NHS
Nottingham and Nottinghamshire

Nottingham and Nottinghamshire NHS Joint Forward Plan 2024/25

2024 - 2028

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

Nottingham City Council

NHS England

Nottinghamshire County Council

CityCare

DHU Healthcare

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 builds on the version published in June 2023. It sets out how we will work differently, where we want to be in five years and how we will get there.

At the start of our second year of our Joint Forward Plan we have taken the opportunity to reflect on progress. This version of the plan, reinvigorates our approach to 2024/25 and sets out our high-level plans for 2028/29.

We continue to be committed to our 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, which has subsequently been reconfirmed in March 2024.

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 continue to face 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. We now face additional challenges with an increased focus on establishing a sustainable financial position to deliver best value for our population.

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.

We are determined 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.

We remain committed to focussing 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.

Our partnership working with our local authorities, public and voluntary sector organisations, our population and communities continues to evolve and strengthen. 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.

Our approach is to embed these three principles as 'the way we work'.

This first year saw the development of the Health Inequalities Innovation Fund to redeploy investment and resources into services to support prevention, earlier detection and interventions that impact on population health. Funding has been allocated across 9 schemes relating to three themes of Severe Multiple Disadvantage (SMD), Integrated Neighbourhood Working and Best Start in Life. We remain committed to our plan to develop this fund and will build on what we have learnt during the first year.

Our teams are being 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. Through our Place based working, training has been delivered to frontline staff to enable them to better support citizens and their families.

We have established frameworks to embed our approach to equity:

- Population Health Framework that will be used together with the Systems Analytic Intelligence Unit (SAIU) approach.
- ICS Social Value Procurement Policy setting out how we will gain efficiencies from our combined purchasing power, and support sustainability and social value in our communities.

SAIU continues to develop data packs and dashboards for system clinical priorities to inform our approach. We have focussed on developing strong foundations for collaborative working at neighbourhood, Place, system and regional level. Our approach to Integrated Neighbourhood Working is emerging to enable teams to be more integrated, developing proactive care to prevent ill health and helping people stay healthier at home for longer. We have been scaling up personalised care planning working with those with lived experience and local communities development of a co-production toolkit. We will actively seek out voices that are seldom heard so that all may contribute to building our transformed system.

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.

Our NHS organisations are committed to delivery of key national expectations. This plan continues to be a primary reference point for future strategic and planning decision making. The plan 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 we reconfirm commitment to remain one of the best performing systems in the East Midlands region, if not our nationally.

NHS Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

NHS Sherwood Forest Hospitals NHS Foundation Trust

NHS Nottingham University Hospitals NHS Trust

NHS Nottinghamshire Healthcare NHS Foundation Trust

NHS East Midlands Ambulance Service NHS Trust

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

Reflecting on key successes from 2023/24

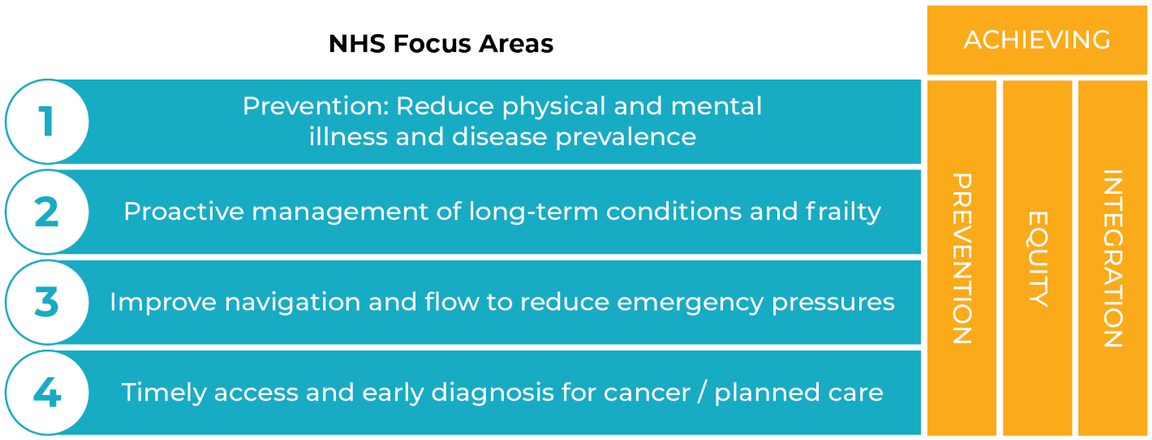
As we start this new year and refreshed plan, we want to take the opportunity to thank our staff for their hard work over the last year. A selection of our achievements are shared below, which demonstrate the strong platform that we have developed for the coming year to further embed PREVENTION, EQUITY and INTEGRATION.

Place Based Partnerships (PBPs) are continuing to develop approaches to Integrated Neighbourhood Working that bring partners and communities together to develop effective support and services tailored to local need.	The ICS was awarded Vanguard Status for NHS Scaling People Services. Three priority areas have been confirmed: Staff Wellbeing; Portability and Passporting including a collaborative approach to flexible staffing; a review of outsourced HR contracts including Employee Assistance Programme.	PCNs are hosting the Workingwell employment advice service within surgery. The service encourages patients struggling to find or stay in work due to a health condition to gain support.
Sherwood Forest Hospitals (SFH) Phoenix Team, a nationally recognised maternity tobacco dependence treatment service, has helped over 200 families to achieve a smokefree birth.	The Targeted Lung Health Check programme has expanded into Nottingham City building on the success of the programme in Mansfield and Ashfield. The ICB has recorded the highest national uptake rate for the programme. Further expansion is planned in 2024 and 2025 with full ICS coverage by 2027.	Partners have signed the Armed Forces Covenant as we we acknowledge and understand that those who serve or have served in the Armed Forces, and their families, should be treated with fairness and respect.
Through the Health Inequalities Innovation and Investment Fund, the ICS is providing wrap around care across Nottingham and Nottinghamshire for those who are facing Severe Multiple Disadvatage (SMD).	Initial stage of the Better Care Fund (BCF) review is now complete. The output will inform commissioning decisions and has identified potential areas to scale up collaborative commissioning including prevention, urgent care, mental health and children and young people.	Virtual wards to support patients who would otherwise be in hospital have been established across the ICS. 181 virtual ward beds across 23 specialties were operational as of 18th December 2023 providing monitoring and support to people in the place they call home.
South Nottinghamshire PBP held an Integrated Neighbourhood Working event in July bringing together more than 80 people to consider how to create healthy and sustainable neighbourhoods. This is now being progressed in the four areas with the highest level of health inequalities: Arnold Town, Cotgrave, Eastwood Town and Hucknall Town.	Nottingham City identified cardiovascular disease as a PCN priority. A review was undertaken using data from the System Analytics Intelligence Unit (SAIU) focused on avoidable deaths, clinical conditions, lifestyle factors and the wider determinants of health. A programme has been initiated offering interventions such as personalised exercise and diet plans and access to classes, a targeted media campaign and providing patients with resources to support healthy lifestyles.	Supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. Partners are working together to jointly develop the same day emergency care pathway to prevent hospital admissions and keep people at home.
SFH introduced new pathways of MRI head, magnesium, lumbar punctures and developing same day ultrasound for deep vein thrombosis into its dedicated medical unit. The Unit has 25 recliners and sees an average of 60 patients per day equating to 37% of patients admitted via emergency methods who were discharged same day.	Bassetlaw PCN are carrying out targeted work to improve uptake of screening by Women in a deprived area. This includes walk-in cervical cytology for Polish women on Saturdays, advertised by Polish leaflets and posters, with a community and voluntary sector interpreter on site. 20 people attended the first session with 17 screened. Further sessions are planned.	Doncaster and Bassetlaw Teaching Hospitals (DBTH) launched a landmark partnership with Retford Oaks Academy and became the second ‘Foundation School in Health’ in UK, bolstering the relationship between education and health across the region.

Since our first plan was published in July 2023, organisations in Nottingham and Nottinghamshire continue to work in a challenging environment. Of note are that:

- Local people and organisations continue to face financial challenges. The rising cost of living is impacting on households and businesses, including health and care staff and services. We are working across our system for the provision of core NHS and social care services, and our partnerships can help align our public sector approach to the rising cost of living.
- Increasing workforce costs are also impacting on the financial sustainability of the health and care services that we provide.
- The pressure of ongoing industrial action continues to impact on health and care services, including our waiting lists and resilience of our staff. Getting back on track with waiting times and access to emergency care, is a top priority for the NHS. We have a track record of successful collaboration during times of pressure on our health and care system, and partners continue to work together to support citizens and staff. We have a whole system response structure to ensure that essential services are maintained.
- Some of our services aren't being delivered to the standards that we would expect for the people of Nottingham and Nottinghamshire. This plan outlines key actions that we will be taking to improve the quality of services and outcomes in population health and healthcare.
- A new Combined East Midlands Authority has been created after a £1.14 billion devolution deal was agreed by the four upper tier councils of Derbyshire County Council, Nottinghamshire County Council, Derby City Council and Nottingham City Council in November 2022. Devolution provides opportunities to improve the economic, social and environmental wellbeing of the people who live and work in the area including:
    - Local control over a range of budgets like the Adult Education Budget, so we can use the money to meet the needs of people in our communities.
    - Local powers to tackle challenges that are specific to our area and harness its true economic potential, for the benefit of everyone who lives and works here.
    - Working more effectively on a larger scale across council boundaries, further strengthening partnership working across and between our counties and cities.

We remain confident that a continued focus on our four NHS focus areas is the right thing to do for local people. Our plan sets a clear direction for health and care services in Nottingham and Nottinghamshire.



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, experiencess 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.

Further detail on our system, the approach to our JFP and ambition is outlined in the first version of our NHS Joint Forward Plan available on our website: healthandcarenotts.co.uk

Our agreed 14 Integrated Care Strategy Priorities
We will support babies, children and young people to have the best start in life with their health, development, education and preparation for adulthood.
We will support babies, children, young people and adults with the greatest needs (the 20% most deprived, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).
We will focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.
We will support frail older people with underlying conditions to maintain their independence and health.
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 'Make Every Contact Count' (MECC) for traditional areas of health, for example mental health and healthy lifestyle and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing.
We will establish a single health and care recruitment hub.
We will adopt a consistent system-wide approach to quality and continuous service improvement.
We will bring our collective data, intelligence and insight together.
We will align our Better Care Fund programme to our strategic priorities.
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.
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. 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.

Evolving our integrated operating model

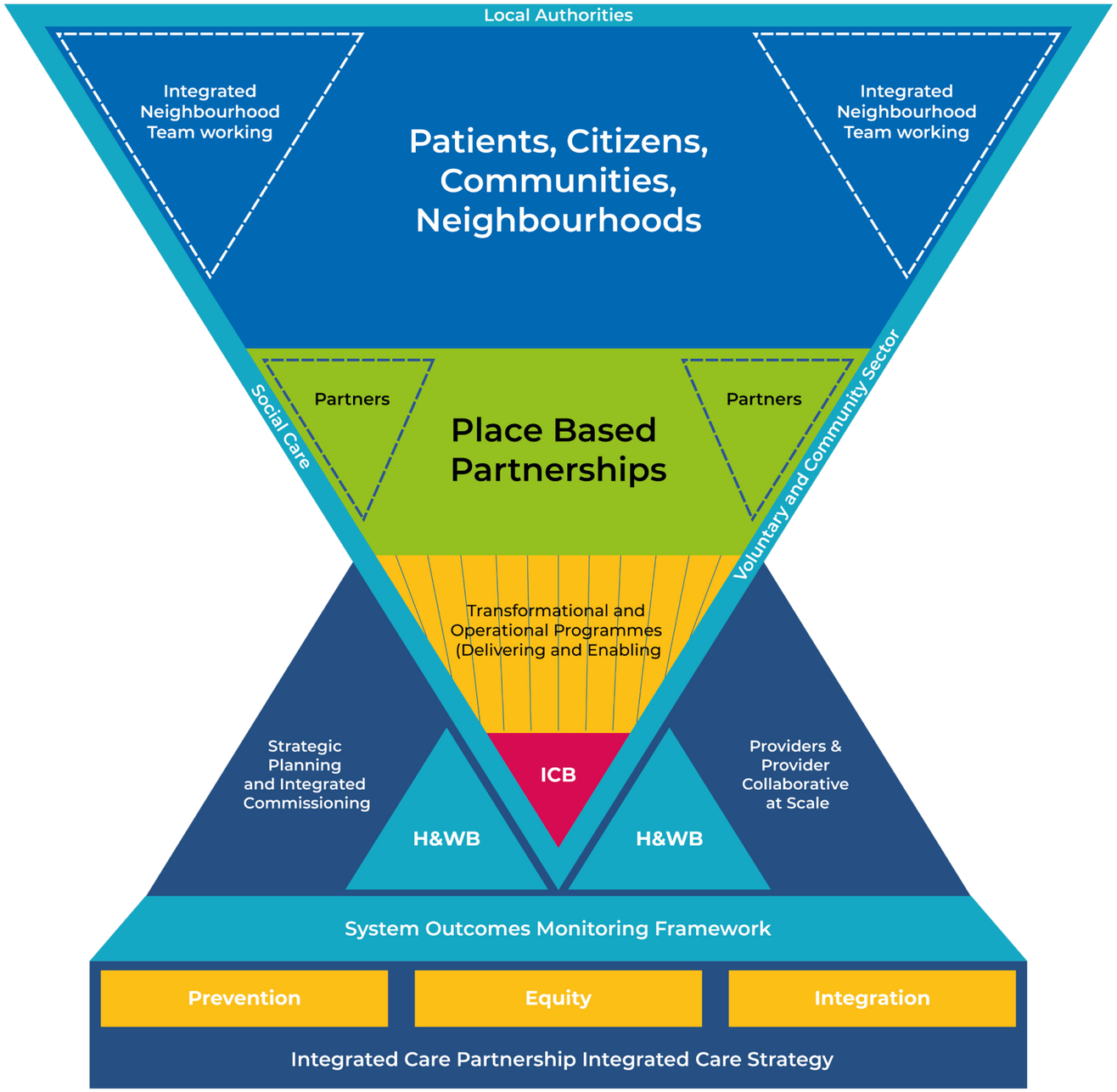


Figure 1.

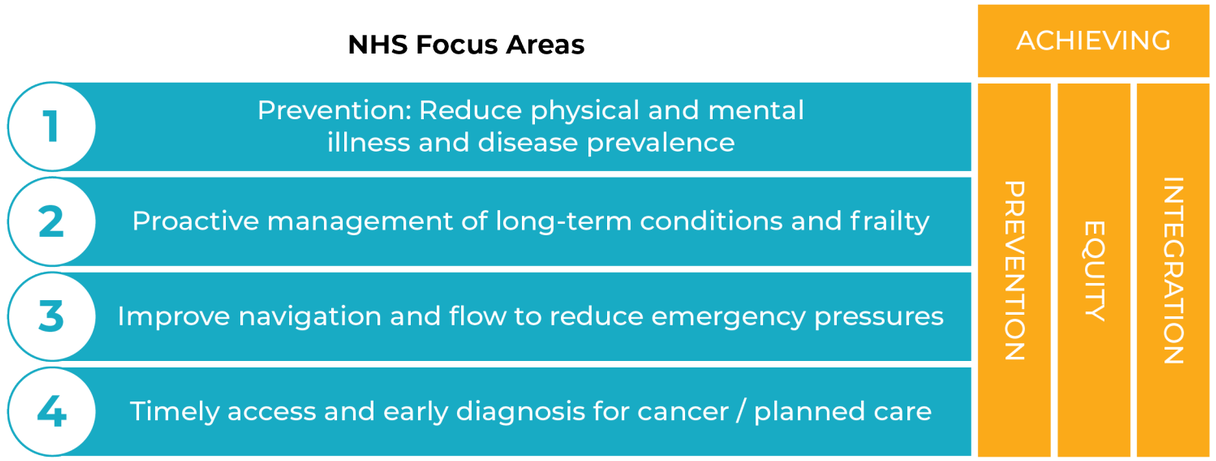
Building our integrated approach

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.



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. 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.

Key areas of focus in 2024/25

In this section 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.

Prevention	Equity	Integration	How we will use our resources differently
Develop our focus on children and young people and Women's Health across all Places	All partners will embed the Population Health Framework and approaches to tackling inequity in Women's Health	Improve navigation and flow to reduce emergency pressures	Developing plans to return the NHS system to financial sustainability
Proactive management of long-term conditions and frailty with development of care pathways that support people to stay well at home for longer	Continued support to eliminate waits of over 65 weeks for elective care, with a focus on reducing Did Not Attends and responding to barriers to access and experience	Workforce aligned to places through integrated neighbourhood working to address health inequalities	Reprioritisation of funding/resources on prevention
Collective focus across our system on a minimum of two Joint Health and Wellbeing Strategy prevention priorities	Continued roll out of the Health Inequalities Investment Fund to target resources to specific population needs	Developing multi-disciplinary personalised care plans and active case finding for those at greatest need to support their health, care and independence needs	Ongoing system review of opportunities for reinvestment based on invest to save and value-for-money principles

Key areas of focus in 2024/25 - our success factors

The Integrated Care Board (ICB) has led the development of an ambitious and credible 2024/25 NHS operational plan which covers the whole population of Nottingham and Nottinghamshire. The plan supports delivery of the local priorities set out in the Integrated Care Strategy and the refreshed NHS Joint Forward Plan.

It also supports delivery of the national priorities as set out in the NHS England 2024/25 Priorities and Operational Planning Guidance, published on 27th March 2024. This confirms that the overall priority for the NHS in 2024/25 remains the recovery of core services and productivity following the COVID-19 pandemic. To improve patient outcomes and experience the NHS is expected to:

1. Maintain collective focus on the overall quality and safety of services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
2. Improve ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity that systems and providers committed to put in place for the final quarter of 2023/24.
3. Reduce elective long waits and improve performance against the core cancer and diagnostic standards.
4. Make it easier for people to access community and primary care services, particularly general practice and dentistry.
5. Improve access to mental health services so that more people of all ages receive the treatment they need.
6. Improve staff experience, retention and attendance.

This should be underpinned by system wide transformation, including the integration and streamlining of care to deliver evidenced-based approaches to prevention, self-care and the effective management of frail older people and those living with long-term conditions. Alongside this the NHS must continue to drive improvements in productivity and operational effectiveness, improve Digital maturity and support delivery of the NHS Long Term Workforce Plan.

The NHS England 2024/25 Priorities and Operational Planning Guidance includes 32 detailed national objectives listed in the table opposite. The ICS is expecting the final version of the NHS operational plan to be compliant with the majority of these national objectives. In the few areas where there remains a challenge to meet the national objective the ICS will continue to push hard for achievement in year.

Partners have agreed ambitious financial plans for 2024/25 in response to significant financial sustainability challenges across the system. These plans include an ambitious 6% efficiency requirement to be delivered through a combination of system transformation and organisational efficiency programmes. Even with such ambitious plans the ICS is unable to meet the national objective to deliver a balanced net system financial position for 2024/25 and is therefore non-compliant in this area.

The final version of the NHS operational plan was approved by ICS Partners and the ICB Board by 2nd May 2024 before submission to NHS England for review and approval which is expected during May.

National NHS Objectives for 2024/25

Area	Objective
Quality and patient safety	Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
Urgent and emergency care	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	Improve community services waiting times, with a focus on reducing long waits
Primary and community services	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
Primary and community services	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
Elective care	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
Elective care	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
Elective care	Improve patients' experience of choice at point of referral
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025
Cancer	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
Cancer	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Maternity, neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
Maternity, neonatal and women's health	Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	Improve patient flow and work towards eliminating inappropriate out of area placements
Mental health	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
Mental health	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
Mental health	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
Mental health	Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
People with a learning disability and autistic people	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
Prevention and health inequalities	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
Prevention and health inequalities	Increase vaccination uptake for children and young people year on year towards WHO recommended levels
Prevention and health inequalities	Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
Workforce	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
Workforce	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	Deliver a balanced net system financial position for 2024/25
Use of resources	Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

Key system changes over the next 5 years aligned to our three principles are:

PRINCIPLES	2024/25	2025/26	2026/27	2027/28	2028/29
Prevention	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. 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. Evidence based review of system prevention offer to reshape and integrate services. Ongoing development of plans for each of the clinical priorities and identification of priorities based on population need to inform future investment decisions Develop our focus on children and young people and Women's Health across all Places.	Collective focus across our system on a minimum of three Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs (one of these addressing healthy behaviour choices). Defining outcomes and targeted approach to the five clinical areas for adults and children and young people based on health equity assessments. Targeted approach to inclusion health groups through Place Based Partnerships. Build on falls prevention services at a Place level.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. All new starters to complete Make Every Contact Count training as part of induction by March 2026.	PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. 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. PBPs will implement a minimum of four Joint Health and Wellbeing Strategy prevention priorities, dependent upon population needs and Place resources. 80% carbon net zero by 2028-32.
	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.				
Equity	The ICB will continue to provide a dedicated £4.5m fund to support improvements in health inequalities and equity, which will be aligned to financial sustainability and ICS priorities. Funding has been committed to support the continuation of 9 programmes across the system.	The Health Inequalities and Innovation Fund will increase by a further £4.5m.	This fund will increase by a further £9m.	This fund will increase by a further £9m.	This fund will increase to accumulate to circa £30-35m.
	Development of new health inequalities dashboard and corresponding reporting. Adopt the principle of 'proportionate universalism' in future transformation, service redesign and in the context of funding allocations across the partnership so that resources are deployed according to need rather than historic allocation.	Metrics and performance reporting to represent activity in relation to population need (aligned with allocations formula). Framework for evaluating the impacting of funding allocations in relation to proportionate universalism. Alignment with Health and Wellbeing Board evaluation according to population need. 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.			
	All partners will embed the Population Health Framework and approaches to tackling inequity in Women's Health.	Ongoing oversight of delivery of our agreed transformation initiatives/commitments across Places, primary care, community and acute sectors.			
	Embed parity of esteem for physical and mental health needs across all policy areas (including maintaining a focus on dementia). Review waiting lists and access criteria against deprivation level criteria, ethnicity and disability data and convert into a clear action plan.				
	Co-production toolkit embedded. Covid-19 recovery for CYP in closing the gaps in physical, education and health needs	Ongoing oversight of co-production approach as part of Integrated Care Strategy commitments. Roll-out of training offer.			

Key system changes over the next 5 years aligned to our three principles are:

<table>
<tr><th>PRINCIPLES</th><th>2024/25</th><th>2025/26</th><th>2026/27</th><th>2027/28</th><th>2028/29</th></tr>
<tr><td rowspan="4">Integration</td><td>Through the Core20+5 Accelerator programme, defining a quality improvement approach to impacting on health inequalities.
Ongoing development of PBPs 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.
Maturing of the provider collaborative.
Ongoing implementation of the Primary Care Strategy.
Integrated commissioning function and quality and market management functions established.</td><td>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.</td><td colspan="3">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.</td></tr>
<tr><td>Embedding of system monitoring and delivery assurance framework for the ICP Strategy and JFP.
Continued development of an agreed inclusive approach to annual JFP refresh.</td><td colspan="4">Ongoing system level assurance and delivery oversight of the ICS Integrated Care Strategy and Joint Forward Plan.</td></tr>
<tr><td colspan="5">Developing multi-disciplinary personalised care plans and active case finding for those at greatest need (Severe Multiple Disadvantage) to support their health, care and independence needs.</td></tr>
<tr><td colspan="5">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.</td></tr>
<tr><td rowspan="4">How we will use our resources differently</td><td>Developing and implementing plans to return the NHS system to financial sustainability.
Reprioritisation of funding/resources on prevention through the Health Inequalities and Innovation Fund, moving from treatment services to prevention services to address system priorities, for example, proactive care and management of long term conditions.</td><td colspan="4">We will create financial headroom to provide resilience for safe and quality services.
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).</td></tr>
<tr><td colspan="5">Continued implementation of the Better Care Fund with specific reference to supporting PBP plan delivery and delivery of 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.</td></tr>
<tr><td colspan="2">Development of equity framework that demonstrates the opportunity to impact on access patient experience and outcomes across interventions including the re-distribution of resources.</td><td>Equity framework refined and model tested in relation to the distribution of financial resources.</td><td colspan="2">Equity frameworks embedded across all activities that provide a strong universal approach with resources targeted to need.</td></tr>
<tr><td colspan="5">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.
We will 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.</td></tr>
</table>

The stark differences between our PCN/neighbourhoods

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. Further details are available in the first version of our NHS Joint Forward Plan available on our website: healthandcarenotts.co.uk

We continue to monitor key indicators of health and wellbeing through our System Analytics and Intelligence Unit (SAIU) dashboards. The below shows a snapshot of population health from last year. We have made progress in some areas, however, we recognise that we are early on our journey of embedding the new approach set out in this plan.

As NHS partners we remain committed to improving inequalities and supporting our system vision set out in the Integrated Care Strategy to ensure that ***every person will enjoy their best possible health and wellbeing.***

Period

202312

The stark differences between our PCN / neighbourhoods

		Deprivation	Risk Factors			Long Term Conditions								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	Severe Frailty	Emergency Admissions	Avoidable deaths	Median age of death
BACHS	62,523	2.4	223.5	182.6	186.3	81.5	33.5	18.0	17.0	38.5	41.2	10.2	12.5	7,991	331.1	77
Clifton & Meadows	34,703	2.5	224.6	185.1	184.6	75.7	32.6	15.2	18.4	39.0	40.6	9.1	7.0	8,190	326.5	83
Bulwell & Top Valley	46,657	2.6	236.9	197.5	178.8	71.4	33.6	14.7	17.0	37.2	44.7	9.6	7.1	8,453	331.5	80
Radford & Mary Potter	46,123	2.7	187.0	185.1	184.9	107.9	24.2	11.1	16.1	43.9	36.0	15.2	15.9	8,391	373.9	74
Nottingham City East	67,001	3.0	186.0	185.1	162.0	73.8	29.3	14.1	16.6	34.9	41.0	13.5	11.9	7,889	385.9	76
Bestwood & Sherwood	55,189	3.5	195.6	156.0	153.1	64.0	21.1	12.9	15.9	34.0	42.2	10.1	7.8	7,361	295.3	80
Ashfield North	51,441	3.9	259.0	164.2	167.6	68.7	25.8	16.4	14.7	37.2	47.7	7.6	9.3	7,760	320.2	80
Mansfield North	59,386	4.1	239.2	154.1	169.0	65.9	26.1	10.3	13.5	36.3	44.4	5.9	10.9	7,291	299.3	79
Rosewood	51,595	4.1	218.5	178.9	151.0	64.2	27.1	12.1	13.8	37.0	42.5	7.6	9.6	7,556	289.8	80
Ashfield South	40,684	4.3	254.3	156.4	153.5	65.9	26.0	10.6	14.2	34.2	44.1	6.5	6.9	7,258	308.3	79
Byron	38,993	4.5	226.5	141.2	155.0	61.1	23.6	11.5	14.9	33.3	47.5	5.2	17.5	7,659	284.5	81
Newgate Medical Group	30,091	4.6	233.2	176.2	143.2	65.7	30.5	12.5	12.5	29.7	42.3	5.7	8.8	6,109	296.5	80
Larwood & Bawtry	37,762	5.1	229.9	136.2	161.3	67.2	30.9	19.0	15.2	34.1	45.5	6.8	14.6	6,507	245.6	80
Retford & Villages	58,166	5.3	229.6	133.6	147.8	57.0	23.5	10.7	12.1	29.1	44.2	5.3	10.3	5,402	227.4	82
Sherwood	63,570	5.3	234.3	141.8	164.4	62.3	23.7	12.3	14.0	36.7	45.7	5.8	10.6	6,958	229.4	81
City South	39,013	5.6	166.3	109.8	151.7	56.7	17.0	9.1	12.9	34.4	43.2	6.6	6.5	6,841	211.6	82
Eastwood/Kimberley	37,859	5.9	223.4	120.5	151.7	56.3	20.5	15.3	14.2	32.7	47.4	5.7	8.2	6,985	232.5	80
Synergy Health	36,068	5.9	213.3	146.2	151.1	53.0	18.3	10.7	15.3	30.7	47.5	7.6	15.1	6,701	263.2	81
Newark	79,263	6.0	192.9	138.0	145.3	50.1	15.8	11.1	12.3	29.7	49.2	5.4	7.8	5,663	236.7	81
Stapleford	22,320	6.1	223.8	137.0	163.8	58.2	21.6	12.8	11.9	30.4	44.8	5.8	4.3	6,709	219.8	80
Arnold & Calverton	34,110	6.5	202.3	122.2	144.5	49.3	17.4	9.5	15.3	30.0	47.1	6.7	9.3	6,387	204.4	83
Arrow Health	39,660	6.6	182.6	115.7	143.9	46.6	15.1	9.9	12.8	28.5	46.2	6.4	5.9	6,357	204.3	82
Beeston	49,691	7.4	175.5	107.3	147.7	51.8	16.4	12.2	13.7	28.8	47.5	7.1	11.2	6,160	221.9	84
Rushcliffe North	42,464	8.5	179.8	97.1	136.0	39.5	14.8	9.1	12.2	27.5	46.9	3.6	5.0	6,010	159.2	83
Rushcliffe Central	52,890	8.8	135.2	67.6	133.0	41.7	10.9	9.6	12.1	27.0	47.4	5.7	5.0	5,090	182.6	83
Rushcliffe South	43,567	9.0	172.2	87.3	135.9	39.5	11.1	9.5	12.2	25.9	46.4	3.6	3.9	5,301	165.9	84
Unity	46,871	5.3	110.0	63.6	143.6	41.1	12.8	9.5	8.4	21.1	38.9	3.6		3,422	118.8	68.5

Bassetlaw Place
Nottingham City Place
South Nottinghamshire Place
Mid 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).

COPD = Chronic obstructive pulmonary disease
CHD = Congestive heart disease

Most deprived PCN neighbourhood
Least deprived PCN neighbourhood

Case Study

One version of the truth data to support hospital discharge Teams from health and social care have worked together to create a 'one version of the truth' discharge dataset that all partners agree is accurate. This data supports collaboration and data-informed practice across the wards and the multi-disciplinary Transfer of Care Hubs in managing the timely, safe and appropriate discharge of older people once they are well enough to leave hospital and return home. It has supported better practice and decision making and more people are now going directly home in a shorter time, leading to people spending 20,000 fewer days a year in a hospital bed at one of our acute hospitals.

The work is being rolled out across all three acute hospital sites in the ICS and is viewed as national best practice, with NHS England and the Department of Health and Social Care featuring the project in their national workshops to consider new metrics for hospital discharge.

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 22-41.

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 and success factors

System interventions	2024/25	2025/26	2026/27	2027/28	2028/29
Prevention: reduce physical and mental illness and disease prevalence	Development of targeted case finding specifically focused on population health needs across Places and system priorities, for example, frailty, severe multiple disadvantage, obesity. 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.		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).		
	System-wide approach to personalised care planning across all sectors (acute, community and primary). Implement structured education programmes.		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	Develop PBP focus on tackling the quality of care in frailty that would be supported by the whole system and its partners. Identify the frailty cohort of focus based on data which indicates where resources are being over utilised and where care could be provided more appropriately. Reinvigorate the Practice Pack model at a Practice, PCN and Place. Frailty same-day emergency care embedded. Asthma diagnosis tools embedded within primary care for children and young people. Increase immunisation and screening uptake for 'at risk' groups.		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.		
	Understand the opportunities for aligned resources and incentives at a PCN and neighbourhood level, and review ICB support e.g. medicines optimisation and Clinical Design Authority. Deliver Primary Care Strategy and integrated approach to Long Term Conditions Management with a focus on the top five health conditions for the population. 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	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.				
	Further 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 with social care established for specific cohorts.				
	Develop a co-located urgent treatment centre at QMC to reduce demand on A&E. Deliver medically safe for transfer plan target and develop trajectory for years 2 to 5.	Embed improvements in length of stay and flow across all acute settings			
	Expand our same-day emergency care offer across hospitals ensuring direct access for all professionals and implementing new data requirements.				
	Transform our P2 and P3 offer to improve patient flow for patients who are medically safe for transfer. and reduce length of stay in P2 beds.				
	Develop an urgent care coordination hub which will act as a single point of access for health professionals				
Timely access and early diagnosis for cancer and elective care	Continued support to eliminate waits of over 65 weeks for elective care. Elective hubs and clinical diagnostic centres established (Newark, City, Mansfield). Expansion of targeted lung health, breast cancer screening, community prostate clinics and community liver surveillance programmes. Identify the top 5 specialities with the longest waits for CYP elective care. Differentiating waits and preoperative care for children and young people where development is disproportionately affected compared to adults.			Ongoing delivery and development of prevention initiatives.	
	Roll-out personalised care, optimise integrated care pathway and referrals. Maximise productivity and make best use of workforce, for example, shared workforce plans, staff digital passports and Making Every Contact Count.				

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 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 for their ongoing care/rehab needs and 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. In order to deliver our system ambitions, we know that we need to think about how we set ourselves up as a system, ensuring that we have clarity of the roles of the different components of our system in delivering our ambitions. Work is underway to develop a system operating model which will start to map out where we think that different functions will sit across our system in the future. We have a number of developing structures or parts within our system, including Place Based Partnerships and Provider Collaboratives.

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 health 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.

There is significant work underway to strengthen provider collaboration and develop provider collaboratives across our system, encouraging Trusts to do things together where it makes sense. We have a number of collaboratives in existence which either span our ICS area, or work across broader areas e.g. the East Midlands. Some of these collaboratives focus on particular service areas and others are geographical based collaborations. The range of work being undertaken in these collaboratives spans clinical pathways and corporate services and we hope that as they continue to evolve, their role in our system will strengthen. Our Provider Collaboratives will continue to mature in a way that enables our provider organisations to work more intimately and collaboratively on key areas in order to secure sustainable local services. 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.

Productivity and efficiency - our financial savings approach

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 20% 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.

In 2023/24 the system spent more than the resources available leading to a financial deficit. Plans are under development to deliver the ambition of financial balance and recurrent financial sustainability within 2 years.

The scale of deficit will require continued focus on financial and workforce control in every organisation, alongside productivity improvement, efficiency and transformation. To drive this, we have a system-wide approach to transformation across 8 system programmes and 10 areas of financial opportunity.

The analysis, using peer benchmarks, has identified £148m to £350m of potential savings deliverable over the medium term. The identified opportunities are in areas of strategic importance and are expected to lead to performance, quality, access and experience benefits in addition to the financial benefit. These opportunities are being used to support the development and implementation of system-wide detailed delivery plans.

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

We will maintain robust processes to manage budgets to ensure best value of the public pound. A single system approach to exploring and delivering efficiency opportunities. We will use benchmarking analysis and national tools (such as Getting 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 make use of relevant productivity guidance and recommendations from NICE.

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. This has worsened in 2023/24 due to inflationary pressures and continuing workforce growth above funded levels.
- **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 20% 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** – return to financial balance in year two and 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 20.
- **Investment in prevention and tackling health inequalities** – £4.5m recurrently invested in health inequalities in 2023/24. Funded schemes remain in place. Additional investment paused in 2024/25 to focus on affordable financial position. Ambition remains to grow this investment further in future years alongside a focus prioritising existing resources to support prevention and equity.
- **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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Financial sustainability	Reduced deficit Improving recurrent underlying deficit	Deliver in year balance	Deliver recurrent financial balance. Create headroom to provide resilience.			✓		✓
Investment priorities	Embed and evaluate impact of 2023/24 investment	Increasing in investment in prevention and equity 0.4% cumulative	0.6% cumulative	1.0% cumulative	1.4% cumulative	✓	✓	✓
Capital investment	Increasing capital usage to support strategic aims Min. 10%	Min. 15%	Min. 20%	Min. 25%	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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Workforce aligned to the place and values to address health inequalities.	Support the workforce to work in a geographical footprint across organisational boundaries aligned to integrated neighbourhood working.	Work with partners to understand what it would take for the workforce to deliver personalised, Strengths based trauma informed care within the MECC principles.	Build on areas of good practice to spread and embed the cultural change required.			✓	✓	✓
Implementation of Partnership Place Plans and PBP maturity.	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.		✓	✓	✓
We will maximise joint commissioning opportunities, particularly around primary and secondary prevention and with our local authority partners.	Identify areas where similar services are commissioned and explore opportunities for alignment Use the Better Care Fund review to support this process	Understand the differences between services to ensure the maintenance of specialist aspects and reduce duplication of provision. Alignment of the offers to support the experience of the person using the service.	Jointly commission a preventative service with local authority partners.	Review the impact of a jointly commissioned service on the people accessing it , the productivity and financial resources.		✓	✓	✓
Development and maturity of Place to enable functions to be delivered at Place and neighbourhood level.	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.				✓	✓

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.

Place supported action on Frailty and Proactive Care

Current state: Our challenges

- Frailty is a common medical condition that is frequently associated with ageing. Over the next 20 years there will be a significant increase in frail people in our ICS.
- The Nottingham and Nottinghamshire system has identified frailty as one of the system priorities where our resources are currently significantly committed and an area of high growth in spend.
- The cost of frailty is not just financial. It is a cost to our people, our quality of care, our services.
- The electronic frailty index shows that across the 65 and over population at PCN level:
  - People identified as Fit varies from 31% - 52%
  - People identified with Mild Frailty varies between 28% and 33%
  - People identified with Moderate Frailty varies between 12% and 21%
  - People identified with Severe Frailty varies between 10% - 18% (excluding Bassetlaw)
- 21.5 % of the following two areas accounts for all over 65 emergency admissions (2019)
  - 7,800 admissions for falls, Injuries and fractures equating to approximately 70,000 bed days.
  - 5,100 Flu and pneumonia emergency admissions equating to 43,000 bed days.
- People classed with severe frailty are 5.9 times more likely to have a flu and pneumonia admission than those people not classed with severe frailty.
- The 65 and over population living alone are 8.8 times more likely to be admitted to hospital than those not living alone.
- People with dementia are predicted to be 8.2 times more likely to be admitted into hospital.
- Having multiple co-morbidities has a significant impact on the odds of having hospital admissions.
- Priority areas:
  - CVD (Heart Failure, Stroke, CHD, hypertension)
  - Respiratory(COPD/Pneumonia)
  - Cancer
  - EoL
  - Frailty/Dementia/Falls

Future state: Our ambition

- Our population is supported to age well, maximising support across health services, Local Authority and the VCSE.
- A reduction in health inequalities across our most vulnerable populations.
- EoL care plans in place for those in the last 12 months of life.
- Experience end of life according to their personal and individual wishes.
- Our population receive expert co-ordinated management of LTCs.
- Our population will be supported to address health improvement with targeted prevention advice and support.
- The population feel supported and empowered to recover and regain their independence in their own home with dignity.
- Our population will have shared decision-making to make important choices about the right care and treatment.
- Reduce inappropriate admissions to hospital.

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

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop a Place focus on tackling the quality of care in frailty: - Understanding the challenge and focus. - Information, intelligence, and evidence base. - Ageing well: preventative approaches. - A reinvigorated approach to proactive care – embedding an MDT approach as standard.	Reinvigorate the Practice Pack model with a focus on frailty Focus on indicators that suggest quality of patient experience / outcomes could be improved Data from other system partners - E.g., social care/acute trusts. Consider General Practice protected time/resource. Review data to map prevalence and identify predominant condition clusters. Approaches will be focused on increased risk stratification and preventative strategies targeting underlying risk factors .	Build on falls prevention services at a Place level. Engage with VCSE and maintain community development models. Tackling loneliness – loneliness collaborative. Develop neighbourhood working models across PCNs and neighbourhoods with focus on prevention/ageing well. Agree approach for engagement with General Practice. Review current provision of services to support MDT provision.	Continuous development and refinement.				✔	✔
Focus on patients with multiple long term conditions.	Local action to test new approaches to the delivery of long term condition management in primary and community care. Align where possible to the Integrated Neighbourhood Working approach.	Review ICB support e.g. medcines and Clinical Design Authority. Understand the opportunity for aligned resources and incentives at a PCN and neighbourhood level.	Continuous development and refinement.				✔	✔

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.
- 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.
- Estates for the growing workforce and community-based delivery of care is restricting delivery.
- A review of current estate and needs for future delivery has been undertaken and plans are being developed to address challenges, maximising the available estate as flexibly as possible.
- Need to work with other providers such as Community Pharmacy with significant communication barriers between the various parties

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 continue to mature allowing them to be in a positive position for leading the ongoing 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.
- To continue with the work started with Community Pharmacy visits to integrate Community Pharmacy into PCNS – this includes starting up a working party with representatives from all stakeholders

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

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
PCN maturity to support INTs.	System leadership development.	Opportunities and cultural change.	Continuous development.			✔	✔	✔
‘Team of Teams’: common purpose and shared endeavour.	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.	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 including GPs, Community Pharmacy, Dental and Optometry

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 integration of pharmacy, dental and optometry contracts and services including Pharmacy First.

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.
- Regular uptake of Pharmacy First and other Community Pharmacy services to increase access as part of Primary Care Access Recovery Plan (PCARP).

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

What	2024/25	2025/26	2026/27	27/28	28/29	Prevention	Equity	Integration
Implementation of primary care strategy. Delivery primarily through Place-based teams working with subject leads at a system level.	Work progressing on priority area of General Practice chapter of Primary Care Strategy. Development of Community Pharmacy chapter. Commence engagement work on dentistry and optometry chapters. ICB Primary care estates strategy completed.	Promote learning and sharing of new ways of working. Implementation of Estates Strategy. Finalise dentistry and optometry chapters.	Develop primary care workforce modelling and response. Promote research.	Development opportunities		✓	✓	✓
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 condition and frailty management, promote referral optimisation, pathway efficiencies. Local support programme in place for practices focused on identified development opportunities. Development of Integrated Neighbourhood Team working. Improve patient comms 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.	Embed benefits of PCN investment e.g. care navigation training, funding for additional roles (ARRS), online consultation, cloud-based telephony, use of NHS App. Tailored working with practices to understand specific resilience challenges.	Review locally enhanced services to promote focus on reduced HI 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).
- National review has indicated that police spend a significant amount of time responding to people in a mental health crisis, and may not be the right agency to provide support.

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, by the people with the right skills, this will support the delivery of Right Care, Right Person. 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	2024/25	2025/26	2026/27	2027/28 2028/29	Prevention	Equity	Integration
Prevention, inpatient, discharge joint working.	Deliver Mental Health Inpatient Strategy Review of phase one implementation. Develop and agree timescale for phase two implementation. Develop plan for years three-to-five transformation. Maintain performance for Adult and Children and Young People services/pathways meeting Long Term Plans standards.		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.	Develop Place-based prevention models aligned to community transformation. Implementation of phase one priorities. Implementation of Right Care, Right Person.	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.	Recovery Action Plan in place to improve performance and focus on integration at a place level Reduce waiting times to services Implement Adult Avoidant Restrictive Food Intake Disorder scoping pathway Implement Community Rehabilitation Pathway Increase and embed psychological therapy service delivery		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.

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

What	2024/25	2025/26	2026/27	27/28	28/29	Prevention	Equity	Integration
Focus on the under-fives to have the maximum preventative impact.	Co-design new pathways with system partners for healthy lifestyles and infant mental health. All Maternity and Neonatal staff have been trained in Cultural Competency and Safety.	Focus on early identification with PCNs and at Place. Review impact to outcomes of training. Develop appropriate local data & intelligence driven interventions.	New pathways embedded. Costs saved reviewed and outcome measures refined.			✓	✓	✓
Reduce inequity of services in maternity and for children and young people.	Implement a Single Point of Access (SPA) for all Children and Young People with healthy weight concerns.	New models of care negotiated and commence.	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.	To scope and design effective joint commissioning for Speech and Language Therapy, Occupational Therapy, sensory approach, and sleep. Reducing waiting times, increase in quality and minimise duplication of offers. Joint data SEND dashboard shared across local authority and health. Reduce waiting times for Initial Health and Review Assessments for Children in Care.	95% of patients waiting for therapy services to continue to receive treatment within 18 weeks of referral.	Work with children and system partners to reduce inequity of outcomes from baseline set in year two.	Maintain and review impact of service.		✓	✓	✓
Improved outcomes for women and babies.	Continued implementation of the three-year maternity and neonatal delivery plan, including the embedding of Ockenden recommendations, with all system partners.					✓	✓	✓
	Implement maternity and neonatal voices partnership model to enable effective coproduction.	Review the impact and ongoing needs based on the evidence from the enhanced model.					✓	✓

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 comprising professionals from all relevant services (such as health, social care, housing, and the voluntary and community sector) 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop a co-located urgent treatment centre at the QMC.	Mobilise front door streaming and triage process, workforce and pathways.	NHSE Designation of UTC.	Implementation, monitoring and evaluation.					✔
Virtual wards.	Mobiilse step up virtual wards and procure remote monitoring technology		Further expansion where appropriate and monitoring of benefits and impact				✔	✔
Transform our P2 and P3 offer.	Recommission P2 and P3 beds based on vision and scope agreed in 22/23. Reduce LOS in P2 beds. Mobilise new service offer	Embed new P2/P3 offer. Monitoring of benefits and impact.	Implementation, monitoring and evaluation.				✔	✔
Develop an urgent care coordination hub.	Integrate UCR and the UCCH. Roll out and embed phase 1 of the UCCH plan. Develop IT solutions for direct booking and electronic transfer of records.	Add pathways to UCCH offer as per mobilisation plan. Monitoring of benefits and impact	Add pathways to UCCH offer as per mobilisation plan. One single number for all health and care professionals. Monitoring of benefits and impact				✔	✔
Expanding the same day emergency care offer.	Mobilising surgical SDEC. Ensuring direct access to SDEC for all professionals. Implementing the new data set for SDEC	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 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Reduce elective backlogs.	To 65 weeks maximum. Identify the top 5 specialities with the longest waits for CYP elective care	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).					✓	✓	
	· Lung health programme · Breast cancer screening · Community prostate clinics · Community Liver Surveillance		Expansion of targeted lung health programme complete.		Monitoring and evaluation.	✓	✓	
Establish Elective Hubs and Clinical Diagnostic Centres (CDCs)	Complete roll out of Newark elective Hub (opened November 2023) Implement GIRFT principles Complete Phase 1 and phase 2 City elective hub roll out	Complete City elective hub phase two. Commence City elective hub phase three. Opening of Mansfield and Nottingham CDCs.	Expansion of CDCs pending confirmation of national funding.			✓	✓	
	· Roll-out personalised care and optimise integrated health. 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. · Refine referral optimisation between primary care and acute providers to enable access to alternatives to face to face appointments, reduce outpatient attendance and Do Not Attends.					✓	✓	✓

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 collective framework to utilise quality improvement (QI), transformation and how this relates to system efficiencies or performance delivery.
- Mixed QI approaches exist within the system and partners with no central understanding of interdependencies for the impact.
- No collective understanding within the system to enable developing levels of expertise and skills to undertake QI in conjunction with local needs or involvement with the population.
- No clear evidence of co-production principles/ opportunities with patients/clients/families and how this informs the priorities for 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 and embed improvement into the management systems and processes.

Future state: Our ambition

- QI, transformation and efficiencies impacts are understood within the system which drives improvement decision making in a shared vision.
- Systematised QI learning and programmes platform accessible within the system allowing for individual system partners priorities with understanding of collective population benefits.
- QI approaches occur within the system and partners with scoping, supporting levels of expertise to undertake QI are clearly defined and understood to deliver locally.
- System and clinical leadership align to enable and embed ethos that QI is a 'second job'.
- Co-production continues to be a tenet of all QI programmes and this informs QI priorities.
- System agility and agreed QI responses to emerging quality challenges with known measurable outputs becomes ‘normalised’.
- Shared and spread learning of evidence-based, high impact improvements, to be embedded into improvement management systems and processes.

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

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
System scoping to enable the preconditions to allow the shaping of a shared purpose and vision related to quality improvement initiatives.	Build consensus and shared vision by scoping and reporting using the framework of NHS IMPACT and feedback of system partners.	Monitor and adjust to align with feedback.	Monitor and adjust to align with bench-marking programme as system position collectively matures.			✓		✓
System understanding of the investment of people and culture supported by leadership behaviours to enable system levels of expertise and skills to undertake QI.	Informed system approaches to systematic QI building on population engagement networks with ICS QI enablers. supported by leadership behaviours to enable system	Adoption of the NHS IMPACT approach within QI communities approach by Q4 2024-25.	Monitor and adjust as improvements are embedded into management systems and processes approach by Q4 2026-27. This can be evidenced by system programmes of work responding to locality needs. Individual system partners have developed shared understanding of whole approaches to improvement learning and sharing which is visible.			✓	✓	✓
System has an understanding of building improvement capacity and capabilities including benchmarking programme.	Alignment of ICS data insights leading to processes to support QI learning capacity and capabilities.	Evidence base developed with local population to inform priorities and links to alignment of capacity and capabilities to undertake.	Progress check. Use QI programme developments to redefine or reprioritise year three to five year ambitions.	Progress check against QI programme activities to inform and adjust priorities . System demonstrates alignment of QI programmes, individual organisations and across sectors		✓	✓	✓
ICS commitment of co-production informs the current QI work.	Reaffirm arrangements for population engagement whilst working towards embedding improvements into management systems and processes.	Create core co-design and co-production within all aspects of QI programmes. Update priorities around management systems and processes	Monitor and adjust to align feedback of QI programmes and projects impacts.	Monitor and adjust as system position collectively matures.		✓	✓	✓

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

- Year on year the system has met and/or exceeded the Long-Term Plan targets.
- Initiatives to embed personalised care approaches are tested and expanded, but not at scale and embedded as business as usual.
- Our workforce does not always have the tools it needs to deliver personalised care.
- Personalised care approaches are not routinely included in commissioning and contracting activity.
- People are not offered a personalised conversation, based on what matters to them, they 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

Future state: Our ambition

- Personalised Care is scaled up and shifts to business as usual.
- Personalised Care approaches are fully understood, scaled up and embedded by system partners, in programmes, commissioning and pathway redesign and at Place.
- The workforce are trained and skilled to deliver personalised care.
- 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.
- People only need to tell their story once and the focus of the conversation is 'what matters to them and what's important to them'.
- Personalised care is a core function that we fund as part of prevention and equity approaches.

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Implement Universal Personalised Care (UPC) embedding and scaling social prescribing, supported self-management, personalised care and support planning and personal health budgets in all system areas.	• Priority areas to embed personalised care are finalised with a System wide UPC Plan in place, system owners and leads agreed. • Agree UPC local targets, owned and shared across Place and programmes of work. • System leads are supported to understand which UPC approaches are relevant and need to be embedded in their plans and how to measure the impact to people. • Develop a knowledge share approach based on the system needs and prioritised to most impactful areas. • Review the team support offer to the system, including Co-production, and its impact from the work in 23/24. • Run an 'It's Ok to Ask' internal and external (public) Communications plan.	• Review the impact, learn and scale up across the agreed areas. Continue to measure progress and impact. • Embed personalised care in commissioning and contracting. • Adopt the personalised care section of the NHS Contract. • Sharing and learning with other ICBs on their approach to contracting. • Deliver ongoing internal and external communications plan.	Quality Assurance of Personalised Care in contracts, including assurance that PHB's are offered to all with a legal right to have and expanded.			✓	✓	✓
Social prescribing and community based support.	Continuation of Green Social Prescribing with system focused deliverables, and implementation of Maternity Link Worker. Expand on the learning to date, focus on cost-benefit analysis, health inequalities, data tracking through the pathway and building models for sustainable funding.	System learning, impact, cost savings and sustainable models. Stronger evidence and models on tracking users and joining up data	Progress check and use evidence to redefine or reprioritise year ambitions.			✓	✓	
Develop and embed a system culture to deliver personalised care and a trained and skilled workforce.	Create a System network of Personalised Care Champions/ Ambassadors. Workforce Charter and Commitments adopted by partners.	• Phased training plan developed to incorporate primary and secondary care workforce. • Maintain and review impact of training on staff, skills and outcomes. • Develop appropriate data & local intelligence driven interventions to continue to embed cultural change				✓	✓	

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
Personalised care is all about working with people, as equal partners, to achieve outcomes, based on what matters to them.	Making healthcare more personalised is one way to target health inequalities This ensures care and support is shaped to individual need and supports equity so that care makes sense to people and focuses on what really matters in their lives.
Enhance productivity and value for money	**Support broader social and economic development**
Personalised care is a proactive, strength-based approach, by working with people as equal partners and focussing on what matters to them, sharing their story on an 'About Me' we shift from being reactive and reduce waste and duplication.	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 and have made good progress of embedding this into our system forums, this is not consistent and not fully implemented.
- 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.
- 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.
- We are not maximising the assets that all of our partners have across the whole health and care system and and have not yet fully realised the opportunities we have through our ICP to hear regularly from our population to feed into our decision-making arrangements.
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Insights hub.	Co-design new hub model with partners		Implementation.				✓	✓
Citizens panel	Evaluation of panel and development of mechanisms at Place	Recruit additional 800 panel members	Evaluation and agree rollout			✓	✓	
Co-production	Ongoing oversight of all co-production activity as part of Integrated Care Strategy commitments.					✓	✓	
	Review and roll-out of training offer.	Evaluation Roll out Co-Production Toolkit				✓	✓	
VCSE Alliance.	Expand membership, including to to faith groups					✓	✓	✓
ICP and ICB reports	Ongoing annual and periodic reports						✓	✓
Service change	Support the Strategic Development activity for the Tomorrow's NUH 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
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, especially in times of budget challenges for the NHS and Local Authorities
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, young people and adults. We need to effectively work together to meet the future challenges of improving resilience across the system.
- Learn from local and national safeguarding rapid reviews, child safeguarding practice reviews and Safeguarding adult reviews including Domestic Homicide Reviews to improve outcomes.
- Develop a systems approach to capturing the Voice of the Child/Young person to improve the experiences in all areas of care
- This is an emerging speciality that requires development across the children's safeguarding 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

- The ICB Safeguarding Children team will work to deliver the plan across the system and in conjunction with the local agendas for safeguarding children and young people.
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	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 numbers and related pay bill costs are potentially the largest rate limiting factors in our ability to deliver the ICS strategy and improve health outcomes for our population.
- Workforce planning is short term and driven by operational targets, which does not address the medium to longer term need for strategic workforce and education planning as set out in the Long Term Workforce Plan and is not informed by population health projections.
- There is no longer workforce transformation funding from Health Education England.
- Post-covid recovery and waiting lists pressures are additional challenges, with workforce productivity remaining lower than pre-pandemic.
- Sustained Industrial action increase costs due to Locum and agency cover and impact 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

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 populations deserve, 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 to move to 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 systems 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 all that desire a career in health and care.
- The financial pressures exacerbated by workforce availability will be reduced by system partners working together on solutions to ensure that we are to utilise our existing workforce efficiently.

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

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Establish ICS people and culture plan and delivery process.	Establishing a sustainable delivery team.	One workforce becomes a reality.	Population health needs drive plans.	Aligned public health, education and training, and workforce plan.		✔	✔	✔
Resourcing including retention.	System attraction and retention approach, including local pipeline.	Expand digital solutions.	Operational system recruitment hub.	Review evaluate and further consolidate.		✔	✔	✔
Strategic workforce planning.	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.	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. Ageing estate negatively impacts our net zero strategy
- There is limited co-ordination of maintenance and utilisation of our estate capacity.
- 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 Backlog of maintenance issues increasing across all providers.

Future state: Our ambition

- Services are located based on need rather than historic arrangements, promoting sustainable travel.
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop an ICS infrastructure strategy.	Finalise our strategy, including a system wide, prioritised list of Estates and Infrastructure Schemes	Increase utilisation of system estates capacity against agree metrics.	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, Data and Technology

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

- Deliver the Digital Notts Strategy 2023-28 - https://prezi.com/view/WAlBPVywyhc231fdWMlx/
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Patient facing digital services.	Increase digital correspondence. Scale eMeet and Greet. Improve access to services through digital.	Expand the use of technology enabled care to support remote monitoring. Explore opportunities around an Internet of Things (IoT) platform.	Digital care planning, expand record access; deploy robotics process automation and Artificial Intelligence (AI) technology.	Personalised approach to health and care services through digital technology. AI technology to increase productivity.	Digital contact becomes the default route for health and care services. Smart homes.	✓	✓	✓
Support intelligent decision making.	Infrastructure to enable data to be used. Develop a data standards approach to improve data quality.	Ensure PHM approach supported. Establish Secure Data Environment for Research.	Embed a systematic approach to developing and monitoring system outcomes.	Augment artificial intelligence and human skills in designing care services. Secure Data Environment for Research embedded.	Augment artificial intelligence and human skills in designing care services.	✓	✓	✓
Digitise frontline services.	Electronic prescribing and drug administration. Review assets and utilisation	Staff enabled to work across any location and integrate care across residential settings.	Electronic patient record deployment in Acute Care. Implement services in line with procurement frameworks held via the Digital Services for Integrated Care catalogue.			✓	✓	✓
Interoperability.	Notts Care Record data baselined	Single health and care record available to all staff with all key organisations onboarded.	Notts Care Recorded embedded.	Further developments in the application including regional sharing, enhanced functionality and features		✓	✓	✓
Digital inclusivity.	Training, access and support. Support the community through VCSE grants	Role of Digital Champions, Digital Carers and Digital Inclusion Co-ordinators to be established.	Develop a model to enable a roving workforce across digital specialty roles	Develop new pipeline talent to address skills gaps across digital..	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 hem.
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Deliver our ICS Green Plan.	Deliver three-plus objectives per programme.	Refresh/refine ICS Green Plan. Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Deliver three-plus objectives per programme.	Refresh/refine ICS Green Plan. Deliver three-plus objectives per programme.	✔	✔	
Securing and embedding clinical/ professional leadership and design for sustainable services.	Expand Faculty for Sustainability to include other clinical and managerial student placements	Staff across all organisations are empowered to make changes, reducing waste in their work.	Faculty for Sustainability embedded and Years 4 and 5 priorities defined.	Implementation, monitoring and evaluation		✔	✔	✔
Achieve national NHS Net Zero targets.	Continue with delivery - strengthen with primary care focus.	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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Medicines across the system.	Finalise and publish ICS medicines optimisation strategy. Strengthen system leadership. Integration of clinical services in Community Pharmacy to build Primary Care capacity. Improve communication and sharing of information about medicines use.	System integration of all pharmacy services, improving equity through development of system-wide solutions.				✓	✓	✓
Medicines commissioning.	Strengthen Area Prescribing Committee capacity. Streamline system working. Develop contracts. Further develop contractual principles and governance for prescribing.	Integration of specialised medicines commissioning. Invest in expertise to support the evolving genomic medicines agenda.				✓	✓	✓
Medicines safety and quality.	Antimicrobial stewardship. Safe prescribing and reducing medicines harm. Reduction in inappropriate polypharmacy. Focus on improvement in the National Oversight indicators.	Patient Safety Incident Response Framework implementation across secondary care and primary care. System oversight of national patient safety alerts. Co-produced Medicines Safety Plans with PCNs.				✓	✓	✓
Medicines finance.	Develop ICS system medicines and prescribing efficiency plans.	Shared learning and collective responsibility - system ownership of the pharmaceutical cost (system £) Ensure medicines expenditure is fully accounted for in new service developments. ICS medicines waste reduction initiatives				✓	✓	✓
Pharmacy workforce development.	Strengthen established Pharmacy Workforce Faculty and develop 3-year plan to Train, Retain and Reform workforce	Develop system working for pharmacy placements for students.	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

- Partners from across sectors working together, including NHS providers, Local Authorities, VCSE Alliance, University of Nottingham, Nottingham Trent University, the local National Institute for Health and Care Research (NIHR) infrastructure and Health Innovation East Midlands.
- 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	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Develop an ICS research strategy.	ICS Research Strategy agreed. Plan and mechanisms in place to operationalise it.	Continued implementation of Research Strategy with partners				✔	✔	✔
Better align research to the ICS strategy.	Build a pipeline of research projects.	Develop ongoing mechanisms to support awareness of and engagement with research activity across the system including integrated delivery of research studies.				✔	✔	✔
Increasing the diversity of those involved in research.	Complete Research Engagement Network Programme and develop sustainability plan.	Implementation and monitoring of plan delivery.					✔	

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.

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.
- Individual ICS partners and Place Based Partnerships, as Anchors, have well established programmes in place.
- ICS priorities for 2023/24 focussed on People, Procurement, Net Zero and Estates and have been delivered through relevant system groups with support through the ACN. Place Based Partnerships continue to support residents around Financial Resilience.
- The ICS has continued to make good progress on this agenda in the context that many of our resources are focussed on immediate operational and financial pressures.
- An ICS wide workshop was held in September 2023, facilitated by the NHS Confederation, to stretch our thinking and identify 2024/25 priorities. This identified three broad themes (1) Employment, Skills and Health (2) Health as an Investment (3) Community Anchor Principle which will be progressed from 2024/25.

Future state: Our ambition

- The ICS will continue to be an active partner in the Universities for Nottingham Civic Agreement, Midlands Engine and will strengthen links with the East Midlands Combined County Authority to understand how we can better support wider social and economic development.
- Employment, Skills and Health – Building on the successful Individual Placement Support Programme, the ICS has ambitions to develop an ICS Health and Work Strategy. The ICS will deliver a health led programme to support people into work, remain in work and thrive in the workplace.
- Health as an Investment – Place Based Partnerships will confirm Health as an Investment priorities and actions which will be co-produced in line with Community Anchor Principles and jointly delivered through Integrated Neighbourhood Working (INW) models in priority neighbourhoods.
- Priorities established in 2023/24 around Net Zero, Procurement and Estates will continue to progress through ICS delivery groups.

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

What	2024/25	2025/26	2026/27	2027/28	2028/29	Prevention	Equity	Integration
Network: Maintain a vibrant ICS Anchor Champions Network (ACN) to define and facilitate delivery of ICS priorities. Partnerships: Strengthen ICS contribution to key strategic partnerships for social and economic development.	Facilitate delivery of priorities through established system groups and partnerships. Define Year 2 strategic priorities.	Facilitate delivery of priorities through established system groups, and partnerships. Define Year 3 strategic priorities.				✓	✓	✓
	Active role in Midlands Engine Health and Life Sciences Board. Active role in UfN Civic Agreement and support key work programmes e.g. diverse employment. Forge new partnerships e.g. D2N2.	Active role in existing partnerships. Continue to forge new partnerships.				✓	✓	✓
Facilitate delivery of key annual priorities	Develop Health and Work Strategy. Identify Health and an Investment Priorities. Procure for Social Value. Continue to support local people with Financial Resilience.	Implement Health as Investment Priorities through Integrated Neighbourhood Working. Procure for Social Value. Continue to support local people with Financial 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
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. How we developed the strategy / engagement
B. Statements of support from the Health and Wellbeing Boards
C. Glossary of terms

Integrated Care Strategy

The Integrated Care Strategy published in March 2023 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 2022.
- An ICP workshop on 9 November 2022.

The Integrated Care Partnership reviewed and refreshed the strategy for March 2024. This process included engaging Health and Wellbeing Boards and partner organisations.

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 initial plan in 2023, 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.

In refreshing the plan for 2024 activities included:

- Targeted meetings with key stakeholders as outlined above.
- Specific workshop and/or meeting discussions with the two Health and Wellbeing Boards to ensure that the plan was aligned to the strategy.
- Listening to and gathering insights from across our Place Based Partnerships.
- A survey for patients, local people and staff, which received 118 responses.
- Discussions with NHS organisations' board members and further established partner forums during February - April 2024.

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.

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.

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.
Integrated Neighbourhood Team	INTs are where people can work together to share resources and information and form multidisciplinary teams (MDTs) dedicated to improving the health and wellbeing of a local community and tackling health inequalities.”	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.
Neighbourhood	The smallest and most local area that services are organised at.	Life expectancy	The average number of years that someone can expect to live.
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 people and culture and corporate services.
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.