NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire NHS Joint Forward Plan

2023 - 2027

Our NHS Joint Forward Plan for Nottingham and Nottinghamshire has been developed with our NHS statutory partners.

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

The plan has also been developed with our wider stakeholder community. Special thanks to the following partners for their support including the VCSE Alliance and Citizens Intelligence Advisory Group.

Bassetlaw Place-Based Partnership

Mid-Nottinghamshire Place-Based Partnership

Nottingham City Place-Based Partnership

South Nottinghamshire Place-Based Partnership

CityCare

Nottingham City Council

Nottinghamshire County Council

DHU Healthcare

NHS England

pics Primary Integrated Community Services Ltd

BCVS Bassetlaw Community and Voluntary Service 50th Anniversary | 1973 - 2023

DementiaUK Helping families face dementia

healthwatch Nottingham & Nottinghamshire

This plan sets out how we will work differently, where we want to be in five years and how we will get there

We have a collective ambition to improve the health and wellbeing of our local population. Our Integrated Care Partnership, acting as the 'guiding mind' of the Nottingham and Nottinghamshire Integrated Care System, published its Integrated Care Strategy 2023-27 in March 2023.

This Strategy describes our ambition, challenges and intended achievements to ensure that ***every person will enjoy their best possible health and wellbeing.***

This ambition is testament to the hard work and dedication of our staff who continue to work tirelessly across all our NHS and partner organisations to deliver safe and high quality health and care services to the people of Nottingham and Nottinghamshire and beyond.

We face multiple challenges in converting this ambition into action. Recruitment and retention of staff remains a priority and demand for services continues to rise. We continue to seek to recover services following the pandemic. Covid-19 highlighted underlying health inequalities across our communities and clear opportunities to improve healthy life expectancy and life chances for those who are most disadvantaged.

This five-year Joint Forward Plan has two specific and interlinked aims:

1. To recover NHS core services and make them sustainable.
2. To show how the NHS will support the delivery of our Strategy by shifting resource from treatment to prevention, focusing on those communities where need is greatest and integrating services around people and their communities.

This Joint Forward Plan demonstrates our determination to stay on course to deliver the ambitions of the Strategy. The Plan provides more detail as to 'how' we will deliver the Strategy, the approach we will take and the specific interventions that we will implement in order to meet our collective ambition over the next five years.

In delivering the Strategy we will retain the three strategic principles of:

PREVENTION, EQUITY and INTEGRATION.

Over the next five years, our collective focus will be on preventing people becoming ill, reducing the impact of ill health and empowering people to manage their illness themselves. We will reduce health inequalities across our population and we will promote equity.

We will do this in partnership with our local authorities, public and voluntary sector organisations, our population and communities. We will build on the momentum of our Joint Health and Wellbeing Strategies to tackle the wider determinants of health and support people to live healthier lives.

We will not simply rely on large-scale change programmes to achieve this. Our commitment to reducing health inequalities, promoting equity and prevention will simply become 'the way we work'. Our teams will be empowered to ensure every contact counts and encourage all voices to be heard in how we respond to our current challenges, as well as co-create our health and care services of the future.

We recognise that achieving our collective ambition will require us to accelerate our collaborative working at neighbourhood, Place, system and regional level. Our teams will be more integrated, developing proactive care to prevent ill health and helping people stay healthier at home for longer. We will rapidly scale up personalised care planning, working with those with lived experience and local communities to co-create solutions that build on personal strengths as well as community assets. We will actively seek out voices that are seldom heard so that all may contribute to building our transformed system.

We will redeploy investment and resources into services to support prevention, earlier detection and interventions that impact on population health. We will seek to reduce inequity across our system, in areas such as improving healthy lifestyles and promoting the building blocks of good health in employment, education and housing.

Over the next five years, these changes will result in a significant cultural shift in the way we work together and a radical overall transformation of the system in which we work.

This Joint Forward Plan commits our NHS organisations to delivery of key national expectations and will be a primary reference point for future strategic and planning decision making. It provides detail on how we will continue to improve and meet or exceed national standards in relation to elective care recovery, patient waiting times, access to primary care and other services. Nottingham and Nottinghamshire performs well compared to certain national indicators and this Plan demonstrates our commitment to remain one of the best performing systems in the East Midlands region, if not nationally.

We know we will not achieve the improvement in our population's health and wellbeing without thinking creatively, acting bravely and maintaining focus. We commend this Joint Forward Plan as a clear statement of our determination to do just that.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

NHS
Nottingham University Hospitals
NHS Trust

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

NHS
East Midlands Ambulance Service
NHS Trust

Introduction

Our Nottingham and Nottinghamshire Integrated Care Partnership has developed an **integrated care strategy** for our system, with the expectation that collaboration across all partners will deliver four core aims, and that delivery of these will be guided by three underlying 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**

We now have to translate this intent into action – encouraging local people, neighbourhoods, communities, staff, Place Based Partnerships and system partners to all play their part. This Joint Forward Plan acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire Integrated Care System (ICS), with intentions in line with our two Joint Health and Wellbeing Board Strategies for the city and county.

This Plan sets out the role that NHS partners will play in collaboration with our wider system partners in delivering our Strategy as well as the national expectations set out by NHS England. We want to be ambitious – we trust the passion, experience and commitment of our staff to enable us to be brave in the changes we intend to introduce or accelerate. We recognise that our communities face huge challenges and that we need to ensure every public pound, and all our combined effort, is focused on helping every person within Nottingham and Nottinghamshire to enjoy their best possible health and wellbeing.

We want to emphasise in this Plan how, by acting as an NHS team within our ICS, we will address the challenges of today as well as tomorrow. We outline the changes that our system will take over the next five years to ensure we have sustainable services by working differently, co-producing these changes with children, young people and adults, and being courageous in our approach. Our delivery plan responds directly to the priorities identified within our Strategy.

Our agreed 14 Integrated Care Strategy Priorities

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' for traditional areas of health, for example, mental health and healthy lifestyles, and incorporate signposting to other services.

We will support children and 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).

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 review our Better Care Fund programme.

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

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.

Underlying principles guiding our delivery

Prevention is better than cure
Equity in everything
Integration by default

Building our integrated approach

Working and behaving differently to deliver maximum impact

We want to transform the way our system works, to improve the lives of the people it serves. In line with the national **Hewitt Review** and the **Fuller Review**, our integration approach is widespread, taking in all levels, including colleagues within existing NHS organisations and the development of our four Place Based Partnerships (PBPs), working alongside system-level transformational programmes. Our PBPs will be characterised by empowered local teams working together across upper and lower tier councils. PBPs will be supported to work with our Primary Care Networks (PCNs) and develop integrated neighbourhood working (sometimes in the form of multi-disciplinary teams). Focus for these teams will be where population health intelligence suggests it would be most impactful, either in terms of improving health and wellbeing outcomes and/or improving cost-effective use of our collective resources. Ongoing evaluation and system level assurance mechanisms will enable us to refine and adapt these approaches as well as rapidly spread good practice and learning.

Our system model (see Figure 1) shows how our various partners 'lock' into our shared integrated system approach. The triangle of inter-dependency is strong, with all partners and elements of our system playing their role in delivering change based on the platform of the Integrated Care Partnership and the Integrated Care Strategy. The three strategic principles of Prevention, Equity and Integration remain the basis for this platform.

The benefits of this approach will be:

- Transformational change driven and owned by people closer to where people live
- Interventions co-designed with a better understanding of the context within which people live – interventions more sensitive to local need and therefore more impactful and cost efficient
- Relationships across partners and with communities are stronger and better able to use local resources – for example, creating innovation through integration/combined posts/shared knowledge and skills transfer
- More direct communication channels – professionals get to the right person/organisation more quickly to resolve the problem. Informal and formal mechanisms of engagement expand opportunities to make appropriate professional connections
- PBPs offering a way to drive local transformational change initiatives working in collaboration with system level experts, in areas such as public health, clinical and social care.

We will review our ICB operating model to further support this integrated system approach (see page 48).

Evolving our integrated operating model

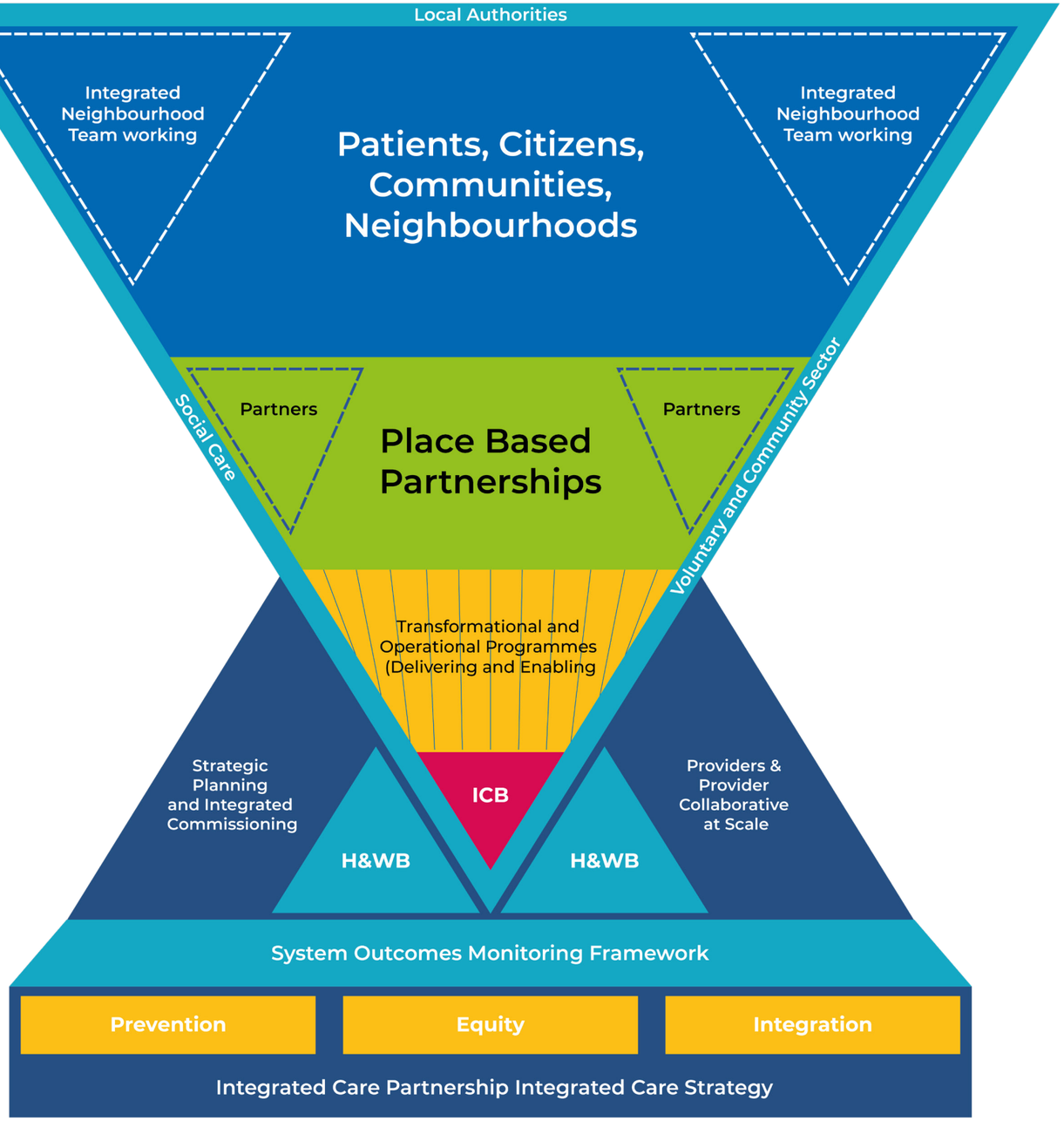


Figure 1.

Building our integrated approach

Delivering through improved prevention, reducing health inequalities and promoting equity

Our Plan is built on the shared commitment of all local NHS leaders to create conditions for success. We value our staff and recognise the significant contribution they can bring to finding creative solutions to the challenges we face. The NHS partner organisations, with local people and our communities, are well placed to ensure a sustainable health and care system that improves the long-term health and wellbeing of the people we serve. We share this motivation with our partners across our local authorities, wider public sector and our voluntary and community services.

We will achieve our future system by creating incentives for change. These areas include changes in focus, funding, structure, process and culture across our organisations, teams and individual staff members.

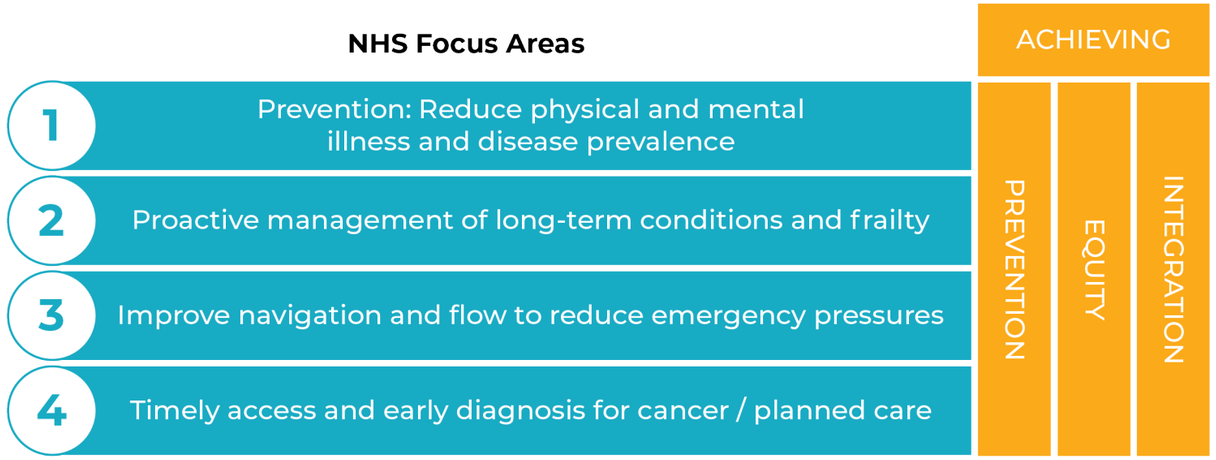
We will continue to deliver on national performance and delivery standards, as outlined within the NHS England 2023-24 Priorities and Operational Planning Guidance (Appendix F).

Delivering today while preparing to meet the challenges of tomorrow

"Prevention, population health management and reducing health inequalities are not a distraction from the immediate priorities: indeed, they are the key to sustainable solutions to those immediate performance challenges." Hewitt Report 2023.

In Nottingham and Nottinghamshire, we know that in a decade there will be a 38% increase in people aged over-85 years living in poor health (see Section 4). By seeking to reduce the growth in demand for costly hospital and specialist skills, unnecessary duplication across services and reducing inappropriate use of all services, we can shift resources into prevention initiatives that reduce demand in later years. We will do this while still maintaining safe and effective support for people when they need it. Alongside this, we recognise that babies, children and young people (aged up to 18 years) make up 20% of our population but 100% of our future. By investing in our services for all ages, across physical and mental health, using evidence and population health intelligence to prioritise where we can make the greatest impact, we will accelerate prevention of future ill health, reduce health inequalities and achieve improvement in health inequity.

Data tells us there are four areas which will significantly contribute to sustaining services today and create the conditions for meeting demand tomorrow. Making the significant impact required needs all NHS organisations to consolidate our collective effort over the next five years.



In pages 9-12 we have summarised NHS transformational expectations in line with our strategic principles. We have included proposed changes to our financial regime and the way we reinvest our resources. This will ensure a financially sustainable system, now and in the future. These commitments recognise that by focusing more on prevention we will generate longer term cost efficiencies that will enable future reinvestment. By promoting equity, we will provide everyone with the opportunity to have improved health and wellbeing (physical and mental). By promoting integration, we will significantly reduce waste and inefficiencies, creating future opportunities for reinvestment.

Developing detailed programme delivery plans and accountability

Our Joint Forward Plan (JFP) recognises the high level of inter-dependency across all those who serve the health and wellbeing interests of the people of Nottingham and Nottinghamshire. It show how we will deliver NHS programmes and initiatives over the next five years and how/where we will place our collective efforts and resources. The principles of oversight of the JFP for partners will be:

- Build on existing and maturing governance frameworks where this works well
- Ensure accountabilities and responsibilities are clearly identified
- Provide clarity of oversight for system partners and ongoing system level awareness of delivery, impact, risks and risk management
- Support ongoing collaboration and commitment to the delivery of agreed activities/programmes of work over the five years as well as an annual Plan re-fresh.

As a system, we will embed a programme approach to monitoring delivery of these initiatives. We will combine our resources to ensure appropriate collaborative oversight and further support to teams where delivery fails to meet our agreed expectations. While this approach will mature, current NHS oversight arrangements are in place to ensure all partners are able to co-produce this emergent approach (see Figure 2).

A high level summary of interventions that specifically address our focus areas is provided on pages 23-24. We provide additional detail of key deliverables in 20 key transformation areas on pages 29-49. Further detailed delivery plans have been developed by subject matter leads across our system which will be used to inform our understanding of progress on delivery of our JFP.

Figure 2.

System changes aligned to our three principles are:

<table>
<tr><th>PRINCIPLES</th><th>Year 1</th><th>Year 2</th><th>Year 3</th><th>Year 4</th><th>Year 5</th></tr>
<tr><td rowspan="6">Prevention</td><td>Refining our approach and commitment to primary and secondary prevention, building on the contributions and strength of all partners.

PBPs will implement a minimum of one Joint Health and Wellbeing Strategy prevention priority, dependent on population needs. PBPs will do more where Place resources support this. Focus will be on key priorities such as smoking, obesity, frailty, mental health, best starts and long-term condition management.

Development of care pathways that support people to stay well at home for longer.

Development of ‘virtual wards’ to enable people to be cared for at home/within their communities safely.</td><td>Collective focus across our system on a minimum of two Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs (one of these addressing healthy behaviour choices). Population health intelligence will guide collaboration with our communities and across partners to maximise this impact, for example, including consideration of wider determinants of health, as well as inter-relationship with promoting equity.</td><td>PBPs will implement a minimum of three Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.</td><td>PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.</td><td>PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources.</td></tr>
<tr><td colspan="5">Building on existing Joint Health and Wellbeing Strategy and delivery plans, to agree prevention approaches across health and care pathways. Improving children and young people outcomes and mental health needs will be evident in all Plans over the five years. Through integration and using the skills and resources across the system and Place, and in particular with the support of the VCSE sector and communities, we will gradually accelerate action that moves population need away from treatment. Impact on equity considered for all prevention initiatives.</td></tr>
<tr><td rowspan="5">Equity</td><td>The ICB will continue to provide a dedicated fund to support improvements in health inequalities and equity. This fund will be a minimum of £4.5m.</td><td>This fund will increase by 0.2% from baseline year one.</td><td>This fund will increase by 0.2% from baseline year two.</td><td>This fund will increase by 0.4% from baseline year three.</td><td>This fund will increase by 0.4% from baseline year four. This accumulates to circa £30-35m.</td></tr>
<tr><td>All system partners will improve data quality for ethnicity and disability for all patients and local people to support future analysis.

Consideration of ‘proportionate universalism’ as part of strategic decision-making processes.</td><td colspan="4">Enacting the principle of ‘proportional universalism’, partners will commit to target resources to higher levels of need informed by system data and intelligence. Solutions co-produced inclusively with local communities, engaging with and listening to those whose voices are seldom heard.

We recognise that a whole population approach is required and that our opportunities relate to the sum of all the parts of the system. Each partner has a role to play in impacting on equity.</td></tr>
<tr><td>All partners will commit to a Population Health Framework.</td><td colspan="4">Ongoing oversight of delivery of our agreed transformation initiatives/commitments across Places, primary care, community and acute sectors.</td></tr>
<tr><td colspan="5">Embed parity of esteem for physical and mental health needs across all policy areas (including maintaining a focus on dementia).</td></tr>
<tr><td>Development of a Strategic Co-production Representative Group. Creation of co-production toolkit and network.</td><td colspan="4">Ongoing oversight of co-production approach as part of Integrated Care Strategy commitments. Roll-out of training offer.</td></tr>
</table>

System changes aligned to our three principles are:

PRINCIPLES	Year 1	Year 2	Year 3	Year 4	Year 5
Integration	PBPs will develop a Place plan outlining delivery of interventions to address key priorities, including Core 20+5 (adults and children and young people) and Joint Health and Wellbeing Strategies. Based on local priorities identified by the System Analytics and Intelligence Unit and public health teams, PBPs will develop integrated neighbourhood team working to curb demand growth, focusing on keeping people out of hospital wherever possible. Delivery will build on the success of our community transformation programme.	Based on identified local and system priorities, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on keeping people out of hospital wherever possible.	Based on local and system priorities identified by the System Analytics and Intelligence Unit, PBPs will develop integrated neighbourhood teams to curb demand growth, focusing on the prevention agenda.		
	Development of a system monitoring and delivery assurance framework for the ICP Strategy and JFP. Development of an agreed inclusive approach to annual JFP refresh.	Ongoing system level assurance and delivery oversight of the ICS Integrated Care Strategy and Joint Forward Plan.			
	Developing multi-disciplinary personalised care plans and active case finding for those at greatest need to support their health, care and independence needs.				
	System transformation programmes will develop strategic plans across the partnership to address key strategic priorities to be delivered at a system level.	Ongoing system level leadership, assurance and delivery oversight with governance that reflects system working. Development of a system level project management office to support oversight.			
How we will use our resources differently	Agreement on system funding and resources for sustainable Place delivery teams and PBPs. Approach based on agreed Place plans and responsibilities, supporting development of integrated neighbourhood team working, delivery of Primary Care Strategy and wider integration approaches supporting delivery of JFP.	Reprioritisation of funding/ resources on prevention, moving from treatment services to prevention services to address system priorities, for example, smoking, obesity, alcohol.	Recurrent investment in prevention where it will have the greatest value, recognising the valuable contribution across all partners (NHS, statutory and non-statutory) and through our structures (with an annual investment uplift dependent upon affordability and return-on-investment assessment).		
	Review of Better Care Fund with specific reference to supporting PBP plan delivery and delivery of the three guiding principles.	Application of Better Care Fund review outcomes to support initiatives aligned to the three guiding principles.	Ongoing assurance of use of Better Care Fund to maximise investment to achieve delivery of the ICP Integrated Care Strategy, Joint Forward Plan and Joint Health and Wellbeing strategies.		
	Development of equity framework that demonstrates the opportunity to impact on access across interventions including the re-distribution of resources. Testing out on a small scale (years one-to-two) moving resources to population need.		Development of equity framework that demonstrates the opportunity to impact on patient experience and outcomes.	Equity framework refined and model tested in relation to the distribution of financial resources.	Equity frameworks embedded across all activities that provide a strong universal approach with resources targeted to need.
	Ongoing system review of opportunities for reinvestment based on invest to save and value-for-money principles. Redistribution of efficiency savings and/or growth funds to those areas of greatest prevention and equity opportunity, to shift health and wellbeing outcomes at a population level. Anchor organisations continue to progress with development of opportunities to advance social value, leveraging the NHS opportunity to contribute to wider social and economic development.				

Critical success factors for our transformational journey will include:

PRINCIPLES	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention	• Health Inequalities Investment Fund to tackle to priorities, for example, tobacco, weight, alcohol and mental health • Evidence-based review of system prevention offer to reshape and integrate services • Commit to increasing percentage spend on prevention • 0.2% of revenue invested in prevention • Develop our Population Health Management approach through the identification of metrics and a system-level reporting framework for NHS as well as Joint Health and Wellbeing outcomes. The ongoing development of detailed analysis to inform future investment decisions • Develop our focus on children and young people across all Places, including progression of UNICEF child friendly status	• System plan for people's first 1,001 days and implement Ockenden recommendations • Review smoking cessation support in antenatal and maternity • Scope multi-disciplinary team family hubs • 0.4% invested in prevention	• All new starters to complete Make Every Contact Count training as part of induction by March 2026 • 0.6% invested in prevention	• 1% invested in prevention	• 90% of frontline care staff completed Make Every Contact Count training • An improvement in healthy life expectancy and life expectancy from birth from 2018-20 baselines • 1.4% invested in prevention • 80% carbon net zero by 2028-32
Equity	• Adoption of 'proportionate universalism' and plan for resource deployment based on need rather than historic allocations: examples of approach provided through commissioning decision-making processes • Improve data quality for ethnicity and disability across primary, community and acute data sets • Review waiting lists and access criteria against deprivation level criteria across acute and community services (including physical and mental health services) • Delivery plan for Core 20Plus5 developed in line with JFP • Identify and address 'care gaps' in anticipatory care and tertiary/secondary prevention across a minimum of the top five high-impact long-term condition areas • 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 • Confirm scope of mental health waiting list recovery programme	• At least 75% of people aged 14-years-plus with learning disabilities will have an annual health check • Annual operating plan 2024-25 resource allocation reflects resource deployment review findings • Ethnicity and disability data and waiting list review findings converted into 2024-25 action plan • Core 20Plus5 plan enacted • Identify and address 'care gaps' in anticipatory care and tertiary/secondary prevention across a minimum of the top 10 high-impact long-term condition areas • Development of an ICS all-age mental health strategy, incorporating mental health waiting list recovery	• Core 20Plus5 plan enacted • Partnership working with all major suppliers that identifies opportunities for local apprentice schemes, supports disadvantaged groups and engages with local providers by March 2026	• Core 20Plus5 plan enacted	• Core 20Plus5 plan enacted • A reduction in the life expectancy gap (measured in years) between those living in the most and least deprived areas from the 2018-20 baseline
Integration	• Create a common view of outcomes/quality and performance across system • Develop 'one version of the truth' dashboard to monitor key system priorities and identify actions • Rotation scheme for allied health professionals by April 2023 and review of opportunities to roll-out to other professions by March 2024 • Recruited head of commissioning posts for Ageing Well and Living Well, and head of quality and market management • Scope and vision for provider collaboration agreed: delegation principles and responsibilities commencing 2024-25 confirmed • System assurance, governance and monitoring arrangements established for key system actions, for example, role of ICB, ICP and health and wellbeing boards • Integrated approach to system-wide acute transformation opportunities scoped and agreed, for example, outpatients • Strategic aims and principles embedded into staff induction by March 2024 • Mobilise implementation of the Primary Care Strategy. Establishment of the Primary Care Strategy Delivery Group • Medically Safe for Transfer annual operating plan trajectories achieved	• Develop a collaborative, virtual intelligence system across the ICS • Integrated commissioning function and a quality and market management function established across ICS • Integrated discharge hubs implemented	• Strategic aims and principles embedded into all staff performance development reviews by March 2026		• An increase of 10% in the number of jointly employed health and care posts

Securing our ambition for our population

What our Joint Forward Plan will mean for us, local people and our partners

Our key programmes of work, implemented via leaders at all levels within organisations, will reinforce our commitment to support integrated working throughout NHS organisations and system partners. We have already embarked on novel ways of working across teams, sharing skills and resources in order to create efficiencies and maximise impact for local people. These approaches will be accelerated and scaled up over the next five years. Case studies of existing initiatives are shown in Appendix E.

We will change the way we engage with our patients, service users and communities. Our working ethos across all NHS partners will be founded on personalised care and care planning, supporting individuals to feel treated as a person rather than a diagnosis. Through the development of social prescribing, care navigation and 'making every contact count', we will generate a new approach to supporting people to achieve their self-identified outcomes.

This ethos will extend to working more closely with people and communities, including those with lived experience and their carers, to co-create and design services to ensure they remain accessible, relevant, effective and value-for-money. We will build on and take learning from the embedded co-production and engagement arrangements already in place for children and young people so that all voices are heard across the system.

Co-production will ensure more effective commissioning decisions and more efficient use of available resources across a community. By adopting an asset-based approach and supporting increased community resilience, often through the expansion of voluntary and community sector services, we can realise our aim of improving socio-economic development. All NHS organisations will contribute, developing collaboration into genuine integration to create new delivery forms – either in relation to direct patient care or in terms of the services that enable that care.

Figure 3 outlines what these changes will mean for our system.

Ensuring delivery and managing risks

Delivery of our Joint Forward Plan will be monitored through agreed governance and oversight arrangements (see page 8). The development of an outcomes framework for providing oversight and monitoring of delivery will require the engagement of all partners. This will include the reporting and collection of high quality data. Our approach to risk management associated with the JFP will remain complementary to organisational and system risk management arrangements. Key risks for the JFP are:

RISK	MITIGATION
Delivery of the JFP and key commitments	System level governance and control mechanisms, supported by clear metrics/milestone reporting, to enable the ICB and partner organisations to monitor, support and be accountable for the implementation of the JFP from 2023-24.
System financial balance impacting on re-investment in prevention	By signing off the JFP, ICB and partners commit to stated investment in health inequalities and prevention. Investment will remain protected across the five years. All partners deliver improvements in the recurrent financial position to secure overall system financial balance
Cultural and structural changes fail to materialise and achieve anticipated benefits	Development of system-wide communications and engagement to help staff/public commitment. Workforce initiatives, combined with system leadership across partners, create the conditions for change. Data-informed decision-making, ongoing maturity of PBPs, Provider Collaborative, joint working across all partners and integrated neighbourhood teams supports embedded and sustainable change.
Individual partner resilience including workforce	Development of collaborative workforce initiatives, greater integration of teams, ongoing support for voluntary and community sector investment, collaboration on estates and digital, and focus on health inequalities, equity and prevention creates opportunities for more efficient use of system resources. All underpinned by continued focus on quality improvement.

What will delivery of our Joint Forward Plan mean for our community?

Figure 3.

	For People	For Staff	For NHS Organisations	For Partners
Promoting Prevention	• Earlier detection of disease • Reduced likelihood of future ill health or current ill health worsening • Empowered to work with staff to develop services and solutions based on need and real-life experiences	• Helping people to stay healthier for longer • Promoting a more holistic approach to patient care • Ensuring physical and mental health needs are addressed	• Avoiding future use of services, ensuring services are available for those that need them when they need them most	• Developing closer working relationships and reducing duplication across organisations • Supporting effective use of resources
Promoting Equity	• Supporting those with severe multiple disadvantage to have improved life chances • Ensuring all voices are heard • Promoting inclusion, valuing diversity	• Making sure all patients have equal opportunity to benefit from the services they provide • Valuing all our staff and supporting them	• Reducing or preventing people dying early from treatable conditions • Making better use of resources to benefit more people	• Enabling better access to non-NHS services that support personalised care • Enabling all our community to fulfil their potential
Promoting Integration	• Reducing the need to engage with multiple NHS staff about the same issue • Being supported on non-medical matters that are important to the individual • Promoting more seamless care across clinical and non-clinical support services	• Promoting multi-disciplinary team working and continuity of care • Making Every Contact Count • Staff feel empowered to work differently	• Creating streamlined care pathways • Increased staff resilience • Creating efficient use of estates • Implementing personalised care	• Making it easier to do business with the NHS • Greater recognition of the value of non-NHS services in supporting health and wellbeing • Building community resilience

What will the Joint Forward Plan mean for our Integrated Care System?

Success in delivering our five-year plan will mean our ICS will:

- Enable every person, young and old, to achieve their best possible health and wellbeing. This includes their physical and mental health.
- Be able to evidence positive impact for our communities in each of our Places and across the system, in terms of both physical and mental health outcomes.
- Demonstrate positive impacts on reducing health inequalities and inequity. Impact will be linked to targeted interventions, tracked through local and national outcomes metrics.
- Urgently make a real shift of NHS resources to prevention related initiatives over the next five years, reflected in how resources are allocated to key priorities and by developing new roles and ways of working.
- Have an inclusive, diverse and innovative culture across the NHS, with a sustainable workforce, local skills pipeline, developing and retaining local talent.
- Recover services fairly from the pandemic – achieve target waiting times with a focus on equity and close the mental and physical health gap for children and young people affected by the pandemic. We will meet quality and national performance metrics while continuing to adopt a more personalised and proactive approach to care. Care in hospital will be complemented by personalised care planning to maximise patient outcomes and help people to stay well at home for longer.
- Consistently make the best possible collective use of our resources and be ambitious to gain the best outcomes for local people – working collaboratively to maximise our impact on both physical and mental health and wellbeing during people's lives.
- Achieve financial balance within a safe health and care system, with high quality, high performing services.
- Be highly visible and relevant in communities, creating effective partnerships with local organisations that drive change and contribute to social justice, community resilience and economic development in our area.
- Use community assets, strengths-based approaches and digital tools to support people to take control of their health and wellbeing, with place-based inclusion strategies to promote health equity.
- Accelerate our research programmes, including service evaluation and audit. We will use population health data, best practice guidance and research evidence 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 to inform this approach.
- Use data and intelligence to help us understand issues better, like smoking and obesity, and to allocate resources on this basis. 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 carers and families.

In order to deliver this future, we will commit to the key system changes outlined on pages 9-11 which affect the way we work with partners and the communities and how we reinvest our funding. Alongside this, we will develop more detailed change programmes across a wide range of services (as outlined in Section 6).

Case study: Equity in everything

Samantha had been in and out of prison throughout her adult life. She was homeless and suffering from poor mental health, but not receiving any mental health medication due to her high levels of substance misuse. The Homeless Health Team and Juno Women's Aid supported Samantha through links made by the multi-disciplinary team. She is now registered with a GP, accessing mental health services and has been referred to the YMCA. Samantha has engaged well and has not been seen by the Street Outreach Team since her move to YMCA accommodation. These outcomes would not have been possible without the new services being flexible and person-centred.

Case study: Prevention is better than cure

Slow cooker courses have been held to support people in Bassetlaw with food insecurity. They have been delivered by ABL Health, in conjunction with Bassetlaw Community and Voluntary Service and Bassetlaw Food Insecurity Network. The aim is to upskill people, improve confidence, connect people and boost health and wellbeing. Participants complete information on nutrition, physical health, mental health, smoking and alcohol and are signposted to different support services. New courses are being held with the Polish community and with adults with mental health and learning disabilities in Newark. Participants: *"The course made me have more confidence in cooking and to socialise more." "It has helped me consider planning menus that are healthier."*

Case study: Integration by default

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. It has access to a multi-disciplinary single point of access and links to the most appropriate service, such as day therapy, carer support or hospice at home support. This has resulted in 81% of people who expressed their preferred place of care being supported to achieve this. Dr Julie Barker, GP and 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."*

Our Integrated Care System

How we work together

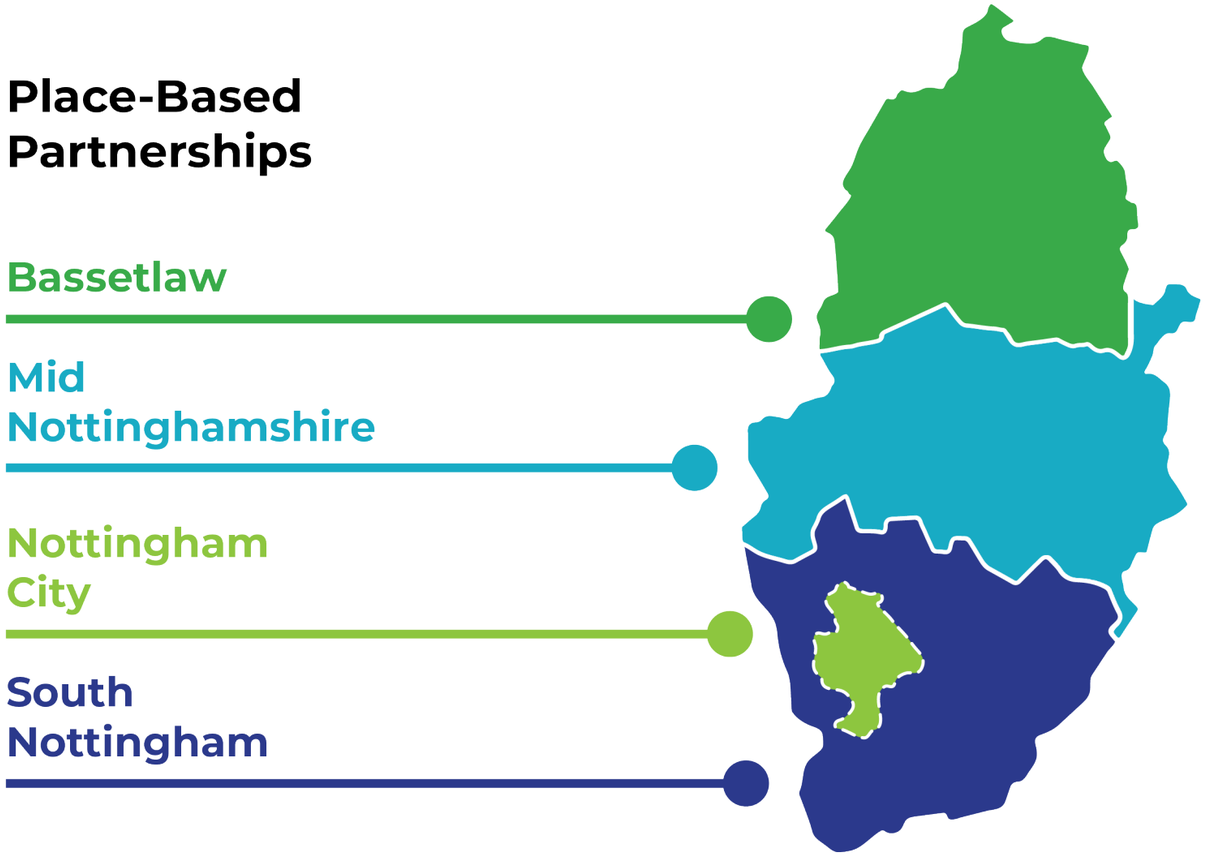
Our Integrated Care System (ICS) has two statutory elements:

- 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) - a statutory committee formed between the NHS Integrated Care Board and upper-tier local authorities. The ICP brings 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 to 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 produce benefits of NHS providers working together, across multiple places to improve quality, efficiency and outcomes, and reduce inequalities in access and experience
- At a whole 'system' (ICS) level

Place-Based Partnerships



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

Our places and partners

Our family portrait - Nottingham and Nottinghamshire Integrated Care System (ICS)			
Nottingham City PBP 396,000 population	South Nottinghamshire PBP 379,000 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 Gredling Borough Council Rushcliffe Borough Council	Mansfield District Council Newark & Sherwood District Council	Bassetlaw District Council
	Ashfield District Council		
Healthwatch Nottingham and Nottinghamshire			

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. The VCSE sector is a critical partner in the ICS and at a Place level.

Our population

Local health challenges

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do – as explained in our Integrated Care Strategy and Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire.

Our population health management experts have looked at what the future might hold in terms of our population's needs and the anticipated demand and capacity required to meet those needs over the next five to 10 years. The outcome of this modelling underlines how we must fundamentally shift our model of care. Overall, the population of Nottingham and Nottinghamshire will grow by 5% over the next 10 years. However, this figure masks very significant growth in our older population with a 38% increase in people over the age of 85 during the same period. We know that age and illness are closely linked. Currently 70% of emergency beds and 54% of emergency admissions in Nottingham and Nottinghamshire are occupied by people over 65 years old despite that age group comprising just 18% of the population. Of the people currently in Nottingham and Nottinghamshire aged over 65, 81% have a long-term condition and/or a diagnosis related to frailty - just 12% are considered 'healthy'.

Frailty, circulatory and respiratory conditions are more prevalent in older people, and as our older population grows, we can expect more people with moderate and severe frailty, heart failure, stroke, congestive heart disease, chronic obstructive pulmonary disease (COPD), cancer, hypertension and diabetes. 15,000 (or 5.5%) of children and young people (aged up to 19 years) have asthma in Nottingham and Nottinghamshire. This indicates significant under-diagnosing, as the national rate is around 10%. Only 53% have a recorded annual review.

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

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

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

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

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

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

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

Our population

Local health challenges

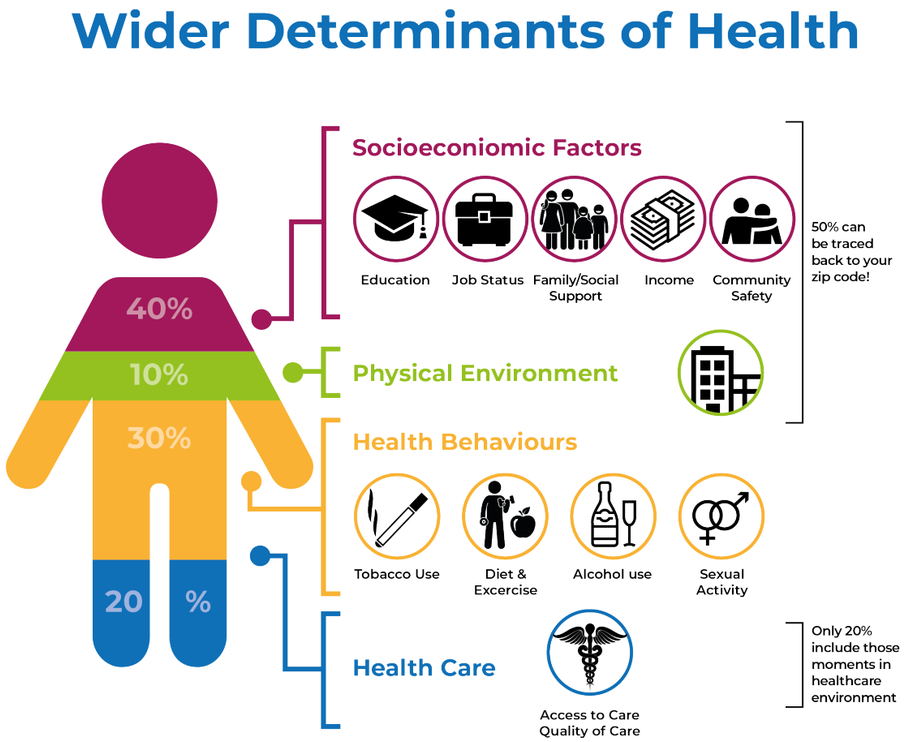
Nearly one in three people with a long-term physical condition also has a common mental health disorder, most commonly depression and anxiety. Across Nottingham and Nottinghamshire, there are 8,880 adults, children and young people aged 15 years-plus on the GP severe mental illness register. These people are:

- At higher risk of emergency admissions compared to the general population
- 4.5 times more likely to die prematurely than those who do not have severe mental illness
- 37% of people identified with severe mental illness are smokers, 34% of obese
- The prevalence of severe mental illness is higher in black and mixed ethnicity groups and in socio-economic deprived areas.

The impact of wider determinants of health on people's physical and mental health, from birth through to end-of-life and the importance of prevention cannot be under-estimated. For example, smoking has consistently remained the greatest contributor to death and disease across Nottingham and Nottinghamshire for the past 30 years. This combination of age and illness (greatly impacted by wider determinants such as healthy behaviours, education, employment and housing) is likely to overwhelm our services in the near future if we continue with the same approach.

We must recognise the continued impact of Covid-19 on our children and young people, with a particular focus on emotional health and wellbeing and school readiness, including speech and language support. A national survey reported that one in six young people (to age 19) now have a probable mental health disorder. This is strongly reflected locally in increased referrals for self-harm, child and adolescent mental health services and school health services.

The high level of relevance of the wider determinants of health on overall health and wellbeing outcomes is reflected in the illustration opposite.



The impact on activity, demand and costs

Population health management data clearly illustrates how demand will increase without action towards greater ill health over the next five years.

For example, mental health services for older people are predicted to see an 11% increase in activity over five years and a 23% increase over 10 years. This is similar to the predicted growth for district nursing services. For primary care, the growth over 10 years is 9%, requiring an extra 600,000 appointments each year.

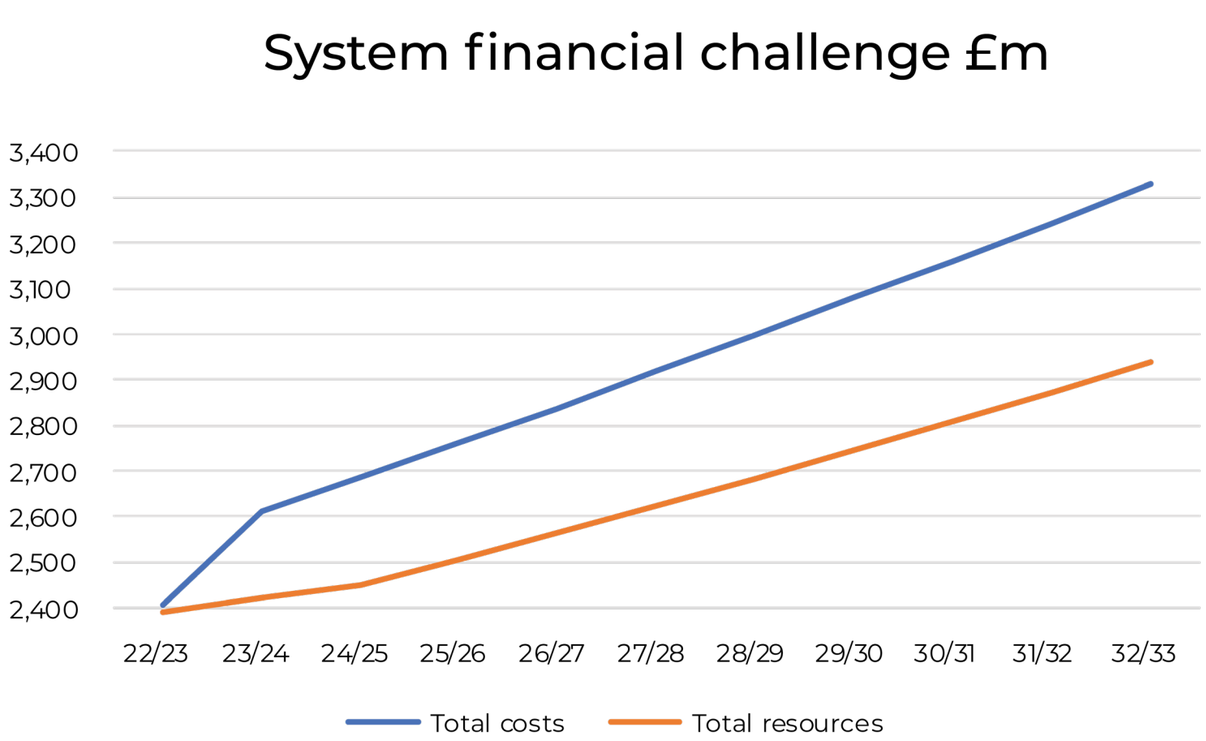
Over five and 10 years, we can expect an 8% and 16% increase in ambulance conveyances and linked to that, a need for a 19% increase in emergency beds (360 beds or about 15 wards).

This modelling does not account for any of the other contributory factors, for example the impact of the current cost of living crisis on both physical and mental health.

The impact of this demand will increase costs within the system. A conservative estimate is that in five years' time (based only on demographic growth in our older population and inflation) and the current underlying deficit, the gap will be £650m, rising to just over £1 billion in 10 years.

Public health analysis clearly identifies the opportunity to mitigate this risk of disease burden for our population and increased service demand and costs, through the development of our approach towards prevention, reducing health inequalities and equity.

Without focused action today, to mitigate the rise in demand currently experienced by health and care services and associated funding, the population is likely to be burdened with poorer health and wellbeing outcomes tomorrow. Our desire to shift significant resource from treatment to prevention, and from acute to community based services, will continue to be severely compromised.



POD	POD2
CHC (patients - snapshot)	Fast Track (Palliative)
Mental Health	MHSOP
Community & Primary Care	District Nursing
Beds	Emergency
EMAS	See Treat & Conveyed
EMAS	See & Treat
Community & Primary Care	GP Appointments

5 year growth	10 year growth
111%	124%
111%	123%
111%	123%
109%	119%
108%	116%
107%	115%
105%	109%

5 year growth	10 year growth
21	46
7,036	14,238
82,701	178,932
157	332
5,894	12,290
2,874	6,108
317,763	606,594

How the data defines our clinical priorities

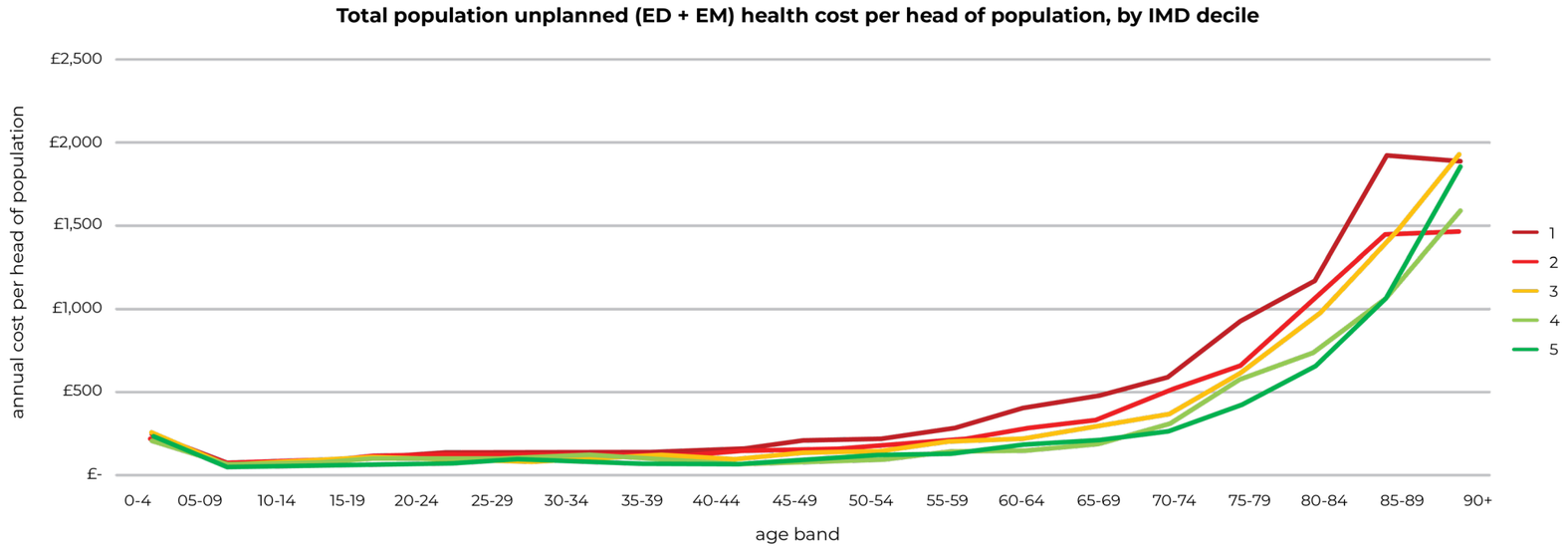
Our clinical prioritisation model, based on a population health management approach, informs the Joint Forward Plan in identifying where our efforts are best placed to reduce demand. This analysis builds on high-level demand predictions and focuses on disease prevalence and associated health conditions that are driving demand across our communities.

The table opposite shows which conditions are driving activity in emergency admissions. The ten most common conditions account for 85% of acute bed days. This data enables us to better identify those cohorts of people that need more targeted support outside of hospital. Our approach signals the importance of reducing health inequalities in order to drive system efficiencies. The graph below shows that people living in the most deprived neighbourhoods have healthcare costs (represented by hospital emergency admissions) which are more than double those in the least deprived. The stark differences in disease burden across Nottingham and Nottinghamshire is illustrated in the chart on page 21. This depicts our Primary Care Networks and the variable health and wellbeing challenges their communities are experiencing.

Our Joint Forward Plan will address these challenges. We will develop integrated neighbourhood team working to improve the management of long-term conditions and promoting active case finding, earlier intervention and wider holistic support through signposting into appropriate non-clinical community-based services. This approach, enabling us to better prioritise secondary and tertiary prevention in the early years of our Plan, will achieve resource efficiencies so we can redeploy funding into additional primary prevention initiatives in later years.

By working collaboratively, with partners, communities and our people, we can co-design and implement changes, that work alongside existing community assets, to reduce health inequalities and help achieve our Integrated Care Strategy priorities.

Diagnosis group	Emergency admx	Bed days	Av Los	Beds	Beds %	Beds cum %
Respiratory	9,680	77,059	8.0	211	18%	18%
Circulatory	7,819	64,233	8.2	176	15%	34%
Fractures and other injuries	4,307	51,993	12.1	142	12%	46%
Digestive	5,639	40,922	7.3	112	10%	56%
Sepsis	2,790	31,762	11.4	87	8%	64%
Mobility	2,769	24,915	9.0	68	6%	70%
Urinary	2,972	22,455	7.6	62	5%	75%
Musculosketelal	1,803	17,149	9.5	47	4%	79%
Dementia, delirium and cognitive problems	1,322	14,075	10.6	39	3%	82%
Cancer	1,176	12,945	11.0	35	3%	85%
Skin conditions	1,123	10,876	9.7	30	3%	88%
Other	1,626	10,654	6.6	29	3%	91%
Anaemnia and other blood disorders	635	9,695	15.3	27	2%	93%
Neurological	1,156	8,067	7.0	22	2%	95%
Post-procedural complications	909	6,688	7.4	18	2%	96%
Metabolism	783	5,929	7.6	16	1%	98%
Diabetes	400	3,822	9.6	10	1%	99%
Other infections	295	2,890	9.8	8	1%	100%
Other mental health conditions	160	1,041	6.5	3	0%	100%
Poisoning and toxic effects	133	683	5.1	2	0%	100%
Burns and corrosions	20	295	14.8	1		
Grand Total	**47,517**	**418,148**	**8.8**	**1,146**		



The stark differences between our PCN/neighbourhoods

		Deprivation	Risk factors (age-adjusted)			Long term conditions (age-adjusted prevalence)								System outcomes		
PCN Neighbourhood	No of patients	IMD decile	Obesity	Current Smoker	Hyper-tension	Diabetes Type 2	COPD	Heart Failure	Stroke	CHD	Cancer	Serious Mental Illness	Moderate/ Severe Frailty	Emergency admissions 1+ length of stay (age-adjusted)	Avoidable deaths (age-adjusted)	Median age of death
BACHS	61,680	2.4	21.5%	16.9%	16.8%	7.9%	3.1%	1.6%	1.6%	3.6%	3.9%	1.0%	3.9%	8,004	355	78
Clifton & Meadows	34,203	2.5	21.6%	17.2%	16.7%	7.2%	3.0%	1.4%	1.7%	3.6%	3.7%	0.9%	2.1%	8,400	329	83
Bulwell & Top Valley	45,878	2.6	22.8%	18.6%	16.4%	7.1%	3.0%	1.3%	1.6%	3.5%	4.1%	0.9%	1.5%	8,227	349	80
Radford & Mary Potter	47,166	2.7	17.5%	17.0%	16.9%	10.4%	2.2%	0.9%	1.4%	4.2%	3.2%	1.5%	4.0%	8,869	429	74
Nottingham City East	65,793	3.0	17.7%	16.9%	14.7%	7.3%	2.7%	1.3%	1.5%	3.3%	3.8%	1.4%	3.4%	7,730	380	76
Bestwood & Sherwood	54,040	3.5	18.7%	13.9%	13.9%	6.2%	1.9%	1.2%	1.5%	3.3%	3.8%	1.0%	2.0%	7,076	296	81
Ashfield North	51,540	3.9	24.6%	15.0%	14.8%	6.4%	2.4%	1.5%	1.4%	3.5%	4.4%	0.7%	1.7%	7,586	323	80
Mansfield North	59,164	4.1	22.9%	13.9%	15.4%	6.3%	2.3%	0.9%	1.3%	3.4%	4.0%	0.6%	2.2%	7,295	326	79
Rosewood	50,717	4.1	20.6%	16.7%	13.6%	6.2%	2.4%	1.1%	1.3%	3.5%	3.8%	0.8%	2.0%	7,291	294	81
Ashfield South	40,460	4.3	24.4%	14.3%	14.0%	6.4%	2.4%	1.0%	1.3%	3.2%	4.0%	0.7%	1.9%	7,312	294	79
Byron	38,408	4.5	21.4%	13.1%	13.9%	6.0%	2.2%	1.0%	1.4%	3.1%	4.3%	0.5%	1.7%	7,496	278	81
Newgate Medical Group	30,076	4.6	21.5%	16.3%	11.6%	6.0%	3.3%	1.1%	1.2%	2.8%	4.0%	0.7%	1.6%	5,917	300	80
Larwood & Bawtry	40,191	5.1	22.3%	13.1%	14.3%	6.6%	3.2%	1.8%	1.4%	3.6%	4.1%	0.7%	3.6%	6,427	251	81
Sherwood	62,794	5.3	22.3%	12.6%	14.8%	6.0%	2.2%	1.0%	1.4%	3.5%	4.2%	0.6%	2.5%	6,726	221	81
Retford and Villages	53,960	5.3	21.7%	11.7%	13.1%	5.4%	1.9%	0.9%	1.1%	2.7%	4.1%	0.5%	2.0%	5,246	207	82
City South	38,198	5.6	15.9%	9.8%	13.9%	5.4%	1.6%	0.8%	1.2%	3.3%	4.0%	0.7%	2.6%	6,975	228	82
Eastwood/Kimberley	37,549	5.9	21.4%	10.9%	13.3%	5.6%	1.9%	1.4%	1.3%	3.1%	4.3%	0.6%	1.8%	6,991	240	81
Synergy Health	30,275	5.9	20.0%	13.0%	13.3%	5.1%	1.7%	0.9%	1.4%	2.9%	4.4%	0.7%	5.5%	6,653	274	81
Newark	78,719	6.0	18.2%	12.5%	13.1%	4.8%	1.4%	1.0%	1.1%	2.8%	4.5%	0.5%	1.7%	5,698	235	81
Stapleford	22,086	6.1	21.7%	12.5%	14.8%	5.8%	1.9%	1.2%	1.0%	3.0%	4.2%	0.6%	1.9%	6,637	233	80
Arnold & Calverton	33,759	6.5	19.0%	11.0%	12.9%	4.9%	1.6%	0.7%	1.4%	2.8%	4.3%	0.7%	2.0%	6,453	203	83
Arrow Health	44,875	6.6	17.9%	11.0%	13.2%	4.8%	1.4%	0.9%	1.2%	2.7%	4.2%	0.6%	1.3%	6,400	219	83
Beeston	49,501	7.4	16.7%	9.9%	13.2%	5.0%	1.5%	1.1%	1.2%	2.7%	4.4%	0.7%	2.4%	6,141	235	84
Rushcliffe North	41,925	8.5	17.5%	8.8%	12.1%	4.0%	1.3%	0.8%	1.2%	2.6%	4.3%	0.3%	1.7%	5,811	163	83
Rushcliffe Central	52,570	8.8	12.9%	6.0%	12.0%	4.2%	1.0%	0.8%	1.1%	2.6%	4.4%	0.6%	1.2%	5,126	171	84
Rushcliffe South	42,646	9.0	16.4%	7.7%	12.2%	4.0%	1.0%	0.9%	1.1%	2.4%	4.2%	0.4%	1.0%	5,169	165	84
Unity	53,068	5.3	9.1%	6.6%	12.9%	3.7%	1.0%	0.7%	1.0%	2.0%	3.6%	0.4%	0.8%	4,182	178	n/a

Key and Notes

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mod Nottinghamshire Place

Unity's population is almost entirely university students and is presented separately due to its atypical population demographics.

IMD value is the **index of multiple deprivation** (calculated based on weighted average of registered patients' Lower Super Output Areas declines as per GP Repository for Clinical Care).

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Risk factors and prevalence data from GP Repository for Clinical Care April 2022
Emergency admissions data from Secondary Uses Service January - December 2022
Avoidable deaths from **Office for National Statistics** (ONS) January 2020 - December 2022
Median age of death from ONS January 2020 - December 2022

Delivering the right care at the right time

Our opportunities for targeting joint efforts to achieve maximum impact

The population health profile of Nottingham and Nottinghamshire highlights the need to prioritise certain actions within the health and care system to address our collective challenges. Prevention measures are crucial as the area faces a higher prevalence of long-term medical conditions, particularly in the most deprived areas. Conditions such as COPD, stroke, heart failure, heart disease, diabetes, asthma and mental health conditions have higher prevalence rates among the most deprived parts of the population. Avoidable deaths in the under-75 age group are primarily attributed to cancer, circulatory, and respiratory conditions, with heart disease, lung cancer, COPD, and stroke being the leading causes.

Emergency pressures are significant within the healthcare system, as evidenced by the high percentage of emergency admissions and bed days relating to the over-65 age group. Issues with management of patient flow in and out of hospitals contribute to longer stays for patients once admitted, despite stable emergency department activity.

The relationship between deprivation and healthcare resource utilization is evident, with individuals in the most deprived areas generally incurring higher healthcare costs per head of population. This has been shown for both in-hospital emergency costs and out-of-hospital spending. Given the clear correlation between age and use of healthcare resources, the projected increase in the older age group by 2033 creates an urgency to take action now.

Reducing planned care waiting list times is critical and we must address the disproportionate impact of waits on children and young people. Long waits before accessing planned care can have life-long consequences on the development of children and young people, impacting their ability to access education and lead full and active lives.

The table below shows the key targeted interventions that will be delivered over the next five years through our Place Based Partnerships, Provider Collaborative and via greater integrated team working.

These interventions focus on the need to reduce illness and disease prevalence, encourage proactive management of long-term conditions to avoid crises/escalation of care, improve navigation and flow to reduce emergency pressures, and reduce planned care waiting lists.

The contribution of ‘enabling’ interventions is further outlined on pages 29-49.

The overall impact on our four aims will be to:

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Enable people to stay well, safe and independent at home for longer. Providing the right care in the right place in the right time.	Ensure services are co-designed and targeted based on shared understanding of health and care needs.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure more efficient use of services and funding by reducing duplication, avoiding waste and addressing inefficient pathways and interventions. Early detection and effective management in order to reduce disease progression/severity and subsequently save resources.	Invest in our community assets and promote more non-clinical support for local people. Enable people to better manage their own health and wellbeing and access support to remain or access work, training and education and make sustainable healthy behaviour changes.

Delivering the right care at the right time

Our opportunities for working differently to achieve maximum impact: high level delivery commitments

System interventions	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention: reduce physical and mental illness and disease prevalence	Increase in early case finding. Develop models for future opportunistic case finding. Targeted support for priority cohort linked to prevention, for example, smoking, obesity in children and young people. Embed Make Every Contact Count across NHS organisations.	Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple deprivation, obesity.	People with multiple long-term conditions receive targeted support in a co-ordinated way with personalisation of care and individualisation of targets. Programme of universal interventions to promote prevention, for example, alcohol, ongoing smoking cessation, obesity (adults and children).		
	Expand self-care/self-management support using approaches sensitive to local and cohort needs. Implement structured education programmes.	System-wide approach to personalised care planning across all sectors (acute, community and primary).	Embed personalised care for all. Expand structured education and learning events consistently across Places and long-term conditions. Development of shared learning opportunities across primary/community and secondary care.		
Proactive management of long-term conditions and frailty to support early identification and avoid unnecessary escalation	Frailty Strategy refresh. Frailty same-day emergency care mobilised/implemented. Frailty data analysis. Focus on diagnostic pathway for children and young people with signs of asthma at an earlier stage. Increase immunisation and screening uptake for 'at risk' groups.	Frailty same-day emergency care embedded. Asthma diagnosis tools embedded within primary care for children and young people.	Working with PBPs to implement joined up frailty pathways across the system. Embed personalised care and advanced care planning for all. Achieve Clinical Design Authority frailty ambitions. Increase rates of annual reviews for children and young people with asthma to support self management plans.		
	Continued identification of physical health issues in people with a serious mental illness thorough physical health checks to ensure proactive management in this group who do not routinely access physical health services. PBPs will support integrated Place plans which address people's physical, mental and social needs (noting that 30% of people with a long-term condition also have a common mental health disorder).				
Improve navigation and flow to reduce emergency pressures in physical and mental health settings	Development of integrated neighbourhood team working across secondary, community and primary care, including the voluntary sector. Establish routine engagement opportunities for clinical interface secondary/primary clinicians.	Embedded integrated neighbourhood team working across community teams. Prioritise those cohorts/pathway development where data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.			
	Develop social prescribing model across all Places/care navigation across primary care, aligned with Make Every Contact Count approach.	Ongoing development of communications and information resources to support awareness of service offers to local people and staff – resources co-designed with users of services, focusing on achieving improved equity across the population.			
	Virtual wards fully established and meeting target activity levels. Integrated care pathways linked to surgery established for specific cohorts.				
	Embed P1 pathway and the transfer of care hubs.	Develop a co-located urgent treatment centre at QMC.	Urgent treatment centre fully implemented.		
	Expand our same-day emergency care offer across hospitals.				
	Agree model for P2/P3 beds: initiate mobilisation.	Transform our P2 and P3 offer to improve patient flow for patients who are medically safe for transfer.			
		Develop an urgent care coordination hub.			
Timely access and early diagnosis for cancer and elective care	Establish elective hubs and clinical diagnostic centre (Newark, City, Mansfield). Expansion of targeted lung health programme. Implementing community-based breast screening in areas of low uptake. Implementing community-based clinics with high incidence of prostate cancer, for example, Afro-Caribbean communities.	City elective hub (phase two). City clinical diagnostic centre complete. Mansfield clinical diagnostic centre complete.	City elective hub (phase 3). City clinical diagnostic centre complete. Expansion of targeted lung health programme complete.	Ongoing delivery and development of prevention initiatives.	
	Roll-out personalised care, optimise integrated care pathway and referral optimisation. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports.				

Delivering the right care at the right time

Our opportunities for working differently to achieve maximum impact: high level success factors

System interventions	Year 1	Year 2	Year 3	Year 4	Year 5
Prevention: Reduce physical and mental illness and disease prevalence	See pages 9 and 11 for success factors related to our focus on prevention initiatives.				
Proactive management of long term conditions and frailty to support early identification and avoid unnecessary escalation	• Using risk stratification to identify, screen and categorise those people at greatest risk of frailty and admission to hospital for PBPs / integrated neighbourhood teams. • Developing multi-disciplinary personalised care plans. • Prioritise tertiary / secondary prevention to delay disease progression. • Reflect the need for system working in all new specialist job plans (for example, geriatricians/orthogeriatricians). • Development of surgical care as part of integrated care pathways across community/acute based teams.	• Established resourced integrated neighbourhood team multi-disciplinary teams to provide holistic care for people at risk of unplanned admission. • Using system intelligence to prioritise specialty areas where non-elective admissions are high, (COPD, frailty, flu, heart disease, stroke, dementia). • Early identification, pulse checks, lung screening, blood pressure, hypertension, cancer screening. • Reflect the need for system working in all job plans. • Target coverage of anticipatory care plans. Roll forwards for years three to five.	• Ongoing implementation of years one and two.		
Improve navigation and flow to reduce emergency pressures in physical and mental health settings	• System review of hospital discharge and implementing the Local Government Association recommendations on transfer of care, one shared data set and culture. • System review of Better Care Fund. • Develop and implement management/admission avoidance plan for care homes. • Deliver medically safe for transfer plan target and develop trajectory for years two to five. • Establish elective hubs and clinical diagnostic centres (Newark, City, Mansfield).	• A co-located urgent treatment centre as the first access point and reducing demand on emergency department. • Broadening the same day emergency care offer and ensuring direct access for this from the ambulance service. • Discharge to Assess – additional investment and resource in P1 capacity to reduce people's length of stay • Creation of up to 500 step up/down virtual beds • City elective hub (phase 2). City community diagnostic centre complete. Mansfield community diagnostic centre complete.	• Ongoing implementation of years one and two.		
Timely access and early diagnosis for cancer and elective care	• Increase opportunities for virtual appointments/advice and guidance for GPs from secondary care/patient-initiated follow-ups beyond national targets, set trajectories. • Design and test approaches to optimise referrals across primary and secondary care with an initial focus on ear, nose and throat and gynaecology. • Delivery plan for community diagnostic centres. • System-wide ICB-supported approach to productivity improvement using mental health/'getting it right first time' data and ambition for top decile performance. • Analyse current waiting lists and anticipated demand and decide final recovery trajectory beyond plan criteria. • Review procedures of limited clinical value and agree system approach. • Delivery plan for the 25% reduction in follow-ups target. • Support development of an approach to early screening, risk assessment and health optimisation for patients waiting for inpatient procedures.	• Deliver musculoskeletal transformation programme. • Support the Index of Multiple Deprivation waiting list review and access audit. • Work with the Provider Collaborative to scope feasibility of at scale cold site given 'Tomorrow's NUH' delay. • Implement plan for procedures of limited clinical value (with necessary consultation). • Deliver 25% reduction in follow-ups. • Spread and adopt learning from the referral optimisation workstream in other specialities	Fully deliver eye transformation programme. Ongoing implementation of years one and two.	City elective hub (phase 3). City community diagnostic centre complete.	

What will delivery of our Joint Forward Plan mean for patient care?

1 Prevention: reduce physical and mental illness and disease prevalence

- Prioritise prevention and early intervention to effectively reduce the incidence and impact of diseases and costly treatments (including planned care) on our health and care system, leading to long-term cost savings and enhanced health outcomes for our population.
- People supported to lead healthy behaviours and maintain good health from birth and for as long as possible, including education to support self-care.
- Services are commissioned in an integrated way across health, education, social care, public health and housing, improving the experience of care for the population and optimising outcomes.
- Achieve an efficient and effective healthcare system, that optimises the workforce available to us, directing resources to where they are most needed.
- Embracing technology and innovation to enhance the tools available increasing productivity for our workforce.
- Adopting digital solutions in an inclusive way (primary care and community) to improve efficiency, accessibility and patient outcomes.

2 Proactive management of long-term conditions and frailty

- Case finding and screening programmes will target population groups where there are inequalities in uptake to support early detection of long-term conditions in line with our Core20PLUS5 approach.
- Priority for those cohorts where population health management data indicates there is greatest opportunity for impact at both Place and system level, for example, frailty, respiratory, hypertension, CVD.
- People with multiple long-term conditions will be supported in a co-ordinated way with personalisation of care and individualisation of targets.
- Staff will be trained to support the complexity of needs of people with long-term conditions and to manage different diseases providing an opportunity to up-skill staff across specialisms.
- We will make every contact count ensuring people are supported for both their physical and mental health needs.
- Integrated neighbourhood team working will promote proactive care co-ordination for the management of long-term conditions – creating a 'team of teams' that wraps care around people.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.
- System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.

3 Improve navigation and flow to reduce emergency pressures in both physical and mental health settings

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow into the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care/rehab needs and plan for longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need hospital care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

4 Timely access and early diagnosis for cancer / planned care

- Cancer and planned care waiting times are within national performance requirements.
- Local people have equitable access based on need with appropriate choice of provider.
- Shared decision making, people offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention, support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

Place Based Partnerships, provider collaboration and system programmes

How we will do things differently: our delivery methods

We are seeking to make big changes in the way we operate as a system. There are three main transformational ways that will enable this over the next five years and beyond. These are Place Based Partnerships (PBPs), our Provider Collaborative(s) and ICS programmes. These will work in harmony with our partners to achieve both the delivery of the Joint Forward Plan and national policy expectations.

By encouraging and supporting our PBPs and Provider Collaboratives to be radical, we have the opportunity to empower local frontline health and care professionals, working within statutory and non-statutory bodies, to implement transformational change which both supports system priorities and the things which matter most to their local communities. Our system programmes will continue to ensure high-level implementation of change where this makes sense in order to achieve population and system-level outcomes.

At a Place level, Integrated Neighbourhood Teams (INTs) and the integrated neighbourhood working approach (INW) will be integral to this transformation. Our PCNs will play a key role in the design and development of these approaches, aligned to the ethos and approach of the Community Transformation Programme. This will enable focus on population health management-identified specific disease/condition cohorts within a Place footprint (for example, diabetes, COPD) as well as cohorts that are geographically focused (such as those living in the most deprived communities/neighbourhoods). PBPs are able to map existing assets, understand their relative importance to local communities, engage with their populations with greater reach and develop co-designed opportunities sensitive to local community characteristics. Front-line coordination, relationship building, local knowledge and direct understanding of patient need can all combine to create a highly effective coalition able to make better use of our scarce resources.

PBPs will develop Place plans aligned to the Integrated Care Strategy priorities and which address identified opportunities to address the wider determinants of health and the Core20+5 heath inequality priorities for both children and adults. Place Plans will also support delivery of NHS priorities, such as urgent/same day care demand and long-term condition management with a focus on specific cohorts and neighbourhoods, based on system intelligence.

The ICB will support overall system maturity by developing and enabling PBPs and the provider collaborative at scale to accelerate towards greater maturity; to 'pull' for greater levels of responsibility and appropriate and proportionate levels of resources, and provide assurance of delivery of agreed commitments. The development of resourcing and assurance frameworks will be accelerated in year one.

Our Provider Collaboratives will continue to mature in a way that enables our provider organisations to work more intimately and collaboratively on key areas such as workforce, 'back office' functions and care pathways in order to secure sustainable local services.

While the Provider Collaborative will provide an 'umbrella' arrangement for NHS statutory partners, it will not be the sole vehicle for driving performance and outcome improvement through provider collaboration. Provider collaboratives may form organically to address specific needs, such as local collaboration between primary and community organisations and general wellbeing support within our Places.

Nottingham and Nottinghamshire ICS health partners will work with existing provider collaboratives across the Midlands to optimise local benefits for local people. For example, opportunities for further collaboration at scale with other ICBs will be considered such as elective recovery and urgent care networks. In appraising options, particular importance will be placed on those with faster and improved access to care, incorporating consideration of health inequalities and equity.

We believe that genuine and meaningful integration of our services and collaboration between all partners will be transformational if we are prepared to collectively create the conditions, and culture for co-operation to become the norm.

How our Places take forward ICS / ICB priorities

How the ambitions of the Integrated Care Partnership, expressed through the Integrated Care Strategy, are supported by the Integrated Care Board's priorities and translated into delivery at Place

ICP Focus Arsing from JSNAs / JH&WBs / IC Strategy	ICB Focus (5YJFP)	Place Focus (PBP Plans)	PCN/Neighbourhood/ District Focus	Identified Population Need at Place identified using PHM e.g.
✔ Prevention	**To support the delivery of the IC Strategy**	Targeted community support for vulnerable cohorts: LD, BAME, Frail Elderly, CYP,20% most deprived communities (CORE20+5)	Providing targeted support/ active case finding to meet specific physical and MH needs of pt cohorts aligned to delivery of CORE20+5 (and smoking) reduction in HI	✔ Higher levels of clinically diagnosed anxiety and depression
✔ Integration	**To recover NHS core services and make them sustainable**	Community and citizen engagement enabling co-design of local services. Communication.	Personalised care planning and budgets including anticipatory care	✔ Higher prevalence of people with life limiting illness
✔ Equity	Prevention: Reduce illness and disease prevalence	Development of integrated neighbourhood teams and primary care resilience	Social Prescribing across all PCNs and wider community supporting identification and response to health and social need e.g. ED/C&YP/MH/IDT	✔ Increased A&E attendances related to MH crisis
✔ Improve outcomes in population health and healthcare	Proactive management of LTC to avoid crises and escalations of care	Promoting Prevention initiatives e.g. screening, vaccinations across Place	Improved early cancer diagnosis, screening, vaccinations based on clinical indicators	✔ Poor medication compliance for LTC management due to cost of prescriptions
✔ Tackle inequalities in outcomes access and experience	Improve navigation and flow to reduce emergency pressures	Cost of Living Crisis initiatives	Development of LTC mgt including obesity, cancer, respiratory, CVD, hypertension, Mental Health	✔ Higher prevalence of conditions e.g. diabetes, respiratory related illnesses, childhood obesity
✔ Enhance productivity and VFM	Reduce elective waiting lists	Encouraging self care and management e.g. through Place wide Digital Literacy and Inclusion	Inter-practice variation reduction: levelling up (e.g. QoF)	✔ Increased demand for food bank support; people in poverty
✔ Support broader social and economic development	**ENABLERS:**	Initiatives supporting local economic regeneration including employment, skills and training	Ensuring equity of access to health care through VC & F2F consultation	✔ Higher levels of poor digital and transport infrastructure
	Workforce strategy	Generating social capital and non-statutory support services through investment in local VCS	Providing targeted support for Clinically Extremely Vulnerable/ High Intensity Users as well as socially vulnerable cohorts.	✔ Increased demand for local counselling support need expressed by local schools and VCS
	LTFM	Promoting Prevention initiatives e.g. Healthy Lifestyles, stop smoking	PCN maturity: development of integrated teams across sector partners; PCN Alliance delivery models	
	LT Demand and capacity plan	Provide targeted community interventions contributing to delivery of H&WB Strategies	Promoting Self care and mgt	
	Capital and Estates plan	Supporting community resilience e.g. extending debt advice and maximising benefit eligible income, digital literacy, self care and management		
	Infrastructure support (e.g. digital/IT, data sharing, estates management, system level communications and engagement)			
	Refreshed outcomes Framework			

Productivity and efficiency

Achieving more within our resource constraints

Through the pandemic, efficiency schemes and expectations were stood down as we focused on maintaining high quality services that met the changing needs of our population. Ongoing challenges in respect to workforce, industrial action and the impact on population health has meant we have struggled to regain the performance and productivity required.

The system has seen a 12.5% increase of staff in post since March 2020 without a commensurate increase in activity levels. To achieve the best outcomes for our population, we need to use existing resources in the most effective way, regaining our collective focus on reducing waste and increasing productivity.

Our Joint Forward Plan commits us to achieving this, with an accelerated focus on driving cost effectiveness and efficiency over the next five years to ensure all our collective resources are focused on achieving the maximum health and wellbeing gains for our population.

Our productivity and efficiency framework comprises three elements:

Clinical transformation

Our population health management approach of prioritising prevention and improving proactive management of long-term conditions, improving navigation and flow, and reducing planned care waiting lists will ease the operational burden on our hospitals. This will reduce the need for additional capacity in busy periods and excess premium staffing costs.

Workforce productivity

Our workforce and associated costs have increased significantly in recent years, while activity levels have remained broadly flat. We will look to develop a deeper understanding of loss in productivity through the pandemic, which will enable decisions on how we can increase future activity and improve outcomes within existing workforce levels. Alongside this, our integrated approach to recruitment and retention will place less reliance on expensive agency costs.

Operational efficiency

A single system approach to exploring and delivering efficiency opportunities. We will use benchmarking analysis and national tools (such as Get It Right First Time) to implement best practice. There is a particular focus on areas of collaboration and integration between partners - more efficient use of our collective estate, back office functions, procurement and medicines management.

In our approach we will make use of relevant productivity guidance and recommendations from NICE.

Oversight of delivery of this framework will be supported by the establishment of a system programme management office. Its function will be to ensure routine monitoring and reporting of progress into the ICB Board and associated oversight mechanisms.

Our summary delivery plans

High level commitments across our key programme areas that will deliver or enable the four aims and three strategic principles of our ICP Integrated Care Strategy, while continuing to meet national policy expectations.

Finance

Current state: Our challenges

- **Underlying financial deficit** – all NHS partners within the system carry underlying deficits, annually managed through non-recurrent means. At March 2023, this deficit is recognised as £143m in total.
- **Productivity and efficiency** – through the pandemic, efficiency schemes and expectations were stood down and since then system partners have struggled to get the same efficiency as we have had previously. The system has seen a 12.5% increase of staff in post since March 2020 without a commensurate increase in activity. The plan needs to reflect how we use these increased staffing levels to deliver improved performance and higher levels of productivity.
- **Shape of spend** – the system strategy is based on shifting costs by investing in preventative services and providing care closer to home. This has not been seen in reality with continuing growth in acute hospital services due to continuing urgent care pressures.
- **Capital availability** – system capital funds are scarce and have historically been used to support business as usual maintenance and replacement, relying on national funds to support larger strategic priorities. This has led to some local priorities remaining unfunded for some years.

Future state: Our ambition

- **Financial sustainability** – achieve recurrent financial balance by end of year three through improved productivity and efficiency, and transformation of services to ease the burden on urgent care services. This will provide improved services for local people and staff and allow for future investment in ICS priorities.
- **Productivity and efficiency framework** – we will implement a framework that will ensure delivery of productivity and efficiency opportunities. The framework looks at clinical transformation, workforce productivity and operational efficiency. Further detail can be found on page 28.
- **Investment in prevention and tackling health inequalities** – year-on-year increased investment in prevention and reducing inequalities with a step change once recurrent financial balance is achieved.
- **Capital resources used to support strategic aims** – ensure a considerable proportion of the system capital envelope is used to support agreed strategic priorities, improving services and providing better outcomes, access and experience for staff and local people.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Financial sustainability	Deliver in year balance Improving recurrent underlying deficit			Deliver recurrent financial balance. Create headroom to provide resilience.		✓		✓
Investment priorities	Increasing in investment in prevention and equity 0.2% cumulative	0.4% cumulative	0.6% cumulative	1.0% cumulative	1.4% cumulative	✓	✓	✓
Capital investment	Deliver capital plan within notified system envelope Capital prioritisation to support strategy	Increasing capital usage to support strategic aims Min. 10%	Min. 15%	Min. 20%	Min. 25%		✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Financial balance will be achieved by greater investment in prevention, providing care closer to home and less pressure on our urgent care services. Ultimately leading to improved outcomes, access and experience.	Explicit focus on investment to drive equity in our most deprived communities through the Health Inequalities and Innovation Fund.
Enhance productivity and value for money	**Support broader social and economic development**
Through improved service productivity and using our resources more effectively.	Targeted investment, alongside system partners, in prevention and wider determinants of health to keep people well for longer.

Place Based Partnerships

Current state: Our challenges

- Low healthy life expectancy has significant consequences for individuals, communities and services.
- Pressures of 'day job' across all partners, with low capacity and resilience in the primary and community workforce promotes focus on transactional, not transformational change.
- 'Today' challenges consume capability to develop and implement 'tomorrow' solutions relating to prevention and ill health avoidance.
- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Voluntary sector infrastructure, capacity and resilience is significantly reduced.
- Balancing NHS national/regional/ICB priorities and those generated by non-NHS PBP partners within current Place based resource constraints.
- The ability to create a cultural shift from a paternalistic approach to one where communities are empowered to make the changes themselves.
- Lack of trust in services by our communities; particularly in areas of high deprivation and among minority communities.
- Historical commissioning decisions which impact on service delivery do not always reflect current population health needs post-pandemic and due to cost of living crisis.
- Lack of system clarity on the vision and opportunities for the delegation of responsibilities to Place.
- Need for recurrent funding streams to facilitate sustainable Place-based transformation activities beyond existing ICB investment in place-based teams.
- Organisational silos inhibit progress on integrated public sector estates solutions.

Future state: Our ambition

- We will see a reduction in health inequalities through transformation of services informed through community insight, co-production and sensitive to local population health needs.
- We will have coordinated communications. We will move from community engagement to community empowerment and asset-based approaches in all we do.
- Our community and voluntary sector will be strong and sizeable, maximising community assets to create resilient communities which can support self care.
- We will maximise our social value capacity to address wider determinants of health.
- The 'Place focused' workforce will have shared purpose/values and feel supported working in the PBP, professional pride and enthusiasm in all they do, built around a unified focus on population health management, strength-based approaches and genuine co-production working alongside the people we serve.
- We will have truly integrated teams following a successful roll-out of integrated neighbourhood working across voluntary and statutory services including primary, community and secondary care services, maximising our skill sets.
- PBPs will hold increased level of delegated responsibility for delivery with appropriate resources.
- We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.
- Our transformation of services will be sustained through long term investment in evidenced based services with reduced reliance on short-term funding and pilots.
- Our service delivery will maximise use of community buildings and assets.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of Partnership Place Plans and PBP maturity.	Implementation of the INT approach. Focus aligned to strategy and PHM identified impact on health inequalities and equity. Support for primary care and PCN development.	Collaborative leadership of neighbourhood model embedded. PCN active participation in INTs, maximising skills and capabilities across PCNs and partners.	Place focused individuals from across partners identifying as 'one team'.	Ongoing development and rollout - review of Place impact and spread of learning. Evaluation in partnership with Academic Health Science Network/ universities.	Neighbourhood working fully embedded. Ongoing review and development of PBP role, function and impact.	✓	✓	✓
Delivery of transformation and prevention programmes through a population health approach.	Continue to deliver existing programmes and identify new areas; formalise governance with PBP partners.	Joint commissioning arrangements in place including budget and agreed outcomes, such as voluntary sector commissioning.	Prevention budget allocated and embedded at Place, maximising influence on social and economic factors that affect health and wellbeing.	Community empowerment fully embedded at Place as a prevention approach.	Fully resourced prevention approach embedded across the PBPs.	✓	✓	✓
Development and maturity of Place to enable functions to be delivered at Place and neighbourhood level.	Co-create with ICB the future ICB operating model to inform future place functions. Place resource model and funding agreed.	Place responsibilities and assurance models established. Recurrent transformational resources established.	Fully delegated responsibilities and performance oversight/ assurance arrangements embedded.	Ongoing review and development of PBP role, function and impact.	Ongoing review and development of PBP role, function and impact.		✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Ensuring a focus on population health need through informed interpretation of data and community insight.	Enabling a 'place and neighbourhood' first approach with local partner and community expertise, and currently under-served populations informing delivery.
Enhance productivity and value for money	**Support broader social and economic development**
Ensure service delivery is as local as possible and joined up across partner organisations to optimise public spend.	Bringing together partners around a broad approach on health and wellbeing with a focus on addressing the wider determinants.

Primary Care Networks

Current state: Our challenges

- Pressures on primary care limit the capacity for PCNs to deliver population health management identified opportunities.
- Capacity and demand in primary care are challenging.
- Workforce pressures growing across primary care, impacting on resilience across the PCNs.
- Estates for the growing workforce and community-based delivery of care is restricting delivery.
- In order to manage current challenges, different models of care are being tested by developing new roles through the national Additional Roles Reimbursement Scheme (ARRS) and through system clinical transformation programmes.
- A review of current estate and needs for future delivery is being undertaken as part of the system estates strategy.

Future state: Our ambition

- Delivery of our Primary Care Strategy supporting resilient/vibrant primary care practices as part of PCNs.
- PCNs across Nottingham and Nottinghamshire are working towards stage three of their PCN maturity by March 2024, allowing them to be in a positive position for leading the implementation of Integrated Neighbourhood Teams (INTs).
- 'Team of teams' to evolve from PCNs with a sense of shared ownership for improving the health and wellbeing of the population with our partners across the system, thus strengthening outcomes for local people, workforce resilience and productivity.
- Integrated Neighbourhood Teams and INT working will deliver a model of care that takes a holistic approach to supporting the health and wellbeing of a community (re-aligning the wider health and care system to a population-based approach, including aligning secondary care specialists to neighbourhood teams). This approach will see a reduction in health inequalities through transformation of services informed through community insight and co-production.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
PCN maturity to support INTs.	PCN at stage 3 of maturity.	System leadership development.	Opportunities and cultural change	Continuous development.		✔	✔	✔
'Team of Teams': common purpose and shared endeavour.	Partners agreement of model. Supportive of change across the workforce.	PCN active participation in INTs maximising skills and capabilities across PCNs and partners.	Implement process improvement. Development of continuous improvement cycles.	Embed INT working.	Development opportunities.	✔	✔	✔
Integration of secondary care into INTs.	Identify opportunities in line with population needs.	Secondary care working within INTs.	Wider system roll-out based on needs of population and secondary care support.	Embed INTs.	Development opportunities.	✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeted approach based on community needs making every contact count through integrated working.	Enhanced services in the community with a focus of those in greatest need, delivered within the community closer to where people live.
Enhance productivity and value for money	**Support broader social and economic development**
Working together to enhance productivity and resilience across the system and its communities reducing duplication.	Wider system working that will maximise opportunities across partners and deliver sustainable health and care services.

Primary Care

Current state: Our challenges

- On-the-day demand impacts ability to focus on people with long-term conditions, escalations and continuity of care.
- Contracting model can be a barrier to innovation / transformation.
- Increasing complexity in patients means more timely access to specialist advice and guidance is required.
- Recruitment and retention challenges causing additional pressure on workforce.
- Opportunities for primary care at scale model not fully realised.
- Lack of communication with public about new roles in primary care impacts on ability to 'see right professional at right time'.
- Challenges with capacity to enable longer consultation times for people with complex needs.
- Movement of services from secondary care to primary care requires appropriate shift in resourcing.
- Most deprived neighbourhoods tending to experience greatest access challenges.
- National capitation funding not necessarily reflective of need.
- Estates constraints hinder primary care service delivery.
- Ensuring successful transfer of delegated responsibilities and hosting function of pharmacy, dental and optometry contracts.

Future state: Our ambition

- Our ICB will be a national exemplar in new models of working between the ICB, Place Based Partnerships and primary care providers.
- To improve on-the-day triage demand and signposting to most appropriate professional.
- Evolve contracting model where relevant to encourage / reward innovation while also delivering national contract requirements.
- Multi-disciplinary team with wider participation of roles working as part of integrated neighbourhood team working approach.
- Improved recruitment and retention and increase in new roles.
- Improved understanding among public / patients about roles and capability of primary care professionals.
- Resource allocation based on a deeper understanding of assessed need, 'proportional universalism' where discretionary funding allows.
- Real time access to advice and guidance, enabled by technology and decision support mechanisms.
- Full implementation of improved access plans and associated GPIT schemes.
- Future primary care provision across all providers remains high quality and sensitive to local population needs.
- 'One public estates' approach becomes business as usual at a Place and system level to meet needs of providers and their communities.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of primary care strategy. Delivery primarily through Place-based teams working with subject leads at a system level.	Implementation of INT approach – supported by PBPs and local transformational teams. Fuller Stocktake expectations met or plans to achieve within two years. Establishment of a primary care strategy delivery group to ensure ongoing oversight/support to achievement of key deliverables.	Promote learning and sharing of new ways of working, such as care navigation and social prescribing, additional roles, prescribing and working with pharmacists. ICB primary care estates strategy completed.	Implementation of estates strategy. Evolving development of primary care workforce modelling and response. Promote primary care research.			✓	✓	✓
Improve primary care access.	All practices achieve NHSE Delivery Plan for Recovering Access expectations. Acceleration of secondary/primary care interface working to support long-term conditions management, promote referral optimisation, and pathway efficiencies. Identify practices for specific targeted support based on patient feedback/access concerns/self reported. Further development of INT working to promote streamlined access to alternative services like self referrals/ referrals to wider practice teams/avoiding GP where appropriate, for example, pharmacists and physio. Improve patient communications to support awareness of local service offer/new ways of working.		Ongoing delivery of NHSE PCN directed enhanced service/delivery plan expectations.			✓	✓	✓
Supporting primary care resilience.	Promoting opportunities for PCN investment, for example, care navigation training, funding for additional roles, online consultation, cloud based telephony. Place teams working with practices to understand specific resilience challenges.	Review locally enhanced services to promote focus on reduced health inequalities and equity/promote practice. Place resources allocation proportionate to practices within highest areas of deprivation/need.	Ongoing review of primary care opportunities for collaborative working. Development of integrated team approaches to prevention programmes, for example, vaccinations.			✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A resilient and vibrant primary care is fundamental to population health management.	Primary care is fundamental to addressing health inequalities and equity.
Enhance productivity and value for money	**Support broader social and economic development**
Technology as well as pathway reviews will realise value-for-money.	Primary care workforce is a significant contributor to our local economic development in terms of staff, as well as enabling communities and people to remain economically active.

Mental health

Current state: Our challenges

- Waiting times remain too long for access to assessment with hidden waits between services where specific mental health services/ organisations operate in silos.
- Pathways are not always clear, do not provide local early support and intervention to reduce escalation, maintain independence in the community and reduce the need for acute services.
- Mental and physical health and wellbeing and social needs are inextricably linked, however services operate in silos and do not recognise interdependencies which support the whole person.
- In addition to meeting and improving performance on all national standards (business as usual).

Future state: Our ambition

- Sustainable local community care model of delivery that aims to optimise people's independence by holistically addressing their physical, mental health and social needs and intervening before people reach crisis point.
- Through integrated care, and better communication between services and those receiving services, people will be cared for in the most appropriate setting for their need. There will be a reduction in avoidable and unplanned admissions to hospital for people with mental health needs, through partners working collaboratively to meet people's needs.
- Through workforce education, we will make every contact count for areas which have been traditionally health focused, incorporating signposting to other services such as financial advice, employment advisors, housing advice and social prescribers to enable people to improve their overall health and wellbeing.
- People will be empowered and supported to self-care, with support from within their communities, maximising the use of community assets.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Prevention, inpatient, discharge joint working.	Development of a system-wide mental health inpatient strategy incorporating admission prevention and discharge and associated implementation plan. Develop Place-based prevention models aligned to community transformation. Implementation of phase one priorities.	Review of phase one implementation. Develop and agree timescale for phase two implementation. Develop plan for years three-to-five transformation.	Review phase two actions. Deliver plans for phase three priorities.			✔	✔	✔
Seamless pathways and provision from increased community provision through to acute and social care, addressing physical and mental health needs.		Review pilot area and learning, agree roll-out and implementation for years two-to-five.	Ongoing review and refinement ensuring a continuous quality improvement approach.			✔	✔	✔
Reviewing waiting times and building on workforce models to utilise all sectors including the voluntary sector.	Review of all waits, 'hidden waits', hand-offs and transfers across adult and children and young people services.	Develop strategy to reduce waiting times with clear timescales and actions, supported by a revised system workforce model.	Implementation of improvement plan, monitoring impact and ensuring infrastructure to enable continuous quality improvement.	Ongoing review and refinement ensuring principles embedded in all new pathway development.		✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
PCN and Place-level support and early intervention to reduce escalation. Develop joint and seamless pathways of care which support the whole person, both physical and mental health issues. Support building resilient communities and people to prevent mental health illness in the first place.	Tailored local support developed utilising information on population needs. Improving life expectancy of people with severe mental illness through improvements in mental health/physical health integration and support. Improving the mental wellbeing of patients with physical health needs including long-term conditions.
Enhance productivity and value for money	**Support broader social and economic development**
Maximising investment that has been made into mental health services over last five years, ensuring services are delivering to meet people's needs. Develop more local integrated provision with services provided in the least acute setting aligning health and social care provision, with acute mental health services only accessed by those who need it. Prevent acute mental health admissions and reduce length-of-stay where admission is appropriate through increased fit for purpose community support.	Increase the number of people with severe mental illness in employment. Increase ability of people with severe mental illness to live independently in the community through appropriate housing and wraparound support.

Maternity, babies, children and young people

Current state: Our challenges

- Covid-19 pandemic has disproportionally affected the development, physical and mental health of babies, children and young people.
- Rates of obesity are rising in childhood, increasing short-term and lifelong negative impact on health outcomes.
- Significant health inequalities exist in maternity & neonatal care meaning worse outcomes for women & babies from minority ethnic groups.
- Access to health services for the most vulnerable groups of babies, children and young people is disjointed and inequitable.
- Numbers of children and young people experiencing signs of mental disorders are increasing.
- Children and young people (aged 0-25) with Special Educational Needs and Disabilities (SEND) are not always identified, assessed or able to access services in a timely way.
- Engagement of children and young people in decisions about their needs and health care is not systematised.
- Transitions between children and young people services and adult services are improving but remain difficult for many.

Future state: Our ambition

- Children, young people and their families continue to co-produce service improvement and transformation across the system and participate in decision-making about their individual plans and support.
- All health service planning incorporates prevention for under-25s, where there are modifiable factors
- Be child friendly. Children and young people's needs are identified accurately and assessed in a timely and effective way. Achievement of UNICEF child friendly recognition.
- Children and young people are well prepared for their next steps, achieve desired outcomes, have supportive and successful transitions into adulthood.
- Children and young people are valued, involved in decision-making about their lives, visible and included in their communities.
- Every woman and birthing person from minority ethnic groups has a safe and positive birthing experience in the place of their choosing.
- Optimise opportunities for laying a firm foundation for good mental health of children and young people through evidence-based support in the first 1001 days of a child's life.
- Families, babies, children and young people are able to access seamlessly delivered support including those at end of life, children in care, those who are neurodiverse, risk of obesity, require sleep support, meeting speech language and communication needs.
- Outcomes are improved over people's life course by focussing on children and young people at earliest stage of prevention and enabling earlier identification and provision of support for emotional health and wellbeing as well as physical.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Focus on the under-fives to have the maximum preventative impact.	Review emerging local evidence base for improving mental health and reducing obesity for under-fives.	Co-design new pathways with system partners.	Focus on early identification with PCNs and at Place.	New pathways embedded. Costs saved reviewed and outcome measures refined.		✓	✓	✓
Reduce inequity of services in maternity and for children and young people.	Seek to understand and co-produce solutions for children and young people with health needs and those who are looked after.	New models of care negotiated and commence. Single points of contact explored and increase skill mix teams.	Maintain and review impact of service.			✓	✓	✓
	Delivery of the system maternity equity action plan. Delivery of the children and young people Core20+5 framework. Implementation of multi-agency models of care embedding thrive model for children and young people with mental health outcomes.					✓	✓	✓
Achieving improved outcomes for vulnerable children and young people, including those who are looked after or with SEND.	• Deep dive into health outcomes for children informed by improvement priorities with children, carers and system partners. • Co-produce new ways of thinking and working with parents/carers and children and young people with SEND or looked after to achieve more timely and meaningful support to address identified challenges. • Streamline approach and improve timeliness to achieve national standards. • Understanding needs of children and adolescents with complex needs and develop a personalised care approach.		Work with children and system partners to reduce inequity of outcomes from baseline set in year two.	Maintain and review impact of service.		✓	✓	✓
	Co-produced SEND strategy alongside review of joint children and young people commissioning plan.					✓	✓	✓
Improved outcomes for women and babies.	Implementation of the three-year maternity and neonatal delivery plan, including the embedding of Ockenden recommendations, with all system partners.					✓	✓	✓
	Development of a new maternity and neonatal voices partnership model to enable effective coproduction.						✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Focus on babies, children and young people at the earliest stage of prevention and intervention improves outcomes over people's lives.	Inequity of service offer perinatally and for babies, children and young people, is addressed through local, personalised and streamlined services.
Enhance productivity and value for money	**Support broader social and economic development**
Investment in prevention and early intervention at the earliest opportunity in people's lives delivers the highest returns on investment.	Children and young people who are happy, healthy and have the best start in life are more productive and economically secure as adults.

Reducing emergency pressures in mental and physical health settings

Current state: Our challenges

- People are assessed for their long-term needs in hospital.
- People spend too long in our hospitals.
- People arrive at the emergency department and are admitted to hospital when their needs could have been met in the community.
- People often have to navigate several services before they reach the one that is most suitable for their needs.
- Our teams and pathways are not always integrated.
- We do not have seven-day working across all services.
- We have inequity of service provision across the ICS.
- We have delays in transferring people from one service to another.

Future state: Our ambition

Flow into the hospital

- People know how and when to access urgent and emergency care services when they need it.
- We have services in place to support people who have urgent care needs to be cared for at home for both their physical and mental health needs.
- People who need to use 999 or our hospitals in an emergency are transferred to the hospital and seen in a timely manner.
- We have services and pathways in place that allow people to receive the care they require in the right place, first time.

Flow through the hospital

- People are treated and supported in hospital to a point when they are medically stable. They will be transferred to a place suitable to their ongoing care / rehab needs and plan for longer term support if required.
- Discharge planning starts on admission (or pre-admission where possible).
- Discharge teams are integrated and work seven days-a-week.
- People are assessed for their longer term needs once they are discharged and not before.
- Only those that need acute care that cannot be provided at home are admitted into a hospital bed, with the remainder going home the same day on same day/community/ virtual ward pathways.
- Physical and mental health services are integrated.

Flow out of the hospital

- Multi-disciplinary transfer of care hubs are established at each hospital and operational seven days-a-week.
- People go home, or to a place that is suitable for the support they require, on the day they are medically safe to do so.
- A culture of trusted assessment is embedded across all organisations.
- Virtual wards are established and embedded across the ICS.
- For people in an acute mental health bed, community provision, appropriate housing and supported living will support prevention of admission and timely discharge.
- Community rehabilitation supports people to maximise their recovery in their own homes.

Preventing readmissions

- Integrated Neighbourhood Teams support people to remain at home and manage their health and wellbeing.
- Our population health management approach supports us to identify those most in need.
- Comprehensive care planning for our most vulnerable patients to keep them well and/or at home in a crisis.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop a co-located urgent treatment centre at the QMC.	Develop model and agree business case.	Implementation, monitoring and evaluation with a view to expanding to Sherwood Forest Hospitals.						✔
Virtual wards.	Further develop and embed virtual wards. Integrated care pathways established for specific cohorts.						✔	✔
Embed P1 and the Transfer of Care Hubs.	Data dashboard developed. Invest in Transfer of Care Hub capacity.	Implementation, monitoring and evaluation.					✔	✔
Transform our P2 and P3 offer.	Scoping and agreeing model.	Transform our P2 and P3 offer to improve patient flow for MSFT patients.					✔	✔
Develop an urgent care coordination hub.	Develop IT solutions.	Integrate urgent community response and the urgent care coordination hub. Develop IT solutions.	Implementation, monitoring and evaluation.				✔	✔
Expanding the same day emergency care offer.	Mobilising surgical same day care at Sherwood Forest Hospitals. Expanding frailty and respiratory same day care at NUH.	Direct access for professionals.	Implementation, monitoring and evaluation.				✔	✔
Development of Integrated Neighbourhood Team (INT) working.	Establish routine engagement opportunities for clinical interface between secondary/primary clinicians.	Embedded INT working across community teams for priority cohorts identified through population health data to avoid admission / prevent re-admission.				✔	✔	✔
Social prescribing and care navigation.	Develop care navigation model aligned with Making Every Contact Count (MECC).	Ongoing development of communications and information resources co-designed with users of services with a focus on achieving improved equity.				✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Supporting more people to remain in their own homes and reducing time spent in hospital.	Commissioning services across the ICS and reviewing and transforming historical pathways while providing more personalised care.
Enhance productivity and value for money	**Support broader social and economic development**
Providers working collaboratively and in integrated teams to make best use of system resources.	Supporting more people to remain at home for longer with improved functional outcomes.

Early cancer diagnosis and planned care

Current state: Our challenges

- Long backlogs of patients waiting for cancer and routine planned care with an over-reliance of non-NHS providers.
- Patients may deteriorate while waiting for routine care and may enter the system via the emergency department.
- Potential inequity of access to some cohorts of the population.
- Workforce challenges across our acute providers.
- Our elective care capacity in acute hospitals can be compromised when there are surges in urgent care demand.
- There are long waiting times for diagnostic tests which can cause unnecessary delays in diagnosis.

Future state: Our ambition

- Cancer and elective waiting times are within national performance requirements.
- Local people have equitable access based on need with appropriate choice of provider.
- Shared decision making, patients offered options to avoid unnecessary procedures and acute intervention with conservative treatment considered at an early stage closer to home.
- Prioritisation of waiting lists includes clinical risk, health equity, population need. Consideration of the specific needs of children and young people and ensuring parity of esteem for physical and mental health.
- Elective hubs are in place, underpinned by best practice in productivity.
- Shared workforce plans and staff retention; support in place.
- Community diagnostic hubs established and GP direct access enabled.
- Expansion of targeted lung health programme starting this year and completed in 2025-26.
- Breast cancer – implementing community-based breast screening in areas of low uptake.
- Prostate cancer – implementing community-based clinics with high incidence – Afro-Caribbean communities.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Reduce elective backlogs.	To 65 weeks maximum.	To 52 weeks maximum.	Meet national operational performance targets.			✔	✔	
Reduce cancer backlogs	Meet all cancer standards as defined in operational performance requirements and enable earlier diagnosis (maintain faster diagnosis standards).					✔	✔	
	Expansion of: • Lung health programme • Breast cancer screening • Community prostate clinics.	Implementation, monitoring and evaluation.		Expansion of targeted lung health programme complete.	Monitoring and evaluation.	✔	✔	
Establish elective hubs Establish CDCs	Newark elective hub. Phase one of city elective hub. Roll out Mansfield clinical diagnostic centre. Plan City clinical diagnostic centre.	City elective hub phase two. Roll-out City clinical diagnostic centre. Complete Mansfield clinical diagnostic centre.	City elective hub phase three. Complete City clinical diagnostic centre.			✔	✔	
	• Roll-out personalised care and optimise integrated health. Referral optimisation. Maximise pathways and productivity. • Make best use of workforce shared workforce plans and staff digital passports. • Implement Make Every Contact Count across teams and integrated care supporting improved patient care/ increase efficient care provision. • Systematise the incorporation of prevention, reducing health inequalities and improving equity across all pathways of care in the management of waits, patient pathway redesign.					✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Earlier diagnosis and care closer to home.	Taking a more personalised approach to care with shared decision making and optimising health prior to elective procedures.
Enhance productivity and value for money	**Support broader social and economic development**
Making best use of our estate and workforce.	Enabling timely access to elective care and maximising health.

Quality improvement

Current state: Our challenges

- No agreed working distinction for quality improvement (QI), transformation and how this relates to system efficiencies.
- Mixed QI approaches exist within the system and partners with no central understanding of impacts.
- No scoping within the system to enable an understanding of the levels of expertise and skills to undertake QI.
- Clear expectation within the system that QI will be lead by clinical leadership and teams without protected time.
- No clear evidence of co-production principles/ opportunities with patients/clients/families and how this informs QI.
- Benchmarking and aim correlation for QI does not always align with data insights from our current data collection schedules.
- Existing quality challenges do not directly link to programmes of QI with measurable outputs.
- Limited learning within the system to enable the adoption and spread of QI inventions where appropriate.

Future state: Our ambition

- QI, transformation and efficiencies impacts are understood within the system.
- Systematised QI learning and programmes platform accessible to the system.
- QI approaches occur within the system and partners with scoping, supporting levels of expertise to undertake QI.
- Clinical leadership and teams have protected time and embed ethos that QI is a second job.
- Co-production is a tenet of all QI projects or programmes and this informs those QI priorities.
- System agility and agreed QI responses to emerging quality challenges with known measurable outputs.
- Share and spread learning of evidence-based, high impact improvements, for example, NICE quality standards, appreciative inquiry improvement, and Get It Right First Time.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
System scoping to enable the development of a system definition of QI.	Build consensus by scoping and reporting for system.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	Monitor and adjust to align with benchmarking programme.	✓		✓
System understanding of the levels of expertise and skills to undertake QI.	Outline agreement with system partners on approach to systematic QI and training needs.	25% of relevant staff trained in system QI approach by Q4 2025-26.	50% of relevant staff trained in system QI approach by Q4 2026-27.	75% of relevant staff trained in system QI approach by Q4 2027-28.	100% of relevant staff trained in system QI approach by Q4 2028-29.	✓	✓	✓
ICS benchmarking programme.	Joint alignment of ICS data insights. Develop processes to support QI learning platform.	Evidence base / data shape with local population informs priorities for year one.	Progress check year two and use evidence to redefine or reprioritise year three ambitions.	Progress check year three and use evidence to redefine or reprioritise year four ambitions.	Progress check year four and use evidence to redefine or reprioritise year five ambitions.	✓	✓	✓
ICS commitment of co-production informs the current QI work.	Scope and build population engagement networks with ICS QI enablers.	Create core co-design and co-production within all aspects of programmes of work.	Monitor and adjust to align with population engagement feedback and impacts.	Monitor and adjust to align with population engagement feedback and impacts.	Monitor and adjust to align with population engagement feedback and impacts.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Targeting systematic QI interventions based on system health outcomes, co-designed with local people representation and clinical leadership, underpinning the commitment to continuous improvement.	Data and people insights will shape and inform QI system priorities to enable interventions to address place population needs.
Enhance productivity and value for money	**Support broader social and economic development**
Improvements in quality reduce costs and improve outcomes.	Supporting greater integrated system learning from QI programmes that can be utilised for adopt/spread interventions.

Personalisation

Current state: Our challenges

- Personalisation is not yet embedded fully as business as usual.
- Our workforce does not always have the tools it needs to deliver personalised care.
- Personalised care approaches are not currently included in all commissioning and contracting activity.
- People have to repeat their story and are not always empowered to share decision making.
- Personalised care initiatives do not receive the investment needed as part of the prevention agenda.
- Making every contact count not seen as a priority across the entire workforce.

Future state: Our ambition

- Personalised care is embedded as business as usual to support delivery of equitable services, with personalised approaches and the eight commitments being adopted in all our work, and as an enabler across all transformation programmes.
- A workforce trained in personalised care: with shared decision making and personalised care and support planning in pre-registration and post-registration professional training.
- Personalised care approaches are considered in all commissioning and contracts to ensure funds are invested to support people in a way that works for them, rather than the traditionally commissioned 'one size fits all' approach. Aligned with Make Every Contact Count.
- People only have to tell their story once and the focus of the conversation is 'what matters to them and what's important to them, not what's wrong with them.'
- Personalised care is a core function that we fund as part of prevention and equity approaches.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Implementation of the Universal Personalised Care Delivery Model and ICB Personalised Care Strategy to embed the six personalised care approaches across all system areas.	Phased approach to include: • Primary care with complex and/or multiple long-term conditions • Cancer pathway • Mental health • Delivery of Make Every Contact Count training to INT staff • Use data to plan and target personalised care to those that would benefit most and to address health inequalities.	Phased approach to include: • Planned care activity • Hospital discharge - personalised care and support plan and, where appropriate, a discharge Personal Health Budget. • Urgent and emergency care.	Progress check and use evidence to redefine or reprioritise year ambitions.			✓	✓	✓
Social prescribing and community based support.	• Green social prescribing to support mental health and wellbeing established • Children and young people and all-age social prescribing models. • Maternity link worker offer pilot undertaken • Infrastructure development.	• Implementation of digital infrastructure solution • Maternity evaluation • Benefits analysis of pathway and system impact.	Expanding social prescribers relevant to benefits and population need.		Fully integrated model across local authority, voluntary sector and NHS for social prescribing and community connectors.	✓	✓	
Embedding personalised care into all commissioning and contracting activity.	• Social prescribing longevity agreed and commissioned • Personalised care elements included in all new commissioning activity.	• Review of all existing contracts to include personalised care • Development of flexibility in commissioning budgets to deliver personalised care including consideration of Place-based social prescribing models.	Ongoing review and refinement ensuring principles embedded in all new commissioning activity.			✓	✓	
Develop and embed a system culture to deliver personalised care and a trained and skilled workforce.	• Development of an ICS training offer and cultural change programme • Strengthen and develop system leadership • Continue to strengthen co-production.	• Roll out of training and culture change programme in phased approach to staff across the system.				✓	✓	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Increase engagement by service users.	Personalised care ensures care and support is shaped to individual need and supports equity.
Enhance productivity and value for money	**Support broader social and economic development**
Reduce duplication of discussion, increase signposting to non-primary care support networks and reduced appointments. Patients better engaging with treatment plans, thus reducing waste, acute exacerbations, medicines safety errors and improving prognosis (reducing demand on services at later stage).	Supporting people in a holistic way has an impact on their individual social and economic circumstances and impacts wider society.

Working with people and their local communities

Current state: Our challenges

- While we have a strong foundation of listening to and working with our population, it is not consistently embedded into our ways of working across all partners in our system.
- We have made good progress in moving from an episodic approach based around service change proposals to a continuous listening programme but this needs more work to be shared across the whole system.
- We are not maximising the assets that all of our partners have across the whole health and care system and have not yet fully matured the way that insights from our population are fed into our decision-making arrangements.
- The opportunity presented by the formation of the ICP and our even closer working with local authority and other partners needs to be fully maximised to the benefit of the NHS and our population.
- The embedding of our co-production approach requires a significant culture change for our staff across the system.

Future state: Our ambition

- Our citizen Intelligence approach is fully embedded across all system partners. Our starting point for all consideration of how we deliver services starts with insights from our population on what services they value, how they want to access them and how they are best delivered.
- Co-production is embedded as default across the system - people with lived experience have an equal voice in all aspect of service development and change.
- These population insights are jointly gathered by all NHS and wider partners and freely available to all organisations within our system and also our residents.
- We consistently measure and monitor satisfaction with the health and care services we deliver and feedback on where we can do better or build on positive examples. This guides our focus.
- Staff know how to share their insights on how services can be better tailored for our population and how to signpost local people to get involved in improving their services.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Insights hub.	Review existing hubs	Co-design new hub model with partners	Implementation.				✓	✓
Citizens panel	Recruit 800 panel members	Evaluation of panel and development of mechanisms at Place	Recruit additional 800 panel members	Evaluation and expansion at Place		✓	✓	
Co-production	Development of Strategic Co-production Representative Group. Recruitment focused on diversity.	Ongoing oversight of all co-production activity as part of Integrated Care Strategy commitments.				✓	✓	
	Development of co-production toolkit to support staff upskilling. Development of co-production system network.	Review and roll-out of training offer. Maturing of network.				✓	✓	
VCSE Alliance.	Expand to faith groups	Develop commissioning framework						
ICP and ICB reports	Develop insight reports for the ICP and ICB							
Service change	Deliver public consultations for Tomorrow's NUH, Newark Hospital and Nottingham and Nottinghamshire and Bassetlaw CCG policy alignment.							

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Services will be better tailored for our population and access will be streamlined, leading to better outcomes.	We will use insights from our population to prioritise areas where we need to focus our attention.
Enhance productivity and value for money	**Support broader social and economic development**
By working together across all partners, we can gather intelligence once for the benefit of everyone. Co-production with people who use services will lead to improvement based on need and experience to support value for money.	Leveraging existing assets such as Nottingham's universities will have wider benefits on the economic and social development of our area.

Safeguarding

Current state: Our challenges

- Partnership working on safeguarding and promotion of the health and welfare of children and young people. We need to effectively work together to meet the future challenges of improving resilience across the system.
- Learn from local and national safeguarding reviews including Domestic Homicide Reviews to improve outcomes.
- This is an emerging speciality that requires development across the children's partnerships and safeguarding adult boards.
- We need to support parents and carers to provide the best possible care for their children - preparing young people for adulthood.
- Lack of specialist provision for domestic abuse survivors within primary care.
- Increasing numbers of referrals into the domestic abuse Multi-Agency Risk Assessment Conference.
- Appropriate access and identification of asylum seekers and survivors of trafficking and modern slavery.
- Child sexual exploitation and abuse across the system and increase in contextualised safeguarding.
- The ICB meeting their statutory duties for looked-after-children health assessments.
- Listening and responding to children and young people and adult victims and survivors of child abuse to guide how services are delivered.
- Assessing and authorising within the community – in patients' best interest and least restrictive options. Deprivation of Liberty Safeguards not fully embedded across community teams.
- Children being cared for in inappropriate settings.
- Implementing the new duties around serious violence and the Domestic Abuse Act 2021 within the ICB and prepare for future duties in the Victims and Prisoners Bill.
- Developing data to evidence safeguarding assurance across the system.
- Identifying the emerging themes and gaps within the system and partnerships.

Future state: Our ambition

- Survivors of domestic abuse are identified and appropriate support provided.
- Survivors of modern slavery and trafficking identified within the system and appropriate support given.
- Those who lack capacity within the community are supported to make decisions and live their lives with the appropriate care and support.
- The ICB is a valued contributor to the Violence Reduction Partnership and meets our Serious Violence Duties.
- We have reliable data which supports the identification of emerging themes and gives assurance around statutory duties being met across the system.
- Ensure there is safeguarding connectivity across the ICS with the NHS agenda.
- We will work with partners across the ICS and other areas to ensure children and young people are in the most appropriate setting, receiving the right services at the right time, to improve outcomes.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Children and young people will receive the right care, in the right setting, at the right time.	Influence the development of D2N2 appropriate care settings for children and young people.					✓	✓	✓
Develop and enhance transitional safeguarding.	Development of transitional safeguarding.					✓	✓	✓
Embedding a trauma-informed approach across the system.	Establishing a data informed approach. Revisiting and defining locally the NHS role in the Serious Violence Duty and Domestic Abuse Act 2021.	Fully integrated approach with primary care for domestic abuse that includes children as victims. Refine process for survivors of child sexual exploitation and abuse.	Data dashboard implemented	Ongoing developments towards model of integrated, data informed approach.	Fully integrated, data informed approach.	✓		✓
Working with our partners to improve outcomes for children in local authority care.	Children leaving care will have a comprehensive leaving care plan.	Processes embedded for children in care/looked after children to have their health assessments completed in a timely way.				✓	✓	✓
Support provided to adults in the community.	Identify Mental Capacity Act cohort, risk profile and proceed in the patients' best interests and least restrictive option.	Develop process of early identification of potentially restrictive care plans in the community and progress via appropriate Court of Protection route. Identify children with special educational needs and disabilities transitions cases requiring deprivation of liberty safeguards. Develop mechanism for early identification of fully-funded adult and pre-18 cases for quick response to application of the Mental Capacity Act/Court of Protection.				✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Support at system and place to embed a proactive safeguarding approach and aid early detection and intervention. This will aim to reduce the impact on people's physical and mental health. It will aim to help reduce adverse childhood experiences that go on to impact on health and socio-economic outcomes throughout people's lives.	Specialist local support that uses data intelligence and local knowledge of the population will improve the outcome of people, for example, those experiencing abuse and trauma and also restrictions upon their liberty.
Enhance productivity and value for money	**Support broader social and economic development**
Early recognition and responding appropriately to safeguard and promote the welfare of people across the system. This will assist in individuals going into crisis and/or requiring hospitalisation or a 'significant response'.	Improving resilience with the system, developing the workforce and promoting trauma-informed culture will aim to reduce all types of abuse, serious violence and responding to individual human rights.

Workforce

Current state: Our challenges

- Workforce is potentially the largest limiting factor in our ability to deliver the ICS strategy and improve health outcomes for our population.
- Workforce productivity is varied and difficult to measure, however using traditional measures of workforce productivity and despite significant increases in workforce numbers, productivity is lower than before the pandemic.
- Organisations' ability to both attract and retain staff has not improved despite great efforts to deliver the People Plan and the People Promise.
- High vacancy levels, sickness absence and transactional human resources' processing volumes have a negative impact on finances due to locum and agency cover and on quality and continuity of care.
- Organisations' interventions to attract high demand staff groups have a negative impact on system staff and adds to cost pressures.
- Workforce planning tends to be short-term and driven by operational targets and does not address the medium to longer term need for strategic workforce and education planning at a system level, informed by population health projections.

Future state: Our ambition

- The system 'one workforce' will consist of the right number of people, to meet demand and improve health outcomes, working at the right location to deliver the treatment and care our population deserves, with the skills and training to support prevention, as well as treatment to enable the population to stay healthy and at a cost that is affordable.
- Organisations will collaborate on a 'one workforce approach' recognising that the future workforce will want to have flexible, rewarding careers within a system that recognises and develops talent and is representative of the population of Nottingham and Nottinghamshire.
- Digital technology will be an enabler to flexibility and resourcing on a system footprint, not an organisational one.
- There will be multiple entry points to employment, supporting all levels of academic and physical ability, to create meaningful and fulfilling opportunities for those that desire a career in health and care.
- The financial pressures caused by workforce availability will be reduced by the development of a flexible contingent system workforce, alongside workforce policies, practices and procedures that are standardised across the system and use technology to automate transactional activity (wherever possible).
- NHS partners will confirm commitment to 'real living wage'.

SUMMARY of what we intend to do over the next 5 years

What	Year 1 Scope and plan	Year 2 Start to deliver and see a difference	Year 3 Deliver and review	Year 4 Deliver and refresh plans	Year 5 Deliver	Prevention	Equity	Integration
Establish ICS people and culture plan and delivery process.	Governance and delivery plans.	Establishing a sustainable delivery team.	One workforce becomes a reality.	Population health needs drive plans.	Aligned public health, education & training and workforce plan.	✔	✔	✔
Resourcing including retention.	Scope and develop plans for shortage skill areas.	System attraction and retention approach, including local pipeline.	Expand digital solutions.	Operational system recruitment hub.	Review evaluate and further consolidate.	✔	✔	✔
Strategic workforce planning.	Agree scope with System Analytics and Intelligence Unit.	Work with partners on a common Strategic Workforce Plan approach.	Establish a common approach to productivity measurement.	Further support service transformation.	Review evaluate and seek further opportunities.	✔	✔	✔
Delivering the future of human resources.	Agree scope and scale with partners.	Fully utilise digital passport.	Develop rotational placements across providers.	Establish core HR working including primary care.	Review evaluate and seek further opportunities.	✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
A skilled and present workforce is better able to deliver improved health and healthcare outcomes including prevention and equity via Make Every Contact Count.	A workforce representative of our diverse communities is better able to understand and address their needs. Our workplaces supported to be smoke free.
Enhance productivity and value for money	**Support broader social and economic development**
Better planning, resourcing and retention will reduce temporary worker costs and improve quality and care.	Supporting multiple entry points to employment for all levels of academic and physical ability supports social and economic development, and renumerate equitably.

Strategic estates and shared infrastructure

Current state: Our challenges

- Across our ICS partner organisations, we have in excess of 800 buildings, in varied condition.
- There is limited co-ordination of maintenance and utilisation of our estate capacity, and the ICS estates strategy is coming to an end.
- Some of our newer/better quality estate is not being fully used, and utilisation across all our estate is not well understood.
- Locations of services is mainly historic, rather than being situated where it is most needed.
- Since the Covid-19 pandemic, the move to hybrid or virtual working means we need less corporate capacity across our ICS.
- Annual capital funds are insufficient.
- There are significant challenges with some estate, for example, Nottinghamshire Healthcare dormitories, Rampton, magnetic resonance imaging (MRI) provision and location.
- Backlog of maintenance issues increasing across all providers.

Future state: Our ambition

- Services are located based on need rather than historic arrangements.
- Co-location of complementary services wherever possible.
- Our newer/better quality estate is fully utilised.
- Create a combined estate which is fit for purpose, big enough to cope with fluctuating demand, but no bigger than necessary.
- We have a clear pipeline of buildings/land for disposal.
- The cost of premises management is kept to a minimum.
- All our buildings are as carbon-efficient as possible.
- National Rehabilitation Centre (NRC) opportunities are maximised.
- Tomorrow's NUH has been successfully navigated through consultation phase, business case approvals and reconfiguration work has begun.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop an ICS infrastructure strategy.	Compile strategy with partners, publish and commence delivery streams.	Year two delivery.	Year three delivery.	Year four delivery.	Year five delivery.			✔
Rationalise our ICS estate.	Gather detailed baseline, agree assessment and prioritisation process.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.	Hand back or dispersal of properties.		✔	✔
Support 'One public sector estate' approaches.	Encourage the collective consideration of estates needs and solutions across Places – working across statutory and non-statutory partners to find efficiencies in the use and adaptation of estates to promote integrated neighbourhood team working and primary care resilience.							✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Support high quality environments for staff and local people, optimising the opportunity for delivery of services that improve outcomes.	Understanding our total ICS estate allows us to make better decisions about sighting services in the most appropriate places for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Ensuring our quality estate is used most productively, allowing us to release estate that is costly to maintain, and prevent capital investment in additional capacity.	Support estates development which contributes to social value within communities and across the system.

Digital

Current state: Our challenges

- Patient-facing digital assets are disjointed and used in silos, which provides inequitable access to health and care services. Technology enabled care to support remote monitoring/remote consultations/virtual wards is limited to pilots or relatively small-scale use in specific teams/organisations. Social care data is not available on the individual – often gets missed as clinical data is prioritised. Data between social care and health still disjointed.
- Data is not held or collected in all digital assets which limits the utilisation of rich data sources to enable intelligence-based decision-making. Where data is held in a digital asset, there are no consistent standards applied.
- Organisations do not have a fully digitised electronic patient record, digitisation does exist but often there are multiple systems which hold patient data in one organisation.
- While information sharing across digital assets has improved, clinical data is often not available to the clinician or professional from one organisation to another to enable them to provide the right care, in the right place.
- Moving to a digital approach to access can exacerbate health inequalities when people do not have access to digital or the skills.
- Significant skills gaps exist across our workforce which means that digital assets cannot be exploited to the full benefit.

Future state: Our ambition

- Develop our patient-facing digital services - we will empower and enable our population to have greater control over their health and care by providing them with access to their digital health and care record so that they can self-manage and access key information and services.
- Support intelligent decision-making - use data to better understand the health and care needs of our local population, helping to focus and tailor resources where they have the most impact. Design and target interventions to prevent ill-health, and to improve care and support for people with ongoing health conditions. Recognising key factors helps us to adapt future local services to improve the overall health of the population.
- Digitise our services to support the frontline - our workforce will have access to effective and efficient digital assets and infrastructure to enable them to provide the best health and care services. Utilising digital assets such as electronic patient records, electronic prescribing, medicine administration systems and automation technologies to reduce burdensome processes, for example, log-in standardisation.
- Enable interoperability across the system - our population will receive the right care at the right time, always. By providing health and care providers with access to key information about the person, reduces unnecessary diagnostics, treatment and enables efficient access to health and care services.
- Support our population and workforce through digital inclusivity - our population and workforce are given access to support, training and equipment to enable them to use digital assets to benefit their health and wellbeing or deliver effective care services.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Patient facing digital services.	Digital correspondence, access.	Expand the use of remote monitoring; explore use of robotics process automation.	Digital care planning, expand record access; deploy robotics process automation technology.	Personalised approach to health and care services through digital technology. AI technology to increase productivity.	Smart homes.	✓	✓	✓
Support intelligent decision making.	Infrastructure to enable data to be used.	Appropriate resources including better analytics, tools and techniques.	Embed a systematic approach to developing and monitoring system.	Augment artificial intelligence and human skills in designing care services.	Augment artificial intelligence and human skills in designing care services.	✓	✓	✓
Digitise frontline services.	Electronic patient record specification development.	Electronic patient record procurement, user based design. Staff enabled to work across any location.	Electronic patient record deployment, exploit existing assets.	Electronic patient record deployment.		✓	✓	✓
Interoperability.	Notts Care Record first tranche of users.	Notts Care Record to bring additional functionality and next cohort of organisations.	Greater functionality added with remaining organisations in Notts onboarded.	Further developments in the application including regional sharing.	Further developments in the application.	✓	✓	✓
Digital inclusivity.	Expand digital inclusion co-Ordinator roles.	Support skills development in community voluntary sector.	Develop non-medical information resources platform.	Whole system workforce training needs analysis.	System workforce development programme.	✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Improved access to services, ability to target services more effectively and reduce inequality.	Provide people with the tools and skills they need to access health and care service, increase patient satisfaction through improved access and services, keep people independent at home for longer.
Enhance productivity and value for money	**Support broader social and economic development**
Utilise technologies to remove time consuming activities such as administrative and chasing around for information to enable care to be provided, reduce did-not-attends, and improve patient flow.	Reduce net carbon footprint through reduced travel and reduction in unnecessary face-to-face appointments, less paper, increase employability through digital skills training.

Greener NHS / sustainability

Current state: Our challenges

- We have a comprehensive ICS Green Plan, approved by the ICS board and ICB Board in 2022. This plan builds on the individual plans/ strategies of our health and care partners.
- Organisations have strong plans and stakeholder buy-in and are delivering well within the confines of their organisation, and we are now starting to amplify learning gained at a system-level.
- The trajectory to carbon net zero cannot be achieved without the buy-in of clinicians and service users.
- Subject matter expertise and clinical capacity for designing sustainable care models, and supporting population health and involvement, has been limited.
- While we have many delivery initiatives, we are not currently able to make accurate measurements of the impact they are having on carbon emissions.

Future state: Our ambition

- Our carbon net zero journey is clinically-led, managerially delivered.
- We become the first ICS to set up a sustainability faculty, supporting clinicians and managers early in their careers to make a difference.
- Healthcare and the councils work as one to deliver their net zero targets.
- We work across ICS and public sector boundaries when we identify opportunities.
- Local people are empowered – they know the steps they can take to reduce their own footprints - and take them.
- Local people travel more 'actively'; relying less on cars, preferring walking, cycling or taking public transport instead.
- All our sites (where possible) have green spaces supporting wildlife and biodiversity, and supporting the wellbeing of local people and staff.
- Staff are empowered to make changes and reduce waste in their own work areas.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Deliver our ICS Green Plan.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Refresh/refine Green plan and deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	✔	✔	
Securing and embedding clinical/ professional leadership and design for sustainable services.	Set up design authority onboard four clinical fellows. Develop clinical programme framework.		Staff across all organisations are empowered to make changes, reducing waste in their work.			✔	✔	✔
Achieve national NHS Net Zero targets.	Continue with delivery - strengthen with primary care focus.	Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	Achieve 80 net zero for NHS footprint emissions. Refine delivery to ensure annual objectives are covered.	Refine delivery to ensure annual objectives are covered.	✔	✔	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Supporting healthier environments that reduce the likelihood of disease onset or exacerbation, for example, respiratory-related conditions such as asthma caused by poor environmental conditions.	Those with higher levels of deprivation are more greatly affected by global warming, air pollution. Tackling the sources of these provides a better quality of life for local people.
Enhance productivity and value for money	**Support broader social and economic development**
Almost all forms of waste reduction support both carbon reduction and saving money, providing better value for the public pound.	Many carbon net zero initiatives have the added benefits of health promotion and/or mental wellbeing.

Medicines optimisation

Medicines are the most common therapeutic intervention, the second highest area of NHS spending after staffing costs, and are associated with a high degree of clinical and financial risk.

Current state: Our challenges

- Between 5 to 10% of all hospital admissions are medicines-related and around two-thirds of these admissions are preventable.
- 30 to 50% of the medicines prescribed for long-term conditions are not taken as intended.
- Investment in medicines to optimise health outcomes and reduce hospital admissions is not maximised.
- Processes to reduce medicines harm need to be embedded through system working.
- Current working practices and systems do not facilitate reduction in medicines waste.
- Lack of interoperability between clinical systems in organisations increases the risk of harm from medicines.
- Pharmacy workforce pressures in all sectors constantly challenge the delivery of system ambitions to transform and optimise medicines use.

Future state: Our ambition

- A quality and safety culture around the use of medicines will be embedded in our system with ownership from all system partners.
- Improvement in outcomes associated with the use of medicines through reducing harm, improving patient access, shared decision making and personalised care.
- Reduction in unwarranted clinical variation, health inequalities and equitable access relating to medicines use will improve outcomes, using population health management and prescribing data to identify need.
- System working and collaboration to transform medicines use to improve the health and wellbeing of our population. Ensure the efficient use of resources and support the greener NHS agenda.
- Pharmacy workforce development (pharmacists, pharmacy technicians working in hospitals, community pharmacies, health and justice, ICB, mental health trust) to attract and retain staff. Education and training to develop career pathways and specialist roles.
- Investment in medicines, digital technology and workforce to improve quality of life and outcomes, and reduce hospital admissions through use of medicines. Active partnership in new models of care such as virtual wards.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Medicines across the system.	Develop system leadership. Co-produce ICS medicines optimisation strategy.	Strengthen system working and develop joint projects including discharge medicine service and community pharmacist consultation service.	System integration of all pharmacy services, improving equity through development of system-wide solutions.			✓	✓	✓
Medicines commissioning.	Strengthen Area Prescribing Committee capacity. Streamline system working.	Integration of specialised medicines commissioning.	Invest in expertise to support the evolving genomic medicines agenda.	Pharmacy representation in system and regional clinical advisory groups.		✓	✓	✓
Medicines safety and quality.	Antimicrobial stewardship, safety initiatives, reducing harm.	Access routes to provision of medication – patient group directions.	Oversight for increasing numbers of non-medical prescribers.	ICS and regional medicines waste reduction initiatives.		✓	✓	✓
Medicines finance.	Manage prescribing expenditure.	Develop ICS system medicines and prescribing efficiency plans.	Ensure medicines expenditure is fully accounted for in new service developments.			✓	✓	✓
Pharmacy workforce development.	Establish pharmacy faculty. Scope workforce, risks and gaps.	Develop system working for pharmacy placements for students.	Develop career pathways and specialist roles.	System pharmacy education programme.		✓	✓	✓

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
System working and collaboration with system partners to transform medicines use to improve the health and wellbeing of our population.	Identification and reduction in unwarranted clinical variation in medicines use to improve outcomes and ensure equitable access to the right care, at the right time, in the right place.
Enhance productivity and value for money	**Support broader social and economic development**
Through strategic medicines oversight and planning, ensure maximum benefit is gained from investment in medicines use.	Optimising health through appropriate medicines use enables communities and people to remain economically active. Reduction in medicines waste and promotion of greener medicines choices positively contributes to reduction in the net carbon footprint.

Research

Current state: Our challenges

- Better aligning the research that is undertaken and the research strengths, expertise and infrastructure of the ICS to the principles and priorities of the Integrated Care Strategy.
- Equity of access to place-based research opportunities with research being delivered where population need is greatest, with people from more diverse and under-served communities shaping, involved in and participating in research.
- Embedding research into everyday practice through opportunities for the workforce to be involved in research as part of their usual roles or to develop a research career.
- Systematically using the evidence from research to inform decision making.

Future state: Our ambition

- A collaborative, integrated and equitable approach to health and care research that aligns with the needs and priorities of the Integrated Care Strategy.
- The benefits and impact of research are maximised to continually improve population health and wellbeing outcomes, high quality joined up care and reduce inequalities.
- To attract, develop and retain a sustainable research workforce providing opportunities to lead and be involved in research that is embedded into everyday practice. Optimising integration as a means of undertaking research across the system and with all partners.
- Research is wrapped around what we do with an embedded evidence-informed approach. There is a strengthened alignment of research findings to shape interventions for mutual benefit and opportunities.
- A culture of evidence-based practice including the ability to test, learn and evaluate across the ICS.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Develop an ICS research strategy.	Develop the strategy with partners.	Implement the strategy in years two-to-five.				✔	✔	✔
Better align research to the ICS strategy commissioning.	Build a pipeline of research projects.	Develop ongoing mechanisms to support research active practices and awareness of and engagement with research activity across the system.				✔	✔	✔
Increasing the diversity of those involved in research.	Apply for NHSE Research Engagement Network Development funding to develop learning.						✔	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Research, and the use of evidence from research, improves outcomes.	Research informs greater understanding of inequalities and how to tackle them.
Enhance productivity and value for money	**Support broader social and economic development**
Utilising the evidence from research enhances productivity and value for money.	Research brings investment into anchor institutions supporting economic prosperity.

ICB operating model

Current state: Our challenges

- Within the ICS family, the ICB has undertaken a considerable development journey from seven individual CCGs and an ICS team to a single organisation.
- The ICB inherited CCG accountabilities to assess health needs, plan, secure and monitor services.
- We also have a new duty to integrate services and a pressing requirement to reduce inequalities. ICBs are required to act as system conveners, coordinators, oversight bodies and as delivery partners.
- We have adapted our operating model accordingly and now operate in a very different manner. Changes to date are in line with our strategic direction, moving from transactional and tactical commissioning approaches to a system orientation.
- The Hewitt Review sets out once-in-a-generation opportunities to transform our health and care system.
- If we are to derive maximum benefit from our new structures, this will require a different culture and everyone will need to play their part.

Future state: Our ambition

Our aim is to move towards a more strategic enabling approach to improve health outcomes and to tackle long-standing operational and financial problems. This means that we will undertake fewer tactical / operational functions and will focus more on longer-term health improvement and broader public sector partnerships.

We will:

- Serve as a pivot point within our health and care system to enable delivery of the four ICS aims.
- Be a well-run, transparent organisation that is effective and impacts on short and longer-term population health outcomes.
- Have the culture and capability to work with and through our partnerships and communities - to assess health needs and target NHS resources to achieve integration, prevention and equity.
- Be relentlessly ambitious for our population, working across the NHS to secure performance improvement, clinical and financial sustainability for local services.
- Approach challenges and constraints in an evidence-based and fair manner, maintaining constructive relationships but not accepting reluctance to progress or poor standards.
- Work systematically to achieve a combination of national NHS requirements and local priorities that are important to our people and communities.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
ICB operating model.	Design and implement.	Implement.	Consolidate.	Review.	Refresh.	✔	✔	✔
Operating within the defined running cost.	Financial viability.	Tracking the running cost reductions.	Review.	Review.	Review.	✔	✔	✔
Engaging, consulting with and change management for our people.	Communications and change management.	Communications and change management.	Review and update communications.	Review.	Review.	✔	✔	✔

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Focus as a strategic commissioning organisation will improve the population's health and healthcare.	Focus as a strategic commissioning organisation will reduce inequalities in outcomes, experiences and access.
Enhance productivity and value for money	**Support broader social and economic development**
The financial viability review of the operating model options appraisal will enable enhanced productivity and value-for-money.	Focus as a strategic commissioning organisation will support greater social and economic development as a network of anchor organisations.

Supporting social and economic development

Current state: Our challenges

- Supporting social and economic development is the fourth aim of the ICS.
- NHS Trusts, as anchor organisations, have already established programmes in support of this agenda.
- The ICB established an Anchor Champions Network (ACN) in 2022 comprising of ICB, Trusts, Provider Collaborative, local authorities (public health and economic development) and Place Based Partnerships.
- The ACN agreed an approach to supporting social and economic value in October 2022.
- The ACN helped contribute to the ICP Strategy under the fourth aim. Priorities for 2023-24 are being taken forward through the net zero, estates, procurement and workforce ICS delivery groups.
- The ACN continues to provide a forum to showcase ideas, share best practice and support ICS delivery groups progress strategic priorities.
- The ACN is maintaining links with Nottingham's universities to ensure strategic alignment.
- Place Based Partnerships continue to support the cost of living crisis response.

Future state: Our ambition

- ICP strategic priorities continue to be delivered through ICS delivery groups in the short to medium term.
- Building on the foundations described above, the NHS now needs to stretch its ambitions and efforts to support social and economic development.
- To help with this, the NHS Confederation has agreed to facilitate an ICP event to challenge our thinking and forward plans:
  1. Stretching shared ICP priorities which leverage our potential as a system and individual anchor institutions
  2. Confirming forward plans for these priorities, including an anchor institution action plan
  3. Defining the role and resource to deliver these plans across Place Based Partnerships, Provider Collaboratives, Trusts and the ICB.
- Continue to identify opportunities to contribute to social and economic development, for example, understand how the NHS can best support D2N2 devolution priorities and enhance its role in civic leadership.

SUMMARY of what we intend to do over the next 5 years

What	Year 1	Year 2	Year 3	Year 4	Year 5	Prevention	Equity	Integration
Support ICS delivery groups to deliver.	See specific 2023-24 plans for green, estates, workforce and procurement.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	Deliver two-to-three major innovations each year.	✔	✔	✔
Strengthening contribution to key strategic partnerships. Enhance our support for social and economic development.	Build key strategic partnerships. Refresh ICP priorities. Confirm forward action plans. Agree roles and resource to deliver the plans at pace.	Increasing support at ICB, Place, Provider Collaborative and organisational level for social and economic development.	Continue to increase health contribution for social and economic development	Continue to increase health contribution for social and economic development	Continue to increase health contribution for social and economic development	✔	✔	✔
Putting actions in place to support local people with the rising cost of living.	Support health and wellbeing and financial wellbeing programmes through Place and anchor organisations.	Continue to support health and wellbeing and financial wellbeing programmes.				✔	✔	

How this will address the aims of the Integrated Care Strategy

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experiences and access
Promotes focus on the wider determinants of health including employment, training and economic development.	Encourages economic regeneration and growth which will impact directly or indirectly on inequalities.
Enhance productivity and value for money	**Support broader social and economic development**
Collaboration across partners will contribute to generation of efficient and effective use of anchor organisational and collective resources.	Actions are aligned to the fourth aim of the Integrated Care Strategy.

Appendices

Contents:

A. Matrix to show compliance to the legislative requirements outlined in the Health and Social Care Act
B. Matrix of compliance to the ICP Integrated Care Strategy priorities and agreed actions
C. How we developed the strategy / engagement
D. Statements of support from the Health and Wellbeing Boards
E. Case studies
F. Delivering the NHS Operational Plan 2023
G. Glossary of terms

Legislative requirement	Description	Where to find this
Describing the health services for which the ICB proposes to make arrangements.	The plan must describe the health services for which the ICB proposes to make arrangements in the exercise of its functions.	Section 5
Duty to promote integration.	Each ICB must exercise its functions with a view to ensuring that health services are delivered in an integrated way and that their provision is integrated with that of health related or social care services, where this would: Improve quality of those services Reduce inequalities in access and outcomes.	Section 5
Duty to have regard to wider effect of decisions.	In making decisions about the provision of healthcare, an ICB must consider the wider effects of its decisions, also known as the 'triple aim' of (a) health and wellbeing of the people of England (including by reducing inequalities with respect to health and wellbeing), (b) quality of healthcare services for the purposes of the NHS (including by reducing inequalities with respect to the benefits obtained by individuals from those services) and (c) sustainable and efficient use of resources by NHS bodies.	Section 5
Financial duties.	The plan must explain how the ICB intends to discharge its financial duties.	Page 30
Implementing any Joint Local Health and Wellbeing Strategies (JLHWS).	The plan must set out the steps that the ICB proposes to take to implement any JLHWSs to which it is required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.	Section 1 and Appendix D
Duty to improve quality of services.	Each ICB must exercise its functions with a view to securing continuous improvement in: the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness outcomes including safety and patient experience.	Page 38
Duty to reduce inequalities.	Each ICB must have regard to the need to (a) reduce inequalities between persons with respect to their ability to access health services and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. There is also a duty to have regard to the wider effects of decisions on inequalities.	Section 5
Duty to promote involvement of each patient.	Each ICB must promote the involvement of patients, and their carers and representatives (if any), in decisions that relate to (a) the prevention or diagnosis of illness in the patients or (b) their care or treatment.	Page 40
Duty to involve the public.	ICBs and partner trusts have a duty to involve people and communities in decisions about the planning, development and operation of services commissioned and provided.	Page 40
Duty to patient choice.	Each ICB must act with a view to enabling patients to make choices with respect to aspects of health services provided to them.	Page 40
Duty to obtain appropriate advice.	Each ICB must obtain appropriate advice to enable it to effectively discharge its functions from persons who (taken together) have a broad range of professional expertise in (a) the prevention, diagnosis or treatment of illness and (b) the protection or improvement of public health.	Section 5
Duty to promote innovation.	Each ICB must promote innovation in the provision of health services (including in the arrangements made for their provision).	Pages 38 and 47
Duty in respect of research.	Each ICB must facilitate or otherwise promote (a) research on matters relevant to the health service and (b) the use in the health service of evidence obtained from research.	Page 47
Duty to promote education and training.	Each ICB must have regard to the need to promote education and training so as to assist the Secretary of State and Health Education England (HEE) in the discharge of the duty under that section.	Page 42

Legislative requirement	Description	Where to find this
Duty as to climate change.	Each ICB must have regard to the need to (a) contribute towards compliance with (i) section 1 of the Climate Change Act 2008 (UK net zero emissions target) and (ii) section 5 of the Environment Act 2021 (environmental targets), and (b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008.	Page 45
Addressing the particular needs of children and young persons.	The plan must set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25.	Page 35
Addressing the particular needs of victims of abuse.	The plan must set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic and sexual abuse, whether children or adults). It must have due regard to the provisions of the Domestic Abuse Act 2021 and accompanying statutory guidance, and relevant safeguarding provisions.	Page 41
Workforce	Evidence-based, integrated, inclusive workforce plans that ensure the right workforce with the right skills is in the right place to deliver operational priorities aligned to finance and activity plans.	Page 42
Performance	Specific performance ambitions with trajectories and milestones that align with NHS operational plan submissions and pay due regard to the ambitions of the NHS Long Term Plan, as appropriate.	Appendix F
Digital / data	Steps to increase digital maturity and ensure a core level of infrastructure, digitisation and skills. These actions should contribute to meeting the ambition of a digitised, interoperable and connected health and care system as a key enabler to deliver more effective, integrated care. This could include reducing digital inequity and inequalities and supporting net zero objectives.	Page 44
Estates	Steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them. This should align with and be incorporated within forthcoming ICS infrastructure strategies.	Page 43
Procurement / supply chain	Plans to deliver procurement to maximise efficiency and ensure aggregation of spend, demonstrating delivery of best value. This could include governance and development of supporting technology and data infrastructure to align or ensure interoperability with procurement systems throughout the ICS.	Page 49
Population Health Management	The approach to supporting implementation of more preventative and personalised care models driven through data and analytical techniques such as population segmentation and financial demand modelling. This could include: developing approaches to better understand and anticipate population needs and outcomes (including health inequalities); using population health management approaches to understand future demand and financial risk; support redesign of integrated service models based on the needs of different groups; and putting in place the underpinning infrastructure and capability to support these approaches.	Section 4
System Development	How the system organises itself and develops to support delivery. This could include: governance; role of place; role of provider collaboratives; clinical and care professional leadership; and leadership and system organisational development.	Section 5 and 6
Supporting wider social and economic development	How the ICB and NHS providers will support the development and delivery of local strategies to influence the social, environmental and economic factors that impact on health and wellbeing. This could include their role as strategic partners to local authorities and others within their system, as well as their direct contribution as planners, commissioners and providers of health services and as ‘anchor institutions’ within their communities.	Page 49

Legislative requirement	Where to find this
We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood	Page 35
We will support frail older people with underlying conditions to maintain their independence and health	Page 31
We will make Every Contact Count (MECC) for traditional areas of health e.g. mental health and healthy lifestyles, and incorporate signposting to other services like financial advice	Page 11
We will support children, young people and adults with the greatest needs (the 20% most deprived areas nationally, those vulnerable or inclusion groups and those experiencing severe multiple disadvantage	Page 35
We will focus and invest in prevention policies 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/COPD/asthma/suicide	Page 11
We will establish a single health and care recruitment hub	Page 42
We will adopt a single system wide approach to quality and continuous service improvement	Page 38
We will review our Better Care Fund Programme	Page 23
We will bring our collective data, intelligence and insight together	Page 44
We will make it easier for our staff to work across the system	Page 42
We will add social value as major institutions in our area	Page 49

Integrated Care Strategy

The Integrated Care Strategy has its origins in the Joint Health and Wellbeing Strategies for Nottingham and Nottinghamshire and, as such, should be seen as both complementary to, and building upon, the aims set out in those documents.

As part of developing the strategy, we listened extensively to the public, patients and stakeholders to check that it reflected the hopes, needs and aspirations of local people and their communities.

The engagement programme included desk research of previous engagement and strategies within the system, 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. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- The October 2022 ICS Partners Assembly, which bought together 161 system stakeholders, carers, service users, patients and citizens.
- The annual Nottinghamshire County Council Shadow event, which was attended by more than 250 children and young people, including young adults with learning disabilities.
- Two virtual public events, which were attended by 48 individuals.
- A survey for people to provide their views on the emerging strategy, which received 206 responses.
- Discussions among ICS partner organisations and Place Based Partnerships during November and early December.
- An ICP workshop on 9 November.

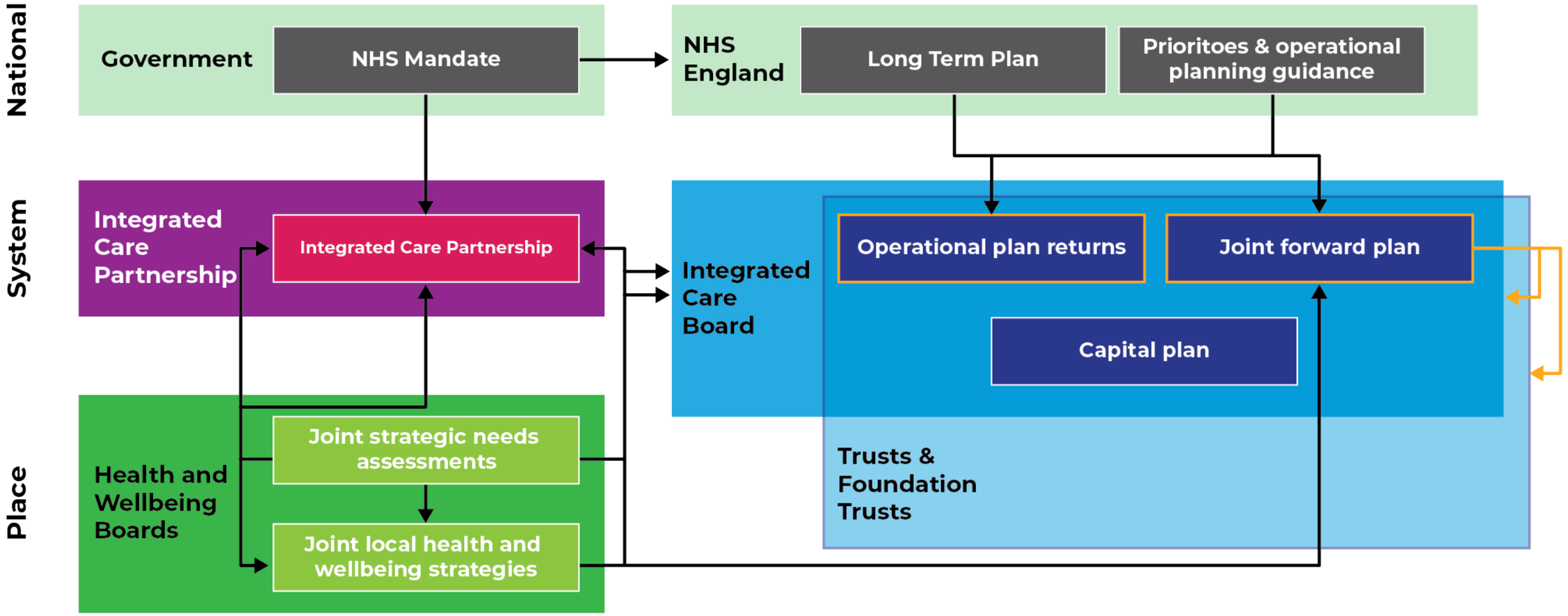
NHS Joint Forward Plan

As described earlier, the JFP acts as the NHS delivery commitment for all NHS organisations within the Nottingham and Nottinghamshire ICS.

In developing the plan, we further engaged with public, patients and stakeholders. The engagement programme built on engagement for the Integrated Care Strategy and included stakeholder meetings, presentations at existing forums, public events and a survey. In total, just under 800 individuals were involved in a range of activities, between May and June 2023. Activities included:

- Targeted meetings with key stakeholders, including voluntary, community and social enterprise sector leaders, Healthwatch Nottingham and Nottinghamshire and local elected representatives.
- Specific workshop and/or meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Hosting the second Nottingham and Nottinghamshire ICS Partners Assembly in May 2023, which was attended by more than 120 system representatives.
- Listening to and gathering insights from across our Place Based Partnerships.
- A survey for patients, local people and staff, which received 168 responses.
- Discussions with NHS organisations' board members and further established partner forums during May and June 2023.
- An engagement report on how we have engaged with people and communities has been produced.

The Health and Wellbeing Strategies for Nottingham and Nottinghamshire summarise health needs and describe the agreed priorities for partnership working. We see these strategies as related and complementary, seeking alignment where possible. The diagram below shows how we see the relationship between these important system plans.



This plan articulates how, as NHS partners within the system, we will deliver the NHS Mandate, while also tackling the most challenging issues for the system, as well as demonstrating how we will meet the aims of the Integrated Care Strategy.

Our Integrated Care Strategy

Our Integrated Care Strategy was agreed in March 2023 and sets the vision for the system. The three guiding principles are:

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. The 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'.

Underpinned by four strategic aims:

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 ensure that health advice is included in every conversation.

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 and being overweight.

Aim three: Enhance productivity and value for money

We will combine our efforts on issues 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 the productivity of our services.

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 support job creation for our population. We will also ensure that our activities are continually monitored and improved in terms of their impact on the environment.

Nottinghamshire County Health and Wellbeing Board

The Nottinghamshire Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire has taken account of its feedback, and the plan clearly articulates the ICBs commitment and contribution to the delivery of the Nottinghamshire Joint Health and Wellbeing Strategy.

Nottingham City Health and Wellbeing Board

The Nottingham Health and Wellbeing Board is satisfied that the NHS Joint Forward Plan for Nottingham and Nottinghamshire takes full account and outlines the ICB's contribution to the delivery of the Integrated Care Strategy. We welcome the strong commitment and connectivity to the Joint Local Health and Wellbeing Strategy.

Case study:

Integrated strategic planning and collaborative commissioning

During 2022 Nottingham City Council, Nottinghamshire County Council and Nottingham and Nottinghamshire ICB developed an ICS Carers Strategy through co-production with unpaid carers. Carers highlighted inconsistency in the offers of support available, confusion about where to seek help and limited opportunity to influence the delivery and improvement of services.

The strategy confirmed a shared aim to improve the quality of life for unpaid carers and to support them to continue in their caring role, while maintaining their own health and wellbeing. Carers identified key priorities for support including:

- Identifying and supporting carers as early as possible.
- Tailoring support to each carer to meet their needs, support their health and wellbeing and maintain their independence.
- Planning for times of crisis.
- Access to respite or breaks to support resilience and ability of carers to continue in their caring role.

The strategy shaped a single ICS model of carers support services which will have the flexibility to deliver person-centred integrated care and continue to develop delivery approaches suitable for different communities through joint working with Place Based Partnerships.

Organisations involved are now undertaking a collaborative commissioning approach with a single joint procurement of new services for unpaid carers, with commencement of a new contract by October 2023.

The ICB Board has overseen development of the 2023-24 NHS operational plan which is ambitious for our population and aims for compliance with all national requirements.

Final operational plans were submitted to NHS England on 4 May following approval by NHS Trust Boards and the ICB Board. The final submitted operational plan is financially balanced and the majority of operational areas are compliant with national requirements (except learning disability and autism adult inpatients and follow-ups).

The 2023-24 operational plan complies with the majority of national requirements, as summarised on this page.

Urgent and emergency care:

The plan is compliant with the requirement that no less than 76% of patients are seen within four hours by March 2024. The ICB plans to consistently meet the 70% two-hour urgent care response standard. The ICS is committed to accelerate the virtual wards programme to achieve the target of 400. Plans are in place to achieve acute bed occupancy below the 92% requirement through 2023-24.

Planned care:

The ICB continues to focus on eliminating 78-week waiters and has a plan to eliminate 65-week waiters by March 2024 (NUH has set an ambition to eliminate earlier). The ICB is compliant with the 105% VBA requirement at ICB level with oversight in place.

Cancer:

Plans are in place at both Nottingham University Hospitals and Sherwood Forest Hospitals to achieve the cancer 62-day backlogs defined by NHSE and meet the faster diagnosis standard by March 2024.

Diagnostics:

A trajectory has been submitted to NHSE which achieves 85% of patients receiving a diagnostic test within six weeks by March 2024 at aggregate and individual modality level.

Mental health:

The ICS is compliant against the mental health investment standard requirement and improving access to mental health support for children and young people, increasing IAPT (improving access to psychological therapies) access, increasing adults supported by community mental health services, eliminating inappropriate out-of-area adult placements, recovering dementia diagnosis and improving access to perinatal mental health services.

Learning disability and autism:

Plans are in place to achieve 75% of people over-14 on a GP learning disabilities register receiving an annual health check and health action plan by March 2024. The forecast for children and young people inpatient performance is compliant with long term plan projections.

Health inequalities:

The ICS continues to address health inequalities supported by a population health management approach, targeting resources and continued delivery of the five priority actions, Core 20+5 adults and Core 20+5 children plans.

People:

Plans are in place to improve retention and attendance through a focus on all elements of the NHS People Promise.

			Key priorities (as described in planning process)	Operational Plan Compliance
1. Recovering our core services and improving productivity	1A. Urgent and emergency care*	**Objectives**	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	Compliant
			Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25	Compliant across the East Midlands.
			Reduce adult general and acute (G&A) bed occupancy to 92% or below	Compliant
	1B. Community health services	**Objectives**	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	Compliant
			Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	To be confirmed
	1C. Primary care*	**Objectives**	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	To be confirmed
			Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	Compliant
			Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Plans in Place
			Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	Compliant
	1D. Elective care	**Objectives**	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Compliant
			Deliver the system- specific activity target (agreed through the operational planning process)	Compliant
	1E. Cancer	**Objectives**	Continue to reduce the number of patients waiting over 62 days	Compliant
			Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	Compliant
			Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Plans in place
	1F. Diagnostics	**Objectives**	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	Compliant
			Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Compliant
	1G. Maternity*	**Objectives**	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury	Maternity plans are in place and continue to be developed
			Increase fill rates against funded establishment for maternity staff	Maternity plans are in place and continue to be developed
	1H. Use of resources	**Objectives**	Deliver a balanced net system financial position for 2023/24	Compliant
2.Delivering the key NHS Long Term Plan ambitions and transforming the NH	2A. Mental health	**Objectives**	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	Compliant
			Increase the number of adults and older adults accessing IAPT treatment	Compliant
			Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Compliant
			Work towards eliminating inappropriate adult acute out of area placements	Compliant
			Recover the dementia diagnosis rate to 66.7%	Compliant
			Improve access to perinatal mental health services	Compliant
	2B. People with a learning disability and autistic people	**Objectives**	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	Compliant
			Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit	Non compliant.
	2C. Prevention and health inequalities	**Objectives**	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024	Compliant
			Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%	Compliant
			Continue to address health inequalities and deliver on the Core20PLUS5 approach	Compliant
	2D. Investing in our workforce	**Objectives**	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Compliant

Final plan: Remaining compliance challenges

Area		Status in the final plan
Follow-ups – achieve a 25% reduction on 2019-20 activity levels through 2022-23.	The main reasons for non-compliance include: • Reducing follow-up appointments in some specialties will result in patients waiting longer, putting them at increased clinical risk and backlogs would rise. • In order to clear overdue numbers, the Trusts would need to recruit additional consultants which is problematic within ophthalmology as patients are on repeat reviews for many years. • 25% reduction in follow-ups equates to 239,664 appointments at NUH alone. • There are currently about 26,000 (reduced from 32,000 this time last year) patients at NUH alone waiting for an overdue follow-up appointment, half are within ophthalmology with audiological medicine and ear, nose and throat (ENT) also having large overdue backlogs. • Nationally target is challenging for most Trusts and compliance is only possible once backlogs are reduced across certain specialties. The Trust will be reducing follow-ups but not to 25%. • 2022-23 referrals are 4.3% higher than the same period for 2021-22, driven by a higher number of internal referrals. This results in more capacity required to address new referrals and less available for overdue reviews.	Not compliant.
Plans to deliver.	The 2023-24 plan to achieve compliancy is as follows: • The system plan will be to reduce the current out-patient backlogs (follow-up overdue reviews) during 2023-24 at both NUH and SFH. • Agree a specialty-by-specialty plan for backlog reductions with clinical oversight to minimise clinical risk. • After backlogs are eliminated, agree specialty-by-specialty plans to reduce by 25%. • The system will look to bench-mark by specialty and agree appropriate new to follow-up ratio. Map new to follow-ups at speciality levels. • Plans for patient-initiated follow-ups/A+G target remain robust and to hit target, but the system will look to extend to give headroom for the 25% reduction described above. • Virtual consultations to maintain 25% through 2023-24. • Capacity released should support the backlog of overdue follow-ups. The activity plan should aim to clear the backlogs and get back to steady state through additional capacity (weekends, insourcing, recruitment). • Overdue lists currently have clinical oversight and are risk assessed to minimise risk of deterioration and this will remain in place. • Focus on the specialties which will not impact on clinical risk or increase backlog during 2023-24. • Improve on schemes to reduce did-not-attends and late cancellations to maximise clinic slot utilisation.	
Learning disability – no more than 27 people in adult inpatient setting by March 2024.	• The ICB remains non-compliant for the number of adults with a learning disability or in an inpatient setting commissioned by the ICB or NHSE. • The current plan is for 37 inpatients by March 2024 (10 for the ICB and 27 for NHSE). • The partnership between the NHS, local authorities and IMPACT has agreed these trajectories as realistic and stretching. These were signed off at the Learning Disabilities and Autism Board on 28 March. • Although this trajectory is not compliant with the Long Term Plan requirement, it has been accepted by NHSE Midlands. • An email from NHSE Midlands on 2 March 2023 confirms that although the ICB is not meeting the LTP targets, the overall plan does not seem unreasonable or unachievable. It goes on to request that the ICB explores whether the LTP target can be met in 2024-25. In response, the system has committed to achieving the LTP commitment of 27 inpatients by March 2025. • The chief executive/executive leads for learning disability are confident that this is be best position that can be achieved in the 2023-24 plan and is viewed as acceptable by NHSE. • The system has ADASS (Association of Directors of Adult Social Services) visiting from 28-30 June 2023 to undertake a peer review to offer assistance on how the system achieves compliance . • Monthly meetings taking place with NHSE to focus compliance.	Not compliant.

Health	The state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.	Integrated Care Partnership (ICP)	ICPs are a critical part of ICSs and the journey towards better health and care outcomes for the people they serve. ICPs provide a forum for NHS leaders and local authorities to come together with important stakeholders from across the system and community. Together, the ICP generates an integrated care strategy to improve health and care outcomes and experiences for their populations, for which all partners will be accountable.
Health inequalities/ Health inequities	Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.	Integrated Care System (ICS)	In an ICS, NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. Statutory ICS arrangements include: • an Integrated Care Partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS • an Integrated Care Board, bringing the NHS together locally to improve population health and care. Within ICSs, it is expected that several place-based partnerships will be agreed. Four place-based partnerships have been agreed in our system.
Healthy life expectancy	The length of time a person spends in good health – in other words not hampered by long term conditions, illnesses or injuries.	Life expectancy	The average number of years that someone can expect to live.
Neighbourhood	The smallest and most local area that services are organised at.		
Primary care network (PCN)	Local collaboration of GP practices, usually covering 30,000 to 50,000 people, working towards integrated primary and community health services.	Place Based Partnerships (PBP)	Place-Based Partnerships are collaborative arrangements that have been formed across the country by the organisations responsible for arranging and delivering health and care services in a locality or community. They involve the NHS, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities (people who use services, their representatives, carers and local residents).

System Analytics and Intelligence Unit (SAIU)	The SAIU brings together and develops existing ICB and ICS workforce with the purpose of delivering: • Population intelligence to support planning and strategy. • Analytical intelligence that spans the entire commissioning cycle. This includes capacity and demand modelling, population health management, and quantifying and evaluating the value of transformational initiatives. • Oversight of regional, national benchmarking data, as well as insight, contextual analysis and comparative information to support the interpretation of local data to improve quality of care and outcomes for our population. • Embedding an analytical approach to health inequalities which underpins all outputs. • Utilising best practice evidence-based interventions and new models to develop improved quality outcomes for our population. The SAIU is an independent team within the ICS that operates across the system.	Provider Collaborative at Scale	Partnership arrangements involving two or more trusts (NHS Trusts or Foundation Trusts) working at scale across multiple places, with shared purpose and effective decision-making arrangements, to: • Reduce unwarranted differences and inequality in health outcomes, access to services and experience • Improve resilience (for example, by providing mutual aid) • Ensure that specialisation and consolidation occur where this will provide better outcomes and value. The Nottingham and Nottinghamshire Provider Collaborative at Scale is between Nottinghamshire Healthcare NHS Foundation Trust, Sherwood Forest Hospitals NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust and East Midlands Ambulance Service NHS Trust, with an initial focus on programmes within the themes of discharge and workforce.
Outcomes	Change in health and wellbeing as a result of an intervention or action, either by an individual (exercising more), community (starting a running group) or organisation (creating more green spaces for people to exercise in).	Universities for Nottingham Civic Agreement	Partners have agreed as anchor institutions for Nottingham and Nottinghamshire a commitment to work together ensuring a joined up approach across several themes, including: • Economic prosperity • Educational opportunity • Environmental sustainability • Health and wellbeing which includes attracting the world's most talented clinicians and healthcare workers to the area, training and retaining local talent to develop their careers in Nottingham and Nottinghamshire; and maximising the economic opportunities provided by the strong local health and life sciences sectors.