Nottingham & Nottinghamshire ICS
Children & Young People's Transformation Programme

Nottingham City Children's Partnership Board

29 March 2022

The Children and Young People's National Transformation Programme

The Children and Young People's National Transformation Programme was established to oversee the delivery of the children and young people's commitments in the Long Term Plan. National and regional programme boards have been created.

Their vision is that every child and young person in England will have equitable access to high quality health and care services which are tailored to their needs and available when they need them. These services will be joined up across health and social care settings to ensure the best outcomes are achieved, enabling every child and young person to achieve their goals and life potential.

Integrate

- We will **integrate services for children and young** people by working with local health system to develop and test integrated models of care. We will then scale proven models of care across the country.
  We will work across health and social care to ensure we are keeping children well and proactively support them to live as healthily as possible.

Improve

- We will **improve quality of care** for CYP with long term conditions like asthma, epilepsy, diabetes and obesity.
- Develop a system to detect the deteriorating child

Include

- We will **include children and young people in national policy and programme** development to ensure that services are designed to meet the needs of CYP.
- Youth Champions and the Stakeholder Council will be central to testing policy development and delivery plans with CYP.

N&N ICS report to the Midlands CYP Transformation Programme Board

- MOU agreed to deliver outcomes as an ICS
- Limited funding - £85K promised for infrastructure to 2024.Reduced to £81K this year with expectation to use across development areas
- Regular updates required on progress

Background – A Case for Change

Obesity

- In 2016, 23% of 4-5 year olds and 34% of 10-11 year olds were overweight or obese and 4% of 10-11 year olds had severe obesity
- **2.5 million children in England are overweight or obese – with 1.22 million significantly obese** and eligible for treatment according to NICE guidance

Asthma

- The UK has one of the **highest prevalence, emergency admission and death rates for childhood asthma** in Europe, despite a slight fall in unplanned admission rates for asthma from 256 to 185 per 100,000 population between 2006/7 and 2016/17 in England

Hospital / ED admissions

- In England, children and young people make up **26% of all emergency department attendances** and are the most likely age-group to attend emergency inappropriately. We know around 30-50% of ED attendances **could be managed in integrated care services** linking primary and community care with paediatric expertise.

Epilepsy

- Epilepsy is the **most common significant neurological disorder** in children under the age of 19: more than one in 220 have epilepsy (approximately 63,400).
- The total costs of admissions attributable to paediatric epilepsy in 2016-17 was £18.4m.

Diabetes

- **31,500 children and young people under the age of 19 have diabetes** in the UK, with 95% having Type 1 diabetes.
- **Rise in obesity may result in more Type 2 diabetes** in the long term

Infant mortality

- **60% of child deaths occur during the first year of life**, and 70% of those are in the neonatal period (within the first month of life). **Without action, UK infant mortality rates could be 140% higher** than other comparable countries by 2030

Background – A Case for Change

Obesity *

Nationally
9.9% children 4-5 years were obese.
1 in 5 children 10-11 years were obese
Nottingham City
12 % children 4-5 years were obese
1 in 4 children 10-11 years were obese
Nottinghamshire County
9 % children 4-5 years were obese
1 in 5 children 10-11 years were obese

Asthma *

Nationally
158.3 emergency admissions for asthma per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 99.8% of other areas in England with a rate of 96 emergency admissions for asthma per 100000 children 0-19 (number =85)

Hospital / ED admissions “

Nationally
655 ED attendances per 100000 children under 4 years
Nottingham City
717 ED attendances per 100000 children under 4 years (number =14900)
Nottinghamshire County
553.2 ED attendances per 100000 children under 4 years (number =24830)

Epilepsy *

Nationally
77.2 emergency admissions for epilepsy per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 55.5 emergency admissions for epilepsy per 100000 children 0-19 (number =130)

Diabetes*

Nationally
51.1 admissions for diabetes per 100000 children aged 0-19

Nottingham and Nottinghamshire
better than 95% of other areas in England with a rate of 38.4 admissions for diabetes per 100000 children 0-19 (number =90)

Infant Mortality **

Nationally
3.9 deaths per 1000 live births for babies under 1 year
Nottingham City
5.6 deaths per 1000 live births for babies under 1 year (number =22)
Nottinghamshire County
3.8 deaths per 1000 live births for babies under 1 year (number = 31)

** 2019-20 ** 2017-19*

Asthma Care Bundle – ICS deliverables

- **Organisation of care:**
  - System asthma lead
  - System paediatric asthma network
  - Develop and maintain clear pathways, ensuring responsibilities between primary, secondary and tertiary care
- **Environmental Impacts:**
  - Air quality
  - Asthma Friendly schools
  - Housing quality
  - Parental smoking
- **Early and Accurate Diagnosis:**
  - Primary care diagnostic hubs
  - Health education strategies

- **Effective Preventative Medicines:**
  - Prescribing standards
  - Personalised asthma care plans
  - Reviews
  - Self-management
- **Management of Exacerbations:**
  - Emergency and urgent care assessment, treatment and referral standards
  - Discharge planning standards
- **Severe Asthma:**
  - Access to severe asthma service
  - Severe Asthma National Network
- **Data and Digital:**
  - CYP asthma dashboard
- **Capabilities, Training and Education Needs:**
  - CYP Asthma Core Capabilities Framework

ICS CYP Clinical & Community Services Strategy
(December 2019)

- **Priorities for change:**
  - **Prevention – a healthy start in life:** *Obesity | School readiness | Vaccinations | Early learning | Whole family approaches*
  - **Improving the health of the whole child:** *Transitions*
  - **Out of hospital services for children:** *Minor physical ailments | Emotional and behavioural diagnosis and support services | Severe disability and complex needs*

- **Transformation proposals:**
  - **Prevention – a family approach to wellbeing and healthy start in life is adopted across the ICS:**
    - *Joined up early help assessment and support | Open access Children's Centres | Emotional wellbeing, resilience and behaviour change | Systemwide awareness of ACEs and trauma informed care | Vaccination uptake | Oral health | Teenage pregnancy | Sex and Relationships Education in schools*
  - **Improving the health of the whole child (1) – an integrated model of care will be adopted to meet the mental health and emotional wellbeing of children and families across the ICS**
    - *Early support for mental distress | Suitably resourced and responsive emotional and mental health support | Mental health crisis services available 7/7 | Resilience charter*
  - **Improving the health of the whole child (2) – developmentally appropriate healthcare in both paediatric and adult services will be provided across the ICS**
    - *Tapered transition experience to the age of 25 years based on development needs | Transition from paediatrics to primary care / Seamless pathways between children's and adult services*
  - **Out of hospital services for children (1): Our young people are at the centre of well planned, integrated and supported transition**
    - *Stratified approach and service provision to support urgent/crisis care in order to avoid unnecessary attendance or admission| Crisis services available 7/7 / Prevention of escalation and crisis presentations in acute providers / Call for care or first response type services*
  - **Out of hospital services for children (2): Disabled children and young people receive child-centred multiagency coordinated services**
    - *Sufficiency of skilled care workers to enable hospital discharge | Whole population, whole system pathways for people with Long Term Conditions and/or complex care | Investment and support for carers*

Linked system strategic, improvement and transformation programmes

- **Safeguarding Children Partnerships (Nottingham City and Nottinghamshire)**

- **Place and local authority CYP programmes:**
  - Place Based Partnerships (PBPs) CYP priorities (Nottingham City / Mid Nottinghamshire / South Nottinghamshire
  - Special Educational Needs & Disabilities (Nottingham City and Nottinghamshire)
  - Looked After Children (Nottingham City and Nottinghamshire)
  - Youth Justice (Nottingham City and Nottinghamshire)
  - Children's Social Care improvement programmes (Nottingham City and Nottinghamshire)
  - Early Help (Nottingham City and Nottinghamshire)
  - Public Health programmes (Nottingham City and Nottinghamshire)
  - Best Start (Nottingham City and Nottinghamshire)
  - Small Step Big Changes (Nottingham City)
  - Nottingham City Children's Partnership Plan (Nottingham City)
  - Child Friendly City Initiative (Nottingham City)

- **ICS-wide transformation improvement programmes:**
  - Mental health transformation programme
  - Learning disability / autism transformation programme
  - Local Maternity and Neonatal System (LMNS)
  - Planned care and cancer
  - Urgent and emergency care, proactive care and self-management
  - Primary care
  - Community care
  - Estates
  - Personalisation
  - Medicines optimisation and pharmacy
  - Prevention, inequalities and wider determinants of health

- **Regional programmes:**
  - South Yorkshire ICS Children's Transformation Programme (Bassetlaw-specific)

What does this all mean for the CYP transformation programme?

- How do we describe the **scope** and **interdependencies** of our CYP transformation programme which reflects:
  - NHS England transformation programme 'must-dos'
  - Broader ICS vision, aims and priorities
  - ICS CYP Clinical and Community Services Strategy
  - Wider system improvement and transformation priorities, *including adult-focused programmes*?

- What are our **big ambitions** for the CYP transformation programme? And how adult-focused programmes help to identify these to support **prevention and early intervention** aims?

- What is our **vision** for CYP across the ICS?

- What **values and behaviours** are required to deliver the programme across all partners?

- How do we ensure this is **co-produced** with children, young people and families and **co-created** with system partners?

West Yorkshire Children, Young People & Families Programme

Ambition: To close the gap in health and wellbeing outcomes for all children and young people across West Yorkshire and Harrogate, no matter where they were born, live and go to school.

Vision: All children and young people will have the best start in life and the support and healthcare needed to enable them to be safe from harm and to enjoy healthy lifestyles, to do well in learning and have skills for life.

Voice of the child and young person at the heart of everything we do asking one question…

"What is it like being a child growing up in West Yorkshire and Harrogate and how do we make it better?"

Children, Young People & Families big ambitions…

Integrated Care System
Nottingham & Nottinghamshire

1. **Best Start:** All babies will have the best start in life growing into healthy children who are safe from harm, enjoy healthy lifestyles, do well in learning and have skills for life with well with supported families.

2. **Healthy Weight, Nutrition & Food Resilience:** Communities supported to be a healthy weight, be active & have access to nutritious food along with trauma informed support to manage their weight no matter their age, background, circumstance or where they live. This includes **halting the trend in childhood obesity by 2024 & halving it by 2030 through a life course approach prioritising reducing the gap between children from most & least deprived communities.**

3. **Family Resilience & Early Help:** Families who have challenges get the care and support they need to ensure that their children are safe and well. This will include developing a **common outcomes framework** to evidence the impact of early help and a **practice approach to online/remote delivery of parenting support and training**.

4. **Children's Healthcare in the Community:** Families will get the right care in the right place at the right time for their acutely ill children. They will be supported to be **happy, healthy and at home with the best care as close to home as possible**.

5. **Adversity, Trauma & Resilience:** West Yorkshire & Harrogate will be **a trauma informed and responsive system by 2030** working with people with lived experience and across all sectors.

6. **Complex Needs and SEND:** Children & young people with additional needs will have a comprehensive offer to support them to have great outcomes in early years, school life and as they move into adulthood. This will include **a consistent offer** and understanding and **responding to the impact of the Covid-19 pandemic**.

7. **Long Term Conditions (Asthma):** Children & young people with asthma will have access to high quality care & receive **consistent advice and information** to enable them to reach their full potential. We will work with families ensuring that their voice is heard and at the centre of what we do. We will work to **achieve a seamless transition of care** between children and adult services.

8. **Long Term Conditions (Diabetes):** Every child & young person with diabetes will **have access to the same level of diabetes care**, education and clinically approved **technology** for effective self-management. **Families' voices will be championed** and represented in diabetes services.

9. **Long Term Conditions (Epilepsy):** Children & young people will receive a consistent offer with **improved access to Psychology Support and Transition Services** using learning from the Epilepsy 12 Audit and the national Epilepsy Quality Improvement Programme.

10. **Palliative & End of Life Care:** Children & young people who have a life limiting condition will get the **right care in the right place at the right time** with support for their families through the life course and at end of life.

What does this all mean for the CYP transformation programme and the Partnership?

- Where do Partners fit within this programme?
- What are the opportunities?
- How does this impact the Partnership's strategic developments i.e. Best Start, Family Hubs?
- Who needs to be involved strategically and operationally?
- Are there existing young people groups that can support the development?

Integrated Care System
Nottingham & Nottinghamshire

Nottingham & Nottinghamshire ICS Context

(for information)

Nottingham and Nottinghamshire ICS

Overview

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 focussed on becoming a fully population health focused health and 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.

ICS members include:

- Nottingham City Council
- Nottinghamshire County Council
- City Care
- Nottingham and Nottinghamshire CCG
- Nottingham University Hospitals NHS Trust
- Sherwood Forest NHS Foundation Trust
- Nottingham Healthcare NHS Foundation Trust

The 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 they are part of the South Yorkshire and Bassetlaw health care system

Challenges to be addressed

The key challenges faced and therefore to be addressed by the Nottingham and Nottinghamshire Integrated Care System 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 and the effective utilisation of health and care system resources.

Health and Wellbeing	• More people are living longer in ill health • Deprived communities and certain groups of people have greatest exposure to factors that impact adversely on health • COVID-19 has had a disproportionate impact which has widened the health inequalities gap
Service Provision	• Current health & care services have been set up to help sick people get well, often in a hospital setting • Do not routinely and systematically identify and support people with ongoing needs • Inequity of access to services (including digital and virtual services) has widened the health inequalities gap
Resource Utilisation	• Increasing vacancies in health and care workforce • Ageing estate with high level of backlog maintenance • Significant financial deficit forecast over next 5yrs, underpinned by recurrent deficit, non-delivery of savings plans and increasing activity/demand • Resource allocation does not reflect population health need

Overview of the ICS footprint

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 Lower Super Output Areas 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 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 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

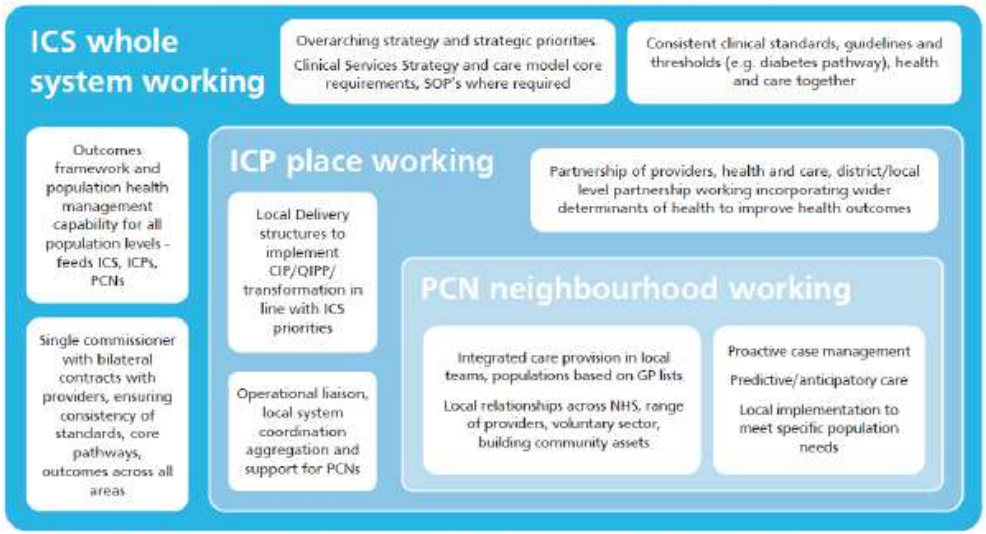
Our ICS must be flexible to meet the diverse needs of our population to tackle local health inequalities and unwarranted variation

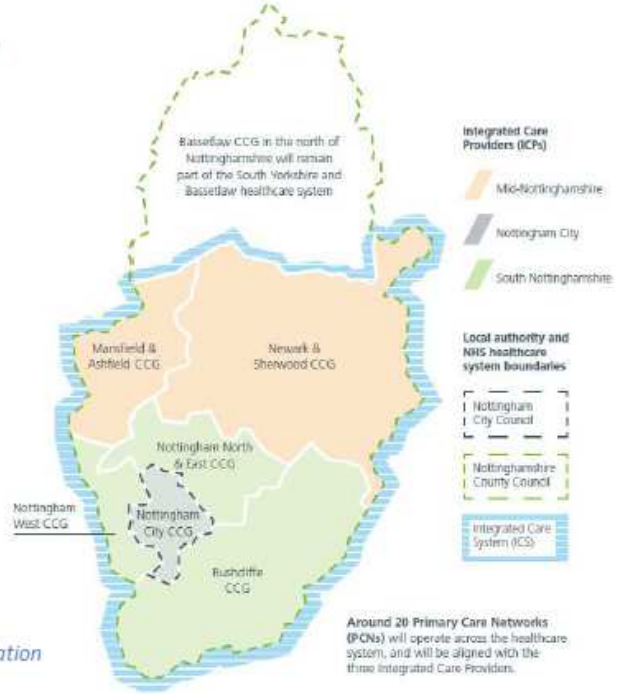
System architecture - *current*

Our current Clinical Commissioning Groups will evolve into a Strategic Commissioner that will have the responsibility to create the best environment for delivery of optimum care. In addressing the population health needs and improving outcomes the Strategic Commissioner will support establishing a system architecture for delivery which enables providers to deliver care at the earliest opportunity and in the most local setting that is appropriate. The strategic Commissioning will operate at a system level and care delivery will operate at a place (ICP) and neighbourhood (PCN) level. The places and neighbourhoods will operate increasingly through co-location, collaboration and integration across all providers and will include both statutory organisations as well as the voluntary sector. As part of the move to the new system architecture, Nottingham and Nottinghamshire have established three Integrated Care Partnerships (ICPs) and 20 Primary Care Networks (PCNs).

At the system level PHM techniques can inform strategic planning or large scale prevention of tertiary services

At the place level PHM techniques should inform integrated care design





At the neighbourhood level care pathways and interventions can be considered, this is the engine room of our population health management approach. Primary Care Networks will identify groups in their local population that without intervention will go on to become unwell, and work with those patients and local services and teams to intervene as early as possible. In particular there can be a focus on health inequalities and about those patients who are known to be heading for early chronic illness and death. This approach will be driven by intelligence from GP (and wider integrated) data sets to identify at risk groups and then proactively intervene, including inviting them to wider health and care community based programmes, including those run by the voluntary sector, and longer GP consultations.

ICS 5 Year Plan (2019/20 – 2023/24)

(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 provide more proactive and integrate care
- 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 vision, aims and ICS sustainability model

In light of the challenges we face we have set an ambitious vision, adopted the triple aim framework and embraced a Population Health Management (PHM) approach. To translate achievement and monitor our performance against these we have developed an ICS Sustainability Model 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 our system sustainability model

(4) Impact & Implications

Finance

- The system has calculated the annual efficiency requirements to deliver the System Strategic Financial Plan (20-21 4% and 21-24 2% p.a.)
- The sustainability model does not yet meet the efficiency requirements in 2020/21 with a remaining gap of £43 million. ICS partners continue to work together to identify further actions to address this.

Capital

- The system is targeting the local sources of capital funding (indicative capital budget) at addressing critical infrastructure risks and service continuity pressures.
- As a deficit financial system local capital funding is limited. External funding is required to address remaining critical infrastructure / service continuity pressures and to deliver the transformational requirements of the LTP c£1 billion

Activity

- Five year do nothing system projections agreed. Sustainability model levers targeted at non elective, A&E, outpatients and length of stay (based on national/local evidence)

Workforce

- Workforce system projections produced on same basis as finance and activity (review and triangulation underway).
- To mitigate workforce pressures we will take targeted actions (system and organisational) to address supply issues and retention.

Population health management (PHM)

Our Vision

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 Triple Aim

To help us address the challenges we face and optimise the performance of our health and care system, we have adopted the triple aim framework - the guiding principles for a truly integrated health and care system:

- 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

This means that as we develop and redesign our health and care system we will simultaneously pursue all three of these dimensions.

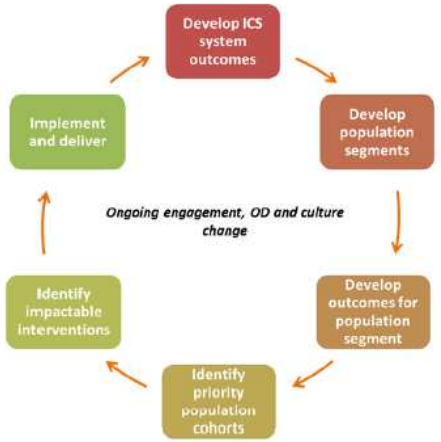
Our Approach to Population Health Management (PHM)

To underpin the delivery of our Vision and Triple Aim and address the key challenges we face, we have embraced a Population Health Management (PHM) approach across our ICS. PHM looks to improve population health by **data driven planning** and **delivery of proactive care** to achieve maximum impact. It includes **segmentation, stratification and impactability modelling** to identify local 'at risk' cohorts – and in turn, design and target interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reduce unwarranted variations in outcomes.

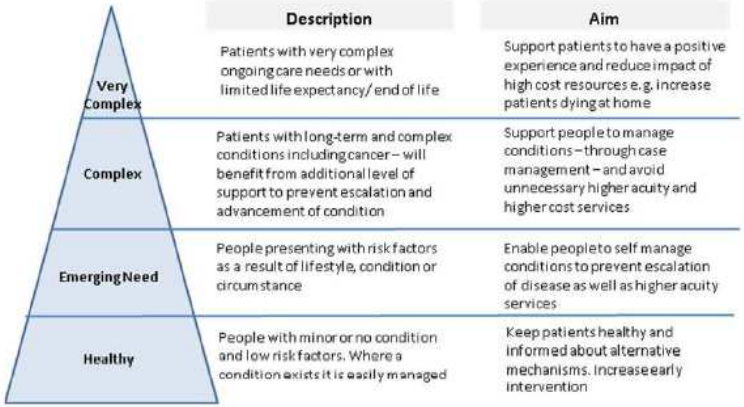
This approach is different from those we have taken before:

- It has a **system wide outcome** focus driven by need and not by existing services – key outcomes are focused on for identified groups, often these groups share more specific common characteristics, not just a disease diagnosis.
- It equips us to take a **systematic risk-stratification approach** – addressing inequalities in care and intervening more actively to promote wellbeing and mitigate further upward risk, complexity and ill health-drawing on different levels of skills and expertise
- It helps us address value when resourcing care. It allows us to **choose the most efficient intervention** and identify who would benefit most across the care pathway, while also enabling us to compare entire pathways.
- It focuses resource planning on **wider or social determinants of health**, and requires us to look at the healthy population, where in the past we may have focused more on the sick or those that already consume health care resources

Overview of our PHM Approach focused on outcomes



Risk Stratification Triangle for Population Segments/Cohorts



Underpinned by linked health and care data sets and analytical methods

ICS Outcomes Framework

The purpose of the framework is to provide a clear view of our success as an ICS 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

Indicator measures for each outcome are included in the supporting information document

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

Cross-cutting themes and enablers

- **Population Health Management**
  - Using date to understand the needs of the population, enabling focus and resources to be tailored to areas where the impact can have maximum impact
  - Helps us to understand our current, and predict our future, health and care needs so we can take action in tailoring better care and support with individuals, design more joined up and sustainable health and care services, and make better use of public resources
  - Partnership across the NHS and other public services including councils, schools, fire service, voluntary sector, housing associations – *recognises that as little as 10% of a population's health and wellbeing is linked to access to health care.*

- **ICS System Levels Outcomes Framework April 2019**
  - **Health and wellbeing:** Our people live longer, healthier lives | Our children have a good start in life | Our people and families are resilient and have good health and wellbeing | Our people will enjoy health and independent aging at home or in their communities
  - **Independence, care and quality:** Our people have equitable access to the right care at the right time in the right place | Our services meet the needs of our people in a positive way | Our people with care and support needs and their carers have a good quality of life
  - **Effective resource utilisation:** Our system is in financial balance and achieves maximum benefit against investment | Our system has a sustainable infrastructure | 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

- **Health Inequalities Strategy 2020-2024**
  - Increase understanding around health inequalities and our local population
  - Promote ways of working across ICS partners, key stakeholders and communities most likely to reduce health inequalities
  - Provide system outcomes which are key to reducing inequalities in health and wellbeing

Cross-cutting themes and enablers (cont.)

- **People and Culture Strategy 2019-2029**

  - Planning, attracting and recruiting people to work in our health and care system
  - Retaining staff and trainees, promoting career pathways and talent management
  - Role redesign and embedding new roles
  - Developing and preparing people to work in new ways, including digital skills development
  - Enabling cultural change and leadership development to maximise system effectiveness

- **Public-Facing Digital Services Strategy 2021-2024**

  - Technology Enabled Care – *providing support for self-management and self-care, remote consultations and checking, telecare services, and using smart and connected home technology.*
  - Digital and Social Inclusion – *support people to get online and become more confident and capable of using digital tools that support their health, care and wellbeing.*
  - Personalisation and Empowerment – *enabling people to use their knowledge, skills and expertise to manage their own health and make informed decisions and their care and treatment.*
  - Co-Production and Design – *working together to design and produce solutions, using the power of shared data and knowledge to spark great new ideas.*

Focus on children and young people (CYP)

Children and Young People

Initiatives to support Children & Young People cut across our Service Priorities and Must Dos. The table below sets out the key initiatives within our system that are directly focussed on this area

System Priority / Must Do	Initiatives targeted at Children & Young People
Prevention	• Focus on children aged 1 year and over incl. being a test site for enhanced Tier 3 services for severe obesity. Establish ICS framework for healthy weight initiative • Develop and implement plans to improve school readiness – aligning NHS and LA plans • Targeted work on immunisations and vaccinations
Personalisation	• Build on existing work (as a demonstrator site since 2018) including a focus on personalised care for looked after children
Mental Health	• Prevention: CYP support into schools expanded to develop mentally resilient schools • Access: Increased access to support via NHS funded MH services and school/college based MH Support Teams • Eating disorders: Service access and waiting times delivered and maintained (95% access standard) • Crisis: 100% coverage across ICS of 24/7 mental health crisis provision that combines crisis assessment, brief response and intensive home treatment functions • 0-25: A comprehensive offer in place that reaches across CYP and adults
Cancer	• Primary HPV testing implemented since June 2018. • New HPV vaccine for boys (aged 12 and 13) will be introduced across England as part of the school-aged immunisation programme from September 2019