Nottingham and Nottinghamshire Integrated Care System 5 Year Plan

2019/20 – 2023/24

DRAFT

Executive Summary

This document sets out our ambitious plan for service and system change over the next five years to improve the health and wellbeing of our local people through high quality care delivered in a sustainable way

In January 2019 NHS England published the NHS Long Term Plan, which set out a 10-year programme of phased improvements to NHS services and outcomes, including a number of specific commitments to invest the agreed NHS five-year revenue settlement.

All local health and care systems in England are required to create a five-year strategic plan covering the period 2019/20 to 2023/24 setting out how they will deliver all the commitments within the Long Term Plan to address the challenges the NHS faces. This document is our five-year plan for Nottingham and Nottinghamshire.

This is not the first time we have developed a five-year plan for the Nottingham and Nottinghamshire health and care system as a whole. In 2016 in response to the ambitions set out in the NHS Five Year Forward View, we developed our Sustainability and Transformation Plan.

We are three years into that plan, and the publication of the NHS Long Term Plan provides the ideal opportunity for us to take stock on what we have achieved and learnt, the challenges we still face and our focus going forward.

This five year plan builds on our previous Sustainability and Transformation Plan , our local Vanguards and the growing commitment to collaborative working across our health and care organisations so we act a single integrated health and care system.

The last three years has seen increasing partnership working between our general practitioners and primary care teams, our community and mental health service provider, the two local acute hospital trusts, the ambulance service, the two local authorities, patient representatives and many others.

This partnership working has been recognised nationally and in 2018 our health and care system was selected to be a pioneer for becoming an Integrated Care System (ICS), an evolved form of a Sustainability and Transformation Partnership (STP) with a new type of even closer collaboration.

Becoming an Integrated Care System is a key milestone on our way to becoming **a fully population health focused care system – a system where all partners are focused on the entire spectrum of interventions, from prevention and promotion to health protection, diagnosis, treatment and care, and integrates and balances action between them**. We are fully committed to delivering the triple aim of:

- Improving the health and wellbeing of our population
- Improving the overall quality of care and life our service users and carers are able to have and receive
- Improving the effective utilisation of our resources

Our plan is therefore focussed on the areas where we believe it will be most important for system partners to move together at pace to transform the way health and care has traditionally been provided. **Our main effort over the next five years is not focussed on reconfiguring the way services are currently provided. Rather breaking down traditional silos in care and establishing, embedding and optimising our integrated care models that ensure people are cared for proactively in the most appropriate setting for their need and ensure optimal use of available resources.**

We believe this will make the biggest difference to improving our system and delivering our triple aim, rather than just reorganising services in the same way they have always been delivered.

An overview of our plan is overleaf.

Executive Summary

The summary below provides a high level overview and introduction to the Nottingham and Nottinghamshire Integrated Care System 5 Year Plan (19/20 - 23/24)

(1) The challenges we face

The health and care challenges we face, and our plans for addressing them, are rooted in the particular needs of our Integrated Care System (ICS):

- Fundamentally, we know that across Nottingham and Nottinghamshire people are living longer in ill health and significant inequalities exist.
- We know we need more action on and improvements in upstream prevention of avoidable illness and its exacerbations to better manage current care demands
- We have made good progress with beginning to 'join up care' however there remain many opportunities to integrate care more effectively and consistently
- There are significant improvements we need to make to the way we deliver urgent & emergency care and mental health
- We do not make best use of our resources; we have medical and nursing vacancies and short supply and do not optimise the use of our estate
- Together these factors have led to poor performance in a number of areas and a forecast financial deficit in health of £430m

(2) Our system sustainability model

To address the challenges we face, we have developed a system sustainability model to act as a framework for the priorities and actions for the whole system and its partners.

This is comprised of three interconnected components:

- A System Outcomes Framework – to provide a clear view of our success as an integrated Care System in improving the health, wellbeing and independence of our residents and transforming the way the health and care system operates
- A Key Performance Indicator Framework – to provide transparency on the key metrics and trajectories we will use to assess our systems performance
- A Resource Sustainability Model – to set out the high impact levers that will change the level of resource (finance, workforce and capacity) used by the system back in line with availability.

Together these form the shared ethos and goals of our Integrated Care System and therefore all its constituent organisations.

(3) Our system priorities

Five priorities form the core of our transformation plans to deliver our system sustainability model and address the challenges we face:

- **Prevention, inequalities and the wider determinants of health**: More action and improvements in the upstream prevention of avoidable illness and addressing inequalities, will improve healthy life expectancy and reduce resource utilisation.
- **Proactive care, self-management and personalisation:** We will accelerate the pace and scale of the work we started to 'join-up' care through our Vanguards to improve support to people at risk of and living with long term conditions and disabilities, thereby giving them more control, reducing exacerbations and the need for care.
- **Urgent and emergency care:** Redesigning our urgent and emergency care system provides our single greatest opportunity to address fragmentation and unwarranted variation – central to this is ensuring the right capacity exists in the right part of the system to ensure care is provided in the most appropriate setting.
- **Mental health:** We will renew our commitment to invest in and transform mental health service to improve the quality of our service and the care they provide, and address the inequalities in mental health
- **Value, resilience and sustainability:** We will deliver increased value, resilience and sustainability across the system (including estates) through the implementation of ICS Sustainability Model (10 levers)

(4) Impact & Implications

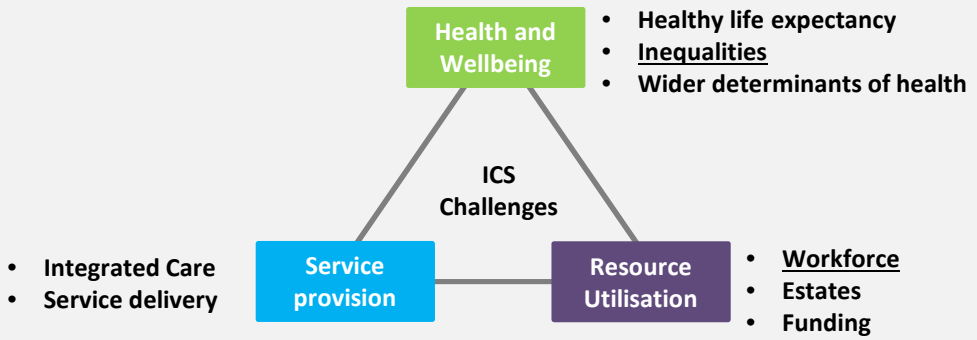
- TBC

(1) Our journey so far and the challenges we still face

We have made good strides forward as a health and care system over recent years, however despite theses developments and improvements, there is still much to be done to tackle historic and ongoing challenges, as well as new ones that have emerged.

The key challenges faced and therefore to be addressed by the Nottingham and Nottinghamshire Integrated Care System (ICS) delivering the commitments set out in the NHS Long Term Plan can be grouped into three categories, that have a reinforcing effect on each other:

- The health and wellbeing of the population
- The provision of services
- The effective utilisation of system resources



Our journey so far

We are now moving into the third phase of establishing our Integrated Care System across Nottingham and Nottinghamshire.

Our vision for our Integrated Care System

Our health and care partners across Nottingham and Nottinghamshire came together in 2016 in a Sustainability and Transformation Partnership (STP) with the collective goal of improving the quality and sustainability of health and care services. This collaboration subsequently evolved into an Integrated Care System (ICS) in 2018.

Our early shared purpose has now developed into a collective vision 'to both increase the duration of people's lives and to improve those additional years allowing people to live longer, happier, healthier and more independently into their old age.'

We are now coalescing around a System Sustainability Model, a framework for our priorities, actions and investments that defines our success in improving the health, wellbeing and independence of our citizens and transforming the was y health and care is provided.

Over recent years our system has been selected to be a Vanguard in a number of areas including enhanced health in care homes, integrated primary and acute care systems and urgent and emergency care , and we are no embedding and spreading the learning of these across the system.

Nottinghamshire is an Integrated Accelerator Pilot site for Personalised Care. Progress has resulted in a move from 85 Personal Health Budgets to 2,300; 500 are joint health and social care. The system has delivered over 16,000 personalised Care and Support Plans and over 20,000 episodes of social prescribing/improved self management.

The system prevention strategy, approved by the ICS Board, has confirmed smoking and alcohol as key initial priorities and a system wide Population Health Management (PHM) programme is in place, which has benefitted from international, national and regional support. The programme has developed an approach for PHM into action covering infrastructure, intelligence and interventions. The ambition is that a comprehensive and systematic approach to PHM is at the heart of our health and care system, building on existing foundations that include nationally renowned examples:

- Stroke prevention through the proactive identification and management of people at risk of stroke due to atrial fibrillation with early work estimated to have saved 75 strokes and 25 deaths in one locality.
- Improved multi-disciplinary team working in primary care which has resulted in better patient outcomes with 13% more people supported at home and admissions to hospital down 12% from the cohort.
- A collaborative endeavour with housing in Mid Nottinghamshire and Nottingham City, with improved outcomes and early discharge from hospital. In Mid Notts a 400% return on investment and significant savings for NHS.
- Development of a crisis response service within two hours that has resulted in 1,520 avoided A&E attends; 613 avoided admissions and reduced LoS in 216 cases .

Workforce and leadership

The system has developed, and approved, a comprehensive 'People and Culture' strategy. New roles have been introduced and are evaluating well including holistic community workers and health coaches, enabling highly skilled professionals to be best used for their specific expertise.

Enhanced professional cultures are being developed with clinicians being supported to make high quality cost effective decisions e.g. through value based healthcare training and locally developed quality and cost incentive schemes. The ICS held it's first local leadership conference in June 2019. In addition, a programme of leadership development is underway for an initial cohort of 50 senior cross sector leaders.

Partnership and governance

Our STP Board has matured into an ICS Board, with an independent chair, elected member / non executive, executive officer and clinical representation from all partner organisations . The Board now sets the system's strategic direction, provides system leadership, holds some delegated accountability and provides system oversight.

A two staged approach has been pursued in the development of strategic and integrated commissioning, its anticipated a new CCG organisation will come into being on 1st April 2020 following formal merger .The system's three Integrated Care Providers (ICPs) are at varying stages of development, all with chief executive leads and confirmed priorities for delivery in 2019/20. These are underpinned by 20 Primary Care Networks (PCNs), each with a Clinical Director and evolving models of collectivised general practice, community MDTs and links with the VCSA.

Our ICS now has a mature Partnership Forum that draws its membership from a range of patient groups and community and voluntary sector organisations ,with plans to replicate this forum at 'Place' level throughout the system.

However despite theses developments and improvements, there is still much to be done to tackle historic and ongoing challenges, as well as new ones that have emerged

Overview of the Nottingham and Nottinghamshire ICS footprint

The health and wellbeing challenges we face are rooted in the particular needs of our population

The Nottingham and Nottinghamshire ICS covers a diverse population of over 1 million people living in the City of Nottingham (332,000) and Nottinghamshire County (764,700), however this does not include the residents of Bassetlaw as this is part of the South Yorkshire and Bassetlaw healthcare system.

City of Nottingham

- There is a rich cultural mix across Nottingham City - 35% of population are from black and minority ethnic (BME) groups
- Nottingham City is the 8th most deprived district in the country. 61 of the 182 City LSOAs fall amongst 10% most deprived in the country and 110 fall in the 20% most deprived
- Life expectancy for males is 77 and females 82 years old, which is below the England average
- 12% of the population are aged over 65, the England average is 18%, 30% of the population are aged 18-29 (full time university students comprise 1 in 8 of population)
- In the short to medium term, Nottingham City is unlikely to follow the national trend of large increases in the number of people over retirement age, although the number aged 85+ is projected to increase
- Despite its young age structure, Nottingham has a higher than average rate of people with a limiting long-term illness or disability
- 13th highest unemployment rate in the country, 12.7% of people are claiming out of work benefits
- Over 2 in 5 households do not have access to a car, this is the highest level of bus use per head outside of London

Nottinghamshire

- Across Nottinghamshire 4% of the population is from black and minority ethnic groups
- Deprivation levels as a whole are comparable with England, however there are some communities with the highest levels of deprivation in the country and some in the lowest levels – 25 Lower Supper Output Areas are in the 10% most deprived areas in England that are concentrated in the districts of Ashfield (9), Mansfield (6) and Newark and Sherwood (3)
- Life expectancy for males is 80 and females 83, which is similar to the England average.
- 20% of the population are aged over 65, compared to the England average of 18%. The population is predicted to continue to age over the next 5 year, with the population aged over 65 expected to increase by c.7% and the population over 85 by c. 8%
- Older people are more likely to experience disability and limiting long-term illness . More older people are anticipated to live alone, increasing by 41% between 2015 and 2030
- Job Seekers Allowance claimant rate (May 18) is 1.1%, same as national figure

Our ICS must be flexible to meet the diverse needs of our population to tackle local health inequalities and unwarranted variation

The challenges we face – Health and Wellbeing

Fundamentally we know across Nottingham and Nottinghamshire people are living longer in ill health and significant inequalities exist

Healthy Life Expectancy and inequalities

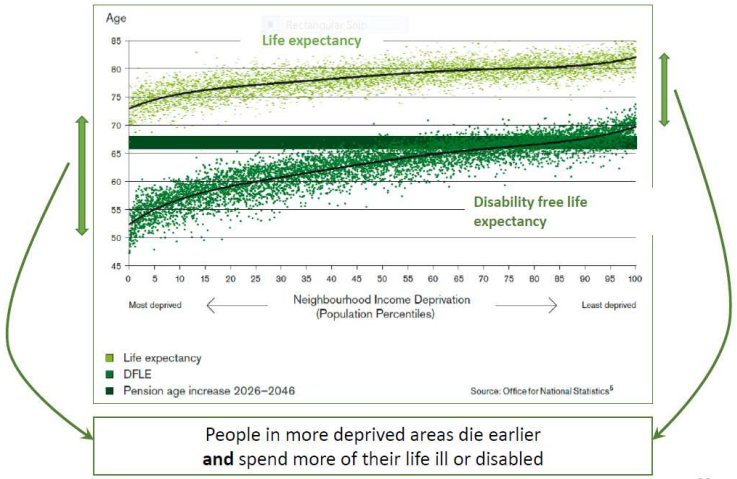
People in in Nottingham and Nottinghamshire are living longer but spending more years in poor health. This undermines the capacity for people to fulfil ambitions such as enjoying independence in their later years. It also represents an increasing window of need during which people are in receipt of health or social care services.

Healthy Life Expectancy reflects the lifetime accumulation of positive and negative influences on health and wellbeing. These start at conception and include the dominant influence of factors such as housing, education, employment, social cohesion, and environment. Loss of healthy life is a strong driver of health and social care utilisation. It is estimated **long term conditions** account around 50% of GP appointments, 64% of outpatient appointments, and 70% of hospital bed days. Much of the care received contributing to this could be avoided by interventions 'upstream' that would improve quality of life and independence.

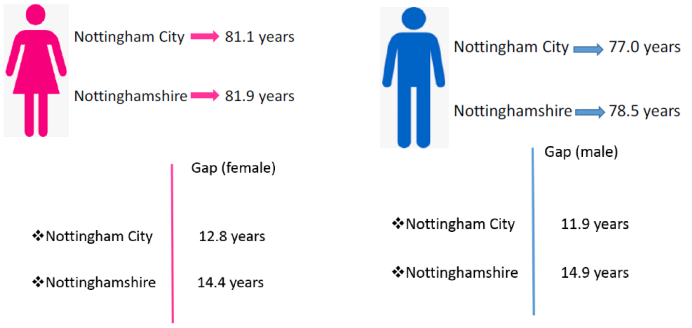
Evidence from the Global Burden of Disease identifies the degree to which key risk factors contribute to ill health. The greatest contributing risks are **tobacco, high BMI or weight, high blood pressure and diet**. When considering at a "place" and neighbourhood level alcohol and tobacco are of particular relevance as they represent a unique constellation of ill health burden and an opportunity to intervene. The proportion of those **aged 65 and over with four or more diseases** is set to double by 2035, with around a third having a **mental health** problem. There is a forecast 22% increase in people living with **diabetes** across the ICS between 2015 and 2035, which means over 9% of the Nottinghamshire population will be living with diabetes.

There are marked inequalities across neighbourhoods on the number of years citizens are expected to live in good health. **The biggest gaps are significant at 14.9 years for males and 14.4 years for females**. People who live in the more deprived communities in our ICS or are part of certain groups such as those with **severe and enduring mental health or learning disabilities** spend more of their lives in ill health. Men with serious mental illness are dying on average 17 years earlier than the general population and women 15 years. In considering our health inequalities, **Cancer, Circulatory and Respiratory disease** have the highest percentage contribution to the overall life expectancy gap between the most and least deprived. For males these three causes of death contribute to 71% in Nottingham and 61% in Nottinghamshire of the life expectancy gap between the most and least deprived areas. For females the contribution is 60% and 54% respectively. Therefore actions to reduce the incidence of these conditions will have the greatest impact on health inequalities.

The Window of Need



Healthy Life Expectancy Gap Across the Nottingham and Nottinghamshire ICS



The Slope Index of Inequality (SII) is the difference in healthy life expectancy between the most and least deprived areas of a population

We must tackle the inequalities in healthy life expectancy that exist across our ICS by focusing on those people and conditions that have the greatest impact

The challenges we face – Health and Wellbeing

We know *it is our deprived communities that have the greatest exposure to a range of factors that impact upon adversely upon health*

The wider determinants of health

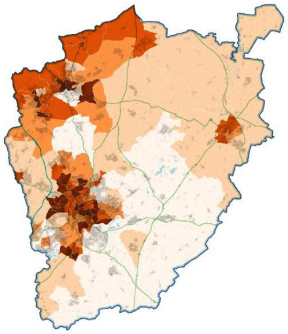
We fully recognise that access to and quality of health care services is only a small contributor to overall health outcomes.

It is our deprived communities that have the greatest exposure to a range of factors that impact adversely on the health of individuals, families and communities, including fuel poverty, poor housing, higher unemployment and low paid jobs, lower educational attainment and poorer access to services. These wider determinants of health underpin lifestyle risk factors such as **smoking**, **physical inactivity** and **poor diet**, which are most prevalent in these communities. The table below highlights this variation.

Measure	Variation		Level	Period
Smoking prevalence in adults	Highest	19.4%	Borough	2017
	ICS Average	16.3%		
	Lowest	9.7%		
Percentage of adults (aged 18+) classified as overweight or obese	Highest	70.7%	Borough	2017/18
	ICS Average	66.2%		
	Lowest	62.6%		

Mental health inequalities are also often linked with wider cultural and societal systems of disadvantage which impact a person's wellbeing, including (but not limited to) adverse childhood experiences, stigma, discrimination and one's environment, such as housing security. These can have a significant impact on a person's wellbeing, and many of these are beyond the remit of the health system alone.

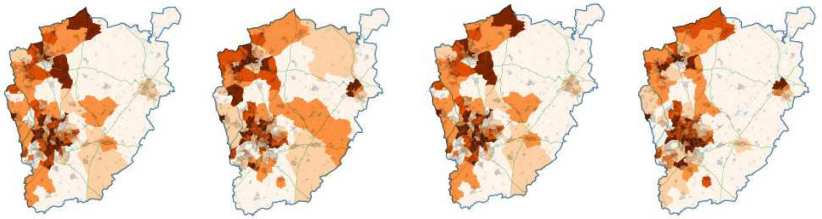
Deprivation across the Nottingham and Nottinghamshire ICS



The most deprived communities in our ICS are found in parts of Nottingham City and around Mansfield, Ashfield and Newark

Many health and healthcare usage indicators are worse in areas with higher deprivation

Darker shading – higher proportion live in most deprived areas

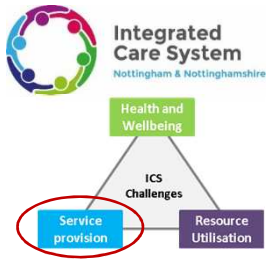


Emergency admissions All age, all cause | Emergency admissions All age, self harm | Emergency admissions Coronary heart disease | Hospital admissions Alcohol harm

Across our ICS we must focus our prevention efforts on the most deprived communities in our ICS

The challenges we face – Service Provision

Significant progress has been made with beginning to 'join up care' through our vanguards, however there remain many opportunities to integrate care more effectively and we are still overly reliant on bed-based care…



Services are not integrated:

- Fundamentally, our current health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care)
- Often characterised by organisational, and role boundaries, not centred on people and communities
- Individuals and teams do not work in an integrated way and are often conflicted and constrained by organisational priorities
- There is a high degree of fragmentation and duplication, and our services are struggling to meet the increasing demand for ongoing need

Care is not always proactive:

- We do not routinely and systematically identify and support people with ongoing needs.
- Often we do not know about these needs until people reach a crisis point.
- Mechanisms for information sharing, care planning and care co-ordination are not as effective as they could be.
- Patients do not always feel able to manage their health conditions
- There are occasions where harm could be prevented for vulnerable people
- Care is generally medicalised; we do not intervene early enough to influence wider determinants of health

A lack of joined up care means our system is overly reliant on beds and care isn't always provided in the right place at the right time

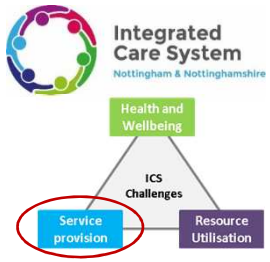
As a result:

- Out of area placements for adults with mental health illness are three times higher than national average
- Current services for people with Learning Disabilities are fragmented and overly reliant on bed based care
- Over 75s make up less than 10% of ICS population, but 1/3 of emergency admissions and 1/2 of emergency bed days. Two thirds of emergency inpatient beds are occupied by the over 65s (c. 1,000 beds/day)
- In 2017/18, 335 elderly people aged over 65 were admitted to care homes in Nottingham (887/100k pop – 12th highest nationally out of 152 LAs), and 987 in Nottinghamshire County (590/100k pop – 78th)
- At least 8,500 (11.6%) emergency admissions/year are for COPD, stroke, heart failure, asthma, diabetes, heart attacks, angina and hypertension
- Up to 10% of hospital admissions in the elderly population are medicines related.
- 45% of admitted spells >7 days; 55% of total bed days relate to 7+ day part of this. 10% of admitted spells >21 days; 17% of total bed days relate to 21+day part of this
- Point prevalence study at Nottingham University Hospitals NHS Trust identified 19% of patients admitted could have been cared for in an alternative setting. This type of study also indicated c.50% of patients in NUH beds (2017) and c.60% of patients in City Care beds were not at an appropriate level (2018)
- Actuarial analysis carried out across Greater Nottingham identified 62% of all medical admissions to acute hospital for those aged <65 and 36% for those aged >65 were avoidable when benchmarked against well managed systems
- Re-admission rates have increased at both Trusts since February 2019, 11.6% increase SFHT, 6.5% at NUH.
- 48.8% of deaths occur in hospital (12months to Dec 18; national average 45.5%). 53.1% in Nottingham City compared to 44.4% in Rushcliffe

The challenges we face – Service Provision

We also know we have significant improvements to make in Primary Care, Emergency and Urgent Care and Mental Health services

Needs checking and updating against final drivers of demand analysis



Primary Care

- 100% of the population is covered by extended access, however around 15% of local people reported their experience of trying to get a GP appointment as poor, and over a quarter of people reported having to wait over a week for an appointment.
- Increasing pressure on General Practice due to increased demand; push for extended hours; complexity of patient needs; inability to attract / retain workforce; financial uncertainty
- Nationally it's been estimated that up to 50% of patients attending General Practice have conditions that may not need a GP and could be treated by less qualified staff
- Variation in screening, early diagnosis and chronic disease management
- As many as 50% of patients do not take their medicines as intended
- 10 GP practices (7.7%) rated Inadequate or Require Improvement (national 4.7%); 7 City practices (13.8%) rated Inadequate or Require Improvement
- Less than half of people in Nottinghamshire with a LTC have had a conversation with a primary care health care professional to discuss what is important to them, a third don't have an agreed care plan

We need to ensure a sustainable primary care workforce so people can get a timely appointment and the necessary support

Emergency and Urgent Care

- Increase in 111 calls where patients recommended to go to A&E (12% 2017/18-18/19) . No. of calls with a disposition 'ambulance dispatch' increased by 18%
- EMAS calls increased by 3.3% between 2017/18 and 18/19 - ambulance conveyances to KMH and QMC increased by 3.7% and 3.1% respectively.
- Total number of A&E attendances at NUH increased 2.3% from 2017/18 to 18/19 – attendances at majors increased by 2.1% (attendances increased by 7.4% when Q4 18/19 is compared with Q 4 2017/18)
- Total number of A&E attendances at SFH increased 4.4% from 2017/18 to 2018/19 (increase in A&E attendances of 7.2% and -2.3% reduction in PC24)
- A&E performance remains on going challenge 80.4% April 2019 (NUH 66.72%/ SFH 90.96%)
- Total emergency admissions at NUH increased by 7.1% from 2017/18- 2018/19('0' day length of stay 14.3%, 1 day 3.8%, 2+ day 2.8%)
- SFH saw an increase in '0' day length of stay between Aug 18 – Apr 19, a reduction in 1 day stays from Oct 18-Apr 19 and an increase in 2+ Jan 19 – April 19.
- DToCs – both acute Trusts higher than national target (NUH 3.59%, SFH 3.91%, Mar 18; target 3.5%)
- Category 2 ambulance response times longer than required 20 min 54s vs 18 min target (Apr 19)

We need to reduce the ever increasing emergency and urgent care demand to relieve the pressure on these services

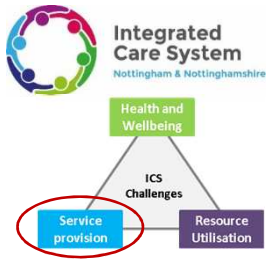
Mental Health

- Performance concerns relating to:
  - IAPT Access: 4.65% against 4.75% target (Feb 19)
  - Children and Young Persons (CYP) access issues :
    - Access rate: 16.9% against 32% target (Q4 2018/19)
    - Eating disorders urgent 1st < 1week: 45.5% against 95% target (Q4 2018/19)
    - Eating disorders routine 1st < 4 weeks: 81.5% against 95% target (Q4 2018/19)
  - Early Intervention in Psychosis (EIP) concordant compliance & data
- 5YFV transformation area challenges:
  - Out of Area Inappropriate placements – remain national outlier on volumes of placements: 2,815 against a local target of 1,698 (Mar 19)
  - Liaison –service model at NUH
  - Crisis – 24/7 CRHT service is not currently offered
  - IPS – Service not delivered across the ICS
  - Physical Health Checks not in line with requirements
- Contacts with Crisis Resolution and Home Treatment Teams per head of population lower than national rate
- Mental health service users account for 19% of all A&E attendances and 26% of all unplanned hospital admissions

We need to improve access to mental health services and transform existing care models so people can receive timely care

The challenges we face – Service Provision

…and continuous improvements to make in other areas…



Planned Care

- Referral Time to Treatment (RTT) was 91.7% against a target of 92% in March 2019. Waiting lists have reduced to +3.5% over March 2018 as an ICS overall.
- SFH not achieving 92% 18 wk RTT (89.96% Mar 2019) – challenges in Dermatology, T&O, Rheumatology, Cardiology, Plastics, Gen. Surgery, Ophthalmology, Urology and ENT
- NUH delivering RTT target, however challenges in some specialties – ENT, T&O, Neurosurgery, Gen. Surgery.
- Contacts with secondary care are not always valuable i.e. procedures of limited clinical value and outpatient appointments – it's estimate 10-20% of patients didn't need to attend a first outpatient appointment and 10-20% of follow-up outpatient appointments could have been seen using an alternative to face-to-face appointments
- Elective services are mostly delivered in hospitals, often a lack of end to end pathway integration
- Fragmented, siloed, duplicated services and a lack of end-to-end integration

We must continue to deliver against the RTT target and ensure our services are convenient and valuable to patients

Cancer

- Access is generally good, however, difficulties in meeting the 62 day wait standard (First definitive treatment – GP Referral) - 79.4% Mar 19 vs 85% target (SFHT 88.36% / NUH 73.2%) - backlogs have increased
- Failing to meet standard for 31 day wait standards
  - First definitive treatment – 92.7% vs 96.0% (Mar 19)
  - Subsequent treatment surgery - 85.6% vs 94% (Mar 19)
- Screening rates are lower than national average in Nottingham City for bowel, breast and cervical cancer
- Significant variations in outcomes locally, and outcomes are significantly lower than national average in parts of ICS

We must reduce the variation in outcomes experienced locally and ensure our cancer services continually meet the care standards

Maternity

- Parts of our system have high rates of smoking at time of delivery which leads to high and variable rates of still birth and neonatal death.
- Nottinghamshire's rate of stillbirth and neonatal death (5.02 per 1,000) has improved however there remains variation across the system with Mansfield & Ashfield continuing to have the highest rate (6.49 per 1,000).
- Lack of pace in implementing maternity transformation (care bundle, continuity of care) – delivery not expected until 2020

We must improve the choice, personalisation and safety of our local maternity services, including neonatal services

The challenges we face – Resource Utilisation

We know we need to address key workforce challenges and use our estate more effectively

Workforce

Workforce supply

- Workforce shortages and a decrease in the number of training places has led to an increase in vacancy figures across the system.

  Registered Nursing Workforce:

  - High number of vacancies and shortage of supply locally (and nationally). Different impact e.g. higher impact in Mental Health and LD.
  - Employers are competing for a reduced supply of registered nurses and midwives. They can readily move if not offer a career development, preceptorship and post registration education opportunities.
  - Turnover is high at 11.14% as is voluntary turnover at 8.14%. Vacancy rates higher than the national NHS average (12.1% vs 9.1%), and locally are especially high in Learning Disability (24.1%) and Mental Health (21.0%) roles. Nursing vacancy rates are also extremely high – 18.9%, which equates to a vacancy figure of 1,412 FTE.

  Medical staff:

  - Particular difficulties in filling training places in Psychiatry, Paediatrics and Emergency Medicine where there are already vacancies in SAS and consultant roles
  - Shortages in Healthcare of Older People, Stroke, Radiology and Oncology
  - Outsourcing of simple planned procedures to other providers in specialties such as Gynaecology has led to a loss of medical training capacity locally that will impact on the future supply of consultants if mitigating actions aren't taken.

- Requirement in GPFV and MHFV to increase numbers of staff in these areas, e.g. 77 more GPs by 2020, 66 more IAPT practitioners by 2021, 30 CYP MH workers, 23 MH crisis workers, 28 EIP practitioners and 11 perinatal MH specialists.
- System wide reliance on agency staff – both a financial issue and clinical risk. The three NHS providers in Nottinghamshire spent c.£40m on agency staff in 2018/19.
- Over a quarter of ICS workforce are over 50 years of age. Over 30% of the Mental Health & LD workforce are over the age of 50.
- The overall turnover for Nottingham and Nottinghamshire ICS is 12.44%, and the voluntary turnover is 7.45%. The highest turnover is across the Planned Care workstream (17.77%).

Health and wellbeing

- Sickness absence higher than the national NHS average (4.4% vs 4.2%), with CityCare (5.6%) and Notts Healthcare (5.4%) both higher than the national average (4.2%), regional average (4.5%) and average for the type of organisation (4.7%/4.8%)
- 57% of the workforce agree/strongly agree that they would recommend their organistation as a place to work

Estates

- LIFT and PFI Estate across the system – high quality, commercial estate
- Utilisation issues (clinical v non clinical and unoccupied estate) of high quality, commercial estate i.e. PFI and LIFT
- System is not meeting Naylor target to create disposals/opportunities for regeneration schemes
- In year capacity pressures create need for urgent short term actions e.g. theatres and bed capacity
- Aging estate with high level of backlog maintenance e.g. City Hospital and QMC
- Ability to drive local investment in capital is limited due to system financial position

316 health buildings including 115 GP owned buildings

£171m annual running costs

£168m backlog maintenance requirement (£110m is high risk)

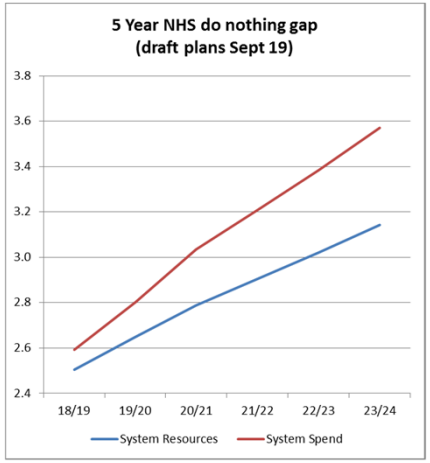
Three acute hospital sites (QMC, Nottingham City Hospital and Kings Mill Hospital represent 70% of the estate running cost and over 80% of the backlog maintenance requirement

The challenges we face – Resource Utilisation

If we do not address these challenges and continue to deliver care as we currently do, over the next 5 years we are forecasting a financial gap of £430 million

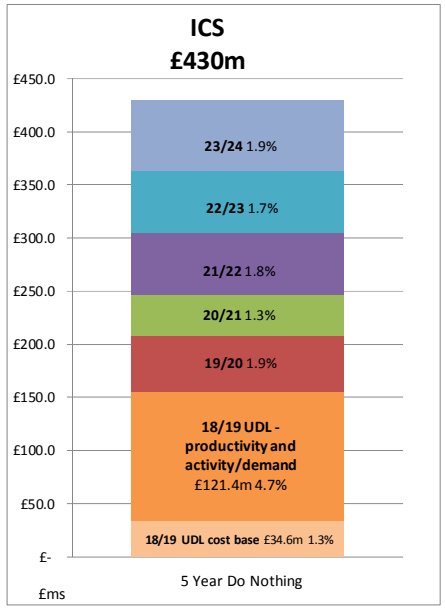
Finance

- The system has a challenging financial positon, with an operational plan for 2019/20 of £65.7 million in year deficit. Key pressures are growth in activity/demand (health and social care), provider pay costs and non-delivery of saving & efficiency programmes.
- The system has a higher levels of fixed costs in comparison to other systems due to PFI costs.
- Our original STP plan (2016) identified a five-year finance and efficiency gap of £628 million (£473 million Health and £155 million Social Care).
- Health figures have been updated for the LTP Implementation Framework. Over the next five years NHS system resources will increase by 26% to £3.2 billion, however costs are expected to increase by over 37%.
- The do nothing five year gap is £430 million before marginal rate emergency threshold (MRET), provider sustainability funding (PSF) and financial recovery fund (FRF). This is a realistic do nothing position NOT a downside scenario.
- There are three areas that are driving this financial gap:
  - Underlying recurrent deficit across all organisations (UDL), this is due to cost base pressures and under delivery of productivity/pathway changes
  - Under delivery of required productivity and efficiency requirements
  - Continuing activity and demand pressures
- NHS is implementing a new financial framework for providers and commissioners and it is expected that in future years we will move away from control totals and sustainability funding.
- The local financial model will include Local Authority. This will be added to future iterations as information becomes available



The system is facing a financial challenge of £430 million over the next five years
(based on a do nothing scenario i.e. continue to deliver care as we currently do)

Over the next five years we must address our underlying deficit, delivery productivity & efficiency requirements and transform the way we deliver care to meet growing demand



The challenges we face - Conclusion

We have a set of interrelated challenges with a reinforcing effect on each other that we must address as an integrated care system

Health and Wellbeing

- More people are living longer in poor health - therefore the period in people's lives when they require health and social care support is steadily rising
- Long Terms Conditions account around 50% of GP appointments, 64% of outpatient appointments, and 70% of hospital bed days – much of this care could be avoided by 'upstream' interventions
- The proportion of those aged 65 and over with four or more diseases is set to double by 2035, with around a third having a mental health problem.
- There is a 22% increase forecast n people living with diabetes across the ICS between 2015 & 2035.
- People from more deprived communities or are part of certain groups (e.g. severe mental health or learning disabilities spend more of their lives in ill health.
- Cancer, Circulatory and Respiratory disease have the highest percentage contribution to the overall life expectancy gap between most and least deprived.
- Our deprived communities have greatest exposure to factors that impact adversely on health – these underpin lifestyle risk factors (smoking, inactivity and diet) and mental health inequalities.

Service Provision

- Our current health and care services have been set up to help sick people get well, often in a hospital setting (reactive episodic care).
- We do not routinely and systematically identify and support people with ongoing needs - often we do not know about these needs until people reach a crisis point.
- Increase in 111 calls where patients recommended to go to A&E and increase in no. of calls with a disposition 'ambulance dispatch'. EMAS calls and increase in ambulance conveyance to A&E. A&E performance remains on going challenge.
- Around 20% of hospital admissions and 50% of bed days could be provided in an alternative setting if appropriate services were available.
- Performance concerns relating to mental health provision (IAP, CYP, EIP) and a lack of pace delivering service transformation (out of area placements, hospital liaison services and crisis support) - mental health service users account for 19% of all A&E attendances and 26% of all unplanned hospital admissions.
- Difficulties meeting 62 day cancer standard and failing to meet 31 day standard - screening rate lower than national av. in the City for bowel/breast/ cervical.
- Increasing pressure on General Practice - increased demand; push for extended hours; complexity of patients; inability to attract/retain workforce; financial sustainability

Resource utilisation

- Workforce shortages and a decrease in the number of training places has led to increases in vacancy in the registered nursing workforce and medical staff.
- System wide reliance on agency staff – both a financial issue and clinical risk. The three NHS providers in Nottinghamshire spent c.£40m on agency staff in 2018/19.
- Over a quarter of ICS workforce are over 50 years of age (over 30% of the Mental Health & LD workforce)
- Sickness absence higher than the national NHS average.
- High quality LIFT and PFI premises exist across the system, including a substantial proportion of an acute hospital site, however their utilisation is not optimised.
- Aging estate with a high level of backlog maintenance – three main acute hospital sites represent 70% of the estate running cost and over 80% of the backlog maintenance.
- NHS system resources expected to increase by 26% over next 5 years, NHS system costs projected to increase by over 37% over next 5 years.
- ICS has higher levels of fixed costs in comparison to other systems due to PFI costs.
- Health forecasting a 5 year 'do nothing' deficit of £430m (before MRET, PSF and FRF), key drivers are underlying recurrent deficit, non delivery of savings & efficiency programmes and increasing activity/demand.

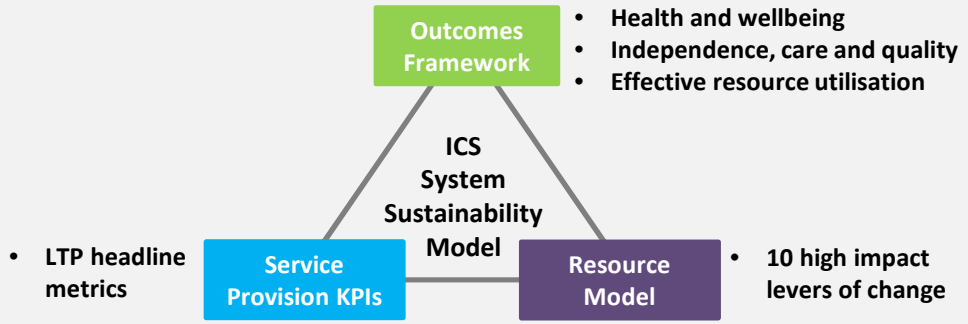
(2) Our System Sustainability Model

To address the challenges we face as an integrated care system (ICS) we have developed a system sustainability model. This acts as a framework for the priorities, actions and investments for the whole system and its constituent partners. It also defines our success in improving the health, wellbeing and independence of our citizens and transforming the way health and care is provided

This is comprised of three interconnected components:

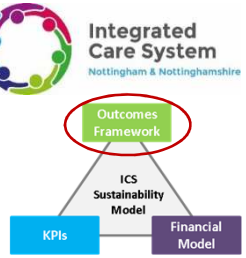
- System Outcomes Framework
- Service Provision KPIs
- System Financial Sustainability model

Our vision for the ICS is ambitious. Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age



Our vision and system level outcomes framework

Based on the challenges we face, we have set an ambitious vision for our ICS that describes what we aspire to achieve for our population



Our vision for the ICS is ambitious: Across Nottinghamshire, we seek to both increase the duration of people's lives and to improve those additional years, allowing people to live longer, happier, healthier and more independently into their old age

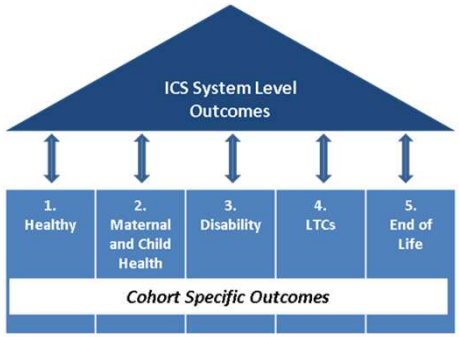
Purpose of our System Level Outcomes Framework

To provide a clear view of our success as an integrated Care System focused on population health we have developed a system level outcomes framework that all partners across the system will work together to jointly to deliver. Through this framework we will show:

- How outcomes for citizens are being achieved across the system;
- Focus plans and inform priorities through clearly articulated measures; and
- Support organisations to work as one health and social care system to deliver impact and continually improve.

The Framework sets out the short, medium and long term outcomes the whole ICS will work together to achieve, and supports strategic planning by ensuring system improvement priorities and investment enable achievement of the outcomes. Our framework reflects a commitment that everyone should have the opportunity to make choices that support independence and wellbeing.

As our ICS continues to move away from a system based on an individual's service utilisation at a point in time to one based on population health delivering outcomes for segments of the population with similar needs , the ICS System Level Outcomes Framework will also act as the 'anchor point' for shaping what the outcomes for each of the population segments should be.



The System Level Outcomes Framework Design

Our ICS System Level Outcomes Framework is based on the triple aim (improved health and wellbeing, transformed quality of care, and sustainable finances) and the priorities within the Health and Wellbeing Board Strategies. The Health and Wellbeing Board strategies are informed by the needs of our population and have undergone consultation and engagement with local health and social care stakeholders and the public.

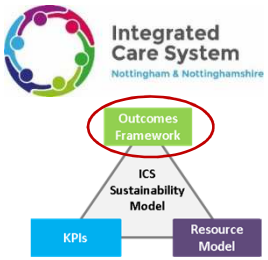
The system level outcomes framework structure reflects the different timeframes over which system level outcomes relating to these ambitions can be tracked and improvements observed, and is based on the assumption that improvements in outcomes that can be measured in the short and medium term will build a strong foundation to drive achievement and deliverability of our long term ambitions.

Domain	3 domains High level grouping or classification based on the triple aim: **Health and Wellbeing** — The impact of health and care services on the health of our population **Independence, care, quality** — The overall quality of care and life our service users are able to have and their experiences of our health and care services **Effective resource utilisation** — The state of our health and care infrastructure and its ability to deliver quality care and improve health and wellbeing long term
Ambition	10 ambitions High level aspiring ambitions for our Nottingham and Nottinghamshire population mapped against the 3 domains
Outcome	28 outcomes System level outcomes and results our health and care system will aim to achieve to deliver our ambitions
Measure	Indicators to demonstrate progress towards or achievement (or not) of our outcomes

Our system outcomes framework continues to evolve and refine to ensure it both meets the needs of the local ICS as well as local and national requirements on Integrated Care Systems.

Our System Outcomes Framework

The purpose of the ICS System Level Outcomes Framework is to provide a clear view of our success as an Integrated Care System in improving the health, wellbeing and independence of our residents and transforming the way the health and care system operates



Health and Wellbeing

Ambition	System Level Outcome
Our people live longer, healthier lives	• Increase in life expectancy • Increase in healthy life expectancy • Increase in life expectancy at birth in lower deprivation quintiles
Our children have a good start in life	• Reduction in infant mortality • Increase in school readiness • Reduction in smoking prevalence at time of delivery
Our people and families are resilient and have good health and wellbeing	• Reduction in illness and disease prevalence • Narrow the gap in the onset of multiple morbidities between the poorest and wealthiest sections of the population • Increase the number of people who have the support to self-care and self-manage and improve their health and wellbeing
Our people will enjoy healthy and independent ageing at home or in their communities for longer	• Reduction in premature mortality • Reduction in potential years of life lost • Increase in early identification and early diagnosis

Independence, Care and Quality

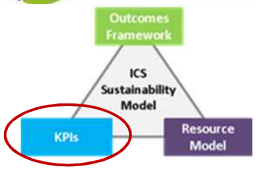
Ambition	System Level Outcome
Our people will have equitable access to the right care at the right time in the right place	• Reduction in avoidable and unplanned admissions to hospital and care homes • Increase in appropriate access to primary and community based health and care services • Increase in the number of people being cared for in appropriate care settings
Our services meet the needs of our people in a positive way	• Increase in the proportion of people reporting high satisfaction with the service they receive • Increase in the proportion of people reporting their needs are met • Increase in the number of people that report having choice, control and dignity over their care and support
Our people with care and support needs and their carers have a good quality of life	• Increase in quality of life for people with care needs • Increase in appropriate and effective care for people who are coming to the end of their lives

Effective Resource Utilisation

Ambition	System Level Outcome
Our system is in financial balance	• Financial control total achieved • Transformation target delivered
Our system has a sustainable infrastructure	• Increase in the total use and appropriate utilisation of our estate • Alignment of capital spending for new and pre-existing estate proposals with clinical and service improvement objectives • Increase in collaborative data and information systems
Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	• Sustainable teams with skill mix designed around our population and mechanisms to deploy them flexibly to respond to care & support needs • Increase in skills, knowledge and confidence to take every opportunity to support people to self-care and take a flexible, holistic approach to people's needs with a strong focus on prevention and personalised care • Increase in the number of people reporting a positive and rewarding experience working and training in the Nottinghamshire health and care system

Slide to be updated

Integrated Care System
Nottingham & Nottinghamshire



Our Key Performance Indicator Framework

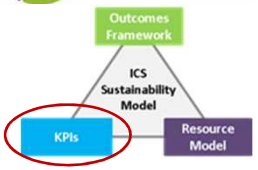
Our system's key performance indicators are aligned to the headline metrics set out in the NHS Long Term Plan, we have set trajectories for these over the period of this plan

Each of our system priorities and programmes also have a set of metrics aligned to the NHS Long Term Plan

LTP Section	Potential Measure description	Target	18/19	19/20	20/21	21/22	22/23	23/24
Prevention	Population vaccination coverage – MMR for two doses (5 years old)		86.9%					
	Measure that reflects the inequalities focus of local plans – measure to be confirmed	Metric not yet defined						
	Coverage of ACTs – percentage of hospitals with the highest rate of alcohol dependence-related admissions with ACTs in place	100%	0%	0%	100%	100%	100%	100%
	Number of people supported through the NHS Diabetes Prevention programme							
	Percentage of people admitted to hospital who smoke offered NHS funded tobacco treatment services							
Urgent & Emergency Care	Community rapid response 2 hour/2 day measure to be confirmed	Metric not yet defined						
	Percentage of non-elective activity treated as Same Day Emergency Care cases	33.0% by 2023/24	27.9%	26.4%	27.8%	29.3%	30.7%	**32.9%**
	Percentage of patients in A&E transferred, discharged or admitted within four hours							
Mental Health	Number of people accessing IAPT services		20,460	22,981				
	Number of children and young people accessing NHS funded mental health services		5,070					
	Mental health access standards once agreed	Metric not yet defined						
Value, Resilience & Sustainability	Percentage of patients with incomplete pathway waiting 18 weeks or less to start consultant led treatment		92.2%	92.6%				
	Patients waiting more than 52 weeks to start consultant-led treatment							
	Elective waiting list size		58,509	56,751				
	Percentage reduction in the number of face to face outpatient attendances							
	Measure on reduction in unwarranted variation achieved by the NHS							
Cancer	Bowel screening coverage, aged 60-74, screened in last 30 months		62.4%					
	Breast screening coverage, females aged 50-70, screened in last 36 months		68.2%					
	Cervical screening coverage, females aged 25-64, attending screening within target period (3.5 or 5.5 years)		76.6%					
	Proportion of cancers diagnosed at stages 1 or 2							
	Proportion of people that survive cancer for at least 1 year and 5 years after diagnosis							
	Percentage of patients starting cancer treatment within 62 days of GP referral		82.4%	86.1%				

Slide to be updated

Integrated Care System
Nottingham & Nottinghamshire



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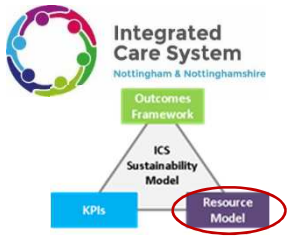
LTP Section	Potential Measure description	Target	18/19	19/20	20/21	21/22	22/23	23/24
Maternity	Reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury, based on MBRRACE data							
Learning Disabilities & Autism	Reliance on specialist inpatient care for people with a learning disability and/or autism (inpatient rate per million popn)		12.85	12.85	12.85	12.85	12.85	12.85
	Proportion of people with a learning disability on the GP register receiving an annual health check							
Other	Percentage of population covered by ICS	100%	100%	100%	100%	100%	100%	100%
	Proportion of providers with an outstanding or good rating from the CQC for the "well led" domain							
Primary Care	GP contract / Primary Care Network Patient reported access measure – measure to be confirmed*							
	Proportion of the population with access to online consultations							
	Access to general practice appointments							
Workforce	Staff retention rate							
	Workforce diversity measure to be agreed	Metric not yet defined						
	Number of GPs employed by NHS		881					
	Number of FTEs, above baseline, in the Primary Care Network additional role reimbursement scheme							
	Nurse vacancy rate							
	Staff well-being measure to be agreed as part of the People Plan	Metric not yet defined						
	Sickness absence							
Digital	Proportion of population registered to use NHS App		0.3%	7.0%	15.0%	25.0%	35.0%	50.0%
Finance	Percentage of overall NHS revenue spent on primary medical and community health services							
	Percentage of overall NHS revenue funding spent on mental health services							
	Percentage of organisations in financial balance							
	Aggregate forecast end of year financial position of providers, commissioners and NHSE central budgets against agreed budgetary limits							
	Total Cash releasing productivity growth (covering acute, mental health and community providers initially)							
	Cost weighted non-elective activity growth							
	[To be confirmed following the Spending Review and the development of the new NHS capital regime]	Metric not yet defined						

Our Resource Sustainability Model

Our system financial model looks at what would be needed to deliver a financially sustainable system for the future



Financial Sustainability Model

- Our five-year plan needs to deliver the requirements of the Long Term Plan, this includes **addressing the current challenges** in the system.
- Our 5 year projections clearly demonstrate our system **cannot resource the do nothing scenario** – limiting factors are workforce, funding and operational capacity.
- The model incorporates the **five financial tests included in the Long Term Plan** :

  1 **Financial Balance**

  2 **Productivity** (cash releasing)

  3 Actions to **support appropriate reductions in activity** (through better integration and prevention)

  4 **Reduce variation in organisational performance**

  5 **Maximise capital investment and assets**

10 high level levers

We have identified 10 high level levers that will change the level of resource (finance, workforce and capacity) needed by the system to deliver sustainable services for the population we serve.

Lever	Description	Scale and trajectory	Gross Savings £m Savings Range (against do nothing plan)		Financial Tests (LTP)				
					1	2	3	4	5
1	Keep people safe and well in their own home and communities and **reduce the need for emergency attendances at hospital** (type 1 A&E attendances and non-elective admissions)	Type 1 A&E without admissions grow by 2.9% in 2020-22 and 1% in 2022-24 Non-elective admissions grow by 2.3% in 2020-22 and 0% in 2022-24	65	75	✔ ✔		✔ ✔		
2	**Reduce inappropriate attendances at A&E departments** through public education and providing alternatives (Minor A&E attendances)	Type 3 A&E grow by 1.5% in 2020-22 and 0% in 2022-24	1	3	✔		✔		
3	Reduce pressures on acute services by ensuring these **beds are only used for clinically appropriate patients through optimal length of stay and integrated discharge** (NEL OBDs)	Reduction in non-elective occupied bed days by 20% over 2020-24	30	40	✔		✔		
4	Deliver care closer to home for **Mental Health Out of Area Placements (OAPs)**	Reduce mental health out of area placements to zero	5	9	✔			✔	
5	Deliver increased value across the system – **Optimise Medicine Spend**	Reduce spend on medicine by 20%	35	40	✔	✔		✔	
6	Deliver increased value across the system – **Reduction in outpatient appointments** through reprovision in alternative ways and reductions in inappropriate appointments	Reduce face to face outpatient appointments by 30%	25	40	✔	✔			
7	Deliver increased value across the system – **Business as usual efficiencies (BAU)** providers and commissioners	Increase productivity across CHC, pathology and other	50	100	✔	✔		✔	
8	Deliver increased value across the system – **Estates and back office**	25% reduction in estates cost (excludes fixed points) Deliver national admin. savings requirement (LTP)	30	35	✔ ✔	 ✔			✔
9	Estimated full year recurrent delivery of **2019/20 transformational plans (QIPP/CIP)**	Maximise recurrent delivery of 2019/20 QIPP and CIP Plans (M4)	90	115	✔	✔	✔	✔	✔
10	Service benefit reviews – Including review of the **core offer**	To be confirmed	-	-	✔				
			331	457					

Our system architecture for delivering our sustainability model

Our Integrated Care System (ICS) bring together NHS organisations, local authorities, voluntary services and other key partners within Nottingham and Nottinghamshire

The ICS will focus on achieving the best possible health and care services for the entire population, as well as for specific populations and neighbourhoods.

At the same time as enabling a more strategic approach, there will be a greater clinical focus on healthcare within specific neighbourhoods through the creation of Primary Care Networks (PCNs). The PCNs across Nottingham and Nottinghamshire will in turn be aligned to one of three Integrated Care Providers to collaborate across a wider area in delivering and improving healthcare services.

The changes also aim to make the NHS more efficient and effective by reducing unnecessary duplication and by placing clinical and other valuable resources closer to the front-line In the future the new Primary Care Networks and Integrated Care Providers will take on some of the existing responsibilities of the CCGs, for example leading the transformation of care pathways and creating a more comprehensive, personalised offer for local healthcare.

Primary Care Networks (PCNs) - NEIGHBOURHOODS

As well as having a view of healthcare across the overall area, it is equally essential that we maintain our focus on local needs within a specific neighbourhood or population. Primary Care Networks (PCNs) are being set up to do exactly that. Around 20 new PCNs will be set up across our area so that organisations providing healthcare services at a local level can work even better together.

PCNs will consist of groups of general practices working together with a range of local providers, including primary care and community services, mental health, social care and the voluntary sector. Through these networks, local health and care providers will focus on delivering more personalised, coordinated health and social care to meet the needs of their particular neighbourhood.

PCNs will be led by clinicians and will be appropriately funded, resourced and supported. They will be aligned to one of three Integrated Care Providers (ICPs) according to their geographical location.

Integrated Care Providers (ICPs) - PLACE

All PCNs will belong to one of three Integrated Care Providers (ICPs). These will serve wider populations living within the geographical areas of Nottingham City, Mid-Nottinghamshire* and South Nottinghamshire**. These areas reflect local authority boundaries overall, and build on existing collaborations and alliances which have proven to work well.

ICPs are alliances of health and care providers, including PCNs, that will work together to deliver care by agreeing to collaborate rather than compete. They will be responsible for the cost, quality and consistency of services for the population they oversee. They will develop better pathways of care for patients and more effective ways of working together. Like PCNs at a neighbourhood level, ICPs will inform commissioning decisions relating to the area they serve.

* Mid-Nottinghamshire: Ashfield, Mansfield, Newark and Sherwood
** South Nottinghamshire: Broxtowe, Gedling and Rushcliffe

Our Integrated Care System (ICS) - SYSTEM

The NHS is not the only body that plays a key role in influencing and responding to people's health and wellbeing. For example, local authorities are a major partner because they provide social care, public health and other services which influence the health and wellbeing of the population. Other important partners include voluntary services and the independent sector.

Under the new changes, NHS, local authorities and other key organisations will form a partnership across a designated geography, called an 'Integrated Care System' or 'ICS'. Locally, our ICS covers the geography of Nottingham and Nottinghamshire excluding Bassetlaw, which is historically aligned to services within South Yorkshire. Together, partners within the ICS will focus on ensuring the best possible health and care services both across the entire area, as well as for specific populations and neighbourhoods.

An ICS organisation will provide clinical and administrative expertise to support health and care partners in working together effectively across the area. It will also take the lead on workforce planning and play a regulatory role.

(3) Our system priorities

To address the challenges we face, underpin the delivery of our System Sustainability Model and deliver the commitments set out in the NHS LTP we have agreed five priorities and five enablers for our Integrated Care System

Priorities

1. Prevention and wider determinants of health
2. Proactive care, self-management and personalisation
3. Urgent and emergency care
4. Mental health
5. Value, resilience and sustainability

\+ Other LTP must dos

Priority Enablers

1. Primary Care
2. People and Culture
3. Information, analytics and digital
4. System financial management and payment models
5. System leadership, governance and oversight

Our strategic priorities to deliver our system sustainability model

To address the challenges we face and deliver our system sustainability model we have identified five priorities and five priority enablers for our ICS. These form the core of our 5 year plan…

Our ICS Priorities

Our plan is focussed on the areas where we believe are most important to address the challenges we face and deliver our sustainability model. Our main effort over the next five years is focussed on breaking down traditional silos in care and establishing, embedding and optimising integrated care models that ensure people are cared for in the most appropriate setting for their need whilst ensuring optimal use of available resources.

Our priorities strongly align and reflect core components of the Long Term Plan and its investment priorities. Underpinning our five priorities are five key enablers that are fundamental to their success.

Enabler Priority	Primary Care	People and Culture	Data, Analytics, Information and Digital Technology	System financial management & payment models	System leadership, governance & oversight
Service Priority 1	**Prevention, inequalities and wider determinants of health** *More action on and improvements in the upstream prevention of avoidable illness and its exacerbations*				
Service Priority 2	**Proactive care, self-management and personalisation** *Improve support to people at risk of and living with long term conditions and disabilities through greater proactive care, self-management and personalisation*				
Service Priority 3	**Urgent and Emergency Care** *Redesign the urgent and emergency care system, including integrated primary care models, to ensure timely care in the most appropriate setting*				
Service Priority 4	**Mental Health** *Re-shape and transform services and other interventions so they better respond to the mental health and care needs of the population*				
Service Priority 5	**Value, resilience and sustainability** *Deliver increased value, resilience and sustainability across the system (including estates)*				
Other LTP	**Other LTP 'must-dos' – Cancer, Planned Care, Maternity, LD and Autism**				

Our focus in 19/20 and 20/21

Our system priorities provide the focus of our change and transformation efforts over the next five years, within each we have prioritised a number of areas for the shorter term to ensure we have a solid foundation to build on

Service Priority	Our focus in 19/20 and 20/21
Prevention, inequalities and wider determinants of health	• **Inequalities** - diagnostic of place based approaches to health inequalities and map interventions against the Population Intervention Triangle • **Smoking** - Target cessation services on low income earners, MH patients, pregnancy and all inpatients and users of high risk OP services who smoke • **Alcohol** - Systematic approach to intervention & brief advice , case management of high volume service users and Alcohol Care Teams established
Proactive care, self-management and personalisation	• **GP registers** - up to date for key patient cohorts; frailty, dementia, CVD, COPD/Respiratory, diabetes, EoL, high intensity users (HIU), MH, LD • **MDTs/ care coordinators** - consistent model embedded across ICS focused on 'top 20%' of key cohorts with clear performance KPIs established • **Condition management** – increase referrals from MDTs and optimise current programme delivery, uptake and completion for key cohorts
Urgent and emergency care	• **Community crisis response** - consistent community crisis model embedded across the system with 2hr response and access to 'step-up' beds • **Integrated urgent care service** - Clinical Assessment Service to move from hear and refer' to a 'consult and complete' model • **Ambulance conveyance** - reduce rates through a variety of mechanisms and reduce handover times, working in partnership with EMAS. • **SDEC** - Comprehensive model embedded in both medical and surgical specialties across the system, including acute frailty services • **Bed utilisation** - embed proactive approach including advanced digital tool to track capacity and flow to allow dynamic management • **Integrated discharge function** - establish consistent system wide function with interdependencies between organisations/teams clearly defined and sufficient 'step-down' capacity available
Mental Health	• **Physical health checks** – delivery as a core part of community health and care model • **IAPT** - improve and expand access to IAPT services • **Children & young people** - increased access to support via school/college based Mental Health Support Teams and increased crisis service provision • **Community Mental Health Teams** - stabilise and bolster core services and develop new care model based on local need and national pilots • **Adult crisis services** – 100% coverage of adult crisis home treatment teams, MH liaison services meet 'core 24' and crisis alternatives provided • **Out of area placements** – inappropriate placements eliminated
Value, resilience and sustainability	• **Clinical productivity** – continue to focus on workforce productivity, outpatient transformation to avoid a significant number of face-to face outpatient visits and ensuring patients have the choice of a quick telephone or online consultation with their GP, saving time waiting and travelling • **Evidenced based pathways and interventions** - Continue to bring together clinicians and managers to develop and implement appropriately standardised evidence based pathways (Clinical Services Strategy - prioritised a further 15 pathways for 20/21), review implementation of national Evidence Based Interventions Programme and continue to streamline benchmarking and opportunities data • **Improvement in value, quality and patient safety** - Invest in Quality Improvement to ensure our staff have the skills and methodology to simultaneously improve care and reduce costs and implement a systematic approach to value improvement using reliable and valid methods • **Medicines Value Programme** – continue to implement medicines value programme • **Development of pathology and diagnostic imaging networks** - Ensure all our pathology services are part of a pathology network • **Best use of assets and capital investment-** improve asset utilisation across acute, primary care and community, reduce transactional costs of managing estate , develop business case to support transfer of properties to local system and develop long-term system capital plan • **Reduce administration costs** - proposed merger of Nottinghamshire CCGs 1 April 2020, consider further options for shared functions across all levels of the system and movement to new contract/payment mechanisms (reduced transactional costs)

System Sustainability Model elements impacted by Initiatives
▲ System Outcomes ▲ Headline KPIs ▲ Resource Model

Integrated Care System
Nottingham & Nottinghamshire

Service Priority 1

Prevention, inequalities and the wider determinants of health

We will continue to focus more actions on and improvements in the prevention of avoidable illness and its exacerbation and reducing inequalities, with an initial focus on tobacco and alcohol related harm

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
NHS Action on Health Inequalities ▲ ▲ ▲	• Accepted as a strategic priority at ICS level • Alignment of actions with H&WB progressed • ICP plans focussing on inequalities • JSNA and RightCare inform commissioning	• Detailed diagnostic in relation to place based approach to health inequalities ✓ • Interventions mapped against Population Intervention Triangle to demonstrate actions ✓ • Population Health Management focused on key inequalities CVD, respiratory cancer, alcohol, tobacco, diet • Scale up focussed/targeted work based on population profiles at PCN and ICP level and ICS priorities
Tobacco and Related Harm ▲ ▲ ▲	• Notts CC - new Integrated Wellbeing Service • Nott. City targeting pregnant/post-natal women, adults with MH and substance misuse issues and LTCs • Health & LA services not fully joined up • Piloting NHSE smoking in pregnancy scheme • ICPs and PCNs adopting priority	• Priority cohorts identified as mental health , low income earners and smoking in pregnancy (inc partners) ✓ • ICP & PCN local, targeted plans relevant to population/priority groups (as above) + ICS wide campaigns ✓ • Pilot NHS England smoking in pregnancy programme in relation to incentives ✓ • All inpatients and users of high risk OP services who smoke offered access to NHS stop smoking services ✓ • Commission a hub and spoke model that is integrated across health and local authorities • Integrating smoking cessation pathways through PHM/e-healthscope/ My NHS App • Evidence based approach to e-cigarettes and vaping as an alternative – to take up PHE recommendations
Alcohol Related Harm ▲ ▲ ▲	• System adopted as a prevention priority • Alcohol in ICS MOU with NHSE • Understanding across citizens on national guidance/units /wider risks to health is low • Identification and Brief Advice (IBA) not systematically and consistently provided • Identification/case management of high volume service users can be improved.	• Systematic approach to IBA - targeted approach at ICP and PCN levels as well as within organisations ✓ • Robust case management of high volume service users across providers, including in EDs ✓ • Establish Alcohol Care Teams to support entry into appropriate support and treatment ✓ • Informed population, skilled and supported workforce, right conversation at right time, sharing information, Increase population understanding of impacts/risks through local campaigns alongside national work • Integrate Employee Health & Wellbeing actions –systematic approach across c.35k staff • Influence local/national policy for preventing alcohol harm - health in all policies across all partners
Diet and Physical Inactivity ▲ ▲ ▲	• Diabetes Prevention Programme implemented and exceeding targets • Tiers 1 to 4 weight management services commissioned. Gap in Tier 3 services for children with severe obesity. • Physical inactivity programmes partly in place	• Continue to promote Diabetes Prevention Programme • Pilot site for enhanced weight management support for those with BMI of 30+ with type 2 diabetes/ hypert. • Further develop plans at ICP level, including expansion of pilots, focussed on addressing inequalities, targeted approach through pilots in years 1&2 followed by evaluation and roll-out in subsequent years • Taking forward Health in All Policies across all partners • Integration of tiers 1 and 2 with 3 and 4 in order to provide a system wide approach to weight management
Children and Young People ▲ ▲	• ICS CYP Prevention sub-group • ICS 5 year plan aligned with CYP H&WB plans • Targeted work on Imms and Vaccs	• Focus on children aged 1 year and over incl. being a test site for enhanced Tier 3 services for severe obesity • Develop and implement plans to improve school readiness – aligning NHS and LA plans • Establish ICS framework for healthy weight initiative
Healthy communities	• Have an Air Quality Strategy to 2028	• Ongoing support to delivery of Air Quality Strategy
Antimicrobial Resistance	• Action plan exists, cross organisation working	• Target groups where highest demand for/reliance on antibiotics, near patient diagnostic test

System Sustainability Model elements impacted by Initiatives
▲ System Outcomes ▲ Headline KPIs ▲ Resource Model

Integrated Care System
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Service Priority 2

Proactive care, self-management and personalisation

We will build on the knowledge, learning and experience gained through our local MDT, Personalisation and Care Home Vanguards to embed and roll these out across our system

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Segmentation and risk stratification ▲ ▲	• Completeness of GP registers variable • Segmentation approach agreed across system • Electronic tool that draws on best practice (e.g. electronic frailty index) available to all GP practices through existing systems - variable understanding /uptake/approach to utilisation	• Ongoing programme of GP register updates embedded across all practices focussed on key patient cohorts (frailty, dementia, CVD, COPD/Respiratory, diabetes, end of life (EoL), high intensity users (HIU), MH, LD) ✓ • Electronic risk strat. tool embed in all practices based on best practice ✓; ongoing development through additional data feeds e.g. import of eCGA from acutes, community Rockwood scores and home devices • Risk stratification focused on 'top 20%' of key cohorts (above) ✓ - moving to 100% of population • Sufficient capacity to analyse/filter stratification output supported by digital technology
Care coordination and MDTs (for populations of 30-50k) ▲ ▲	• Primary & Community integrated MDTs/care coordination in place across all practices in ICS • Different care models, standard operating procedures (SOP) and capacity in place • MDT/care coordination focus on top 2-5% • Local Integrated Accelerator Sites and Vanguards to share learning from and build on	• Consistent MDT/care coordinator model/SOP embedded across ICS ✓; anticipatory care spec. in place • Care coordinators case manage 'top 5%' and co-ordinate 'top 20%' to access care mang'mt. programmes ✓ • Transparent responsibility/accountability structure for MDTs and performance/results (KPIs) within each PCN defined, monitored and shared; PCNs support optimise MDT/care coordinator delivery ✓ • Expand MDTs in line with care model/standard operating model, capacity model and demand • Develop local role/care models for additional support to MDTs (community pharmacists, link workers, physician associates and physiotherapists) – on going programme of recruitment and evaluation
Disease and condition management programmes ▲ ▲	• Disease and condition management programmes in place across system, however provision is; fragmented, inequitable, not always based on best practice, do not optimise digital technology and self-care. • Uptake and completion rates are variable	• Increased support to 'top 20%' (moderate risk) cohort of patients from disease/condition management programmes, incl. self care, facilitated by MDTs/care coordinators ✓ • Optimise current programme delivery, uptake and completion prioritising those supporting frailty, dementia, CVD, diabetes, MSK, COPD/respiratory disease, EoL, HIU and carer support ✓ • Increase capacity, incl. through digital in condition/disease management programmes in line with optimised provision and local need e.g. echocardiography and pulmonary rehab.
Personalised care ▲ ▲	• Demonstrator site since 2018 focussed on cohorts relating to: continuing healthcare/ looked-after children/carers' breaks/joint funded budgets /Section 117/wheelchairs	• Focus on scaling-up and increasing pace of work to date. Personalised care expanded by focusing on key cohorts - LD, MH, Respiratory, Neurological, physical disability, older adults, CYP, diabetes and EoL. Personal health budgets focussed on wheelchairs, HIU and transforming care; scale up in individual funding requests, S117 and CHC fast track. Roll out shared decision making building on work complete don MSK and cancer.
Enhanced health in care homes (EHCH) ▲ ▲	• Nottingham City CCG & Rushcliffe CCG work with care homes are national exemplars • However, variation exists across the system that needs to be addressed	• All older people - Comprehensive Geriatric Assessment ,using red bags and supported by 'Significant 7' ✓ • Fully implement EHCH framework so every care home resident in ICS benefits from upgraded NHS support. • Whole system approach with partnership working at every level - focus on meds optimisation and care planning focussed on frailty, end of life, dementia, oral health, nutrition and hydration support • PCNs drive, embed and sustain improvements. Care homes engaged with PCNs and improvement efforts
Medication optimisation ▲ ▲	• Community pharmacists exist, however provision is variable/inequitable/not fully integrated	• All practices and MDTs benefit from a community pharmacist undertaking structured mediation reviews, improving medicine optimisation and safety, supporting care homes and running clinics – supported by IT decision support tools - PCNs tailored approach to delivery/model of care based on local context

System Sustainability Model elements impacted by Initiatives
▲ System Outcomes ▲ Headline KPIs ▲ Resource Model

Integrated Care System
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Service Priority 2

Urgent and Emergency Care

We are undertaking significant improvements to deliver a standard core offer across the system that addresses our performance issues and meets the needs of the population.

NEED TO REFLECT STROKE PROVISION AND LINK TO LOCAL CSS

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Out of Hospital Urgent Care ▲ ▲ ▲	• Extended Hours Access in place (and same-day in hours access?) - limited networking of GP practices providing same day access • Single point of access for community crisis response (Call for Care) in 2 hour exists in Mid Nottinghamshire, different approaches across Greater Nottingham • Range of models in use to support community crisis response, including an Intensive Rapid Response Service and Intensive Support at Home initiative • Underutilised capacity 'step-up' community beds in Greater Nottingham	• PCNs provide same day access to through a network of practices and/or hubs. Out of Hours services will be either aligned or integrated • Implement Call for Care model across Greater Nottingham to allow more patients to benefit from 2 hour response care needs to avoid hospital admission ✓ • Consistent integrated community crisis model across system :response within two hours; providing a 'pull approach' by supporting active management of patients at front door of A&E ; bridge gaps in social care support and accelerate complex discharges into the community from hospital ✓ • Identified and commissioned capacity for 'step-up' community beds across the system, including up to date information on bed availability via digital tool ✓
Pre Hospital Urgent Care ▲ ▲ ▲	• Hear and Treat and See and Treat services in place, opportunities to develop further • Continuing to build data connectivity/use of information with Social care data • Detailed understanding of demand drivers and how services are working together e.g. 111, EMAS, GP out of hours. This is informing the procurement of Integrated Urgent Care Service • Development of front door approach at all key sites	• Integrated Urgent Care Service across the system comprising an integrated Clinical Assessment Service (CAS) and Urgent Treatment Centres. The CAS will move from a 'hear and refer' to a 'consult and complete' model. with the aim to close the majority of calls within its services or make direct booking into another service e.g. a GP surgery within a PCN or Urgent Treatment Centre✓ • Reduce ambulance conveyance rates through a variety of mechanisms, working in partnership with EMAS. Reduce ambulance handover times by adoption of new ambulance service protocols ✓ • Extend coverage of social care data access across the system including the ambulance service and Mental Health Liaison Service • Front door – any further developments?
Hospital Care – Flow and Right Place ▲ ▲ ▲	• Same Day Emergency Care (SDEC) model embedded in Mid Nottinghamshire (early adopter) and evolving in Greater Nottingham • Acute Frailty Services meeting service hours standards with plans to extend these further • Bed utilisation and point prevalence studies are used retrospectively to understand bed utilisation	• Comprehensive standardised model of Same Day Emergency Care (SDEC) embedded in both medical and surgical specialties across the system, including acute frailty services operating >70 hours/week, in reaching to A&E and achieving a frailty assessment within 30 minutes of arrival by a MDT delivering a comprehensive geriatric assessment ✓ • Embed proactive approach to bed utilisation including advanced digital tool to track capacity and flow to provide more timely information to allow dynamic management of capacity (supported by HSLI funding) ✓
Effective Integrated Discharge ▲ ▲ ▲	• Integrated discharge approaches in place at both acute providers including red/green day approach, discharge teams, daily 9am ward rounds • Trusted assessor pilot in Mid Nottinghamshire • Flexible transformational monies targeted at place based schemes e.g. HFID, IHS • Step down capacity not fully utilised	• Continue to build on integrated discharge approach/processes and embed (including output from trust assessor pilot) – establish consistent system wide integration function with interdependencies between organisations/teams clearly defined✓ • Evaluate transformational schemes (ROI and value impact) ✓ • Identified and commissioned capacity for across system for intensive step-down rehabilitation beds and less intensive step-down rehabilitation at home or 'beds with care' ✓

System Sustainability Model elements impacted by Initiatives
▲ System Outcomes ▲ Headline KPIs ▲ Resource Model

Integrated Care System
Nottingham & Nottinghamshire

Service Priority 4

Mental Health

We will renew our commitment to invest in and transform mental health service to improve the quality of our service and the care they provide, and address the inequalities in mental health

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Prevention and the wider factors ▲	• TBC	• TBC
Implementing an approach focussing on the individual ▲ ▲	**SMI Physical Health Checks** • Recovery action plan in place • Working with PCNs - focus on practices with low % • Personalisation programme focused on personality disorders	**SMI Physical Health Checks** • Delivery of physical health checks core part of community health and care model, enabling community mental health services to offer support to those not on SMI registers, that require extra support ✓ • Follow-up delivery of or referral to appropriate NICE recommended interventions and personalised care planning, engagement and psychosocial support.
	IAPT services • Recovery action plan in place • IAPT – LPT pathway in place for pain and cancer • TBC	**IAPT services** • Access to IAPT expanded. Robust Step 2 pathways to increase throughput of patients underpinned by training to support staff retention and development. ✓ • Seamless pathways of referral between Step 4 and IAPT providers to manage clinical risk and ensure patients are not unnecessarily referred back to GPs ✓ • Ongoing focus on long term condition pathways into IAPT services (e.g. diabetes)
Improving access ▲ ▲	**Perinatal Mental Health** • IAPT self referral pathway developed to improve access for antenatal and postnatal women • Current provision of inpatient specialist perinatal mental health care – Mother and Baby Unit • Service currently meeting access standards. • Needs assessment and scoping of extended support offer underway	**Perinatal Mental Health** LINK TO LOCAL CSS • Service based on RCP guidance & NICE recommendations - additional capacity to increase access • Extend duration of care (12 to 24 months post birth) & provide partner assessment sign posting. • Service based on RCP guidance and provided by MDT that offers a range of NICE-recommended psychological therapies in antenatal/postnatal mental health, incl. pre-conception care & counselling. • A model of Maternity Outreach Clinics to provide support to women experiencing mental health difficulties directly arsing from/related to the maternity experience, underpinned by the evidence base and learning from other systems, developed in partnership with Primary Care Networks
	CYP Mental Health • Access: Review of current service model, pilots underway to inform new service model • Eating disorders: Waiting times being met for urgent referrals, near target for routine – service specification scheduled to be refreshed in 2019/20 • Crisis: Current service does not meet standards • 0-25: Transition processes in place between CAMHS and AMH, flexible transition being scoped	**CYP Mental Health** • Access: Increased access to support via NHS funded mental health services and school/college based Mental Health Support Teams – plans and services align to those for CYP with LD/autism/SEND/CYP services/justice ✓ • Eating disorders: Service access and waiting times delivered and maintained • Crisis: Coverage across ICS of 24/7 mental health crisis provision that combines crisis assessment, brief response and intensive home treatment functions ✓ (100% coverage by Yr.5) • 0-25: A comprehensive offer in place that reaches across CYP and adults

System Sustainability Model elements impacted by Initiatives
▲ System Outcomes ▲ Headline KPIs ▲ Resource Model

Integrated Care System
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Service Priority 4

Mental Health

We will renew our commitment to invest in and transform mental health service to improve the quality of our service and the care they provide, and address the inequalities in mental health

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Improving access ▲ ▲ ▲	**Adult SMI Community Care** • CMHTs: Not able to offer timely access based on CCQI standards resulting in long waits and increased pressures across the services. • IPS: Service currently in place however resource levels vary across ICS, plans in development to align provision across the system and meet access standards • EIP: Access targets met, service not fully NICE compliant, new service model required	**Adult Severe Mental Illness (SMI) Community Care** • Stabilise and bolster core CMHT and develop new care model based on local need and national pilots ✓ • Implement new integrated model spanning community provision and dedicated services and increase access & capacity - thresholds removed so people can access care, treatment and support at earliest point of need Access to psychological therapies will be increased for people with psychosis, bipolar disorder and 'personality disorder'. These will be built around Primary Care Networks • IPS: Increased capacity for Individual Placement and Support – all services operate in line with fidelity to the stablished, evidence based model • EIP: New service model to deliver access targets, incl. a move to standalone services and increases in specific treatment pathways and physical health support. Service for 14-65yr olds and those with ARMS
	Mental Health Crisis Care and Liaison • Investment and transformation monies agreed combined with realignment of resources to develop core fidelity standard crisis services across ICS footprint by 2020/21. • Transformation funding also allocated to develop alternatives to Crisis such as Sanctuaries and Crisis Houses – implementation plan and transformation KPIs to be agreed.	**Mental Health Crisis Care and Liaison** • CYP crisis care: 100% coverage (by year 5) across ICS of 24/7 mental health crisis provision that combines crisis assessment, brief response and intensive home treatment functions ✓ • CRHTs: 100% coverage of adequately resourced 24/7 adult CRHHTs operating in line with best practice – likely to include jointly commissioned and/or delivered services with non-NHS partners ✓ • Liaison MH: All general hospitals have mental health liaison services meeting 'core 24' standard ✓ • Crisis alternatives: A range of complementary & alternative crisis services (sanctuaries, crisis houses etc) to A&E and admissions (including in VCSE/LA provided services) within all local mental health crisis pathways ✓ • Ambulance MH response: MH professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-scene response in line with clinical quality indicators. • Care via 111: Connection of urgent mental health services to IUC to access to crisis care 24/7 via NHS 111
	Therapeutic Acute MH Inpatient Care • OAPs: Substantial amount, recovery plan in place • Therapeutic offer: Current LoS 39 days	**Therapeutic Acute MH Inpatient Care** • OAPs: Inappropriate adult acute OAPs eliminated ✓ • Therapeutic offer: Improved therapeutic offer to improve patient outcomes and experience of inpatient care, and reduce average LoS in all adult acute inpatient MH settings (to an average of 32 days or fewer) ✓
	Suicide reduction and bereavement support • Strategy refreshed & action plan developed, bereavement support funding in place	**Suicide reduction and bereavement support** • Local suicide reduction programme in place, delivered in partnership with public health and local authorities. Infrastructure for bereavement support in place.
Provider Collaboratives ▲	• Awaiting input from specialist commissioning	• Awaiting input from specialist commissioning

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Service Priority 5

Value, resilience and sustainability

We will deliver increased value, resilience and sustainability across the system (including estates) through the implementation of ICS Sustainability Model (10 levers)

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Clinical productivity	• Providers driving workforce productivity, supported by workforce tools and evidence based approach • ICS is meeting the agency ceiling target • Outpatient transformation included in 2019/20 contracts as part of aligned incentive contracts (see planned care section) • Different referral models in place across the system • Targeted pathway development e.g. MSK, End of Life • ICS Elective Care workstream in place to review opportunities, supported by ICS Clinical Reference Group and RightCare Delivery Partner	• Continued focus on workforce productivity (aligned with People & Culture enabler) ✓ • Continue with outpatient transformation to avoid a significant number of face-to face outpatient visits (alternative models and reducing inappropriate activity – see planned care section) ✓ • Review current pathway models as national specifications/requirements are issued e.g. MSK first contact • Ensure all patients have the choice of a quick telephone or online consultation with their GP, saving time waiting and travelling ✓ • Ensure we optimise the separation of urgent from planned services to make it easier for hospitals to run efficient surgical services • Review current referral models , supported by referral best practice guidelines ✓ • Improve community minimum dataset for improvement in productivity and planning
Evidence based pathways and interventions	• Clinical Services Strategy – brings together clinicians and managers to develop standardised evidence based pathways (5 pathways in 19/20 – respiratory, CVD (stroke), maternity & neonatal, frailty and CYP) • ICS Medical Director leading an Innovation Exchange with AHSN • Implemented national statutory commissioning guidance from Evidence Based Interventions Programme • For 19/20 system plan developed an ICS Opportunities Pack, pulling together information from RightCare, GIRFT and Model Hospital. This supported the development of 19/20 Transformational Plans • Developing benchmarking packs for PCNs	• Continue to bring together clinicians and managers to develop and implement appropriately standardised evidence based pathways (Clinical Services Strategy - prioritised a further 15 pathways for 20/21) ✓ • Agree system wide actions, following Innovation Exchange with AHSN ✓ • Review implementation of national Evidence Based Interventions Programme and ensure it is consistently embedded across the system ✓ • Continue to streamline benchmarking and opportunities data, with appropriate reports at all levels of the system – to support clinically led transformation and value based decision making ✓
Improvement in value, quality and patient safety	• ICS Medical Director leading a work programme to develop approach/processes across the system to implement continuous quality improvement (CQI) and continuous value improvement (CVI) • Implemented a consistent approach for EQIA at planning footprint level for 19/20 system operational plan	Continue to build on our approach to quality and value improvement: • Implement the national Patient Safety Strategy which outlines how we will continue to improve patient safety, reduce harm and the substantial costs associated with it • Invest in Quality Improvement to ensure our staff have the skills and methodology to simultaneously improve care and reduce costs through clinically led programmes such as RightCare, and GIRFT ✓ • Implement a systematic approach to value improvement using reliable and valid methods of monitoring, analysis, evaluation and improvement of care delivery and system integration and synchronisation ✓

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Service Priority 5

Value, resilience and sustainability

We will deliver increased value, resilience and sustainability across the system (including estates) through the implementation of ICS Sustainability Model (10 levers)

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Medicines value programme	• As in previous years, organisational efficiency programmes include schemes for 19/20. Areas being targeted are medicines optimisation, high cost drugs, prescription processes, reduction of waste and self care	Continue to implement Medicines Value Programme: ✓ • Ensure all providers have implemented electronic prescribing systems (reduce errors) • Reduce the prescribing of low clinical value medicines and items which are readily available over the counter • Proactively manage spend on high cost drugs by utilising biosimilars where possible • Develop a single formulary • Develop incentive schemes at ICP/PCN level
Development of pathology and diagnostic imaging networks	• ICS Opportunities Pack has identified opportunities to deliver savings and efficiencies across pathology and diagnostics (up to £5 million). Agreed that this needs to be taken forward at a total system level and an SRO has been identified to work with the system to develop plans, oversight will be through the ICS Financial Sustainability Group	Support the development of pathology networks (by 2021) and diagnostic imaging networks (by 2023): • Ensure all our pathology services are part of a pathology network, which will mean quicker test turnaround times, improved access to more complex tests at a lower overall cost ✓ • Networks will provide better career opportunities for healthcare scientists and clinicians
Best use of assets and capital investment	• ICS Estates Planning Group established and has developed a system wide work programme • Consolidated baseline data for current estate and identified opportunities for savings • Consolidated existing organisational capital plans	System wide actions agreed: • to improve asset utilisation across acute, primary care and community ✓ • to rationalise non clinical estate, partly delivered through proposed CCG merger • to reduce transactional costs of managing estate , develop business case to support transfer of properties to local system ✓ • to reduce carbon footprint by improved energy efficiency across the system • to develop long-term system capital plan (BAU and transformation) ✓
Reduce administration costs	• CCGs have developed plans to deliver 20% reduction in running costs (supported by proposed CCG merger) • Shared functions in place (within ICS and with external partners) e.g. financial services , xxxx • Aligned incentive contracts in place for 2019/20 • Organisational efficiency programmes include schemes for 19/20	Develop plans to deliver national requirement of delivering savings by 23/24: • Proposed merger of Nottinghamshire CCGs 1 April 2020 ✓ • Consider further options for shared functions across all levels of the system ✓ • Movement to new contract/payment mechanisms (reduced transactional costs) ✓
Maximising buying power of NHS	• As in previous years, organisational efficiency programmes include schemes for 19/20 e.g. xxxx	Continue to maximise the buying power of the NHS: • Use of the Purchase Price Index and Benchmarking Tool (PPIB), GIRFT clinically led procurement work and Support Supply Chain Coordination (SCLL) • Optimise our purchasing power using the national NHS procurement organisation and consolidate the way local and regional procurement teams operate

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LTP must do

Cancer

We will deliver the expected treatment standards for cancer, improve outcomes and reduce inequalities

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Early diagnosis	• Bowel screening non attenders info. imported into e-healthscope to allow practices to contact patients to encourage uptake. • Lung Health checks piloted in Nottingham City (20 practices). M&A piloting National Targeted Lung Health Checks. • CCG cancer profiles to analyse CCG/GP cancer metrics including referral rates. Outlying practices visited to review data/agree educational support. • 2WW referral forms standardised/built into GP systems for auto-population • FIT colorectal test implemented across the ICS, initial results showing increases in cancers detected and earlier stage. • Full suite of direct access diagnostics available to GPs (NICE guidance). • Sherwood Forest and NUH implementing National Timed Diagnostic pathways, when fully implemented will deliver faster diagnostics. • Vague symptoms pathway implemented in Greater Notts. Precursor to Rapid Diagnostic Centre (RDC) - ICS bidding for National targeted funding.	• Work with PCNs to maximise uptake of new Bowel Screening test ✓ • Continue to expand Lung Health checks across Nottingham City and other targeted population within the ICS. Complete national pilot in M&A CCG ✓ • Continue to monitor GP Cancer metrics and work with outlying practices to improve performance. • Continue to refine FIT pathway reviewing thresholds and link to RDC service.. • Implemented fully National Timed Cancer Diagnostic pathways to deliver new faster diagnostic standard. • Vague symptoms pathway expanded across ICS. RDC services implemented in Mid & Greater Notts. • HPV?
Improved treatment	• *Cancer Alliance have been asked to liaise with Spec comm to provide narrative*	
Personalised care	• Electronic health needs assessments/cancer care plans being rolled-out. • Health and Wellbeing events now being delivered on a regular basis. • Roll-out of stratified follow up pathways at NUH underway, started at SFH. • Excellent access to psychological therapies at SFH. Improving at NUH with pilot of Cancer IAPT service. • Specialist Cancer Rehab programme in community. • Pilot for system wide approach to cancer patient nutritional care at NUH. • Piloted Community Care Service in Nottingham City • Remote monitoring pilots using patient portals underway at NUH and SFH using DrDoctor and Infoflex.	• Complete full implementation of e-hna's and cancer care plans for all tumour sites across the ICS • Expand delivery of Health and Wellbeing Events • Full implementation of stratified pathways. • Continued expansion of psychological therapies across ICS. • Full implementation of system wide approach to nutrition care. • Implement Macmillan 'Right by You' Care model across ICS utilising £1.4m investment from the charity. • Fully roll out of remote monitoring using patient portals.

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LTP must do

Planned Care

We will continue to develop and transform planned care services to deliver efficient and effective care to our population

Initiative	Current state	Our focus (to 2023/24) ✓ *Key Priority for 19/20 & 20/21*
Fundamental redesign of outpatients	• System wide project transformation plans in place (both acute providers) to deliver reductions in face to face outpatient appointments through redesign of pathways and care models. This is supported by aligned incentive contracts • The planned reductions in 2019/20 for 34,000 (12%) in Mid Nottinghamshire and for xx,xxx (xx%) in Greater Nottingham • Work programme to establish consistency across the ICS (where appropriate): ➢ ICS Policy for Consultant to Consultant referrals ➢ ICS Service Restricted Policy ➢ ICS Service specifications for Advice & Guidance ➢ Adoption of single clinical pathways e.g. xxxx ➢ Standardisation of Referral Best Practice Guidelines in progress • There is an xx% reduction in GP referrals (excluding 2ww for cancer)	• Continue with year on year reduction of face to face outpatients both first and follow up appointments to meet the LTP target of 30% by 2023 (reducing inappropriate activity and redesign of care models. Prioritised specialties are xxxxxxxx ✓ • Continued use of technology to support transformational change for outpatients by roll out of Patient Knows Best and NHS App across the system. Dr Doctor being piloted at one of the Trusts ✓ • Further adoption of personalised care approaches through Patient Activation Measures (PAMs) • Explore the concept of frequent attenders and referrals without subsequent activity (as undertaken for A&E /urgent care attendance) • Public Facing Digital Services (PFDS)
Short waits for planned care	• System wide group in place to develop activity models (strategic and ops) • Focus on delivery of waiting time targets: ➢ Plans in place to ensure zero 52 week waiters for remainder for 2019/20 ➢ Plans and trajectories in place to reduce 40+ week waiters ➢ Pilot site for patient choice at 26 weeks commences September 2019 (Mid Nottinghamshire – one specialty) ➢ Roll out of capacity alerts in appropriate specialties • Care models developed to support deliver of short waits in planned care, including self-referral model for physiotherapy (Mid Nottinghamshire), ESCAPE pain (or equivalent) • Demand and Capacity Programme (supported by HSLI funding) • Plans in operation to improve theatre capacity	• No 52 week waiters from 2020-2023 ✓ • Continual reduction in patients waiting more than 40 weeks ✓ • 26 wait patient choice of provider rolled out from April 2020 ✓ • Continue to develop care models to support short waits in planned care e.g. full roll out of First Contact Practioners (FCP) by 2023/24 • Continue to implement Demand and Capacity Programme (HSLI funding) • Continue to review and implement plans to improve theatre productivity • Direct listing for surgical procedures (where appropriate) • Continue roll out of shared decision making & health optimisation of patients.
Drive Planned Care transformation across the system	• ICS elective transformation plan in place for 2019/20, with ICS Elective work stream assuring/monitoring delivery of transformation. This is supported by system wide elective dashboard (provider and commissioner) • Benchmarking data used to drive transformation (Right Care, GIRFT, model hospital, NHSE best practice) • Review of procedures against British Association of Day Cases Guidance • Deep dive in elective care drivers of demand across ICS commenced	• Share learning and models across the system to enable delivery of productivity and transformation at pace • Continuous review of benchmarking and available data to identify opportunities (ICS Elective Care Workstream) • Service benefit reviews e.g. Community Ophthalmology Service

Integrated Care System
Nottingham & Nottinghamshire

LTP must do

Maternity and Learning Disability & Autism

We will continue to develop and transform our maternity and Learning Disability & Autism services

Initiative	Current state	Our focus (to 2023/24)
Maternity		
Reduction in stillbirth & mortality	• SBLCBv2 implementation plans developed and underway • ATAIN action plans submitted to NHS R supported by LMS and EMNODN • Mechanisms developing for oversight and position monitoring	• Saving Babies Lives Care Bundle fully implemented and monitored via SCOG • Maternal Medicine Networks established • Specialist pre-term birth clinics developed
Better Births	• 5 Continuity of Carer pilots in place with further launch dates planned • Trusts supporting Mat. & Neo. Safety Collaborative; champions identified • Clinical Services Strategy in development & LMNS PFDS trailblazer • Personalised care plans developed and implementation plan in place • Information on Choice of birth setting developed for digital publication	• Continuity of Carer Teams operating for 51% of women focused on populations with highest need • All patients have access to Maternal Digital Care Records and care plans • Building a workforce fit for the future • Community hubs operational
Postnatal support	• LMNS maternity service providers BFI accredited • Postnatal gap analysis & implementation plan to be completed by Mar. 20 • Increased postnatal continuity for women with high need via CoC roll-out	• Accredited infant feeding programmes in place and standards maintained • Good access to postnatal pelvic health clinics and postnatal physiotherapy in community settings
Improved Neonatal Critical Care	• Neonatal Review- Better Newborn Care completed – awaiting report • Alignment between lo al Clinical Services Strategy and Neonatal Review	• Maternal and neonatal care centres triaging care close to home as possible • Expert neonatal workforce developed & additional NICU cots in place Care Co-coordinators working with families within clinical neonatal networks
Learning Disabilities		NEEDS VALIDATING/ALIGNING WITH LOCAL CSS
Tackling the causes of morbidity and preventable deaths	• Local unmet need, gaps in care, inequalities? • Need to increase no. of people with LD/ASD offered GP annual health check and ensure prescribed medication is appropriate • Notts HC signed up to STOMP Pledge. Steering group set up - looking at ways practice can be streamlined/ improved and information disseminated • Currently have 28 unassigned LeDeR reviews. 24 in progress and 58 completed. Extracting learning from reviews and developing action plans	• Continued promotion of the GP annual health check – supported by digital flags • Primary Care Liaison Nurses continue to work with GPs to verify LD registers, and identify hard to reach citizens – target 14 to 25 yr olds with low attendance • Agree specific annual health check for people with ASD and what specific areas of physical health inequality to be targeted, based on national pilot • Action plan developed by STOMP group LeDeR learning to focus on Self-advocacy, Mental Capacity, End of Life Care,
Understanding the needs of people with LD.ASD	• Specialist promotion and awareness training in place - need to scope areas of workforce that need to be prioritised and gaps that exist • LD improvement standards included within contracts for local LD services within Foundation Trusts - rolled out across providers going forward	• Specialist services continue to promote local training/awareness of LD/ASD informed approaches. TCP workforce workstream to continue to offer training specific to identified issues to NHS and community support providers. • Commissioning standards for health checks for children in residential schools
Timely diagnostic support	• No keyworkers for most complex CYP accessing MH/LD services • New model of specialist wrap around assessment &treatment, as well as inpatient in-reach to support discharges, with 7 day ICATT service and the introduction of a new community LD/ASD community forensic team. • Residential unplanned care service that offers community based residential placements for people in crisis who do not require hospital admission.	• Keyworkers for most complex CYP who are accessing MH/LD services, specialist education services and who are inpatient or at risk of becoming inpatients • Ensure inpatient services are only utilised when required and for the shortest length of time possible . Ongoing review of the use of segregation and restraint in inpatient settings, and continuation of the use of the 12 point discharge plan for all LD/ASD inpatients

Integrated Care System
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Priority enabler

Priority enabler – Primary Care

We will strengthen our Primary Care offer, developing the Primary Care Network model to improve access and deliver a broader range of care closer to home for our population

Initiative	Current state	Our focus (to 2023/24)
Increasing the numbers of Nurses and GPs	• Ahead of trajectory submitted 2019-20 operational plan • Under-doctored areas within the system specifically in City, Mansfield and Ashfield locations are being targeted • IGPR not providing the pipeline expected – mitigated by significant take up of practices as Tier 2 sponsors and system readiness to offer posts to international trainees from our own (and other) VTS schemes – 16 practices approved with other applications in progress • GP Retention strategies in place for First, Mid and Senior years through a coordinated programme (Phoenix) run by the LMC – addresses all aspects of the GP Retention Toolkit • Robust GPN 10 point plan in place • Appointment of additional newly qualified nurses to 13 GPN posts with funded Fundamentals Training in place • Single Training Hub established for Nottinghamshire	• Continue Trainee Transition scheme to support career decisions and therefore retention in the Nottinghamshire system of newly qualified – reducing attrition rates • Targeted support around return to work cohorts eg Maternity/Paternity leave • Alignment of flexible working opportunities to system needs as determined by PCN CDs • Further targeted work with the Locum community • Mitigate any gaps by releasing GP time new ways of working including digital as well as through creation of capacity with introduction of additional roles (Clinical Pharmacists, Physician Associates, First Contact Physiotherapists, and First Contact Community Paramedics) • Further establish Training Hub capacity and capability to meet workforce planning and workforce development requirements of Primary Care • Increase supply of clinical placements in practices – aids recruitment and retention • Make Nottinghamshire an attractive place to work: Explore opportunities of integration of workforce across PCNS and system partners with a focus on the population health needs and delivering improved, proactive models of care
Existing GPFV Commitments	• Range of GP Resilience schemes in place • Clerical and reception staff training offer in place	• Develop GP Resilience programme further including: leadership skills, training, PCN level organisational development, practice manager roving support, group consultations pilot • Move the Phoenix Programme in partnership with the Training Hub into business as usual and supporting wider workforce not just GPs • Roll out on-line consultations, inc. video consultations - in place by October 2020

Primary Care Networks	• All 20 PCNs live since July 2019 , at varying stages of maturity
	• PCN Clinical Directors Network established
	• Partnerships and relationships with other healthcare providers being developed at ICP level
	• Locally developed Nottm/Notts Enhanced Care Homes Framework (ECHF) in place
		• Undertake PCN level maturity assessments and draft development plans by Jan 2020
		• Produce System wide PCN development plan for 2020/21
		• Build on existing initiatives to develop service specifications in line with published guidance (expected April 2020) for:
		  • *anticipatory care*
		  • *personalised care*
		  • *structured medication review*
		  ▪ *early cancer diagnosis support*
		  ▪ *Enhanced Health in Care Homes*
		• Further develop local PCN risk stratification information and PCN dashboards
		• Improve existing data quality and detail on carers and carer support

Improve Community Health Services	• a range of models in use to support Community Crisis Response, including an Intensive Rapid Response Service and an Intensive Support at Home initiative	• Enhanced Health In Care Homes (EHCH) *[see SP2 Proactive Care section]* • Care Co-ordination and MDTs to deliver anticipatory care *[see SP2 Proactive Care section]*

Integrated Care System
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Priority enabler

Priority enabler – People and Culture

We have a 10 year People & Culture Strategy that is structured into five strategic priorities that support all change programme areas at ICS, ICP and PCN levels

Initiative	Current state	Our focus (to 2023/24)
Planning, attracting and recruiting people	• Employers competing for clinical staff from restricted pool of availability leading to internal movement rather than additional capacity • Young people are not attracted into health & care roles • Significant vacancy levels in nursing overall and MH and LD in particular	• Collaborative approaches to planning & recruitment of business critical roles led by HR & OD Collaborative with attractive employment offers & contractual models including portfolio working • Establish system wide Talent Academy to co-ordinate careers activity, apprenticeships, work experience, volunteer expansion, ambassadors, career pathways • Expand clinical placement capacity across all sectors to train locally
Retaining staff and trainees, promoting career paths and talent management	• Movement of staff across borders to neighbouring systems for education & career development opportunities • Loss of experienced clinicians through early retirement/burn out • Low retention of medical graduates & foundation doctors in our local system on completion of training	• Notts ICS as Employer of Choice through flexible employment offers & good employment practices consistently applied& focus on staff health & wellbeing • Retention schemes in nursing & general practice including fellowships, portfolio working, improvement projects. Early engagement with trainees to shape employment offers. • Improve learner experience and access to CPD opportunities, protected learning time
Role redesign and embedding new roles	• Significant gaps in nursing and some medical specialties cannot be met by projected supply • Current plans tend to be based on traditional clinical roles	• Strategic workforce modelling to enable planning based on functions & skills rather than professional roles • Roll out of Nursing Associates, Physician Associates, Medical Team Administrators, Social Prescribers, Clinical Pharmacists, Community Paramedics
Developing and preparing people to work in new ways, including digital skills	• Teams are not always designed around patient need or in the right place to deliver person centred care & support • We are not optimising use of new technology by our staff or our service users and people do not have the confidence or skills required • Analytics skills & capacity are not in place to deliver system working/population health requirements	• Equip our teams to work in partnership with service users to deliver personalised care & support and focus on promoting independence & good lifestyle choices (holistic working) • Integrated teams supported to work safely & effectively across care settings • Develop a Nottinghamshire Institute of Data Analytics across academia, health and local government, to boost the capacity of analytical workforce
Enabling cultural change and leadership development to maximise system effectiveness	• Fragmented leadership & management development programmes at organisational level restricts opportunities for relationship building between settings & is not cost effective • New ways of working and integrated teams will require cultural change & embedding into HR and management systems	• Collaborative leadership development offer where this will add value • Talent mapping at system level to support career development across organisational boundaries • Authentic engagement with multi professional leaders to build sustainable relationships to support leadership of change • Facilitation of OD support for change programmes at all levels of the system

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Priority enabler

Priority enabler – People and Culture

Our five People and Culture priorities will combine to tackle the challenges we face in key workforce groups

Workforce Group	Key plans to address	
Registered Nursing workforce	• Nursing associate role & training programme • Legacy mentor • International recruitment	• Established learning and development partnership • New partnership with Nottingham Trent University • New approaches to recruitment
Medical Staff	• Medical Workforce Group established to develop bespoke solutions with HEE • Piloting Medical Team Administrator roles to release capacity • UEC – Development of Advanced Clinical Practice skills and upskilling	• Exploring Physician Associate roles • R&R financially based incentives • Joint appointments • Grow own consultants through CESR route • Clinical Fellowship schemes
General Practitioners	• GP retention schemes • Targeted enhanced recruitment incentives	• General Practice Nursing 10 Point Plan • Training Hub
Mental Health workforce expansion in line with new care models and investment	• CYP - Revised service models and reviewing new roles • Perinatal - Revised service models and reviewing new roles • IAPT – Development of PWP roles and introduction of band 5-6 accelerated programme	• Crisis – Revised service models and reviewing new roles incl. trainee nurse associates/PSWs • EIP - Revised service models and reviewing new roles incl. trainee nurse associates/PSWs
Maternity	• Workforce modelling approach to test a range of scenarios	• Developing proposal to take co-ordinated approach to Maternity Support Worker based on success of Trainee Nursing Associate project
Healthcare Scientists	• Scientists Training Programme (STP) • Practitioner Training Programme	• Opportunities to strengthen Clinical Academic Careers for HCS • Successful overseas recruitment in Nuclear Medicine and Radiotherapy Physics
Social Care / Residential Care	• Focus on changing existing relationships and expectations of partners and the public by focusing on outcomes that promote independence, fairness and value for money	• Development of Ambassador Network and co-ordination across health and social care • Roll out of Holistic Worker competences
Independent Sector	• Working with Optimum Workforce Leadership to support investment in workforce development • Support development of Advanced Clinical Practice in the sector	• Engagement of sector in Holistic Worker Competence Programme • Inclusion in Notts Talent Academy Initiative

NEED TO REFLECT AHPs EG PHYSIOS AND NEED FOR ADDITIONAL CAPACITY E.G FIRST CONTACT PHYSIOS- WIDER OPPORTUNITIES E.G LEISURE CENTRES

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Priority enabler

Priority enabler – Data, Analytics, Information and Technology (DAIT)

We have just begun the process of developing our strategy in this area in the context of becoming a fully mature ICS, as this work evolves it will continue to shape our plans in this area

Initiative	Current state	Our focus (to 2023/24)
Develop provider digitisation to a fully digital state by 2024	• Aging legacy patient information systems operated in organisational silos - not a suitable basis for transforming care or sharing data • IT infrastructure is aging and cannot support the fast login times that clinicians and care professionals need • IT infrastructure and policies built around protecting organisations from external threats, but this makes the mobility of care staff difficult to support and makes data sharing difficult	• Replace all core Patient Administration / EPR systems across acute, community and mental health providers with modern systems that support real time patient flow and transfers of care and the interoperability and data needed - Digital First philosophy • Implement a system wide electronic prescribing and administration system • Upgrade all end user devices and supporting infrastructure such as networks with those that can support 10 second login times • Build the IT infrastructure so that clinicians and care professionals can work with full capability in any of the buildings we deliver care from, including patients' homes, citizens' homes, care homes and the homes of staff
Develop single summary health and care record that draws from systems operated by health & care providers	• In addition to the Medical Interoperability Gateway, have 2 locally configured portals or shared records with different data scope, one is a bespoke development, the other a commercial package with contracted end date of 2022-2023 • Have good local experience of integrating data together for GPs and other staff for direct patient care.	• Work towards a single summary health and care record to support direct care and associated workflow for clinicians and the care giving staff • Develop a data repository and analytical toolset based on the above for direct care and for secondary uses such as research and planning, to support PCNs, ICPs, providers, local authorities and the strategic commissioner / ICS • Widened direct and secondary use of data for patient benefit

Develop Public Facing Digital Services so that those citizens that want to interact with our services digitally can do so	• Have limited experience in offering an electronic interaction for patients and the public
	• Have a wide range of different assistive technology solutions in place in citizens' homes
	• Starting to develop a Nottinghamshire Health and Care App with a commercial company
		• Develop the Health and Care App so that it can support:
		  • Video consultations between care providing staff and patients / citizens
		  • Collection of patient-reported outcomes and the maintenance of a personal health and care record by service users and the public
		  • Integration with home based and wearable devices
		  • Greater sharing of data between citizens and their care providers

Develop analytical services to support population health management	• Larger organisations have well developed data warehouses and analytical teams; smaller organisations do not
	• Data distributed across organisations & not all in one place
	• Initial skills assessment shows that we do not have enough people with data science skills
		• Develop an integrated data environment in which all health and care data is brought together with data about the wider determinants of health
		  • Enhancing the size of teams with specialist public health skills
		  • Develop our analytical staff so that many of them become data scientists
		  • Develop Nottinghamshire Institute of Data Analytics across academia, health and local government, to boost the capacity of analytical workforce

Establish new culture and governance arrangements for agreeing &overseeing new investments	• Sometimes a weak connect between business drivers and IT projects, but Connected Nottinghamshire has delivered several beneficial collaborative IT solutions over last 6 years • No real collaborative work around shared analytical products	• All new technology is deployed correctly with required cultural and behaviour change, and clear integration into the business processes • All parties represented on governance board that approves all new digital initiatives and provides technical support for analytical initiatives • Agreed strategy and 5 year rolling programme of investment

Integrated Care System
Nottingham & Nottinghamshire

Priority enabler

Priority enabler – Data, Analytics, Information and Technology (DAIT)

The application of digital technology will continue to play a key role over the next 5 years as we continue to transform our system – we have a number of initiatives planned and further opportunities identified

	Prev.	Proact.	UEC	MH	Eff.	Cancer	Planned	Mat	LD	Primary C
In place										
• GPRCC/e-healthscope	✓	✓	✓	✓		✓	✓	✓	✓	
• F12/Ardens (pathway guidance & referral/consultation templates)	✓		✓	✓			✓			
• Care home bed capacity			✓				✓			
• MIG							✓			
• NHS App deployed across GP practices (direct booking)										
In Flight / Planned										
• Remote monitoring via patient app	✓									
• Social and information prescribing via patient app	✓									
• Dos and 111 integrated into patient app	✓									
• Digital inclusion programme to support upskilling of population	✓									
• Single personal centred digital care and support plan	✓	✓	✓	✓						
• Remote monitoring via targeted information prescriptions		✓								
• Digital 'information prescribing' functionality		✓					✓			
• Self care monitoring and notification via patient app		✓		✓			✓			
• Digital ReSPECT		✓								
• Skype in care homes		✓								
• Local Health and Care Record		✓	✓	✓			✓	✓		
• S1 migrations		✓	✓	✓				✓		
• NHS App / 111 online			✓							
• 111 direct booking into GP practices			✓							
• Capacity and Flow			✓							
• NUH/NCC Integration project			✓	✓						
• Virtual appointment s via video messaging / on line consultations			✓	✓			✓	✓		
• NHS App as single front door										
Opportunities										
• Push out targeted messaged via patient facing app	✓									
• Increase use/consistency of e-healthscope uptake	✓	✓	✓	✓						
• Scale up content /availability of information prescribed digitally	✓			✓				✓		
• Remote monitoring via patient app / peer to peer support	✓							✓		
• Assistive technology linked to patient app	✓						✓			
• Access to digital market place for Personal Health Budgets	✓									
• Digital management of Personal Health Budgets	✓									
• GP IT futures			✓							
• IDCR			✓						✓	
• Improved DoS			✓							
• SFH/NUC/Nottingham City integration			✓							

Integrated Care System
Nottingham & Nottinghamshire

Priority enabler

Priority enabler – System financial management and payment models

We will continue to develop system financial management and payment models to support clinically led service transformation

Initiative	Current state	Our focus (to 2023/24)
Develop system reporting to support value based decision making	• System wide financial governance meetings in place (ICS Finance Directors Group and ICS Financial Sustainability Group) • System wide reporting for income and expenditure in place, this includes ICS and ICP dashboards • Established monthly triangulation process in place • 2019/20 reports expanded to include activity and capital • Metrics identified as part of ICS Outcomes Framework	• Continue to develop system wide reporting, include cash and workforce alignment. Develop reports for all levels of the system i.e. PCN • Continue to develop financial reporting to support ICS Outcomes Framework • Building on costing work (see below), develop reporting on cost drivers and variances across the system • Provide financial information to support the system approach to delivering best value and continuous value improvement
Develop payment mechanisms and risk management to align incentives across the system	• System wide workshops held with all partners to review payment mechanisms and best practice/learning (local and national). Workshops supported by National Pricing Team (NHSE/I) • Through vanguard programme trialled outcomes contract and consolidated local learning. This ceased when CQUIN was fully directed to national requirements. • Local contract arrangements for 2019/20 have moved away from PbR -aligned incentive contracts in place with both acutes	Continue to develop contracting and payment approaches through system wide workshops (with support from national team), with a focus on: • Incentivising the overall ICS Strategy e.g. recognise integration and shift of services • Options for management of financial risk across the system • Tariff developments and how these impact on local arrangements • Open and transparent mechanisms to understand how cost pressures are managed across the system
Develop a granular understanding of the cost of delivery health and social care services	• Costing used to support decision making primarily at an at organisation level • Nationally acclaimed PLICS programme at NUH • Improving PLICS in mental health and community (local and national) • System PLICS pilot underway – Diabetes • Transformational savings plans (QIPP) primarily calculated at PbR and translated into cost	Continue to build on development of system costing data: • Inclusion of social care and public health • Develop system cost pathway models • Costing approach to support population health management (PHM) approach – e.g. understanding of costs provision of care within agreed population segments • Ability to understand cost at all levels of the system (PCN, ICP, ICS) • Transformational plans based on system cost impact
Develop a financial recovery approach (medium term)	• Short term actions focused on annual QIPP and CIP programmes • Non recurrent mitigations, leading to underlying recurrent deficit • Primarily organisationally focused, starting to have system wide discussions	• Development of five-year plan, supported by financial sustainability model • Savings plans to be developed on a cost basis at the outset, recognising impact across finance, activity and workforce • Build on model to link to outcomes and value impact
Capital and cash regime to support better capital investment	• Developing reporting on capital in 2019/20 • System wide governance in place for Estates Planning • Review of Estates Strategy through NHSI/E checkpoint process	• Reporting developed (as above) • Five year capital plan developed (prioritised with clear BAU and transformation areas) • Utilisation of estates a key lever in financial sustainability model.

Integrated Care System
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Priority enabler

Priority enabler – System leadership governance and oversight

We will build on being an early adopter ICS to become a mature population health focused care system – where all partners focus on the entire spectrum of interventions, from prevention through to treatment

Initiative	Current state	Our focus (to 2023/24)
Integrated Care System	• Collective system responsibility executed through ICS Board, chaired by an Independent Chair and meeting in public. The Board provides system leadership and oversight to system strategy, system reform and operational delivery in accordance with a Memorandum of Understanding with NHSE/I • Self assessment against ICS Maturity Matrix identified ICS as 'maturing ' in 4 areas and 'developing' in one.	• ICS governance will continue to develop in accordance with a dynamic and evolving system. By end of 2019 proportionate review of ICS governance will have been completed. • System (ICS), Places (ICPs) and Neighbourhoods (PCNs) continue to develop/operate in line with population needs and ICS strategy. Review of ICPs' development/impact undertaken in 20/21 • ICS ambition is to achieve a high performing 'thriving' system across all domains of national Maturity Matrix by April 2021 and for the benefits of a comprehensive approach to population health management and integrated care to translate into quantifiable improvements in outcomes, quality, cost of care together with staff satisfaction.
Strategic Commissioner	• Alignment and consolidation of health commissioning is being progressed through establishment of Nottingham and Nottinghamshire Strategic Commissioner following merger of six CCGs by April 2020. • Collaborative commissioning arrangements are in place with the Local Authorities, through the Better Care Fund (BCF).	• Over next two-years commissioning will increasingly be based on the outcomes the system aspires to achieve at the population level, as well as operational and performance metrics that reflect system efficiency. Work will progress on the development of long term contracts with our ICPs, tied to the delivery of outcomes as well as performance. • The Strategic Commissioner will play a pivotal system leadership role in supporting ICPs and PCNs in improving outcomes and addressing unwarranted clinical variation/health inequalities. • Work will be progressed to confirm any next steps in further integrating health and social care commissioning in support of improved population health and wellbeing.
Provider Partnerships	• Governance structures are developing at Place (ICP) and Neighbourhood (PCN) levels • Governance group, of each ICP, comprises health, LA, district councils and wider representation e.g. community and voluntary sector membership. • The ICPs and PCNs at varying stages of development but each ICP has a Chief Executive Lead and each PCN has a confirmed Clinical Director. Commissioning and provider staff are being aligned to these structures	• Over next two-years, work will continue within, and where sensible across, each ICP on development of a dedicated system leadership team. This team will increasingly have day-to-day responsibility for implementation, incl. providing tools/practical support to PCNs as needed. • Over time, the ambition for primary, community, acute and potentially social care providers to collectively take on risk for outcomes, quality and cost of care for local populations; with clarity of responsibilities and risk matched to individual providers along pathways of care . • During 2019/20 ICPs and PCNs are accessing a range of development and support offers centred on collective system leadership, the development of effective relationships, population health management etc. This will continue over the coming years.
System Transformation / Programme Delivery	• System wide have been in place for some time. These continue to evolve , aligning to the new ICPs and PCNs. • The system has self assessed as being 'developing' in 'Capacity and system transformation change capability.' • System benefits from an OD collaborative and has developed a local Quality and Service Improvement Redesign (QSIR) college.	• Continue to benefit from system transformation support offers e.g. from NHSE/I and other organisations such as Sir Muir Gray's Centre for Triple Value Health Care and learning arising from a local case study which has been supported by Nottingham Trent University. • Develop subject specific strategies (e.g. ICS strategy for 'Data, Analytics, Digital and IMT') to confirm capability and capacity gaps together with plans to address, which could include, for example, establishment of a local Institute for Health and Care Analytics. • Consider strategic approach to 'building' and 'buying' the skills and resources for delivery of the transformation programme if a systematic approach to value improvement is to be achieved.

(4) Impact and implications

Activity

The system has developed a five-year demand model to support the five-year plan development. The model presents a "do nothing" and "do something" plan.

System wide five-year demand model developed to support the develop of the five-year plan.

Key elements included in demand model:

- **Forward projections were based on three year rolling averages**, adjusted for non-recurrent impacts and known changes.
- **2018/19 Outturn**
- Assessment of **coding / counting pathway changes** (to prevent any unintentional skewing of trends)
- **Growth assumptions** at a local delivery level (place) derived from a review of historical activity trends, demographic growth and include adjustments for age and disease prevalence
- Review of **planning policy changes** and assessment of required activity levels to deliver the planning requirements
- **Impact of 10 high level levers** (sustainability model)

The output of the model was then reviewed as followings:

- Management review (CCG/ICS)
- System wide workshop to confirm and challenge
- Review and sign off at ICS Planning Group

Recognising that activity/demand pressures are a key driver to the financial and operational pressures facing the system, the model has been developed to clearly articulate the "do nothing" and " do something" plan

	Do Nothing Activity Projections 20-24			Do Something Activity Projections 20-24		
POD	Total ICS	Mid Notts	Greater Nottm	Total ICS	Mid Notts	Greater Nottm
GP Referrals	3.1%	3.0%	3.1%			
Other Referrals	3.0%	3.0%	3.0%			
Total Referrals	3.1%	3.0%	3.1%			
First Outpatients	3.1%	3.0%	3.1%			
Follow-up Outpatients	3.1%	3.0%	3.1%			
Total Outpatients	3.1%	3.0%	3.1%			
Day Cases	3.7%	3.1%	3.5%			
Elective Inpatients	2.9%	1.4%	3.1%			
Total Elective Spells	3.6%	2.9%	3.2%			
0 LoS Non-Elective	5.2%	5.1%	5.3%			
1+ LoS Non-Elective	3.5%	4.5%	4.2%			
Total Non-Elective Spells	4.1%	4.7%	4.6%			
A&E Attendances Type 1	3.0%	5.1%	4.7%			
A&E Attendances Other	2.7%	4.9%	2.6%			
Total A&E	3.1%	5.0%	3.9%			

TBC

Workforce

tbc

TO BE COMPLETED

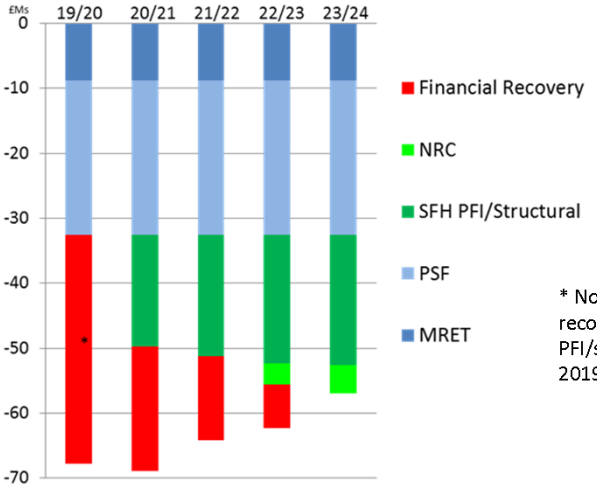
Finance

The financial sustainability model provides a framework for the system level change required to address our challenges within available resources (workforce, estate and funding)

Delivery of Financial Balance (In year trajectory / control totals)

The NHS financial framework is changing with further detail expected for 2020/21. The strategic financial plan and in-year deficits have been developed with all ICS partners. The table and chart below outline the in year deficit positions BEFORE marginal rate emergency threshold (MRET), provider sustainability funding (PSF) and financial recovery funding (FRF).

	2019/20 £000s	2020/21 £000s	2021/22 £000s	2022/23 £000s	2023/24 £000s
Financial Plan before MRET,PSF and FRF	-67,708	-68,933	-64,141	-62,305	-56,980



* Note: Financial recovery includes SFH PFI/structural deficit for 2019/20

Basis of assumptions:

- **MRET –** assumed that this will be received each year on a flat cash basis (in line with technical guidance
- Support is given in some form for **PSF** funding previously received by Sherwood Forest Hospitals and Nottingham University Hospitals (either through tariff or similar PSF approach)
- Support is given in some form for **expenditure that is not funded through CCG core allocations or the tariff** : Sherwood Forest Hospitals PFI/structural deficit and revenue implications of NRC (national initiative)
- The **remaining financial recovery element improves over the 4 years to nil.**

Delivery of Savings and Efficiency Requirement

The system has calculated the annual savings and efficiency requirements to deliver this in year financial trajectory. This is based on the following:

- Do nothing financial gap
- 2019/20 underlying recurrent deficit (current operational plan)
- Assessment of impact on underlying deficit of delivery against the 2019/20 savings and efficiency programme
- Other areas that are expected to impact e.g. NRC national initiative

LTP Estimated Annual Efficiency Requirement £'M	2019/20	2020/21	2021/22	2022/23	2023/24
	-140.3	-65.8	-56.3	-59.0	-67.6
	5.2%	2.4%	1.9%	2.0%	2.2%

Savings and efficiency requirements will be delivered through the **Financial Sustainability Model** (see page 20), supported by strategic delivery plans.

FINANCIAL SUSTAINBILITY MODEL - 10 HIGH LEVEL LEVERS	
1	Keep people safe and well in their own home and communities and **reduce the need for emergency attendances at hospital** (type 1 A&E attendances and non-elective admissions)
2	**Reduce inappropriate attendances at A&E departments** through public education and providing alternatives (Minor A&E attendances)
3	Reduce pressures on acute services by ensuring these **beds are only used for clinically appropriate patients through optimal length of stay and integrated discharge** (NEL OBDs)
4	Deliver care closer to home for **Mental Health Out of Area Placements (OAPs)**
5	Deliver increased value across the system – **Optimise Medicine Spend**
6	Deliver increased value across the system – **Reduction in outpatient appointments** through reprovision in alternative ways and reductions in inappropriate appointments
7	Deliver increased value across the system – **Business as usual efficiencies (BAU)** providers and commissioners
8	Deliver increased value across the system – **Estates and back office**
9	Estimated full year recurrent delivery of **2019/20 transformational plans (QIPP/CIP)**
10	Service benefit reviews – Including review of the **core offer**

Strategic Delivery Plans

Delivery plans for ICS priorities, LTP Must Do and enablers: key milestones and risks

TO BE UPDATED

Transformational Funding

The local system will receive additional transformational funding over the next five years to continue to develop services for our local population

Transformational Funding (Fair Shares):

Through the implementation of the ICS strategic priorities, LTP Must Dos and enables, the system will transform the way services are delivered to better meet the needs of the population. The funding allocated to systems, through the LTP planning process, will be targeted as follows:

			19/20 £Ms	20/21 £Ms	21/22 £Ms	22/23 £Ms	23/24 £Ms
Mental Health		The expansion of community mental health services for Children and Young People aged 0-25; funding for new models of integrated primary and community care for people with SMI from 2021/22 onwards; and specific elements of developments of the mental health crisis pathways.	1.2	1.2	4.1	8.2	11.0
Primary Care		This funding includes the continuation of funding already available non-recurrently to support Extended Access and GP Forward View funding streams, (eg practice resilience programme), and associated commitments must be met. Additional funding is also included to support the development of Primary Care Networks.	3.7	3.9	4.3	4.5	4.4
Ageing Well		Deployment of home-based and bed-based elements of the Urgent Community Response model, Community Teams, and Enhanced Health in Care Homes.	0.0	0.6	1.3	3.8	6.3
Cancer		Rapid Diagnostic Centres funding in 2019/20 only; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.	2.2	1.7	1.3	1.3	1.3
Other	**CVD, Stroke and Respiratory**	Increased prescribing of statins, warfarin and antihypertensive drugs; Increased rates of cardiac, stroke and pulmonary rehabilitation services; increased thrombolysis rates; and early detection of heart failure and valve disease.	0.8	0.8	1.7	2.5	7.6
	CYP & Maternity	Local Maternity Systems funding; Saving Babies Lives Care Bundle funding from 2021/22; postnatal physio funding from 2023/24; funding for integrated CYP services from 2023/24.					
	LD Autism	Funding for rollout of community services for adults and children and keyworkers from 2023/24.					
	Prevention	Tobacco addiction - inpatient, outpatient/day case and Smoke Free pregnancy smoking cessation interventions.					
		Total	7.8	8.2	12.7	20.2	30.6

Transformational Funding (Targeted):

In addition to the service changes implemented as part of the fair shares transformational funding, the system is working with NHS England and Improvement to pilot and implement changes at pace.

During the five year plan the system will implement:

- Alcohol Teams pilot in xxx (£xx million)
- Lung Cancer Screening in Mansfield (£xx million)
- Xxxxxxx
- Xxxxxxx
- Xxxxxxxx

In addition to the agreed transformational schemes above, the system is discussing further opportunities in the following areas:

- Xxxxxxxxxx
- Xxxxxxxxxx
- xxxxxxxxxx

Capital

tbc

TO BE COMPLETED

Key risks

tbc

TO BE COMPLETED

(5) Our local engagement

Our Local Engagement Approach

We have engaged extensively and widely, in partnership with Healthwatch, to ensure that our local system strategy is both guided by the priorities of our populations and endorsed by key stakeholders.

Background

To support the implementation of the Long Term Plan, each local area was asked to undertake engagement with their populations to understand what matters to local people in their health services and to inform the development of a local system plan.

Healthwatch England, the organisation that supports local Healthwatch organisations, worked closely with the NHS to coordinate a programme of national engagement. We have worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to undertake an extensive programme of engagement with local people.

We have spoken to over 1,000 people across Nottingham and Nottinghamshire in our engagement about topics such as mental health, urgent care, health prevention and more. These conversations with local people have given us a wealth of insight that will help us improve local services and deliver the national NHS Long Term Plan in a way that reflects what matters to people.

Our Approach

The Nottingham and Nottinghamshire ICS has worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to deliver an extensive programme of public engagement on the NHS Long Term Plan.

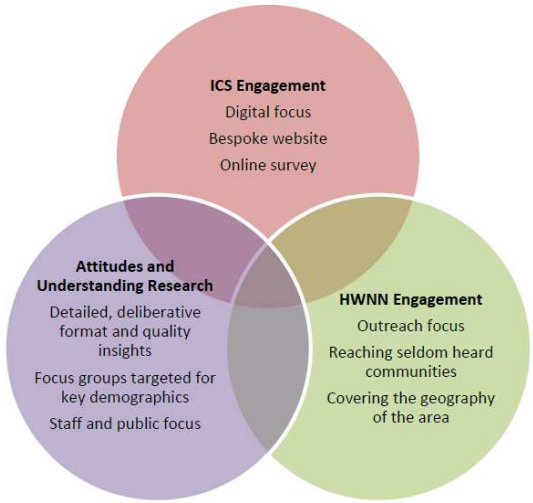
Our approach includes:

a) Public engagement by the ICS communications and engagement team, through digital and face-to-face channels

b) Public engagement by HWNN through face-to-face channels

c) Understanding and Attitudes Research by social research agency Britain Thinks, delivered through a series of focus groups with staff and members of the public.

The elements above form the key parts of our engagement approach. While each element includes a different focus, the programme is underpinned by core themes and questions. This model is summarised below.



The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.

Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:

a) Understanding how important each priority is to people;

b) Understanding what matters most to people within each priority

c) Discussing the priorities in terms of hypothetical 'trade-offs' e.g. investment in prevention versus investment in treatment, to generate debate.

Our Local Engagement Approach

We have engaged extensively and widely, in partnership with Healthwatch, to ensure that our local system strategy is both guided by the priorities of our populations and endorsed by key stakeholders.

We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.

Headline Summary of Findings

There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.

1. Public views about priorities and pressures within the system are strongly influenced by the national media narrative on the NHS or on personal experience of services

2. People most value having a free at the point of need healthcare model, frontline staff and the accessibility of services within the NHS

3. There is widespread support for urgent and emergency care and mental health, which are among the system's top priorities

4. While there is public support for a focus on finance and efficiency, this is not as significant as support for other areas

5. People are broadly supportive of a focus on preventative activity, with some reservations

6. There are mixed and ambiguous views about personalisation, choice and control

7. There is only lukewarm support for digital innovation in healthcare and a lack of understanding of the value of digital technology to improve access

8. The public are mostly uninterested in hearing about system change

9. Staff are concerned about diminishing resources and increasing demand

Conclusion

The above summary of the extensive engagement undertaken to date should give confidence that the plans being developed in Nottingham and Nottinghamshire are in line with the priorities of our local population and will help to support the implementation of the local system strategy over the coming period. The partnership working with HWNN, drawing on their reach, independence and expertise in engagement has enormously strengthened the quality of the outputs and lays strong foundations for the future.

Next Steps

The insights outlined above have been widely shared across the system including at the system's public Board meeting, at its stakeholder group (Partnership Forum), at the Strategic Commissioner's Public Engagement Committees and at the various committees of the Local Authorities in the area. They have also been shared and used at the various strategy development workshops used to develop the strategy as outlined in our main submission. There is a commitment to continue to use these insights for future system transformation and commissioning activities and to support the launch and promotion of the system's strategy to its external audiences.

Further Information

A fuller version of this summary of the Engagement approach can be found in the Appendices and further information including;

- The full questionnaire and diversity screening
- The detailed data tables and further analysis
- The full report from Britain Thinks
- The complete engagement log and record of meetings

can all be found online at: https://healthandcarenotts.co.uk/get-involved/surveys-and-consultations/