DRAFT DOCUMENT

To be considered by the Nottingham and Nottinghamshire Integrated Care Partnership on 22 March 2024

Appendix A

Integrated Care System
Nottingham & Nottinghamshire

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

Integrated Care Strategy 2023 - 27

March 2024

Nottinghamshire County Council

Nottingham City Council

NHS

Contents

Foreword

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

We know that many people in Nottingham and Nottinghamshire could be living longer, healthier, happier lives than they currently do. To address this, our ICS health and care partners agreed in 2023 to work together to ensure that 'every person will enjoy their best possible health and wellbeing'. That is our vision, and this Integrated Care Strategy will guide us as we seek to deliver that vision over the next five years.

Our strategy was set against a backdrop of very challenging times as we sought to recover from the pandemic and cope with the cost-of-living crisis, issues which have both had a huge impact on people's health and wellbeing. Colleagues across the health and care system were facing an unprecedented challenge in delivering services, with pent-up demand from the pandemic, the ongoing increased demand on services due to Covid-19 and seasonal viruses, significant shortfalls of staff across services which are running a high number of vacancies, and continued pressures on budgets. In setting the strategy we were mindful that staff reported feeling over-stretched, stressed and exhausted.

Collectively we acknowledged that this is a situation that cannot be tolerated. We have to do things differently.

In spite of the challenges that we continue to face, we believe there is cause for optimism and that we have an opportunity to change how we approach improving health and wellbeing, with a sense of common purpose and shared endeavour across all partners. We have reviewed our strategy for the coming year to ensure that it continues to set out a way forward to best improve services, access, outcomes, experiences and, critically, tackle health inequalities.

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

We remain committed over the next five years to:

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

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

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

We will work together for the people of Nottingham and Nottinghamshire to improve the health and wellbeing of our population, to make a difference through our combined resource and work in new and innovative ways.

Dr Kathy McLean OBE
Chair of the Integrated Care Partnership

Chair, NHS Nottingham and Nottinghamshire

Cllr Linda Woodings
Vice Chair of the Integrated Care Partnership

Chair of Nottingham City Health and Wellbeing Board

Cllr John Doddy
Vice Chair of the Integrated Care Partnership

Chair of Nottinghamshire Health and Wellbeing Board

Plan on a page

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

Why are we here?

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

What are we going to do: Our aims and principles

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

Prevention is better than cure

Equity in everything

Integration by default

What we need to achieve

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

How are we going to do it

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

Three key principles to system working:

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

Three core values:

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions
- We will challenge each other if we fall short of upholding these principles and aims.

Our agreed 14 Integrated Care Strategy Priorities
We will support children and young people to have the best start in life with their health, development, education and preparation for adulthood.
We will support children, young people and adults with the greatest needs (the 20% most deprived, those in vulnerable or inclusion groups and those experiencing severe multiple disadvantage).
We will focus on health, wellbeing and education for children and young people to help improve employability and life chances for future generations.
We will support frail older people with underlying conditions to maintain their independence and health.
We will focus and invest in prevention priorities, like tobacco, alcohol, healthy weight, oral health and mental health, to support independence, prevent illness, poor birth outcomes and premature death from heart attack/stroke/ cancer/ chronic obstructive pulmonary disease (COPD), asthma and suicide.
We will 'Make Every Contact Count' (MECC) for traditional areas of health, for example mental health and healthy lifestyle and incorporate signposting to other services like financial advice which support people to improve their health and wellbeing.
We will establish a single health and care recruitment hub.
We will adopt a consistent system-wide approach to quality and continuous service improvement.
We will bring our collective data, intelligence and insight together.
We will align our Better Care Fund programme to our strategic priorities.
We will make it easier for our staff to work across the system.
Use our collective funding and influence to support our local communities and encourage people from the local area to consider jobs in our organisations.
We will add social value as major institutions in our area.
Work together to reduce our impact on the environment and deliver sustainable health and care services.
Underlying principles guiding our delivery ↓ **Prevention is better than cure** **Equity in everything** **Integration by default**

Strategic aims

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

Aim one: Improve outcomes in population health and healthcare

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

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

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

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

Case Study

One version of the truth data to support hospital discharge

Teams from health and social care have worked together to create a ‘one version of the truth’ discharge dataset that all partners agree is accurate.

This data supports collaboration and data-informed practice across the wards and the multi-disciplinary Transfer of Care Hubs in managing the timely, safe and appropriate discharge of older people once they are well enough to leave hospital and return home.

It has supported better practice and decision making and more people are now going directly home in a shorter time, leading to people spending 20,000 fewer days a year in a hospital bed at one of our acute hospitals.

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

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

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

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

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

Aim two: Tackle inequalities in outcomes, experiences and access

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

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

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

Case Study

BAME wig project

Feedback from patients at Nottingham University Hospitals NHS Trust showed that that no black hairdressers were on the list of eligible suppliers of wigs for patients suffering from alopecia due to cancer treatment.

The Black Asian Minority Ethnic Shared Governance Council worked closely with Sistas Against Cancer, a Nottingham based community support group that offers peer support to anyone affected by cancer or anyone supporting someone with cancer. They approached Nottingham Hospitals Charity for funding to purchase appropriate wigs and scarves for trial.

The project initially started off for BAME patients experiencing hair loss following chemotherapy, however the service now caters for all patients experiencing hair loss regardless of ethnicity. As of September 2023, 70 patients have accessed the trichologist services (providing scalp care).

Onyinye Enwezor, Development Lead for Clinical Leadership and Chair of the BAME council, said: "Within the African and Caribbean culture, a woman's hair is her pride but it's also her husband's pride and her family's, so that loss of hair feels like a huge chunk of their dignity is being taken away from them."

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

What will we do?

We will prioritise equitable investment in prevention across the ICS, focusing on the key priorities of the two local Joint Health and Wellbeing Strategies. This will include:

- Creating an Inequalities and Innovation Investment Fund to tackle the top prevention priorities for local people, including tobacco, alcohol, healthy weight and mental health
- Agreeing to adopt the principle of 'proportionate universalism' in future funding allocations across the partnership so that resources are deployed according to need rather than historic allocation
- Completing an evidence-based system review of the prevention offer and operating model to reshape and integrate services

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

Key actions

- Development of an ICS all age Mental Health Strategy
- A commitment to increasing the proportion of spend on prevention.

Our ambitions

- Best start in life indicators
- A smoke free generation by 2040 ensuring that we take an equitable approach to working with our most vulnerable groups:

  - Reduction in smoking prevalence in adults (aged 18+) to 5% by 2035.

  - Smoking prevalence in adults (18+) with serious mental illness (SMI)
  - proportion (%)

  - Smoking prevalence in adults in routine and manual occupations (18 years to 64 years).
- A 10% reduction in alcohol-related hospital admissions from 2020/21 baseline
- A stabilisation of the rising rates of obese and overweight adults (aged 18 +) from 2020/21 baseline (split by deprivation where possible)
- Suicide rates (persons, directly standardised rate per 100,000) to be statistically similar or lower than the England average by 2027/28
- A reduction in the numbers of children under 10 years who require tooth extraction in hospital

Aim three: Enhance productivity and value for money

Our priority: We will establish a single health and care recruitment hub.

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

Our priority: We will adopt a consistent system-wide approach to quality and continuous service improvement.

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

Our priority: We will align our Better Care Fund programme to our strategic priorities.

What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will ensure our Better Care Fund programme is meeting the needs of local people and aligned with the ambition of this strategy	**Key actions** ◦ Review of the Better Care Fund programme completed. Areas being explored where we can expand the programme and go further

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

Case Study

Promoting Independence Service

The Promoting Independence Service, delivered by Bassetlaw Action Centre, works with health and voluntary sector colleagues to provide practical interventions to help people regain their independence following a hospital stay.
The support offered by the service includes befriending, home support with daily living tasks, housing advice, support to get active and a community car scheme.
Patients are equipped with the tools and services they require to continue their recovery at home, regaining their independence, without specific time limitations.
It is estimated that the service is saving £686,400 to the healthcare system every year in reduced hospital bed days.

Our priority: We will make it easier for our staff to work across the system.	
What will we do?	**How will we know we have got there?** A five-year ambition unless otherwise stated.
We will make it as easy as possible for staff to work across different teams and organisations. This will include: ◦ Establishing jointly employed head of commissioning posts for Ageing Well and Living Well, and head of quality and market management ◦ Further developing the Memorandum of Understanding for mutual aid between organisations ◦ All NHS providers being registered to utilise the digital staff passport to support movement of staff between organisations ◦ Developing a rotational scheme to support allied health professionals to move between sectors (NHS providers, primary care and social care) ◦ Establishing an integrated commissioning function and a quality and market management function across the ICS ◦ Developing integrated discharge hubs to encourage an integrated approach to service delivery ◦ Reviewing data sharing agreements to ensure staff have access to the information they need to deliver the best care	**Key actions** ◦ Recruited Head of Commissioning posts for Ageing Well and Living Well, and Head of Quality and Market Management ◦ Refresh signed Memorandum of Understanding for mutual aid between NHS organisations by Q2 2023/24 and explore potential to roll out to wider partners where appropriate by March 2026 ◦ Digital staff passport being fully utilised by March 2025 ◦ Working with partners on a common Strategic Workforce Plan approach. ◦ Integrated discharge hubs implemented ◦ Integrated commissioning function and a quality and market management function established across ICS ◦ Streamlined, appropriate information sharing in place ◦ Agreed an ICS staff induction which sets out the expected standards across the workforce to embody this strategy's principles

Aim four: Support broader social and economic development

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

What will we do?

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

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

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

Key actions

- Strengthen ICS contribution to key strategic partnerships for social and economic development.
- Partnership working with all major suppliers that identifies opportunities for local apprentice schemes, supports disadvantaged groups and engages with local providers by March 2026
- Universities for Nottingham Civic agreement approved across all organisations party to the agreement
- Finalise our Estates Strategy, including a system wide prioritised list of Estates and Infrastructure Schemes by March 2025
- Staff across all organisations are empowered to make changes, reducing waste in their work by March 2026
- Progress with delivery of national and local priorities and opportunities to reduce carbon emissions, as outlined in our ICS Green Plan

Our ambitions

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

Our ambitions

Carbon Net zero
For scope 1 and 2 emissions:

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

Supported by:

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

Case Study

Small Steps Big Changes Family Mentor Service

Family Mentors are a highly trained paid peer workforce that deliver the Small Steps at Home evidence-based programme of child development and preventative health support to parents of 0—4-year-olds.

The Family Mentor Service provides social value through commissioning established voluntary and community sector organisations that employ local people based on aptitude not qualifications. It provides accredited training at Level 2 (equivalent to GCSE). The Service is co-produced with and co-delivered by the community it serves and the mentors speak 14 non-English home languages.

Parents reported improvements in wellbeing and confidence in both parents and children, children eating healthy food options, and improved sleeping routines and behaviour (2019). Children who used the service scored significantly higher on communication and gross motor areas of the Ages and Stages Questionnaire in the first year.

“It has been amazing having a Family Mentor and sharing the first 4 years of my child’s life with her – the good, the bad and the hilarious., Knowing I could ask her anything without her judging me has been great.” Amanda, Aspley.