Integrated Care System
Nottingham & Nottinghamshire

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

Integrated Care Strategy 2023 - 27

Nottinghamshire County Council

Nottingham City Council

NHS

Contents

Foreword

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

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

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

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

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

Over the next five years, we will:

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

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

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

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

Dr Kathy McLean OBE
Chair of the Integrated Care Partnership

Chair, NHS Nottingham and Nottinghamshire

Cllr Adele Williams
Vice Chair of the Integrated Care Partnership

Chair of Nottingham City Health and Wellbeing Board

Cllr John Doddy
Vice Chair of the Integrated Care Partnership

Chair of Nottinghamshire Health and Wellbeing Board

Plan on a page

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

Why are we here?

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

What are we going to do: Our aims and principles

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

Prevention is better than cure

Equity in everything

Integration by default

What we need to achieve

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

How are we going to do it

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

Three key principles to system working:

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

Three core values:

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

Executive summary

Background

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

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

Strategic principles

The strategy is based on three guiding principles.

Principle 1: Prevention is better than cure

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

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

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

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

Principle 2: Equity in everything

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

Principle 3: Integration by default

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

Strategic aims

Aim one: Improve outcomes in population health and healthcare

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

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

Aim two: Tackle inequalities in outcomes, experiences and access

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

Aim three: Enhance productivity and value for money

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

Aim four: Support broader social and economic development

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

Introduction to the strategy

How we will organise ourselves to deliver the strategy

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

How we will deliver the strategy

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

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

Strategy evaluation

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

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

The national context

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

Our Integrated Care System

Our ICS has two statutory elements:

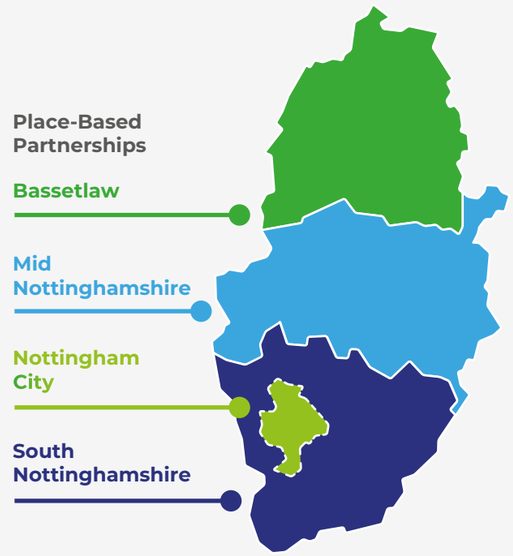
- Integrated Care Board (ICB) – a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB works to deliver the ICS outcomes with partners from across our system
- Integrated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

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

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

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

Figure 2: Place areas of the Nottingham and Nottinghamshire ICS



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

Figure 3: The structure of the Nottingham and Nottinghamshire ICS

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

The health and wellbeing of our population

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Strategy engagement with people and communities

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

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

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

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

Guiding principles

Our Integrated Care Strategy is built on three guiding principles:

Principle 1: Prevention is better than cure

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

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

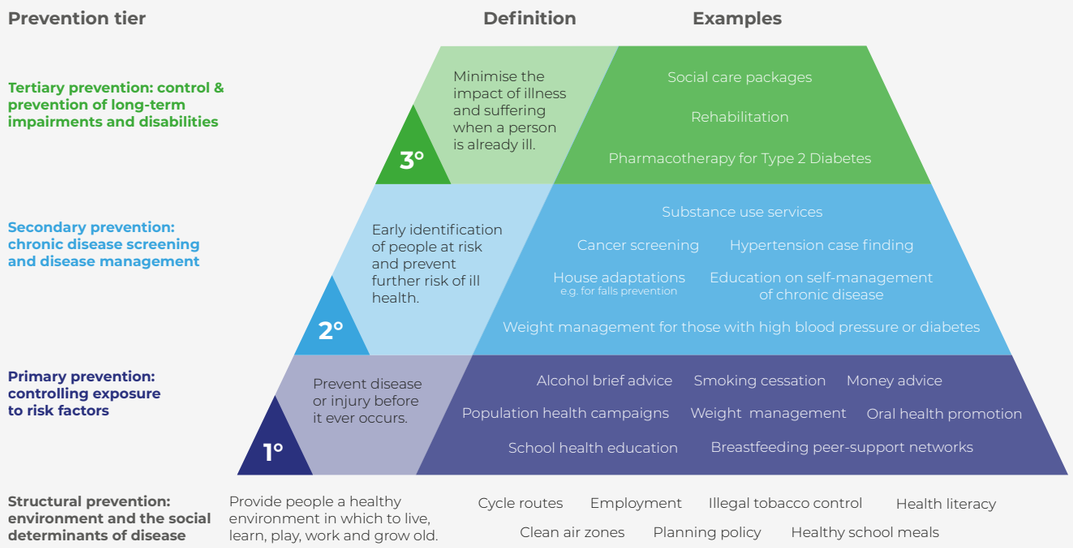


Figure 4: How different levels of prevention can improve health and wellbeing outcomes for people and help reduce or delay the future need for health or care services.

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

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

For this strategy, the ICS will focus on:

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

Principle 2: Equity in everything

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

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

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

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

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

Principle 3: Integration by default

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

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

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

Strategic aims

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

Aim one: Improve outcomes in population health and healthcare

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

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

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

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

Case Study

Ravnita, Bulwell

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

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

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

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

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

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

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

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure that all health and care staff understand the building blocks of health and health inequalities and are competent and confident to deliver brief interventions on a range of prevention topics to support people's wellbeing. This will include: ◦ Developing a Making Every Contact Count[22] (MECC) framework for action across ICS organisations ◦ Developing a flexible approach to MECC training and support that will be owned and tailored by the different services across the ICS. This will be linked to health literacy, shared decision making, better three conversations and strengths based approaches ◦ Embedding MECC training into the personal development plans and appraisals of all health and care staff, with consideration that MECC becomes mandatory training ◦ Clarifying signposting and referral mechanisms into prevention services, collaborating with local health and wellbeing services ◦ Prioritising brief interventions or those of greatest need ◦ Maximising the potential of roles that support the whole person, such as Social Prescribing Link Workers	**Key actions** ◦ MECC framework developed **Our ambitions** ◦ A reduction in under 75 mortality rate from causes considered preventable from the 2017-2019 baseline ◦ 90% of frontline health and care professionals to have completed MECC training by 31st March 2028 ◦ 70% of overall workforce to have completed MECC training within the past 5 years by 31st March 2028 ◦ All new starters to have completed MECC training as part of standard induction across all employers by March 2026 ◦ An increase in referrals into prevention services from 2022/23 baseline to 31st March 2028 ◦ An increase in the number of Social Prescribing Link Workers across the system

Aim two: Tackle inequalities in outcomes, experiences and access

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

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

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

Case Study

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

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

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

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

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

Aim three: Enhance productivity and value for money

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

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

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

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

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

Case Study

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

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

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

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

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

Aim four: Support broader social and economic development

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

What will we do?

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

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

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

Key actions

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

Our ambitions

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

Our ambitions

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

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

Supported by:

- 100% of electricity from renewable sources -April 2023
- 0% of secondary care sites primary heat sources are oil fuelled on– April 2023
- Ensuring over 90% of our owned or leased fleet vehicles under 3.5 tonnes are low emission vehicles, and 5% of those will be ULEV or ZEV (ultra-low – or zero- emission vehicles)
- CO_2 impact of inhalers is reduced by 50% by 2028

Case Study

Nottinghamshire Healthcare NHS Foundation Trust has used the Green Impact sustainability initiative to help staff, patients and service users deliver sustainability improvements and help contribute to the Trust's Green Plan.

The Trust has run Green Impact for four years, including during Covid-19, and in this time over 600 staff and 250 patients and service users have been involved in this sustainability work within the Trust, with over 1,200 individual sustainability actions completed.

Lynn Walker, Head of Sustainability, says: "Green Impact is a fantastic way to get involved in helping to make a difference to environmental performance, deliver sustainable change and reduce our carbon footprint. Teams sign up to a toolkit made up of fun and engaging actions on a range of issues including food, waste, energy, travel and biodiversity, all of which support the Trust's overarching aim of delivering sustainable healthcare."

How we will deliver the strategy

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

Supporting our workforce

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

We will support our staff and teams in:

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

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

Working with people and their communities

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

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

Evidence-based approach

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

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

Focus on outcomes

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

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

Our delivery organisations and partnerships

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

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

Enabling infrastructure

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

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

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