social factors.

16. Stratification groups the population, based on complexity of different risk factors and/or increased risk of poor outcomes and/or the amount of resource required

to achieve the best outcomes, e.g. older people with mild, moderate or severe frailty.

17. The implementation of the PHM outcomes framework will also use a logic model approach to help the system identify the outputs, activities and inputs required to achieve the desired outcomes, which should show improvements in shorter timescales compared to the outcomes they support, and which can be monitored and reported in a timelier manner.

18. To monitor and evaluate improvements to PHM outcomes, in addition to the national and international tools already used, the local secure data platform will be used to process, link, analyse and report data from health, care and wellness partners from across the system. This will allow poor outcomes, inequalities in access, experience and outcomes to be identified, as well as opportunities to improve outcomes and reduce health inequalities for disadvantaged groups throughout the ICS. Through the direct patient care system for PHM, eHealthScope, front-line health and care staff will also be able to address these care gaps by targeting individuals and offering interventions.

Launch Plan

19. Communication and engagement about the strategy is crucial to:

    a) Raise awareness among staff, stakeholders and the public.

    b) Provide clarity on what the strategy involves, how it will be implemented and what outcomes are expected.

    c) Engage staff, stakeholders and the public to help build understanding, trust and collaboration, underpinned by our system values.

    d) Manage expectations about what the strategy can achieve and the role our people can play.

    e) Build momentum to keep staff, stakeholders and the public engaged and motivated, which is important for the sustainability of the strategy.

20. All partners in the Integrated Care System will have a role to play in communicating and engaging with their staff, stakeholders and citizens throughout the implementation of the strategy. This will need to be owned and delivered through the management line within organisations to ensure that staff feel connected to the Strategy and it is not seen as something which is owned remotely. We suggest that our System Executive Leadership Group and our Senior Leadership Teams work together to describe our ambitions, what this means for our people and their role in its success.

21. The overall objectives of the strategy launch are to:

a) Ensure that the Integrated Care Strategy is understood and adopted into everyday working practice by staff across health and care.

b) Ensure that there is a level of awareness of the Integrated Care Strategy amongst the population, supporting existing behaviour change campaigns.

22. Communications and engagement will be tailored to each of the following audiences:

a) System leaders

b) Staff – health and care

c) Public

d) Stakeholders – including MPs, Councillors, GPs, Healthwatch, Voluntary and Community and Social Enterprise organisations, Patient Participation Groups, Foundation Trust Governors

e) Media

23. The activity supporting the Integrated Care Strategy will need to be a medium-term endeavour – this will become the ongoing 'thread', wherever possible, within staff and public communications from the system. Therefore, whilst there will be some key activity in March and April, other elements of the launch activity will come in at other times over the coming period.

24. A range of communications activity is planned over the next 12 months:

a) Development of a strategy summary

b) Development of a plan on a page

c) New web pages on the ICS website, including case study features, mirrored wherever possible on partner organisation websites

d) Developing a 'pledge' for staff, stakeholders and citizens stating how they will work towards the aims of the strategy

e) Animated video to explain the aims and principles.

f) Social media plan over 12 months

g) Partner toolkit: to include social media assets, video, case studies, internal text, stakeholder messages.

h) Series of staff briefings focusing on different aims, delivered by all partner organisations

25. Further consideration is to be given to the development of the following activities:

a) A system-wide staff awards or celebration activity – highlighting integrated working

b) A process by which staff can submit examples of great integrated working and areas where more focus is needed

c) A printed newsletter for frontline staff highlighting best practice of integrated working

26. Partner organisations have committed to communicating the new strategy and the key actions that will be needed by each audience. An initial, non-exhaustive, outline of this planned activity is in Appendix D. This will grow and evolve over time to incorporate more activity.

27. Beyond 12 months will be just as important to our success. With that, we propose that we regularly review, learn, and take actions to support the embedding of our strategy in all organisations. This will require collaboration between all organisational leadership teams.

28. Suggested key leads, groups, and forums responsible for engagement and communication include:

a) System Executive Leadership Group

b) System Communications and Engagement Leads

c) Partner Senior Leadership Teams

Integrated Care System
Nottingham & Nottinghamshire

Every person will enjoy their best possible **health** and **wellbeing**

Integrated Care Strategy 2023 - 27

Nottinghamshire County Council

Nottingham City Council

NHS

Contents

Foreword

The Nottingham and Nottinghamshire Integrated Care System (ICS) brings together partner organisations from across health and care with a renewed focus on providing joined up services and improving the lives of all people who live and work in the city and county.

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do. To address this, our ICS health and care partners have agreed that we will work together to ensure that 'every person will enjoy their best possible health and wellbeing'. That is our vision, and this Integrated Care Strategy will guide us as we seek to deliver that vision over the next five years.

This strategy is being presented against a backdrop of very challenging times as we seek to recover from the pandemic and cope with the cost-of-living crisis, issues which have both had a huge impact on people's health and wellbeing. Colleagues across the health and care system are facing an unprecedented challenge in delivering services, with pent-up demand from the pandemic, the ongoing increased demand on services due to Covid-19 and seasonal viruses, significant shortfalls of staff across services which are running a high number of vacancies, and continued pressures on budgets. We are mindful that staff report feeling over-stretched, stressed and exhausted. It is a situation that cannot be tolerated. We have to do things differently.

In spite of the challenges, we believe there is cause for optimism and that we have an opportunity to change how we approach improving health and wellbeing, with a sense of common purpose and shared endeavour across all partners. This strategy sets out a way forward as to how we can best improve services, access, outcomes, experiences and, critically, tackle health inequalities.

It is built on a series of important principles - placing a greater emphasis on supporting wellbeing and preventing ill health; ensuring equity in our approach to supporting people and their communities; and seeking to better integrate services – and we have made significant progress in each over the last few years. However, there is much more to do.

Over the next five years, we will:

- Reframe health and wellbeing as an asset, not a cost. We recognise that without good health and wellbeing, life becomes infinitely harder for people from all backgrounds
- Focus on children and young people, including the most vulnerable such as those with autism, special educational needs, disabilities and looked after children. They are the future and everything that we can do to support them to make a healthy start in life is an investment that benefits us all
- Increase investment in wellness, as well as sickness, and focus resources in such a way that frail older people are supported to remain independent in their own home and reduce our current reliance on hospital and social care
- Recognise that while some services are universal, access to the majority is not and where inequity in access or outcomes exists, we will seek to rectify it
- Use data and intelligence to help us understand issues better, like smoking and obesity. We will tailor and personalise support for people, so that they feel empowered to make healthy changes in areas that are important to them and their families

- Work together as a system, embracing the views and experiences of local people. We will work on the basis of what is best for our population, best for our system and best for our organisation, in that order and, in doing so, enable our staff to work across the system in genuinely integrated ways
- Make careers in health and care an attractive option for all, especially our young people, so that our workforce is representative of the people we serve
- Spend our money wisely, recognising the challenged economic circumstances and we will seek to support local business when we are buying goods and services
- Be honest, transparent and accountable for delivering what we set out in this strategy and we will be the first ICS to report progress in ways that puts health and wellbeing on a par with finance, wealth and productivity

The strategy highlights the importance of our role as large public sector organisations in adding 'social value' to our local communities. This will be particularly seen through the way we spend our money and how we recruit to our workforce in creating additional benefits for society. We also want to make sure that we are doing all that we can to reduce our impact on the environment and deliver sustainable health and care services.

With the ICS now in place, and with an enhanced sense of partnership working throughout all agencies, across the city and county, we must embrace this opportunity to improve the health and wellbeing of our population, to make a difference through our combined resource and working in new and innovative ways.

Dr Kathy McLean OBE
Chair of the Integrated Care Partnership

Chair, NHS Nottingham and Nottinghamshire

Cllr Adele Williams
Vice Chair of the Integrated Care Partnership

Chair of Nottingham City Health and Wellbeing Board

Cllr John Doddy
Vice Chair of the Integrated Care Partnership

Chair of Nottinghamshire Health and Wellbeing Board

Plan on a page

This is the five-year strategy of the Nottingham and Nottinghamshire Integrated Care System (ICS). Figure 1, below, summarises our vision, key aims, guiding principles and our approach to delivery.

Why are we here?

Our vision: Every person will enjoy their best possible health and wellbeing

What are we going to do: Our aims and principles

1. **Improve outcomes** in population health and healthcare	2. **Tackle inequalities** in outcomes, experiences and access	3. Enhance **productivity and value for money**	4. Support broader **social and economic development**

Prevention is better than cure

Equity in everything

Integration by default

What we need to achieve

• We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood • We will support frail older people with underlying conditions to maintain their independence and health • We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example mental health and healthy lifestyle and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing	• We will support children, young people and adults with the greatest needs (the 20% most deprived, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage) • We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack/ stroke/ cancer/ chronic obstructive pulmonary disease (COPD), asthma and suicide	• We will establish a single health and care recruitment hub • We will adopt a single system-wide approach to quality and continuous service improvement • We will bring our collective data, intelligence and insight together • We will review our Better Care Fund programme • We will make it easier for our staff to work across the system	• Use our collective funding and influence to support our local communities and encourage people from the local area to consider jobs in our organisations • We will add social value as major institutions in our area • Work together to reduce our impact on the environment and deliver sustainable health and care services • We will focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.

How are we going to do it

Supporting our workforce	**Working with people and their communities**	**Evidence based approach, whilst encouraging innovation**	**Focus on outcomes and impact to ensure we're making a difference**	**Our delivery vehicles**	**Having the right enabling infrastructure**

Three key principles to system working:

- We will work with, and put the needs of, local people at the heart of the ICS
- We will be ambitious for the health and wellbeing of our local population
- We will work to the principle of system by default, moving from operational silos to a system wide perspective

Three core values:

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions

Executive summary

Background

In July 2022, the Nottingham and Nottinghamshire Integrated Care System (ICS) became one of 42 ICS partnerships set up across the country. Our ICS brings together local health and care organisations to improve population health and healthcare, tackle unequal outcomes, experience and access, enhance productivity and value for money and help local organisations to support broader social and economic development.

The strategy has been produced at a time of significant challenge to the health and care sector, with a rising demand for services, issues with both staff recruitment and retention, and financial pressures. This is the first strategy produced by the ICS and is set to run for five years. The strategy has been produced following extensive engagement with local people and communities and key stakeholders and is based on existing work, such as the two local Joint Health and Wellbeing Strategies.

Strategic principles

The strategy is based on three guiding principles.

Principle 1: Prevention is better than cure

There is a saying that 'prevention is better than cure'. We know that finding a health problem early or helping people know when to ask for help can mean that:

- People need less treatment
- We can stop more serious illness
- We can stop diseases getting worse.

By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing. For the ICS, this means taking action now at all levels of the system to identify how we can build a preventative approach into service delivery.

This includes acknowledging that the building blocks for good health sit outside the GP's room and hospital ward, and are influenced by other factors such as where we are born, grow, live work and age. There are many opportunities to integrate prevention and these wider social factors into our everyday thinking about health and care which will improve people's health and wellbeing in the most effective and efficient way.

Principle 2: Equity in everything

We believe that a 'one size fits all' method for what we do across health and care can create barriers and exclude certain groups of people, ultimately impacting on the needs of the population and demand across the system. The principle of equity recognises that not all people have equal health and care access, experience or indeed outcomes. This strategy sets out that for some people and communities more support and resource might be required to achieve similar outcomes to others.

Principle 3: Integration by default

In past years, different health and care organisations have developed their plans in relative isolation of one another, leading in some cases to fragmented services. Local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'.

Strategic aims

Aim one: Improve outcomes in population health and healthcare

From birth through to end-of-life, and every contact with services inbetween, we want to maximise the opportunities for improving people's health and wellbeing. Babies, children and young people make up 20% of our population (ages 0-18 years)[1] and we want to support children and young people to have the best start in life with their health, development, education and transition to adulthood.

Those aged 65 years and over make up less than one in five (19%) of the Nottingham and Nottinghamshire population[2]. However, many of our population experience a greater number of years spent in ill health than seen on average for England and as a result are more likely to experience multiple long-term conditions that increase their risk of hospital admission. We want to support older people to stay well, remain independent and, where preventable, reduce admissions to hospital.

Aim two: Tackle inequalities in outcomes, experiences and access

Our second aim is to tackle inequalities in health outcomes, experiences and access – and increase equity (fairness in approach) for the people of Nottingham and Nottinghamshire. We will aim to support people in greater need (those living in the 20% most deprived areas, in vulnerable or inclusion groups, those experiencing severe multiple disadvantage, and special educational needs and disabilities). We will focus and invest in prevention priorities, like tobacco, alcohol and substance misuse, healthy weight, oral health and mental health, to support people's independence, prevent illness, poor birth outcomes and premature death from heart attack, stroke, cancer, chronic obstructive pulmonary disease (COPD), asthma and suicide.

Aim three: Enhance productivity and value for money

We have a duty to ensure that we make the very best use of the funding received for health and care. Our strategy sets out a range of focus areas that should result in better value, improved ways of working and, in turn, better support for local people. This includes seeing organisations working closer together, removing traditional organisational barriers, and a drive to improve the quality of services.

Aim four: Support broader social and economic development

The ICS partner organisations employ 70,000 people and have a combined spend on goods and services of £3.6 billion. How and where that money is spent, how we support our local communities, encourage young people and adults from the local area to consider jobs in our organisations, and how we offer employment opportunities for all, are areas where partners can increase the 'social value' of what we do. We also want to make sure that we are doing all that we can to reduce our impact on the environment and deliver sustainable health and care services. An example of social value in procurement is Nottingham University Hospitals' ongoing replacement of 18,000 square metres of glass windows, sourcing local suppliers where possible, funded by a £70 million national Decarbonisation Scheme grant.

Introduction to the strategy

How we will organise ourselves to deliver the strategy

Oversight and ongoing review of the strategy is owned by the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), which brings together NHS, social care, public health and independent and third sector providers. The ICP is a statutory committee jointly formed between the local NHS Integrated Care Board and upper-tier local authorities (Nottingham City Council and Nottinghamshire County Council). All partners – NHS, local government, the voluntary, community and social enterprise sector, and other agencies linked to the ICS – will have a role to play in implementing the strategy. There are a number of formal partnerships which will support the delivery of the strategy including Health and Wellbeing Boards, Place-Based Partnerships, Provider Collaboratives at Scale and the Voluntary, Community and Social Enterprise Alliance.

How we will deliver the strategy

Our staff are at the centre of our ambition for integration to deliver better care and support to local people. We are working across the ICS to take a 'one workforce' approach, inclusive of all staff involved in supporting local children, young people and adult's health and wellbeing. This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care.

All system partners are committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. Implementation of the strategy will therefore be under-pinned by a process of co-production. This will become the default position for how we will work with people as equal partners at all stages of the design, development and commissioning of health and care services and support.

Strategy evaluation

In order to ensure a positive impact is being made, monitoring of the strategy will be achieved through an ICS outcomes framework. This framework looks at how we measure progress against our aims – how we listen to the views of our population, how services are being delivered and how we assess the state of people's health and wellbeing.

We are working across the ICS to take a 'one workforce' approach, inclusive of all staff involved in supporting local people's health and wellbeing.

The national context

Our Integrated Care System (ICS)[3,4] is a partnership of organisations that has come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in Nottingham and Nottinghamshire. This is the first Integrated Care Strategy produced by our system.

Our integrated care system

Our ICS has two statutory elements:

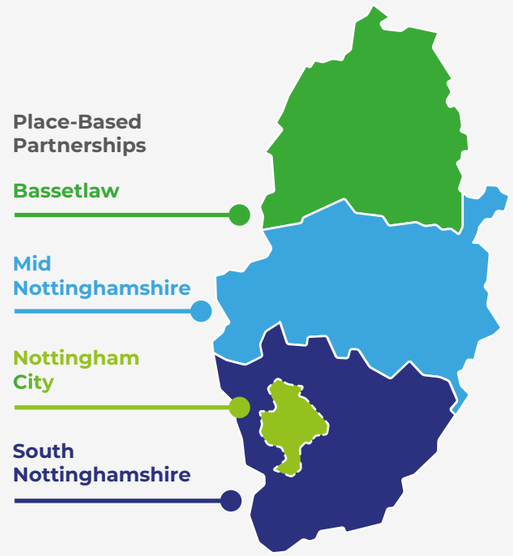
- Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system
- Integrated Care Partnership (ICP)[5] - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population.

With a combined annual budget of £3.6 billion for the commissioning and provision of health and care services, the partners collaborate at:

- A 'neighbourhood level' through 23 primary care networks (PCNs) covering populations between 30,000 and 50,000
- At a 'place level' through four Place-Based Partnerships (PBPs): Bassetlaw, Mid Nottinghamshire, Nottingham City, and South Nottinghamshire. Each PBP serves a population of about 120,000-350,000 people and leads the detailed design and delivery of integrated services across their localities and neighbourhoods. These involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners
- Through 'provider collaboratives at scale' which bring NHS providers together to achieve the benefits of working at scale across multiple places to improve quality, efficiency and outcomes and address unwarranted variation and inequalities in access and experience across different providers
- At a whole 'system' (ICS) level

The voluntary, community and social enterprise (VCSE) Alliance will be an essential part of how the system operates at all levels. This will include involving the sector in how we govern and run the system, how we use data and insights to better understand our population, and how we intend to re-design services.

Figure 2: Place areas of the Nottingham and Nottinghamshire ICS



23 Primary Care Networks (PCNs) will operate across the healthcare system, and will be aligned with the four Place Based Partnerships.

Figure 3: The structure of the Nottingham and Nottinghamshire ICS

Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)			
Nottingham City PBP 396,000 population	South Nottinghamshire PBP 378,000 population	Mid Nottinghamshire PBP 334,000 population	Bassetlaw PBP 118,000 population
8 PCNs	6 PCNs	6 PCNs	3 PCNs
NHS Nottingham and Nottinghamshire Integrated Care Board (ICB)			
Nottingham University Hospitals NHS Trust		Sherwood Forest NHS Foundation Trust	Doncaster and Bassetlaw NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust (mental health, learning disability and autism)			
Nottingham CityCare Partnership (community provider)	Nottinghamshire Healthcare NHS Foundation Trust (community provider)		
111 and NEMS			
East Midlands Ambulance NHS Trust			
Voluntary and community sector input	Voluntary and community sector input	Voluntary and community sector input	Voluntary and community sector input
Nottingham City Council (Unitary)	Nottinghamshire County Council		
	Broxtowe Borough Council Gedling Borough Council Rushcliffe Borough Council	Mansfield District Council Newark & Sherwood District Council	Bassetlaw District Council
	Ashfield District Council		

The health and wellbeing of our population

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do.

Here is an illustration of the scale of need and poor health in the local communities of Nottingham and Nottinghamshire:

More than **50,000** people in Nottingham and Nottinghamshire of working age who are 'economically inactive' have long term health problems [6]

Across Nottingham and Nottinghamshire, **36,684** children live in relative low-income families, including over a quarter of those living in Nottingham City

Nottingham (40.8%) and **Bassetlaw (38.4%)** both have significantly higher proportions of children in year six who are overweight [7]

Compared to national figures, both **Nottingham (13 %)** and **Nottinghamshire (12.6%)** have significantly higher prevalence of babies born to mothers who were smoking at the time of delivery [8]

On average, women living in Nottingham can expect to live **57.5 years** in good health, compared to **60 years** for women in Nottinghamshire. This is lower than the England average of nearly 64 years

Life expectancy for men is significantly lower than England in Ashfield, Mansfield and Nottingham, at between **76.6 and 78.2 years**

Among those aged 65 years and over, the proportion of people identified as having **moderate frailty varies between 12% and 21%,** and **severe frailty between 10% and 18%,** varying across Nottingham and Nottinghamshire

Black and Asian people died from Covid-19 at significantly higher rates than White groups in the East Midlands, illustrating the structural inequalities faced by some groups [9]

More than **65% of adults** across Nottingham and Nottinghamshire are overweight or obese

More than **11,000 hospital admissions** and more than **4,500 preventable deaths** each year in our ICS are caused by smoking [10]

Data over the past two years shows **one in six young people** aged 6-19 years now has a probable **mental health disorder** [11]

Compared to other systems, we have a **high prevalence of obesity, diabetes, chronic kidney disease** and **coronary heart disease** [12]

More detailed information on local health needs and inequalities is included in the Joint Strategic Needs Assessments (JSNAs) which inform the work of the Health and Wellbeing Boards in Nottingham and Nottinghamshire. They are available on Nottingham Insight[13] and Nottinghamshire Insight[14].

The Joint Health and Wellbeing Strategies for Nottingham[15] and Nottinghamshire[16] summarise health needs and describe their agreed priorities for partnership working.

Strategy engagement with people and communities

This strategy has its origins in the Joint Health and Wellbeing Strategies for Nottingham[17] and Nottinghamshire[18] and, as such, should be seen as both complementary to, and building upon, the aims set out in those documents.

We have listened extensively to the public, patients and stakeholders during production of the strategy to check that it reflected the hopes, needs and aspirations of local people and their communities.

The engagement programme included desk research, stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 750 individuals were involved in a range of activities, between October and November 2022. A full engagement report has been produced[19].

We are committed to continue engaging with our communities and harnessing co-production through the delivery of this strategy.

Guiding principles

Our Integrated Care Strategy is built on three guiding principles:

Principle 1: Prevention is better than cure

There is a saying that 'prevention is better than cure'. We know that finding a health problem early or helping people know when to ask for help can mean that:

- People need less treatment (for example, immunisation can stop serious illnesses like meningitis)
- We can stop more serious illness (for example, changes in diet and weight-loss can reduce the risk and, in some cases, reverse the need for medications for type 2 diabetes or heart disease)
- We can stop diseases getting worse (for example, physical activity rehabilitation programmes to help people recover after a heart attack, or transition for young people with long term conditions into adult healthcare services).

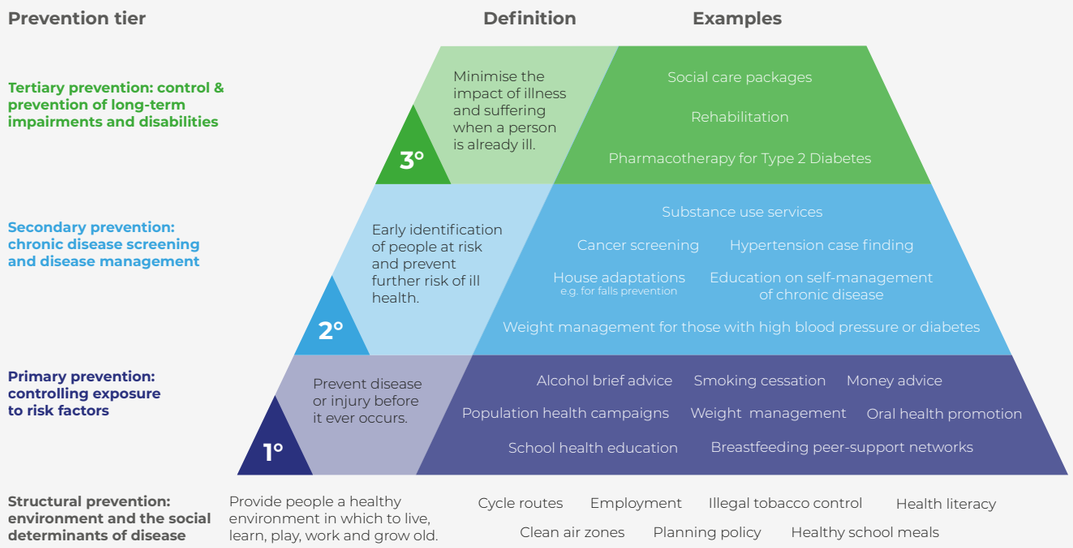


Figure 4: How different levels of prevention can improve health and wellbeing outcomes for people and help reduce or delay the future need for health or care services.

By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing.

For the ICS, this means taking action now at all levels of the system to identify how we can build a preventative approach into service delivery. We know that health is affected by more than healthcare provision. It is also influenced by other factors such as where we live; what we eat; how many family members and friends we have nearby to support us; if we work; or how much time we spent in education. Acknowledging that the building blocks for good health sit outside the GP's room and hospital ward is key in our approach to influencing health and care needs; there are many opportunities to integrate prevention and these wider social factors into our everyday thinking about health and care.

For this strategy, the ICS will focus on:

- Prioritising prevention across the health and social care system
- Moving the NHS from a 'treatment only' to a health and wellbeing service
- Considering how social care can intervene earlier to support people to remain healthy and independent for as long as possible
- Making sure the local organisations play a full role in supporting building and increasing 'social value' and strengthening communities, as well as helping families and carers in supporting an individual's independence, health and wellbeing.

Principle 2: Equity in everything

Equity has been adopted as a core guiding principle of the ICS, recognising that a 'one size fits all' method for what we do across health and care can create barriers and exclude certain groups of people, ultimately impacting on the needs of the population and demand across the system.

Figure 5: The difference between equality and equity. Source: Robert Wood Johnson Foundation (Better Bike Share, 2017)

It is important to be clear by what we mean by 'equity' as the word is often used interchangeably with 'equality', although they have different meanings. Equality means ensuring that everyone has the same opportunities and receives the same treatment and support. Equity is about tailoring the approach to people's needs, in order to make things fair.

Our strategy on tackling inequity will be based on an approach called 'proportionate universalism', as set out by Sir Michael Marmot in a national review into health inequalities[20]. This means that actions must be universal (in keeping with the founding principles of the NHS) but with a scale and intensity that is proportionate to the level of disadvantage need.

'Proportionate universalism' aims to improve the health and wellbeing of the whole population, while simultaneously seeking to improve the health and wellbeing of the most disadvantaged fastest.

Principle 3: Integration by default

Many of our organisations and teams will be serving the same communities and the same individuals, but in many instances, they will be doing it independently of one another. This leads to situations for people with multiple health and care needs having different agencies visiting for support at different times during the day. This is not in the best interests of local people or our workforce and teams. We want to support our workforce and teams to work in a more integrated way to ensure that local people have care that is joined up around them.

Achieving integration will depend on a culture of collaboration, bringing together:

- Our communities, who will help shape the delivery of services to meet their needs
- NHS services, including primary care, community, mental health and hospitals
- Local authority services, including social care, public health, housing and planning
- The voluntary and community sector involved in health and care as well as supporting broader determinants of health
- And supporting a more joined up response alongside other public services such as schools, police, fire and job centres.

Strategic aims

Overarching Ambitions of the Integrated Care Strategy		
Improving Healthy Life Expectancy	**Improving Life Expectancy**	**Reducing Health Inequalities**
An improvement in years of healthy life expectancy at birth from the baseline for 2018-2020 - yet we acknowledge that this may well require a longer timeframe than five years.	An improvement in years of life expectancy at birth from the baseline for 2018-2020 - yet we acknowledge that this may well require a longer timeframe than five years.	A reduction in life expectancy gap (measured in years) between those living in the most and least deprived areas of the ICS from 2018-2020 baseline.

Aim one: Improve outcomes in population health and healthcare

Our priority: We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood by: • Prioritising the first 1,001 critical days including implementing recommendations from the Ockenden Review[21] to equitably transform our maternity services • Develop multidisciplinary family hubs to support the holistic needs of all children and families and equip parents to make informed decisions • Tackling the impact of Covid-19 on our children, with a particular focus on emotional health and wellbeing and school readiness, including speech and language support • Delivering our six physical health transformation programmes, with a particular focus on developing a system approach to childhood obesity	**Our ambitions** • A reduction in the proportion of women smoking at time of delivery to close the gap between the local and England average so that the ICS matches the England average by March 2028 • An improvement in breastfeeding prevalence at six to eight weeks after birth to achieve an ICS average of 56% by March 2028 • A stabilisation of the rising rates of obese and overweight children in year six to a 2.7% rise from the 2021/22 baseline up to March 2028

- Recognising young carers at the earliest opportunity and ensuring that appropriate person-centred support is in place following a needs-led, strengths-based and personalised conversation
- Prioritising those children at greatest need. We know our most vulnerable groups can be similar to adults but also include those with special educational needs and disabilities, children in care and youth justice system, plus from the LGBTQ+ community and those with complexities requiring therapeutic placements to meet their emotional, behavioural and physical needs to avoid prolonged acute hospital stays
- Ensuring that palliative and end of life care services for children and young people are flexible and meet their needs

- Increase the percentage of children with free school meal status achieving a good level of development at the end of reception from the national average to statistically better than the national average by March 2028
- A sustained positive annual reduction from the 2020/21 baseline of 380.6 per 100,000 hospital admissions as a result of self-harm
- To continue to exceed the national annual targets set for numbers of children and young people who access mental health services
- By March 2028, 90% of children and young people who are identified in their last year of life have had an anticipatory care planning discussion recorded

Case Study

Ravnita, Bulwell

Family Mentors are providing a home visiting service for families in four areas of Nottingham to share advice and guidance around key child development outcomes.

Small Steps Big Changes have recruited Family Mentors from these local communities who have lived experience of parenting. The Family Mentors help to build trusted relationships with the families they support.

Family Mentors can give advice and support on topics such as breastfeeding, weaning, teething, sleeping and play.

"My son loves our Family Mentor dearly. My son's overall development is amazing and that is because of her support. She was not only a Family Mentor but a friend, and such an amazing listener. Her visits were incredibly useful for me. I cannot thank her enough for listening and being there for me."

Our priority: We will support frail older people with underlying conditions to maintain their independence and health.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will focus on supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. This will include: - Using risk stratification to identify, screen and categorise those people at greatest risk of frailty and admission to hospital - Developing multi-disciplinary personalised care plans for those at greatest need to support their health, care and independence needs - Seeking parity of esteem for mental and physical health needs including a focus on dementia - Prioritising secondary and tertiary prevention (including social care, falls prevention, home adaptations, and technology) to delay disease progression and maintain independence for as long as possible - A system review of hospital discharge and reablement pathways to get people back to their place of home as quickly and independently as possible. This includes implementing the Local Government Association recommendations on transfer of care, one shared data set and culture - Recognising carers of all ages at the earliest opportunity, and ensuring that appropriate person-centred support is in place following a needs-led, strengths based and personalised conversation - Further improving infection prevention and control practice and reducing antimicrobial resistance to reduce the likelihood and impact of hospital acquired infections	**Our ambitions** - A 5% reduction in emergency hospital admissions over the next 5 years compared with an unmitigated growth scenario - A reduction in the rate of emergency admissions due to falls in people aged 65 and over (rate per 100,000) - An increase in the proportion of people who feel they have control over their daily life - Achieve the NHS England annual target for the proportion of adults in contact with secondary mental health services living independently, with or without support - 100% of discharges made on the same day or the next day as the person was deemed medically safe for discharge/ medically fit for discharge (MFFD) - Achieve annual targets to increase the proportion of people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services (effectiveness of the service and offered the service) - An increase in the proportion of carers who reported that they had as much social contact as they would like - An increase in carer reported quality of life score - To achieve national ICB annual targets to reduce hospital acquired infections including MRSA BSI, C.difficile and Gram -negative bloodstream infections (GNBSI) - Reduce healthcare associated Gram -negative bloodstream infections (GNBSI) by 50% by 2024/25

Our priority: We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure that all health and care staff understand the building blocks of health and health inequalities and are competent and confident to deliver brief interventions on a range of prevention topics to support people's wellbeing. This will include: ◦ Developing a Making Every Contact Count22 (MECC) framework for action across ICS organisations ◦ Developing a flexible approach to MECC training and support that will be owned and tailored by the different services across the ICS. This will be linked to health literacy, shared decision making, better three conversations and strengths based approaches ◦ Embedding MECC training into the personal development plans and appraisals of all health and care staff, with consideration that MECC becomes mandatory training ◦ Clarifying signposting and referral mechanisms into prevention services, collaborating with local health and wellbeing services ◦ Prioritising brief interventions or those of greatest need ◦ Maximising the potential of roles that support the whole person, such as Social Prescribing Link Workers	**Key actions** ◦ MECC framework developed **Our ambitions** ◦ A reduction in under 75 mortality rate from causes considered preventable from the 2017-2019 baseline ◦ 90% of frontline health and care professionals to have completed MECC training by 31st March 2028 ◦ 70% of overall workforce to have completed MECC training within the past 5 years by 31st March 2028 ◦ All new starters to have completed MECC training as part of standard induction across all employers by March 2026 ◦ An increase in referrals into prevention services from 2022/23 baseline to 31st March 2028 ◦ An increase in the number of Social Prescribing Link Workers across the system

Aim two: Tackle inequalities in outcomes, experiences and access

Our priority: We will support children, young people and adults with the greatest needs (the 20% most deprived areas nationally, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage)

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will prioritise the areas and population groups of most need, including those living in the most deprived areas, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage. This will involve embedding a 'proportionate universalism'[23] approach, delivering a core service to our people, but tailoring the scale and intensity to the level of need. This will include: ◦ Delivering the priorities of the adult and children and young people NHS England Core20Plus5[24] frameworks - https://bit.ly/41ygkfl ◦ Equitable access to immunisation and screening and health checks, including babies and children and those for people with severe mental health and learning disabilities ◦ Identifying and addressing the 'care gap' in effective anticipatory care and secondary prevention interventions that are not completed, to provide a holistic, personalised approach to care, prioritising those most in need ◦ Embedding a trauma informed approach across the system ◦ Ensure support and services for those with palliative and end of life care needs are in place and equitably available children, young people and adults - https://bit.ly/3mgPzMw ◦ Delivering the priorities of the NHS Mental Health Implementation Plan and adopting the reforms to the Mental Health Act ◦ Reviewing progress of the local Learning Disability and Autism Programme	**Key actions** ◦ Improving the data quality for ethnicity and disability **Our ambitions** ◦ To achieve equity in access and experience and equal outcomes from services for those of greatest need ◦ To meet the Core20+5 ambitions across the five clinical areas for adults – maternity, severe mental illness, cancer, respiratory and cardiovascular disease – and children and young people - epilepsy, asthma, mental health, diabetes and oral health ◦ A reduction in non-elective activity through proactive management of long-term conditions to achieve Long Term Plan and ICS Clinical Prioritisation ambitions ◦ 80% of target staff attending trauma informed approach training ◦ At least 75% of people aged 14 or older with a learning disability will have had an annual health check (NHS Long Term Plan[25]) ◦ Reducing the number of people with learning disabilities and autism in an inpatient environment and increasing the number of people living in their local community, in line with our system trajectory

• Focusing on populations including those with severe mental illness, homelessness, domestic abuse, severe multiple disadvantage, financial vulnerability, multiple or life limiting illness, ethnic minority groups, care leavers and people with learning disabilities and/or autism • Focusing on children and young people with complex needs requiring therapeutic placements	

Case Study

An outreach nursing team is supporting housebound patients to receive the same primary care services as everyone else. The team offers holistic support for vulnerable people, including health and wellbeing support, long term condition reviews, vaccinations and education around medication.

Pam Topley, Trainee Nurse Associate, said: "I helped a lady who had just lost her husband and had no relatives nearby for support. She was locked away at home with the blinds closed and feeling depressed. I made referrals for bereavement counselling and she said afterwards that she felt there was now hope. I will go back and visit her soon to carry out a wellness check."

Jane Streets, Community Practice Nurse, said: "The biggest thing is the social and educational aspect. It's important to have that face-to-face contact as we pick up things that we couldn't just over the phone. We can provide the whole range of nursing services that housebound patients would receive if they could attend their GP practice, ensuring they are not disadvantaged because they cannot get to the practice."

Our priority: We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight , oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack/ stroke/ cancer/ chronic obstructive pulmonary disease COPD, asthma and suicide.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will prioritise equitable investment in prevention across the ICS, focusing on the key priorities of the two local Joint Health and Wellbeing Strategies. This will include: • Creating an Inequalities and Innovation Investment Fund to tackle the top prevention priorities for local people, including tobacco, alcohol, healthy weight and mental health • Agreeing to adopt the principle of 'proportionate universalism' in future funding allocations across the partnership so that resources are deployed according to need rather than historic allocation • Completing an evidence-based system review of the prevention offer and operating model to reshape and integrate services	**Key actions** • Development of an ICS all age Mental Health Strategy • A commitment to increasing the proportion of spend on prevention. **Our ambitions** • Best start in life indicators • A smoke free generation by 2040 ensuring that we take an equitable approach to working with our most vulnerable groups: - Reduction in smoking prevalence in adults (aged 18+) to 5% by 2035. - Smoking prevalence in adults (18+) with serious mental illness (SMI) -proportion (%) - Smoking prevalence in adults in routine and manual occupations (18-64). • A 10% reduction in alcohol-related hospital admissions from 2020/21 baseline • A stabilisation of the rising rates of obese and overweight adults (aged 18+) from 2020/21 baseline (split by deprivation where possible) • Suicide rates (persons, directly standardised rate per 100,000) to be statistically similar or lower than the England average by 2027/28 • A reduction in the numbers of children under 10 years who require tooth extraction in hospital

Aim three: Enhance productivity and value for money

Our priority: We will establish a single health and care recruitment hub.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will explore opportunities to develop a single health and care recruitment hub. This is likely to include: ◦ Leading on joint recruitment, enabling deployment and sharing of staff to respond to service needs. This could include benchmarking and exploring opportunities across the ICS and the wider D2N2 Local Enterprise Partnership ◦ Completing work to explore opportunities to address parity issues for care workers across the system	**Key actions** ◦ Workforce is more reflective of our local population at Place (split by deprivation, age, ethnicity, gender and disability) – through all levels / bands. To determine what the breakdown currently is by March 2024 then develop bespoke targets by Place **Our ambitions** ◦ Provider collaborative at scale partners working together from April 2023. By April 2024, the model may be expanded to include wider partners for selected shared staff groups, such as care support workers and nurses ◦ A reduction in ICS health and care staff turnover rate to 10% by March 2028 ◦ An increase of 10% in the number of jointly employed health and care posts ◦ A reduction of staff sickness and absence rates to pre-Covid levels (4.5%)

Our priority: We will adopt a single system-wide approach to quality and continuous service improvement.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will adopt a single system-wide approach to quality and continuous service improvement, exploring opportunities and aligning where practicable.	**Key actions** ◦ Strategic aims and principles embedded into staff induction by March 2024 and all staff performance development reviews by March 2026 **Our ambitions** ◦ Staff trained in system-wide quality and improvement approach by quarter four, building on QSIR foundations - 50% by Q4 2024/25.

Our priority: We will review our Better Care Fund Programme.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure our Better Care Fund[26] programme is meeting the needs of local people and aligned with the ambition of this strategy	**Key actions** ◦ Completed review of the Better Care Fund programme by March 2023. This review will seek to assess how the Better Care Fund has performed and how it has helped increase integration – as well as looking to explore areas where we can expand the programme and go further

Our priority: We will bring our collective data, intelligence and insight together.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will collaborate on our collective data, intelligence and insight. This will include: ◦ Creating a common view of outcomes, quality and performance across the ICS ◦ Looking for opportunities for alignment across the system to support service planning and integration ◦ Developing 'one version of the truth' through agreed system metrics and dashboards ◦ Developing a pipeline for the next generation of data, intelligence and insight workforce across the system	**Key actions** ◦ Development of a collaborative virtual intelligence system across the ICS ◦ An agreed ICS outcomes framework, with associated dashboards, that is used to identify priorities across the system

Case Study

Joint working has led to a reduction in people in Mid Notts attending emergency departments with end-of-life care needs from 5,304 (2019/20) to 3,433 (2021/22).

The End of Life Together partnership identifies people with care needs and offers advanced care planning. They have access to a multi-disciplinary single point of access and are then linked to the most appropriate service, such as day therapy, carer support or hospice at home support.

Dr Julie Barker, the GP end of life care lead, said: "One of my patients was diagnosed with advanced cancer. He lived alone and although he had a caring family, they couldn't meet his complex care needs as he reached the end of his life. On discharge from hospital, the wonderful team at Beaumond House offered him the choice of support at home with their Hospice at Home team or bed-based care. He opted for the latter and spent his last days comfortable, cared for, enjoying homemade soups he described as delicious and his family and friends spending as much time with him as they wished. His symptoms were well controlled with subcutaneous medication, and he died peacefully. His family were thankful for the care he had received."

Our priority: We will make it easier for our staff to work across the system.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will make it as easy as possible for staff to work across different teams and organisations. This will include: ◦ Establishing jointly employed head of commissioning posts for Ageing Well and Living Well, and head of quality and market management ◦ Further developing the Memorandum of Understanding for mutual aid between organisations ◦ All NHS providers being registered to utilise the digital staff passport to support movement of staff between organisations ◦ Developing a rotational scheme to support allied health professionals to move between sectors (NHS providers, primary care and social care) ◦ Establishing an integrated commissioning function and a quality and market management function across the ICS ◦ Developing integrated discharge hubs to encourage an integrated approach to service delivery ◦ Reviewing data sharing agreements to ensure staff have access the information they need to deliver the best care	**Key actions** ◦ Recruited Head of Commissioning posts for Ageing Well and Living Well, and Head of Quality and Market Management ◦ Refresh signed Memorandum of Understanding for mutual aid between NHS organisations by Q2 2023/24 and explore potential to roll out to wider partners where appropriate by March 2026 ◦ All NHS organisations signed up to and using the new strategic digital staff passport by March 2024 ◦ Rotation scheme for allied health professionals by April 2023 and review of opportunities to roll out to other professions by March 2024 ◦ Integrated discharge hubs implemented ◦ Integrated commissioning function and a quality and market management function established across ICS ◦ Streamlined, appropriate information sharing in place ◦ Agreed an ICS staff induction which sets out the expected standards across the workforce to embody this strategy's principles – and helps equip staff in this regard by Q2 2023/24

Aim four: Support broader social and economic development

Our priority: We will add social value as major institutions in our area

What will we do?

We will use our role as large public sector organisations that are linked integrally to place, people and communities (anchor institutions), to go beyond normal service delivery. We will use our resources and influence to maximise social, economic and environmental impacts (social value[28]) to improve the building blocks of health and reduce inequalities. Collectively, we have the potential to leverage our size and strengths to deliver greater benefits. We will also need to consider how other anchor institutions (private sector) can contribute to our aims and their local communities. This will include:

- Building on the work of local authorities to align the social value approach across the system
- Strengthening the ICS Anchor Champions Network to explore how we maximise support for social and economic development through the collective work of anchor institutions and the ICS delivery groups
- Implementing the Universities for Nottingham Civic Agreement[29] as our mission for anchor institutions across the ICS and D2N2 Local Enterprise Partnership
- Reducing our environmental impact by delivering our ICS Green Plan
- Putting actions in place to support local people with the rising cost of living, including signposting to relevant support services and fair reimbursement for skills
- Work directly with young people, looked after children, care leavers and carers including those with special educational and disabilities to consider working in health and care

How will we know we have got there? A five-year ambition unless otherwise stated.

Key actions

- Agreement of a collective procurement social value strategy for ICS partners, gaining efficiencies from our combined purchasing power, and supporting sustainability and social value in our communities by March 2024
- Partnership working with all major suppliers that identifies opportunities for local apprentice schemes, supports disadvantaged groups and engages with local providers by March 2026
- Universities for Nottingham Civic agreement approved across all organisations party to the agreement
- Refresh our Estates strategy by June 2023
- Active championing and sharing patient pathway schemes that drive innovation and reduce consumption and waste by March 2024
- Progress with delivery of national and local priorities and opportunities to reduce carbon emissions, as outlined in our ICS Green Plan

Our ambitions

- Increase the % of health and care workforce under the age of 25 years
- An increased proportion of the population with health conditions who are supported back into work.

Our ambitions

Carbon Net zero[31]
For scope 1 and 2 emissions:

- 80% carbon net zero by 2028-2032
- 100% carbon net zero by 2040

Supported by:

- 100% of electricity from renewable sources -April 2023
- 0% of secondary care sites primary heat sources are oil fuelled on– April 2023
- Ensuring over 90% of our owned or leased fleet vehicles under 3.5 tonnes are low emission vehicles, and 5% of those will be ULEV or ZEV (ultra-low – or zero- emission vehicles)
- CO2 impact of inhalers is reduced by 50% by 2028

Case Study

Nottinghamshire Healthcare NHS Foundation Trust has made a big green impact by saving £10,000 and avoiding over 100 tonnes of carbon in just one year thanks to an environmental initiative.

Green Impact helps staff and patients improve their environmental performance and working environments, with 555 staff and 245 patients being involved since the launch two years ago. Staff have an online workbook of manageable actions on issues including food, waste, energy, travel and biodiversity.

Harriett Tyler, Environmental Officer, said: "Actions include using a redistribution system to rehome unwanted furniture, electrical equipment, and office consumables, and other actions include going paperless, reducing travel, using resources more sustainably, reducing the use of plastic, and even listening to our newly-launched 20 minute green pod webinars."

How we will deliver the strategy

For our strategy to be successful it will mean that many of our colleagues and teams will need to adapt the way that they work. This will require an approach which prioritises the needs of the population first, then the system, and then the employing organisation.

Supporting our workforce

We are working across the ICS to take a 'one workforce' approach, inclusive of all staff involved in supporting local people's health and wellbeing. This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care. In line with this, we will review our People and Culture Strategy[32] to ensure that it meets the ambitions of the Integrated Care Strategy.

We will support our staff and teams in:

- Improving how we best make use of colleagues' skills and capability to make services better. We will lead the process of co-designing and developing an integrated workforce development plan, including developing new roles and new ways of working, built around population health modelling (gaining insights from analysing data). This will ensure our workforce is deliberately designed and developed to meet current and future health and care needs.
- Establishing a workforce representative of our population. Our aspirational goal is to have a workforce that reflects the communities we serve, through all levels/bands. Our equality, diversity and inclusion (EDI) leads will work collaboratively to support our people and culture programmes and to embed EDI principles and practice into all aspects of planning and delivery. We will continue to grow and develop our EDI Partnership Group and staff networks (race equality, disability and sexual identity) to provide support for existing staff. We will actively identify and remove inequity in all its forms across the ICS to foster a sense of belonging and in return broaden participation and engagement.
- Expanding CARE4Notts Health and Care Careers Academy to support people into work. CARE4Notts provides a single point of access to promote health and care careers, delivering information, advice and guidance, focusing on schools and colleges, young people and growing the future talent pipeline to ensure our teams reflect the diversity of our local population. We also have a Foundation School in Health, a partnership between Doncaster and Bassetlaw Teaching Hospitals and Retford Oaks Academy. We will continue to progress apprenticeship routes into clinical and non-clinical roles and a system approach to support diverse and inclusive work placements. We recognise the social value and impact within our local communities to better enable, develop and provide career opportunities to those who are under-represented, due to existing processes within securing and further career development.
- Embedding organisational development, culture and quality improvement. In, October 2022, we established our new system People and Culture function. Working with local health and care partners, we will set our vision and objectives, supported by a collection of measurable outcomes for improvement. System strategic areas include equality, diversity and inclusion, health and wellbeing, organisational development, leadership and talent management, training and education, and quality improvement.

We want a workforce that is deliberately designed and developed to meet current and future health and care needs.

Working with people and their communities

We are keen to further improve our work with the people and communities we serve by:

- Co-producing services alongside local people as equal partners to understand what matters to them. All system partners are committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. We will embed co-production as the default position for how we will work with people including children and young people as equal partners at all stages of the design, development and commissioning of health and care services and support. Further information on the approach to be taken is available in the Working with People and Communities Strategy[33].
- Embedding a true system culture into the way that we work. Culture and leadership development will be appropriately invested in and supported as a health and care system. We will attract, develop and retain our workforce through a demonstration of behaviours, style and technical capability. We will develop leadership capability and capacity by designing culture transformation and leadership programmes that are inclusive and outcome focused. Our interventions will be underpinned by collaborative leadership development, and where networks and spaces are created to support connectivity, conversations and act as a safe space to build and nurture relationships.
- Embedding personalised care and social prescribing. We will increasingly shift from a reactive, professional-led, illness-focused 'medicalised' approach, towards a proactive, strength-based, partnership and holistic care approach.

Evidence-based approach

We want to work together to embed an evidence-based continuous improvement approach. This will include:

- Building on our successful data, analytics, information and technology (DAIT) approach. Further information on how we will progress areas such as digital information, systems and services is contained in our DAIT strategy[34].
- Accelerating our research programmes, including service evaluation and audit. We will use evidence from research to inform the choices and decisions we make. We will work together with our population, Nottingham's universities and our local National Institute for Health and Care Research infrastructure. We support the ambition to become an Academic Health Science Centre which combines excellence in research, education and care.
- Developing a system-wide approach to quality improvement. Our partner organisations have committed to working together to build on our current System Quality Strategy[35] by incorporating principles and approaches from this to form a system-wide delivery plan.

Focus on outcomes

In order to ensure we are making an impact, monitoring delivery of the strategy will be achieved through the ICS outcomes framework. This framework is built from system outcomes relevant to each aim, which are measured by a set of metrics that apply across all that we do - service delivery, service change, transformation, people and culture.

Through our System Analytics and Insight Unit, we will develop a way of measuring people's health and wellbeing at neighbourhood, place and system level, using a 'Gross Domestic Wellbeing'[36] measurement. This will be supported by feedback from our population about what is and is not working for them.

Our delivery organisations and partnerships

In addition to the Integrated Care Partnership, there are a number of formal partnerships which will support the delivery of the strategy. These include:

1. **Health and Wellbeing Boards** – statutory committees of Nottingham City and Nottinghamshire County Councils respectively, with membership across public health, social care, children's services, the NHS and local Healthwatch.
2. **Place-Based Partnerships** – formed by organisations responsible for arranging and delivering health and care services in a locality or community. They include the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector, and people and communities.
3. **Provider collaboratives at scale** – delivering benefits of mutual aid working across a wider footprint, both within places and between places.
4. **Primary care** – GP practices, multi-disciplinary teams and primary care networks (groups of GP practices and others working together) implementing the Primary Care Strategy[37].
5. **Voluntary, Community and Social Enterprise Alliance** – formally embedded within the ICS. The Alliance will engage and embed the sector within the system governance and decision-making structures. The purpose of the VCSE Alliance is to enable every citizen to enjoy their best possible health and wellbeing, by bringing together local representatives of national and regional VCSE organisations as a single point of contact, to generate citizen intelligence from the groups and communities that they work with.

Enabling infrastructure

To implement the strategy, we will be reliant on the enabling support of:

- **Finance** – the challenges to public sector financing mean that the strategy will need to be delivered within our organisations' resources. How we use our funding will be a key enabler to the delivery of the strategy. As statutory organisations we will develop a set of guiding principles, in line with our ambitions for Nottingham and Nottinghamshire, to inform how our resources are used, achieving value for money and ensuring budgets are balanced.
- **Estates** – our ICS Estates Transformation Programme aims to complete the SHAPE database (capturing all public estate) so our baseline position is clear. Our ICS has identified the development of its next estates strategy as one of the key deliverables to support achieving our strategic ambitions. This will be developed on the basis of 'one public estate' so we deliver integrated care at place, using our estate in the most efficient ways.
- **Sustainability** – partner organisations have already agreed a Green Plan for the system to support the NHS achieve its commitment to becoming carbon neutral by 2040 and support the ambition set by Nottingham City Council for Nottingham to be the first carbon neutral city in the UK, with a target of net zero emissions by 2028. Our ICS Green Plan outlines the specific actions and priority interventions for achieving carbon net zero, to lay the foundation to deliver carbon emission reductions through the delivery of sustainable health and care services.

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Integrated Care System
Nottingham & Nottinghamshire

Every person will enjoy their best possible **health** and **wellbeing**

Integrated Care Strategy 2023 - 27

Summary

Nottinghamshire County Council

Nottingham City Council

NHS

Background

Our Integrated Care System brings together local health and care organisations with a renewed focus on providing joined up services and improving the lives of all people who live and work in the city and county.

This strategy covers the period up to 2027. It has been produced following extensive engagement with local people and communities and key stakeholders and is based on existing work, such as the two local Joint Health and Wellbeing Strategies.

The strategy is based on three guiding principles:

Principle 1: Prevention is better than cure

By focusing on prevention, we can make sure we use our limited resources most efficiently and improve people's health and wellbeing. This can mean that people need less treatment, we can stop more serious illness and can stop diseases getting worse.

Principle 2: Equity in everything

The principle of equity recognises that not all people have equal health and care access, experience or indeed outcomes. This strategy sets out that for some people and communities more support and resource might be required to achieve similar outcomes to others.

Principle 3: Integration by default

Local people have told us that they want joined up and seamless services. By making collaboration between all the workforce and teams the normal way of working, and by harnessing our resource and ingenuity, we can re-shape services to become more integrated, treating the 'whole person'.

Strategic aims

Here are our four aims and some examples of how we are working towards them:

Aim one: Improve outcomes in population health and healthcare

We will support children and young people to have the best start in life and also work to ensure frail older people with underlying conditions maintain their independence and health. We will also maximise the benefits of working together across the health and care system to get good health included in every conversation.

Case Study

Ravnita, Bulwell

Family Mentors are providing a home visiting service for families in four areas of Nottingham to share advice and guidance around key child development outcomes.

Small Steps Big Changes have recruited Family Mentors from these local communities who have lived experience of parenting. The Family Mentors help to build trusted relationships with the families they support.

Family Mentors can give advice and support on topics such as breastfeeding, weaning, teething, sleeping and play.

"My son loves our Family Mentor dearly. My son's overall development is amazing and that is because of her support. She was not only a Family Mentor but a friend, and such an amazing listener. Her visits were incredibly useful for me. I cannot thank her enough for listening and being there for me."

Aim two:
Tackle inequalities in outcomes, experiences and access

We will focus our efforts on the 20% of our population that need our support the most due to their income or other circumstances that mean they are disadvantaged in society. We will also invest in prevention activities around issues such as: smoking, alcohol abuse, being overweight and more.

Case Study

An outreach nursing team is supporting housebound patients to receive the same primary care services as everyone else. The team offers holistic support for vulnerable people, including health and wellbeing support, long term condition reviews, vaccinations and education around medication.

Pam Topley, Trainee Nurse Associate, said: "I helped a lady who had just lost her husband and had no relatives nearby for support. She was locked away at home with the blinds closed and feeling depressed. I made referrals for bereavement counselling and she said afterwards that she felt there was now hope. I will go back and visit her soon to carry out a wellness check."

Jane Streets, Community Practice Nurse, said: "The biggest thing is the social and educational aspect. It's important to have that face-to-face contact as we pick up things that we couldn't just over the phone. We can provide the whole range of nursing services that housebound patients would receive if they could attend their GP practice, ensuring they are not disadvantaged because they cannot get to the practice."

Aim three:
Enhance productivity and value for money

We will combine our efforts on things like recruitment and the movement of staff around the system as well as pooling our expertise around data, analytics and insights. We will also check that existing joint working programmes are still delivering what we need and work together to continually improve services.

Case Study

Joint working has led to a reduction in people in Mid Notts attending emergency departments with end-of-life care needs from 5,304 (2019/20) to 3,433 (2021/22).

The End of Life Together partnership identifies people with care needs and offers advanced care planning. They have access to a multi-disciplinary single point of access and are then linked to the most appropriate service, such as day therapy, carer support or hospice at home support.

Dr Julie Barker, the GP end of life care lead, said: "One of my patients was diagnosed with advanced cancer. He lived alone and although he had a caring family, they couldn't meet his complex care needs as he reached the end of his life. On discharge from hospital, the wonderful team at Beaumond House offered him the choice of support at home with their Hospice at Home team or bed-based care. He opted for the latter and spent his last days comfortable, cared for, enjoying homemade soups he described as delicious and his family and friends spending as much time with him as they wished. His symptoms were well controlled with subcutaneous medication, and he died peacefully. His family were thankful for the care he had received."

Aim four: Support broader social and economic development

We will work together as large public sector organisations and with other partners like our Universities and the private sector to maximise investment and grow in jobs for our population. We will also ensure that our activities are continually monitored and improved in terms of their impact on the environment.

Case Study

Nottinghamshire Healthcare NHS Foundation Trust has made a big green impact by saving £10,000 and avoiding over 100 tonnes of carbon in just one year thanks to an environmental initiative.

Green Impact helps staff and patients improve their environmental performance and working environments, with 555 staff and 245 patients being involved since the launch two years ago. Staff have an online workbook of manageable actions on issues including food, waste, energy, travel and biodiversity.

Harriett Tyler, Environmental Officer, said: "Actions include using a redistribution system to rehome unwanted furniture, electrical equipment, and office consumables, and other actions include going paperless, reducing travel, using resources more sustainably, reducing the use of plastic, and even listening to our newly-launched 20 minute green pod webinars."

Plan on a page

This is the five-year strategy of the Nottingham and Nottinghamshire Integrated Care System (ICS). Figure 1, below, summarises our vision, key aims, guiding principles and our approach to delivery.

Why are we here?

Our vision: Every person will enjoy their best possible health and wellbeing

What are we going to do: Our aims and principles

1. **Improve outcomes** in population health and healthcare	2. **Tackle inequalities** in outcomes, experiences and access	3. Enhance **productivity and value for money**	4. Support broader **social and economic development**

Prevention is better than cure

Equity in everything

Integration by default

What we need to achieve

- We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood
- We will support frail older people with underlying conditions to maintain their independence and health
- We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example mental health and healthy lifestyle and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing

- We will support children, young people and adults with the greatest needs (the 20% most deprived, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage)
- We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack/ stroke/ cancer/ chronic obstructive pulmonary disease (COPD), asthma and suicide

- We will establish a single health and care recruitment hub
- We will adopt a single system-wide approach to quality and continuous service improvement
- We will bring our collective data, intelligence and insight together
- We will review our Better Care Fund programme
- We will make it easier for our staff to work across the system

- Use our collective funding and influence to support our local communities and encourage people from the local area to consider jobs in our organisations
- We will add social value as major institutions in our area
- Work together to reduce our impact on the environment and deliver sustainable health and care services
- We will focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.

How are we going to do it

Supporting our workforce	**Working with people and their communities**	**Evidence based approach, whilst encouraging innovation**	**Focus on outcomes and impact to ensure we're making a difference**	**Our delivery vehicles**	**Having the right enabling infrastructure**

Three key principles to system working:

- We will work with, and put the needs of, local people at the heart of the ICS
- We will be ambitious for the health and wellbeing of our local population
- We will work to the principle of system by default, moving from operational silos to a system wide perspective

Three core values:

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions

How we will organise ourselves to deliver the strategy

All partners – NHS, local government, the voluntary, community and social enterprise sector, and other agencies linked to the ICS – will have a role to play in implementing the strategy. Oversight and ongoing review of the strategy is owned by the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), which brings together NHS, social care, public health and the voluntary, community and social enterprise sector.

Our staff are at the centre of our ambition for integration to deliver better care and support to local people. We are working across the ICS to take a 'one workforce' approach, inclusive of all staff involved in supporting local people's health and wellbeing.

This will enable us to make the most of skills and talent across our system, building integrated teams with the adaptability and capacity to support prevention and deliver person-centred care.

All system partners are committed to putting people at the heart of all that we do by consistently listening to, involving and collectively acting on, the experience and aspirations of local people and their communities. Implementation of the strategy will therefore be underpinned by a process of co-production. This will become the default position for how we will work with people as equal partners at all stages of the design, development and commissioning of health and care services and support.

Integrated Care System
Nottingham & Nottinghamshire

Nottingham City Council | Nottinghamshire County Council | NHS

Appendix C

Integrated Care Strategy Metrics Task and Finish Group

1. Recognising the ICP desire to have ambitious defined metrics, a task and finish group was established to oversee this work.
2. The group was chaired by the Deputy Director of Public Health at Nottinghamshire County Council. Membership included representation from Local Authorities, ICB, including System Analytical Intelligence Unit (SAIU), NHS Providers and Place Based Partnerships.
3. A set of objectives and guiding principles were developed to support the Metrics Task and Finish Group, which were supported by the ICP Chair and Vice Chairs.
4. The Metrics Task and Finish Group objectives were to:
    a) Agree a set of strategic outcomes for the Nottingham and Nottinghamshire health and care system and its population.
    b) Agree quantifiable ambitions for each of the above.
    c) Map deliverables to these strategic outcomes.
    d) Gain assurance that the deliverables will achieve the target level of ambition for each of the outcomes.

Principles

5. A "less is more" approach should be adopted in order that each of the strategic outcomes can have sufficient consideration by the ICP.
6. c.40 outcomes have already been proposed, and the default is that these should be the outcomes included in the strategy:
    a) Any changes to this should be highlighted and the rationale given (e.g. metric X is an operational deliverable rather than a strategic outcome; metric Y is unclear and therefore cannot be quantified; no data exists for metric Z)
7. The outcomes should be measurable, and robust baseline data should exist to understand the current state and likely future trajectory.
8. The outcomes should span the entire health and care system (NHS and local authority), and wider determinants of health where appropriate.
9. Consideration should be given as to how the outcomes in the strategy meet the four aims and three principles of the ICS.

10. Consideration should be given as to how the outcomes in the strategy align to the Joint Health and Wellbeing Strategies, ICS Outcomes Framework and PHM approach.

11. Ambitions should be set at ICS level, but also need to be set at Place/LTLA level (as appropriate and noting that Place/LTLA level work may continue into 2023/24):

    a) Consideration should be given to any targets already established and proposals for a stretch target developed for ICP discussion as appropriate.

    b) In setting and agreeing ambitions at a sub-ICS level, consideration needs to be given to equity and focus on improving outcomes for the most disadvantaged in our system.

    c) system resources (financial and workforce) should then be prioritised in a way that enables this equity principle to be delivered.

12. For NHS partners, further detailed work will be progressed in the Joint Forward Plan, which may expand on the scope of the strategy, but should keep the agreed outcomes at its core.

13. Where an outcome has been identified there should be clear planned deliverables to give confidence that an improved trajectory can be achieved, which will inform and assure the level of ambition proposed and agreed.

Appendix D – Integrated Care Strategy Launch Plan

Channel	Other detail
Nottingham and Nottinghamshire ICB	
Intranet news	
Virtual team briefing	Different monthly sessions dedicated to different aims / case studies / team profiles
Staff news	Weekly
Animated video to explain Strategy aims and principles	To be shared on ICS website, social media and via partner comms toolkit
Strategy web pages on ICS website	Include case study features
Partner toolkit	Including social media assets, video, case studies, internal text, stakeholder messages
Social media	Initial launch posts followed by themed months. Facebook, Twitter, LinkedIn – ICB and ICS channels
ICS newsletter	Strategy special edition in late March, followed up by regular coverage and case studies
TeamNet	For primary care staff
GP bulletin	Weekly e-bulletin
Place Based Partnerships	
Newsletters	Bi-monthly
Social media	
PBP websites	
Primary care bulletin	For Bassetlaw
Nottingham University Hospitals NHS Trust	
Internal bulletin	All staff email reaching 19,000 staff, twice weekly
Anthony May's Friday video	Weekly on a Friday
Intranet	Front page intranet article
'Ask the Exec' session	Staff engagement session with Anthony May and other exec members
Social media	Facebook x 3 (staff facing / patient facing / private staff Facebook groups), Twitter x 2 (staff facing / patient facing), LinkedIn / Instagram
Maternity newsletter	(if suitable)
Sherwood Forest Hospitals Trust	
Staff briefing	Every Tuesday
Staff bulletin	Every Thursday at King's Mill
Chief Exec's blog	
Intranet news	
Staff social media	

Appendix D – Integrated Care Strategy Launch Plan

Channel	Other detail
Stakeholder newsletter	End of each month
Trust matters	End of each month
External board meetings	Mentions on CX and Chair's board intros
Public website	
Public social media	
Doncaster and Bassetlaw Hospitals	
The Hive	Staff intranet
Staff Facebook group	Over 6000 colleagues
Staff app	Includes push notifications
Staff e-bulletin	Weekly
Social media	
Nottinghamshire Healthcare Trust	
Ifti's Colleague Update	3 x a week to all 10,000 staff
Intranet	
Staff Facebook group	5000 members
Line Managers Update	Internal newsletter
Team brief	Internal monthly senior management event and associated Team Brief newsletter
Website	
Social media	Twitter, Facebook, Instagram
South Notts PBP newsletter	Monthly
East Midlands Ambulance Service	
Enews	Staff update
Staff emails	
Workplace by Meta	Targeted at Nottinghamshire staff
Intranet news	
Social media	
Nottinghamshire County Council	
Intranet	
Team talk	Monthly
Social media	Facebook, Twitter, Instagram
Newspaper column/ press release	
ASCH practitioners newsletter	Weekly
Your Life bulletin (50+)	Every 3 months

Appendix D – Integrated Care Strategy Launch Plan

Channel	Other detail
Early Years partners children's centres	
Health and Wellbeing bulletin	Every fortnight
Nottingham City Council	
Intranet	
Social media channels	Facebook and twitter
PICS	
Staff conference	3 x a year
Staff newsletter	Monthly
Senior meeting briefings	
Intranet	
Citycare	
Cascade	Weekly staff electronic newsletter
Virtual staff briefings	Fortnightly, chaired by chief exec or exec director
Stakeholder newsletter	Quarterly, printed and electronic copies
Intranet news	
NCGPA	
CCO update	For staff
Share information with member practices	
Practice social media	
NCGPA social media	Twitter and LinkedIn

Meeting Title:	Integrated Care Partnership
Meeting Date:	17/03/2023
Paper Title:	**Integrated Care Partnership 2023/24 Annual Work Programme**
Paper Reference:	ICP 22 023
Report Author:	Lucy Hubber, Director of Public Health, Nottingham City Council Jonathan Gribbin, Director of Public Health, Nottinghamshire County Council Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire Integrated Care Board Alex Ball, Director of Communications and Engagement, NHS Nottingham and Nottinghamshire Integrated Care Board
Report Sponsor:	Kathy McLean, Chair of the Integrated Care Partnership (and ICB Chair) Cllr. Adele Williams, Joint Vice-Chair of the Integrated Care Partnership (and Chair of the Nottingham City Health and Wellbeing Board) Cllr. John Doddy, Joint Vice-Chair of the Integrated Care Partnership (and Chair of the Nottinghamshire County Health and Wellbeing Board)
Presenter:	Lucy Branson, Associate Director of Governance, NHS Nottingham and Nottinghamshire ICB
Recommendation(s):	The Integrated Care Partnership is asked to **discuss** and **endorse** the proposed work programme for 2023/24, noting that this will be subject to ongoing review and refinement over the coming months as new ways of working evolve and embed.

Summary:
This paper presents an indicative meeting schedule and work programme for the Integrated Care Partnership and its supporting ICS Partners Assembly for 2023/24.

How does this paper support the Integrated Care System's core aims to:	
Improve outcomes in population health and healthcare	The Integrated Care Partnership (ICP) is established to further the four core aims.
Tackle inequalities in outcomes, experience and access	As above.
Enhance productivity and value for money	As above.
Help support broader social and economic development	As above.

Appendices:
None

Report Previously Received By:
The proposal has been co-produced by the three statutory partners of the ICP and shared in advance with the Integrated Care Strategy Steering Group.

Are there any conflicts of interest requiring management?
No.

Is this item confidential?
No.

Integrated Care Partnership 2023/24 Annual Work Programme

Introduction

1. This has been an atypical year for the Nottingham and Nottinghamshire Integrated Care Partnership (ICP), which was established as part of new statutory arrangements in July 2022 as a joint committee of Nottingham City Council, Nottinghamshire County Council and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB).
2. This first nine-month period of operation for the ICP has been focused on the development and publication of the first Integrated Care Strategy for Nottingham and Nottinghamshire.
3. In line with good governance practice, as we move forward into 2023/24, we now need to establish an annual work programme for the ICP and its supporting ICS Partners Assembly, which sets out a coherent cycle of business for the next year of meetings.
4. The purpose of this paper is to present an indicative work programme for review and discussion.

Purpose of the Integrated Care Partnership

5. The ICP has been established as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System (ICS).
6. A summary of the ICP's purpose as described within its terms of reference is as follows:
    a) The primary purpose of the ICP is to produce an Integrated Care Strategy and Outcomes Framework for Nottingham and Nottinghamshire.
    b) The ICP will review the impact of the Integrated Care Strategy, focusing on improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and supporting broader social and economic development.
    c) The ICP will also receive reports on insights gained from service users and citizens.
    d) The ICP will consider the extent to which the Integrated Care Strategy needs to be revised.
7. The ICP's terms of reference stipulate that it will meet at least twice per year and will be supported in its work by an ICS Partners Assembly comprised of wider stakeholders.

Proposed outline work programme and schedule of meetings

8. The below table presents a high-level outline work programme for 2023/24, in line with the ICP's terms of reference; however, it is recognised that this will be subject to ongoing review and refinement over the coming months as new ways of working evolve and embed.

Date	Meeting	Proposed High-Level Focus
Mid-Late May 2023	ICS Partners Assembly	• To share the final Integrated Care Strategy and highlight where the feedback from the previous Assembly meeting has been incorporated. • To seek the views of wider stakeholders on how the Strategy would be implemented (including some consultation on the NHS Joint Forward Plan). • To spotlight progress on the ICS Green Plan (in line with the fourth aim). • To launch and open for nominations the ICS Staff Awards.
September 2023	Integrated Care Partnership	• To receive insights from service users and citizens, including summary of the population changes as captured in the 2021 Census, and a summary of learning from recent large-scale public engagement exercises. • To review the impact of the Integrated Care Strategy and consider the extent to which the conditions for success have been established and embedded. To include updates on the work to develop healthy life expectancy and life expectancy targets, and the work to understand and identify health inequalities within each specific metric.

Date	Meeting	Proposed High-Level Focus
		• To consider progress in developing the Population Health Management (PHM) Outcomes Framework.
October 2023	ICS Partners Assembly	• To update on the impact of the Integrated Care Strategy following ICP consideration. • To announce the winners of the ICS Staff Awards. • To consider other business as appropriate
March 2024	Integrated Care Partnership	• To review the impact of the Integrated Care Strategy and consider the extent to which any revisions to the strategy may be required. • To review the Integrated Care Partnership's terms of reference, proposing any amendments should these be required in readiness for 2024/25. • To discuss and agree the ICP's work programme for 2024/25.