NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire NHS Joint Forward Plan
Executive Summary

2023 - 2027

Our Joint Forward Plan

Our Integrated Care Partnership has published an an **integrated care strategy** which describes our ambitions for local people and how we are going to work together differently to ensure:

Every person will enjoy their best possible health and wellbeing.

We are now producing a **Joint Forward Plan** which outlines in more detail the work that NHS partners will undertake, working collaboratively across our system, to deliver these ambitions.

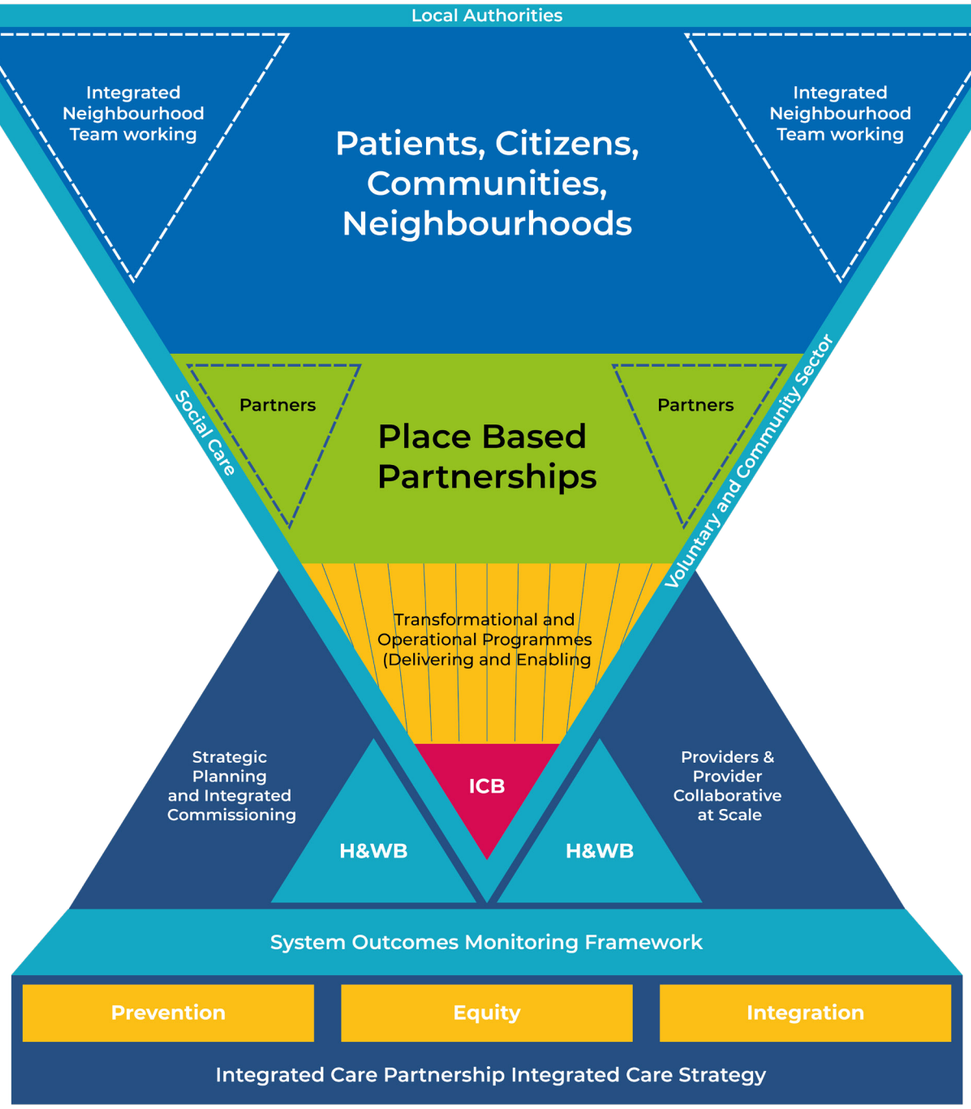
We recognise that there are still unacceptable differences in health and wellbeing outcomes, access to services and experience of services across our city and county. While some people live healthier lives for longer, this is often not the case for others, especially those living within more deprived communities. Taking action on these differences is a priority for our NHS. This applies to both physical and mental health needs. Our Joint Forward Plan outlines the actions we will take to radically alter the way in which we work together, focusing far more on preventing ill health, reducing health inequalities and inequity, using our combined commitment and resources. Our actions will be brave, ambitious and transformational.

As part of this transformation, we will work in a more integrated way at system and local level. Greater integration at a local level will be through Place Based Partnerships (PBPs) and local neighbourhood team working. Health and care provider organisations will work more closely at a system level in the form of a Provider Collaborative(s). Our Integrated Care Board (ICB) will also explore further opportunities to collaborate with NHS partners across the region and nationally. We will ensure an equal focus on mental and physical health, adopting a life course approach that addresses the specific needs of children and young people as well as those in later life.

NHS partners will accelerate partnership working with local authorities, public and voluntary sector organisations, our population and local communities. The principle of co-production will drive our agenda, ensuring that those with lived experience remain active participants in the design and delivery of local and system solutions. We will use population health data and intelligence, alongside local knowledge and experience, to identify priorities and opportunities for achieving better outcomes for people. Our local neighbourhood teams will build trusted relationships that ensure change will be embedded and sustainable.

Over the next five years, the combined impact of these changes will result in a significant cultural shift in the way we work together and will radically transform the system in which we work.

Evolving our integrated operating model



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 combination, our success in these areas will lead to the delivery of our strategic ambitions:

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**

What will our Joint Forward Plan mean for the way we work together?

The NHS Joint Forward Plan is based on three strategic principles:

Prevention is better than cure
Equity in everything
Integration by default

Guided by these principles, our delivery initiatives focus on four key areas that provide the greatest opportunity to improve population health by making better use of our scarce resources. By focusing on these four areas, we will release more capacity and resources to invest in prevention initiatives in the latter years of our transformational journey. This focus also enables us to meet the obligations required of us by national policy and the NHS Operational Plan. Our Plan will be refreshed annually to ensure we continue to focus on the right priorities for our people.

Our four areas of focus 2023-24 to 2027-28

1. **Prevention: Reduce physical and mental illness and disease prevalence**
2. **Proactive management of long-term conditions and frailty**
3. **Improve navigation and flow to reduce emergency pressures in both mental and physical health settings**
4. **Timely access and early diagnosis for cancer and planned care**

Initiatives that are most critical to meeting the expectations of our ICP Integrated Care Strategy, Joint Forward Plan and national policy expectations

Achieving	How?	What does this mean? Examples	Success factors
PREVENTION, EQUITY, INTEGRATION	Shifting resources into prevention, promoting equity and reducing health inequalities.	**Minimum** investment of a dedicated Health Inequalities Investment Fund of 0.2% of ICB budget in 2023-24 (£4.5m) with commitment to increase over the five-year period. Review of our Better Care Fund to support delivery of the JFP and Joint Health and Wellbeing Strategies. Implementation of a single system approach to exploring and delivering efficiency opportunities using benchmarking analysis/national tools to implement best practice. Systematic approach by all providers to 'bake in' principles of prevention, equity and integration into business as usual. Implementation of 'proportionate universalism' across strategic decision-making processes.	**Minimum** 1.4% investment dedicated to health inequalities by year five. Investment in initiatives that provide legacy of improved outcomes by reducing health inequalities/inequity. Efficiency and productivity expectations delivered and re-invested into patient care.
	Integrated neighbourhood team working and Place Based Partnerships (PBPs).	Increased collaboration and integration between health and care professionals at a local level aligned to delivery of specific interventions identified within Place Plans and/or system agreed programmes. Focus on high impact pathways of care, for example, frailty, severe mental illness, and best start. PBP Plans aligned to evidence-based priorities (Place and system level). Plans inclusive of mental and physical health needs, adults, children and young people, for example, smoking and obesity. Support primary care resilience and primary care network (PCN) development.	Embedded and evidenced integrated neighbourhood team approach across PBPs. Make Every Contact Count, co-production and asset-based approaches in place. Cultural shift to population focus.
	Provider Collaborative supporting 'at scale' transformation.	Joint working arrangements established across multiple provider organisations for targeted provision of services, for example, urgent care pathways, diagnostics, virtual wards, and social and economic development through anchor organisations.	Achievement of target outcomes and transformation of pathways as delegated including supporting system financial balance.
	System-level programmes providing leadership and expertise, for example, mental health, children and young people, maternity, ageing well, primary care, quality improvement.	Focus on population needs that address issues of health inequality and inequity across our system. Holistic support for individuals including parity and recognition for co-existence of physical and mental health needs. Outcomes will be improved over people's lives including equitable outcomes for vulnerable children and young people.	Programme activity focused on system priorities with multi-partner engagement and oversight delivering JFP commitments: • System mental health inpatient strategy implemented. • Mental health transformation plan implemented. • Delivery of children and young people's NHSE Core20+5.
	Developing our workforce. Promoting resilience and new ways of working.	Increased staff flexibility and flow across teams and geography to support outcomes. Promotion of, and embedding, our three strategic principles of prevention, equity and integration into the way that teams work.	Establishment of a recruitment hub, staff passports, shared/common training programmes. Common system level policies and processes including quality framework, service improvement and co-production approaches.

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

	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 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.