Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Mental Health Pathway: Strategic Plan 2024/25-2026/2027

Our Vision

Integrated Care System
Nottingham & Nottinghamshire

Our Vision is to provide an integrated mental health pathway which delivers local, inclusive, safe, personalised, and therapeutic care that meets the needs of individuals in Nottingham and Nottinghamshire.

Our focus will be on supporting people to live well in their local community with the building blocks of good mental health in place to maintain positive mental health and resilient communities. People will have access to good quality support, information and care to manage their own mental health and wellbeing and will know where to go to access the right care at the right time to prevent the need for accessing services or an inpatient admission.

If people do need support from inpatient services, they will receive high quality care in their local area in the least restrictive environment to meet their needs.

People will only stay in hospital for the time they need to, with partners working together to identify and act upon any housing and support needs to enable people to go to the place they call home as soon as they are ready. There will be well coordinated and effective housing and community support to enable people to receive support in the place they call home.

To ensure all parts of the system across health, local authorities and the voluntary, community or social enterprise (VCSE) sector meets the needs of the individuals it supports, it is essential we review and transform all parts of the system as one connected whole, rather than looking at separate sections in silos. Working together to deliver this strategic plan will ensure we develop local care that focuses on supporting people as individuals, with personalised care and support to meet people's needs and improve their outcomes and experiences of care and support.

We have worked together with system partners to develop the vision and approach outlined in this strategic plan, including:

mind

Framework
For your future

NHS
Nottingham and Nottinghamshire
Integrated Care Board

TURNING POINT
inspired by possibility
CELEBRATING 60 YEARS

Nottingham City Council

EAST MIDLANDS ADULT SECURE CARE SERVICES
IMPACT
Having a positive impact on our futures

Nottinghamshire County Council

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Executive Summary

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The strategic plan aims to localise and realign mental health inpatient services into an integrated mental health pathway over a three year period to ensure the right care is being delivered, in the right place, at the right time, and in the least restrictive environment.

There is a clear case for change, as well as significant concerns about the quality of care delivered in inpatient services and a challenging system financial position that need to be addressed.

All parts of the mental health care and support system (whether delivered by NHS, Local Authority, independent sector or VCSE services) impact each other and are inextricably connected to people's experiences of care. To achieve our vision and address our local challenges, system partners plan to transform the whole mental health pathway with a strong focus on community support to enable people to live well and access support in their local community without the need for an inpatient admission. If people do need support from inpatient services, they will receive high quality care that meets NICE standards in their local area and in the least restrictive environment to meet their needs.

The delivery of our vision is underpinned by 3 strategic pillars focused on what good looks like in Nottingham & Nottinghamshire:

Strategic Pillar 1
Improving access to care and support in the right place at the right time.
Clear pathways into the full range of system services and support; improved information sharing among partners with a 'no wrong door' approach; increased community-based support and early intervention to reduce crisis, with integrated commissioning for timely solutions to address gaps.

Strategic Pillar 2
How we deliver high quality care or people
Good quality inpatient provision in place which improves outcomes and experiences of care; local care is tailored to individual needs, prioritising least restrictive placements and eliminating out of area placements; individuals are viewed as citizens rather than a diagnosis or risk; system-wide workforce and culture that supports good quality care.

Strategic Pillar 3
Timely discharge to the place people call home
Increased housing and support to enable people to live in the place they call home; identifying needs early at admission to support discharge (housing and wider support); putting people at the heart of their discharge planning; improved system data to inform planning and commissioning to meet local need.

System partners have developed key areas of focus within these pillars that will enable the system to deliver on the vision for the integrated mental health pathway.

Values driving the work

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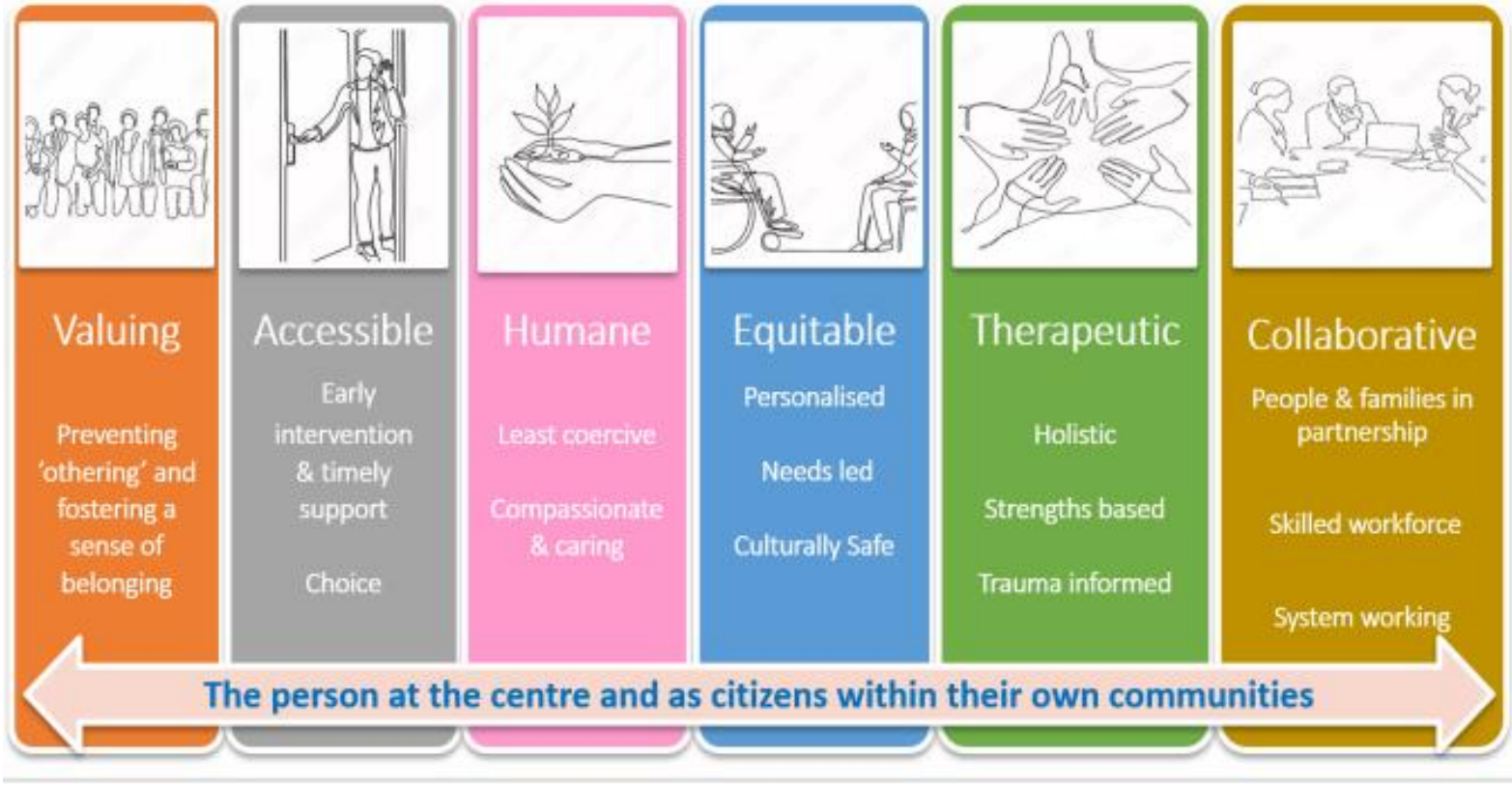
The value statements developed in the NHSE commissioning framework for inpatient services will form the foundations for our work.

These values have been developed nationally in partnership with frontline clinicians and people with lived experience of inpatient services and will form the framework for the work we will undertake locally to commission and deliver services that meet the needs of our local people. As a system we have measured ourselves against these values and used the self-assessment as a model to support the development of our system priorities and strategic pillars.

Annual assessments against these value statements will help us to assess what has been achieved as a system and areas that require further focus.



Plan on a page

Current state: our challenges

- Concerns about the quality of care delivered in inpatient services
- Length of stays in hospital are longer than clinically needed, causing strains to services and worse outcomes for patients including out of area placements
- Pathways not always clear, do not provide local early support and intervention to reduce escalation, maintain independence in the community and reduce the need for acute services
- Waiting times remain too long for access to assessment with hidden waits between services where specific mental health services / organisations operate in silos
- There are growing numbers of people with autism in mental health inpatient services requiring care and support and an environment that meets their needs
- Access to services are further reduced when people have co-morbidities or additional complexities
- Services operate in silos resulting in an inability to recognise the mental, physical and social support needs required for the whole person
- Finances are a significant challenge for all system partners, including the VCSE sector where short term contracts could impact the future support offer.

Future state: our ambition

- People will have access to good quality support, information and care to manage their own mental health and wellbeing and know where to go to access the right care at the right time
- People will be supported to live well in their local community to prevent the need for an inpatient admission to hospital
- If people do need support from inpatient services, they will receive high quality care in their local area in the least restrictive environment to meet their needs
- People will only stay in hospital for the time they need to, with partners working together to identify and act upon any housing and support needs to enable people to go to the place they call home as soon as they are ready
- Sustainable local community care model of delivery that aims to optimise people's independence by holistically addressing their physical, mental health and social needs and intervening before people reach crisis point
- There will be a reduction in avoidable and unplanned admissions to hospital for people with mental health needs, through partners working collaboratively in an integrated way to care for people in the most appropriate setting for their need.

What	Year 1	Year 2	Year 3	Valuing	Accessible	Humane	Equitable	Therapeutic	Collaborative
IMPROVING ACCESS TO CARE AN SUPPORT IN THE RIGHT PLACE AT THE RIGHT TIME	• Clear integrated mental health pathway offer of the full range of high- quality system services and support in place • Establishment of 'no wrong door' processes. • Improved public facing information to support prevention and self-management • Strengthened Multi Disciplinary Team (MDT) approach to support partnership working for people with most complex needs. • Identification of joint commissioning opportunities across NHS, LA and VCSE sector to strengthen community support offer and bridge the gap from GP to Crisis Services.	• Exploration of Trusted Assessor models to reduce number of assessments on an individual's journey • Analysis of waiting times and impact of community signposting • Required service development/commissioning undertaken.	• Review of impact to ensure continuous quality improvement • Associated improvement activity or commissioning undertaken.		X	X	X		
HOW WE DELIVER HIGH QUALITY CARE FOR PEOPLE	• Bed modelling plans agreed and actions developed to ensure right size and type of provision in place • Completion of Optimal Care Programme in Adult Mental Health inpatient services to support flow • Review of rehabilitation provision to end 'locked rehabilitation' approach and support care in least restrictive environment • Quality monitoring and improvement processes strengthened and in place • Plan to eliminate out of area placements delivered • Experts by experience model to support programme delivery established and embedded • A system-wide workforce and culture approach developed (including system recruitment and retention plan and system training offer) • Neurodiversity awareness training and Oliver McGowan training rolled out. • NHT completion and embedding of NHSE culture of care programme • Cultural competency training and community health promotion established to reduce stigma in communities • NHT compliant with Patient and Carer Race Equality Framework & themes embedded across whole pathway.	• Service redesign undertaken to ensure local provision in place to cease practice of out of area placements • Development undertaken on preventative services for people with Personality Disorder and older people (MHSOP) • Shared personalised care plans that travel with the individual between partner services established • Embed culture of shared decision making and 'it's okay to ask' • Agreed principles for suitable environments developed, with a focus on the needs of people with autism. • Coproduction approaches across services embedded • Trauma informed workforce approach rolled out to staff.		X	X	X	X	X	X
TIMELY DISCHARGE TO THE PLACE PEOPLE CALL HOME	• System performance online dashboard developed (including national and local indicators to measure effectiveness) • Personalised discharge plans established with processes for sharing with system partners • Processes in place to support identification of housing and support needs for discharge at point of admission • Demand forecast models for supported living and wraparound capacity completed • Market development undertaken to grow provider market based on need • Peer support opportunities to develop community networks in place for people to build a sense of belonging.	• Demand forecasting model developed to inform planning and commissioning • Options established and delivered to support NHS and social care interoperability of Notts Care Record • Opportunities explored to maximise Personal Health Budgets (PHB's) for discharge • Opportunities to develop community advocacy explored.		X		X	X		X

Introduction to Our Mental Health System

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Our Mental Health Care and Support System includes:

- Nottinghamshire Healthcare NHS Foundation Trust (NHT) - the main provider of intellectual disability, mental health, community health, forensic and offender healthcare services in the Nottingham and Nottinghamshire system
- Nottingham and Nottinghamshire Integrated Care Board (ICB) - responsible for commissioning good quality, effective services that meet population need
- Two local authorities: Nottingham City Council and Nottinghamshire County Council - which provide social care and commissioning services
- IMPACT Provider Collaborative - provide low and medium adult secure care services
- Eight housing authorities: one in Nottingham City and seven district/boroughs in the County footprint
- A varied Voluntary Community and Social Enterprises (VCSE) sector providing support to local people.

Despite increasing numbers of discharges from NHT (22% more discharges from acute mental health beds in 2023 compared to 2022*), the capacity of mental health inpatient services remains a challenge. The volume of out of area bed days and current inpatient lengths of stay are symptoms of a system that needs to make improvements in optimising care pathways. Current demand and the length of stay of people accessing inpatient mental health services has led to an increase in sub-contracted beds and out of area placements, which tend to be more expensive than local provision but of more concern means people receive care and support away from their local communities, impacting on their connections with family and friends. A focus on timely discharge from hospital to support optimum patient flow is needed to enable the right sizing of both hospital and community capacity in the local system and reduce out of area placements. All system partners have a role to play to support people to leave hospital as soon as they are ready and live in the place they call home.

Recent investigations have identified concerns and areas for improvement in the quality of inpatient care in Nottinghamshire. The system and all individual partners are also experiencing a challenging financial position which impacts capacity across the mental health system. Working together in partnership will help to address these challenges and ensure best value for money.

Within Nottingham and Nottinghamshire we have variable deprivation across the system with Nottingham City being in the top five most deprived local authorities in England. Prevalence of Severe Mental Illness (SMI) across our Place Based Partnerships show a clear correlation between deprivation index and severe mental illness, with the highest levels of SMI in our lowest areas of deprivation in Nottingham City and Mid Nottinghamshire areas (see table 1*).

*Source: NHT data & System Analytics & Intelligence Unit data

Table 1: deprivation and serious mental illness

Primary Care Network	IMD decile	% of SMI
BACHS	2.4	1
Clifton & Meadows	2.5	0.9
Bulwell & Top Valley	2.6	0.9
Radford & Mary Potter	2.7	1.5
Nottingham City East	3	1.4
Bestwood & Sherwood	3.5	1
Ashfield North	3.9	0.7
Mansfield North	4.1	0.6
Rosewood (mansfield)	4.1	0.8
Ashfield South	4.3	0.7
Byron	4.5	0.5
Newgate	4.6	0.7
Larwood and Bawtry	5.1	0.7
Sherwood	5.3	0.6
Retford and Villages	5.3	0.5
City South	5.6	0.7
Eastwood/Kimberly	5.9	0.6
Synergy	5.9	0.7
Newark	6	0.5
Stapleford	6.1	0.6
Arnold & Calverton	6.5	0.7
Arrow	6.6	0.3
Beeston	7.4	0.7
Rushcliffe North	8.5	0.3
Rushcliffe Central	8.8	0.6
Rushcliffe South	9	0.4
Unity	5.3	0.4

The case for change

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Our local population

Demand for mental health services continues to grow in our system, with mental health support accounting for a substantial proportion of the care and support offered to our population of 1,267,866 people. We also know that people have physical and social support needs alongside their mental health needs which adds a level of complexity to the care they require and the number of organisations involved in their support.

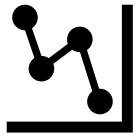
As of March 2024, there are 8,540 patients diagnosed with Serious Mental Illness (SMI) and 12,235 patients diagnosed with Personality Disorder (PD)

25% **of GP appointments over the last 12 months were with people who had a diagnosed mental health condition**

64,070 **people had a contact with a mental health provider in the last 12 months**

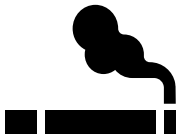
During 2023, 13% of patients on the SMI register and 15% of patients on the PD register had at least one emergency department admission (compared to 6% of the general population)

72% of SMI patients and 50% of PD patients have at least one additional long term condition



Prevalence of SMI is highest amongst people of black ethnicity (1,367 cases per 100,000 population compared to 711 cases for people of white ethnicity)

There are more females diagnosed with PD compared to males (56% : 44%).



37% of patients diagnosed with SMI and 39% of patients diagnosed with PD are current smokers

30% of patients diagnosed with SMI and 36% of patients diagnosed with PD have a history of alcohol misuse

70% of patients diagnosed with SMI and 65% of patients diagnosed with PD are either overweight or obese.

Data Source: SAIU

The case for change

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Mental Health services in Nottinghamshire

There are concerns about the quality of care delivered in inpatient services

Waiting times remain too long for access to assessment and support, with hidden waits between services

Pathways are not always clear to members of the public and professionals impacting ability to access local early support to prevent hospital admission

Inpatient length of stay impacts capacity and leads to a reliance on Out of Area Placements

25 The number of people in Out of Area Placements (June 24)

Growing numbers of people with autism in mental health inpatient services require care and support and an environment that meets their needs

175 The number of people in secure care (June 24)

Opportunity to learn from development work undertaken in Learning Disability and Autism services

Rehab is often seen as a last resort instead of bespoke placements.

The Nottinghamshire System

All parts of the mental health care and support system (whether delivered by NHS, Local Authority, independent sector or VCSE services) impact each other in relation to demand, capacity, people's experiences of care and finances

Coproduction with people with lived experience needs improvement

Increased development of patient choice for people with complex needs is required

Services operate in silos resulting in an inability to recognise the mental, physical and social support needs required for the whole person and a lack of knowledge of all the services available across all areas of the pathway

Finances are a significant challenge for all system partners, including the VCSE sector where short term contracts could impact the future support offer

Workforce challenges make long-term culture change challenging

A lack of a system data sharing approach makes commissioning accommodation provision and supportive discharge services that meets future demand in the community challenging.

What do people who use our services say?

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The following key themes have been taken from insights captured from people with lived experience through patient interviews (17 people), Our Experts by Experience for integrated Mental Health Meetings (10 attendees), engagement sessions with existing groups at Beeston Middle Street Resource Centre and Arnold Mental Health drop-in (47 people) and Healthwatch Nottingham and Nottinghamshire Specialist Mental Health Services Report (367 responses):

Access is challenging

'We get told there's all these services, all this help,...but actually getting it is near impossible'

GP's lacked knowledge and understanding of mental illness and the support services available, despite being seen as the first place to go for mental health concerns

People report **not feeling listened to by primary care**

It feels like a postcode lottery, with the quality of care that service users received being somewhat determined by their locality and eligibility

Once you get support it feels like services are **quick to discharge** you and you feel **abandoned**

If we have **any additional needs** on top of mental health needs it feels as though people push you from one service to another as **you don't fit the "box"**

Worries about inpatient care

Sense of **fear of returning to inpatient services**, feeling trapped/institutionalised and days merging into one – "I would do anything to avoid sectioning"

Concerns around **use of medication and feelings of distrust** and fear.

Impact of seclusion making the individual feel criminalised rather than a patient to be cared for.

Long length of stays as detrimental to health

The need for personalised care

Importance of being seen as an individual and not "a problem", with **personalised care that treated 'the person, not the diagnosis' .**

The 'one-size-fits-all' approach disregards people's racial, ethnic, and cultural backgrounds.

People feel they have to **repeatedly share their stories** and experiences, which caused distress

If people looking at referrals and providing services **saw us as people** rather than a "case" or a "bed" it would make a difference

We deserve person-centred care with **compassion and understanding**

What people want to see

There is a need for **more community services**

Care that supports **purpose, routine and independence**

Strengths based approach – that sees the best in people and what we can achieve

A 'handholding' or 'buddy' service would be useful to provide **structured support for people following their discharge**

An increase in **advocacy services** and **support in the community** after discharge

Reduction of **revolving door** – "support after discharge essential to stop me **bouncing back** into hospital again and feeling like a failure"

Scope

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To achieve our vision and address our local challenges, system partners plan to transform the whole mental health pathway, not just inpatient services themselves. This means that system partners will review and transform the full range of commissioned services and support delivered by NHS, Local Authority and VCSE organisations including:

LIVING WELL IN THE COMMUNITY

Community information and support that enables people to live well in their local community and access support at the right time

INPATIENT SERVICES

If people do need support from inpatient services, they will receive high quality care in their local area in the least restrictive environment to meet their needs.

POST DISCHARGE SUPPORT

Coordinated and effective housing and community support to enable people to leave hospital as soon as they are ready and receive support in the place they call home.

Inpatient services scope includes:

- **Acute Mental Health inpatient services including services for people with learning disabilities and Autism and Psychiatric Intensive Care Units (PICU)**
- **Mental Health Rehabilitation inpatient services, including services for autistic people and people with learning disabilities – open and 'locked'**

While a full review of secure care is not in scope of this work, IMPACT provider collaborative will be a key partner in this work due to the interdependencies with inpatient care, particularly in relation to pathway flow and its potential impacts on secure care.

If the system is successful in its aims to care for people in their community and prevent the need for inpatient services, not all people who access this pathway will move through to requiring inpatient services, which will support care in the least restrictive environment. We will also focus attention on discharge support services to ensure people receive the support they need in the community to prevent unnecessary readmissions to inpatient care. The focus on community based support will support flow across the whole pathway, relieving pressures on inpatient services and ensuring the best level of care for people who need to access services on the pathway.

Our commitment to working together

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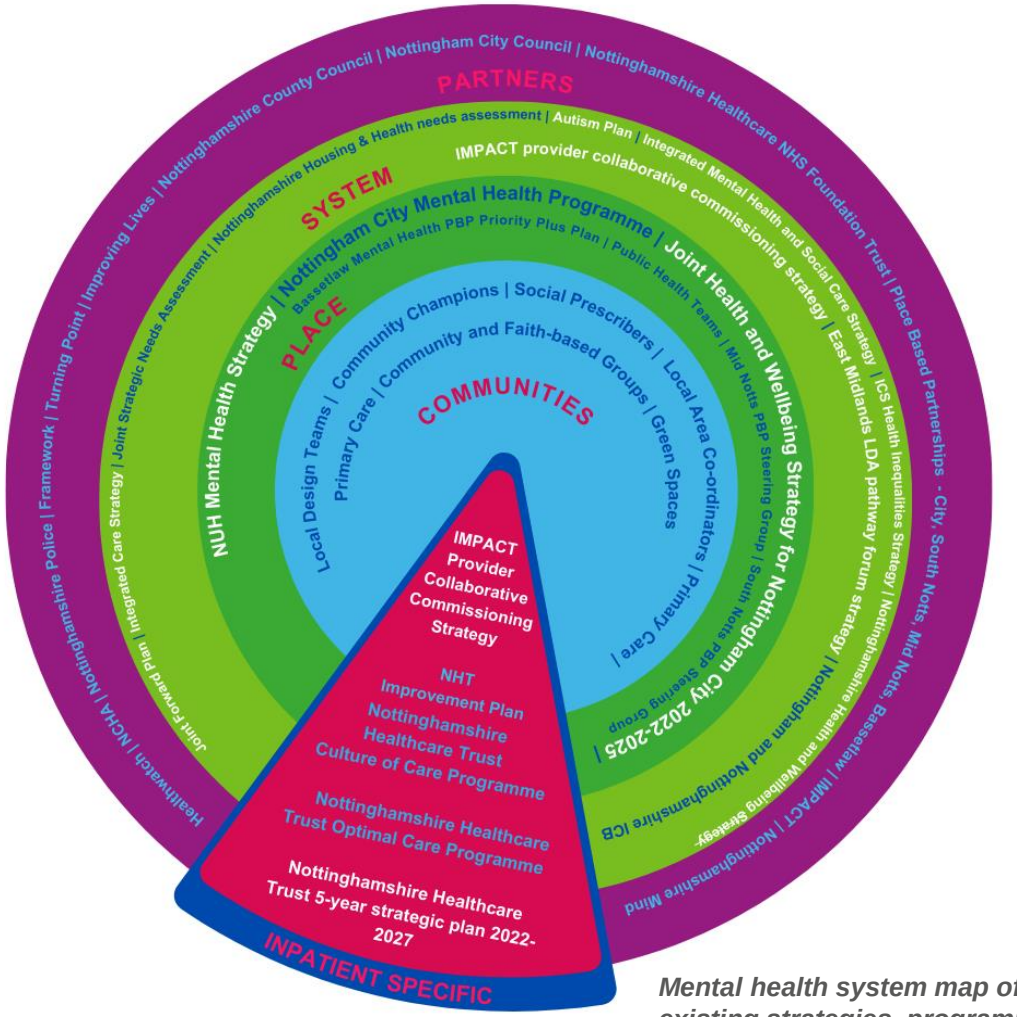

Mental health system map of alignment with existing strategies, programmes of work and partnerships

All system partners across health, local authorities and the voluntary, community and social enterprise (VCSE) sector will work together to ensure we include the full range of mental health care and support available to people in their local communities, as well as working with people with lived experience as equal partners so that we develop support that meets everyone's needs.

All of our system partners are committed to:

- putting the needs of the person at the heart of everything we do
- sharing data and information in a timely way to support the needs of the person
- undertaking a system approach to workforce challenges
- bringing their skills and learning to help improve our local model
- respecting the views of all partners in an equal relationship
- being part of a system that is together accountable for services
- being clear on individual roles and responsibilities
- coproducing the integrated mental health pathway with experts by experience as equal partners
- exploring opportunities for working together at a place and system level, as well as on wider geographical footprints across neighbouring Integrated Care Systems.

The Strategic Plan has been developed in alignment with existing strategies, programmes of work and partnerships, both at place and system wide levels, to ensure maximum impact. This is illustrated in the mental health system map. Partnership and system wide integration work at a system and place level is key to the success of our approach and to ensure all our collective assets are utilised.

Coproduction with people with lived experience

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How we captured voices of lived experience for our strategic plan

- Initial work was carried out by connecting coproduction activity already existing within our system. Patient voice has been captured through workshops and focus groups with several engagement and community groups over a range of areas, cohorts and needs; active patient feedback to operational staff and findings from previous research projects (including the Healthwatch Specialist Mental Health Services Report, November 2023).

Integrated Mental Health Experts by Experience (EbE) Group

- The Integrated Mental Health Experts by Experience Group launched in April 2024 to coproduce, drive and review the delivery of our strategic plan. There are currently 12 active members from a wide cross section of the Nottingham and Nottinghamshire community with experiences from a range of mental health support and services. We are supporting members to join as equal representatives throughout our governance structure, with plans to have EbE representation on our Oversight group during Summer 2024. Community ND faith groups, clinical settings and carer's organisations shared information about the group to support involvement from diverse communities.
- Funding for coproduction will be prioritised to deliver agreed priorities.

Coproduction partner network

- A system-wide network of support for partners who are delivering and offering coproduction and engagement opportunities for people accessing the mental health pathway has been developed. The network will develop a community of practice and resource support tools to ensure coproduction is embedded in the delivery of all care and support.
- Funding for coproduction will be prioritised to deliver agreed priorities.

Capturing the voices of those lesser heard

- We are committed to ensuring the voices of those at risk of stigma, isolation and 'othering' are supported and actively sought to be included within our coproduction work, and plan to develop this by working with community and faith groups who have existing relationships and have built trust with these communities. This will include a focus on race health inequalities, experiences of the LGBTQIA+ community and those experiencing transitions into age-related services.
- We have heard from the voices of those individuals in out of area placements to support our self assessment, as well as having voices from members who have been placed out of area within our experts by experience group to ensure that the voices of people placed out of area are not forgotten
- We will work with local community, faith and voluntary groups to support individuals to foster active citizenship for individuals within their local communities.
- We will include voices of those experiencing severe multiple disadvantage, aligning with partner work across the system and the lived experience work that has been developed in this area.

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The Future of the Integrated Mental Health Pathway

What we are looking to achieve

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Our Vision is to provide an integrated mental health pathway that delivers local, inclusive, safe, personalised, and therapeutic care which meets the needs of individuals in Nottingham and Nottinghamshire.

To deliver the vision we will aim to achieve:

- **A clear mental health and wellbeing offer to support people to live well in their local community and know where to go to access the right care at the right time**
- **A greater proportion of people with mental health needs, including those with a learning disability or autism, being supported in their community, in ways that promote their citizenship and human rights**
- **Good quality inpatient care in the most appropriate and least restrictive environment to meet the needs of people who require inpatient care, with a focus on discharge from day one**
- **The right size and type of local inpatient provision for when people need it, reducing reliance on sub-contracted beds and eliminating out of area placements**
- **Care that is delivered in the least restrictive environment and an end to the use of 'locked rehab'**
- **Care that focuses on supporting people as individuals, rather than as a diagnosis or a risk, with personalised care and support that meets the needs of all people**
- **Improved experiences of care and support by people who access them, with smooth transitions between services**
- **Timely discharge from hospital with housing and support needs in place to enable people to leave hospital as soon as they are ready and receive support in the place they call home**
- **A system workforce and culture that is supported to deliver personalised care and support that is strengths based, trauma informed and culturally competent to meet the needs of people accessing care and support.**

How we will achieve this

Delivering good quality services

- We recognise there is more we need to do to deliver high quality services and all partners will continue to support Nottinghamshire Healthcare NHS Foundation Trust while they address Care Quality Commission recommendations, the NHSE recovery support programme, and implement the NHT Improvement Plan.
- The ICB will continue to monitor the quality of services through the Quality Assurance framework, working with providers to undertake quality insight visits supported by ad hoc visits to address any concerns.
- The ICB will strengthen host commissioner arrangements for people in mental health inpatient services and develop robust home commissioner arrangements for those people out of area, with a focus on strengthening patient experience.
- All intelligence available to the system will inform learning, scrutiny and improvement actions across both NHS and Independent Sector providers, including Safe and Wellbeing reviews, Serious Incidents, Learning from Lives and Deaths Report and learning from Patient Safety Incident Response Framework.
- NHT will develop and embed learning from the NHSE culture of care programme.

Providing joined up care

- A review of Multi-Disciplinary Team working in the inpatient environment will ensure the right infrastructure is in place to bring all key partners together to focus the right care, treatment and support to people at the right time to meet their needs while they are in hospital and when they prepare for discharge to the place they call home.
- Strengths based, person-centred, and trauma informed care approaches will be implemented across the system workforce to support individuals to achieve their outcomes in the most appropriate way.

Preventing unnecessary admissions to hospital

- Strengthening our prevention approaches will enable people to manage their own mental heath and wellbeing to live well in their local community.
- We will maximise the skills and expertise of all system partners in developing alternative care in the least restrictive environment and build on opportunities within community mental health transformation to strengthen community services to support people in crisis and avoid unnecessary admissions to hospital.

All means all

- The system will work together to meet the needs of all people who experience mental health problems including those more vulnerable and at greater risk of developing mental health problems through greater prevention approaches, maximising the connections of local community groups in a culturally safe way.
- We know there is more work to do to meet the needs of people with autism in mental health inpatient settings, and this will be a key priority for 2024/25 by focusing on upskilling and supporting the workforce to deliver care and developing autism-friendly environments.
- We will ensure there are reasonable adjustments in place to support individuals to achieve their best outcomes when they receive support as well as ensure equitable access to care and support services.

Evidence based care

- All commissioned services will promote needs-based care in line with national guidance and standards (such as Getting It Right First Time and National Institute for Health and Care Excellence) and evidence-based recommendations from local reviews.
- The development of a Mental Health system dashboard will form the foundation for routine monitoring of prevalence, inequalities and system performance to inform quality improvement and transformation and will ensure senior oversight and assurance. This will generate evidence-based demand forecasting to inform future planning and commissioning activity to meet need.

Local continuity of care

- We want people to receive high quality care in their local area in the least restrictive environment to meet their needs. Plans are in place to return patients in out of area hospital placements back to Nottinghamshire in a planned way that focuses on the individual and meets their needs so they can be closer to the place they call home.
- We recognise some people do not have the support of family and friends, whether they are in placements close to home or out of area. We will develop solutions with the VCSE sector to ensure people have a connection to someone they know and trust in their local community for when they return to the place they call home and to support active citizenship.

Strategic Pillars

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Three strategic pillars have been developed to deliver on our vision and aims:

Strategic Pillar 1
Improving access to care and support in the right place at the right time.

Strategic Pillar 2
How we deliver high quality care for people.

Strategic Pillar 3
Timely discharge to the place people call home.

System partners have developed key areas of focus which will enable the system to deliver on our vision. These areas of focus will be underpinned by the three strategic pillars and have informed the development of the strategic plan and key milestones for the next three years as detailed on pages 15-17.

These will be supported by system enablers to develop:

- A system that recognises and values the experience and expertise of all partners and utilises the VCSE sector in all areas of prevention, service delivery and discharge support.
- A system that coproduces with a diverse range of people with lived experience as equal partners so that we develop support that meets everyone's needs.
- A skilled workforce with sufficient capacity and a shared system culture and system-wide trauma informed approach that enables the delivery of compassionate, safe, personalised, humane and therapeutic care.
- System data approaches that support real-time data sharing across partners to support patient care, with quality performance monitoring and demand forecasting to inform planning and commissioning to meet local need now and in the future

3 Year Strategic Plan

An overview of the next 3 years activity with key milestones

Integrated Care System
Nottingham & Nottinghamshire

This strategic plan contains a high level overview of the key areas of focus with overarching milestone deliverables that will support system partners to deliver on the vision for the integrated mental health pathway. This will be supported by detailed operational plans for delivery, which will set out the key steps required to move the system to the direction set out in this plan, along with the alignment of any existing groups or initiatives underway to maximise impact. This plan will be reviewed yearly to ensure it remains an active document. Each area of focus and associated activity will be reviewed to ensure continuous quality improvement.

Strategic Pillar	Areas of focus	Year 1	Year 2	Year 3
Improving access to care and support in the right place at the right time	Clearer pathways into the full range of high quality system services and support	Clear mental health offer in place across the system covering high quality universal, community, targeted support and hospital admission services (including eligibility and referral criteria) delivered across the VCSE sector, local authorities and NHS. Establishment of 'no wrong door' processes Embedding of personalised care approaches across pathway Development of integrated pathways to reduce people being signposted repeatedly back to their GP.	Clear transfer processes & signposting in place to ensure people access right care at right time.	Review of impact to ensure continuous quality improvement.
	Improved information sharing, including referrals and escalation	Information sharing agreements established across partnership. Signposting materials to support no wrong door approach and shared with key partners/contact points. Improved public facing information to support prevention and self-management Strengthened Multi Disciplinary Team (MDT) approach to support partnership working for people with most complex needs.	Exploration of Trusted Assessor models to reduce number of assessments on an individual's journey. Analysis of waiting times and impact of community signposting.	Review of impact to ensure continuous quality improvement.
	Bridging the gap from GP to Crisis Services	Clear information on the range of care and support available across the system is shared with Primary Care. Review of work already underway in primary care mental health practitioners and links to Local Mental Health Teams to increase impact. Gap analysis undertaken. Identification of joint commissioning opportunities across NHS, LA and VCSE sector to strengthen community support offer and bridge the gap from GP to Crisis Services.	Identification of joint commissioning opportunities across NHS, LA and VCSE sector to support strategic aims. Required service development/commissioning undertaken.	Review of impact to ensure continuous quality improvement.

Strategic Pillar	Areas of focus	Year 1	Year 2	Year 3
How we deliver high quality care for people	Good quality inpatient provision in place	Review of existing service specifications & development of new specifications to ensure reflective of all national guidance (commissioning, NICE & GIRFT) to ensure quality of care being delivered. Bed modelling plans agreed and actions developed to ensure right size and type of provision in place and reduction in reliance on sub-contracted beds. Completion of Optimal Care Programme in Adult Mental Health inpatient services to ensure robust systems and processes in place to support flow. Review of Trauma Informed Care Pathway (female personality disorder) as flow priority and actions developed Review of rehabilitation provision to end 'locked rehabilitation' approach and support care in least restrictive environment. Quality monitoring and improvement processes strengthened and in place. Plan to eliminate out of area placements delivered. Review of local PICU provision for women to end out of area placements. Multi Disciplinary Team infrastructure developed and electronic care plan go live	Service redesign undertaken to ensure local provision in place to cease practice of out of area placements. Level 2 rehab commissioning and procurement process undertaken with East Midlands commissioners Self assessment and focused development on preventative services for people with Personality Disorder Self assessment an focused development on preventative services for older people (MHSOP) community placements and specialist housing	Associated improvement activity or commissioning undertaken
	Strengthening personalised care: treating the person, not the diagnosis	Culture change/training programme established to embed personalised care. Personalised discharge plans established with processes for sharing with relevant system partners.	Establish shared personalised care plans that travel with the individual between partner services. Embed culture of shared decision making and 'its ok to ask'	Review of impact to ensure continuous quality improvement
	Addressing health inequalities and delivering equity	Data profile development of people who are using different types of services. Identification of gaps and review of local provision undertaken. Review of current mixed sex accommodation, with actions to resolve. Development of system approach to cultural competency training Community health promotion established to reduce stigma in communities NHT compliant with Patient & Carer Race Equality Framework & themes embedded across whole pathway	Required commissioning undertaken to ensure local provision in place to meet need. Agreed principles for suitable environments developed, with focus on needs of people with autism System review of estates and suitability of environments	
	Improved system integration	System visibility of all services & support. Relationships developed between partners at all levels (focus on operational level). Clarity on partner roles and responsibilities. Programme of system-wide events to strengthen partnership culture Approved Mental Health Practitioners (AMHPs) provision integrated as key part of the pathway	Model for shared accountability of system performance developed. Online resource sharing tool developed	
	Coproduction with people who use services as equal partners	System-wide coproduction and engagement approach developed. Experts by experience model to support programme delivery established and embedded within governance. Coproduction and engagement plan to actively include the diverse voices of people who use care and support services developed and delivered.	Consistent and proactive approach to coproduction across all organisations. Coproduction approaches across services embedded. System-wide approach to shared learning and application of insights developed. Review of impact to ensure continuous quality improvement.	
	A system-wide workforce and culture that supports safe, personalised therapeutic & trauma-informed care	System training offer established, maximising opportunities across organisations. System ethos established to enable staff to feel safe and supported to solve complex challenges together. Trauma informed system workforce approach agreed. System recruitment and retention plan developed. Neurodiversity awareness training & Oliver McGowan training rolled out. NHT completion and embedding of NHSE culture of care programme	System training offer rolled out. Trauma informed workforce approach rolled out to staff. Neurodiversity awareness embedded within Mental Health services. Recruitment and retention plan embedded. Review of impact to ensure continuous quality improvement.	

Strategic Pillar	Areas of focus	Year 1	Year 2	Year 3
Timely discharge to the place people call home	Improved system data	System performance online dashboard developed (including national and local indicators to measure effectiveness). Information sharing processes established. Real time patient reporting developed with system partners to support patient care and flag risk and issues.	Demand forecasting model developed to inform planning and commissioning Options established and delivered to support NHS and social care interoperability of Notts Care Record	Review of impact to ensure continuous quality improvement
	Strengthening personalised care: putting people at the heart of their discharge	Personalised discharge plans established with processes for sharing with relevant system partners. Opportunities explored to maximise Personal Health Budgets (PHB's) for discharge. Focused work on those medically fit still in hospital and partners actions to support.	Revised processes operational	Review of impact to ensure continuous quality improvement
	Identifying needs early at admission (housing and wider support)	Processes in place to support identification of housing and support needs for discharge at point of admission. In-reach of partner expertise to wards established. Information sharing and reporting processes in place to ensure all partners aware of support needs and associated actions.	Review of impact to ensure continuous quality improvement	
	Increased housing and support to enable people to live in the place they call home	Gap analysis undertaken to inform service development. Demand forecast models for supported living and wraparound capacity completed. Review and modelling of required S117 aftercare support completed with associated actions identified. Mental Health needs reflected in local housing plans. Joined up approaches to accommodation-based services in the community for the most complex people established. Market development undertaken to grow provider market based on need	Required system commissioning undertaken. Review of impact to ensure continuous quality improvement	

Supporting people with Learning Disabilities and Autism

Integrated Care System
Nottingham & Nottinghamshire

There is a system-wide learning disability and autism programme that is leading the work to ensure people with a learning disability or autism only stay in hospital for the time that they need to. Partners are focused on preventing inappropriate inpatient admissions and strengthening discharges, with key work focused on reducing the amount of people requiring a specific learning disability and autism inpatient bed in mental health services. Priority work for 24/25 includes:

Maintaining the reduction in admissions of people with LD and/or ASD into an inpatient setting

Development of a respite and unplanned care model within the community.
Workforce training offer across the partnerships to reduce breakdown of community placements.
Continued promotion of Annual Health Check with support to low performing GP practices and a focus on accessibility for black and minority ethnic communities.
Continued use of Dynamic Support Register partnership working approach and Keyworking Teams supporting young people up to 25 years of age at risk of hospital admission.
Exploration of options for reasonable adjustment team to provide pathway advice and upskill workforce in mental health settings to prevent admission and to increase quality of care.

Strengthening discharges from inpatient settings

Developing local authority commissioning plans and market development work to develop discharge provision to meet need.
Exploration of capital housing bid expression of interest with NHSE.
Strengthened oversight of individuals with a Lack of Progress (LOP) towards discharge
Review of respite provision and day provision to meet need and reduce admissions.

Delivering equity

Capacity and demand review on Autism and ADHD referrals to inform future. commissioning intentions and longer-term investment to reduce waiting times.
Continued learning from Learning from Lives and Deaths Reviews (LeDeR) to inform improvement.
Reviews of existing commissioning services to ensure needs of people with down syndrome are met.
Joint training opportunities and upskilling of staff on supporting people with autism and Championing Oliver McGowan Training
Continued embedding of coproduction.

To complement this work, there will be a specific focus on supporting the needs of people with autism who are in a mental health inpatient environment. This will include a focus on training the workforce to support people with neurodiversity and developing autism-friendly environments and the way in which people work across mental health services.

Addressing Health Inequalities

Integrated Care System
Nottingham & Nottinghamshire

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They occur when people experience disparities in outcomes, experience and access to care and support due to their identity, their specific characteristics or unavoidable external factors, such as their income, education, access to green space and healthy food, the work people do and the homes they live in.

Through delivery of the strategic plan, we are committed to working with all our partners to identify risks of adverse health inequalities, consider impact (both directly and indirectly) from service and policy changes and positively work towards the reduction of health inequalities for people who are risk of further stigma and exclusion.

We will use national and local tools to support us in this work including:

Core20PLUS5: a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population, the 'Core20PLUS', which includes the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) and 5 clinical areas of focus which include Severe Mental Illness.

Patient and Carer Race Equality Framework (PCREF): NHS England's first mandatory anti-racism framework for local mental health trusts to adhere to. We will be working with partners at Nottinghamshire Healthcare Trust to support them in this implementation and applying best practice to other areas across our pathway to promote consistency.

Race Health Inequalities Matrix: Nottingham City Place Based Partnership has coproduced a matrix tool to help organisations providing health and social care services to self-assess their approach to address race health inequalities. Learning from the matrix tool will be applied to other areas of health inequality concern including LGBTQIA+ communities, women and people with neurodiversity.

Severe Multiple Disadvantage work: we will actively work with partners and programmes of work across Nottingham City and the County to meet the needs for those within our community who are identified as having severe, multiple disadvantages. This includes working alongside the development of the local Practice Development Unit (PDU) that supports partners and providers to support our most vulnerable communities.

System Trajectories

Integrated Care System
Nottingham & Nottinghamshire

The system is committed to ensuring that people only stay in hospital for the time that they need to and receive care in their local area in the least restrictive environment to meet their needs. To support this, all partners will work together to support people to leave hospital and go to the place they call home as soon as they are ready to. We will monitor this through key trajectories including:

Out of area placements	The system will aim to achieve zero out of area mental health inpatient placements by March 2025. Plans are in place to repatriate patients in out of area hospital placements back to Nottinghamshire in a planned way that focuses on the individual and meets their care and support needs. This means that from April 2025, the system will be able to deliver local care for all citizens who use mental health inpatient services.
Length of stay in hospital	We will monitor and review the length of stay of people in hospital and undertake system actions to address any issues preventing discharge to ensure people only stay in hospital for the time that they need to due to their medical needs. Targets will be developed through detailed delivery plans and will be reflected in contracts.
Number of people with learning disabilities and autism in inpatients	There is a continued system focus on supporting individuals with learning disabilities and autism to leave hospital as soon as they are ready. By March 2025 there will be no more than 32 adults with LDA in inpatient beds.
Ending the use of 'locked rehabilitation' beds	The system has an ambition to end the use of 'locked rehabilitation beds' and move to the levels of rehabilitation care as described in the commissioning framework to support the delivery of care in least restrictive environment by the end of the 3-year plan period. A review of local rehabilitation provision will be undertaken by Autumn 2024 to inform commissioning on a regional footprint by Autumn 2025.
Bed modelling	All this activity will be supported by the development of bed modelling plans to ensure Nottingham and Nottinghamshire has the right size and type of hospital bed provision in place to meet local need, as well as reduce reliance on sub-contracted private beds. Along with the right size and type of supported accommodation in place to support hospital discharge. This will be undertaken in Year 1 to inform 25/26 planning.

What will this mean for our community?

Integrated Care System
Nottingham & Nottinghamshire

For People

Has knowledge of and can access the range of care and support available so they can manage their own needs and live well in their local community.

Receive high quality care in the right place at the right time.

Receive inpatient care in their local area in the least restrictive environment to meet their needs.

Only stay in hospital for the time they need to, with housing and support in place to meet their needs in the community.

Empowered to work with staff to coproduce services and solutions based on need and real-life experiences.

Care that meets the needs of all people.

For staff

Valuing all our staff and supporting them with a trauma informed approach.

Delivering a more personalised and holistic approach to care and support.

Promoting multi-disciplinary team working.

Making every contact count

Understanding the range of services available to support with a person's mental, physical and social needs.

For NHS organisations

Ensuring the right size and type of inpatient services are available for those that need them when they need them in the least restrictive setting.

Making better use of all system resources to benefit more people.

Creating clearer pathways of care.

Implementing personalised care

A workforce and culture that supports safe, personalised, therapeutic and trauma-informed care.

For all System organisations

Improved system integration and relationships.

Experience and expertise of all partners is recognised and valued.

Improved information sharing to support patient care.

A shared system culture that enables the delivery of compassionate, safe, personalised, humane and therapeutic care.

System data approaches to inform planning and commissioning to meet future need.

An integrated system approach to commissioning and delivery of care and support services to maximise value for money across the system.

Governance

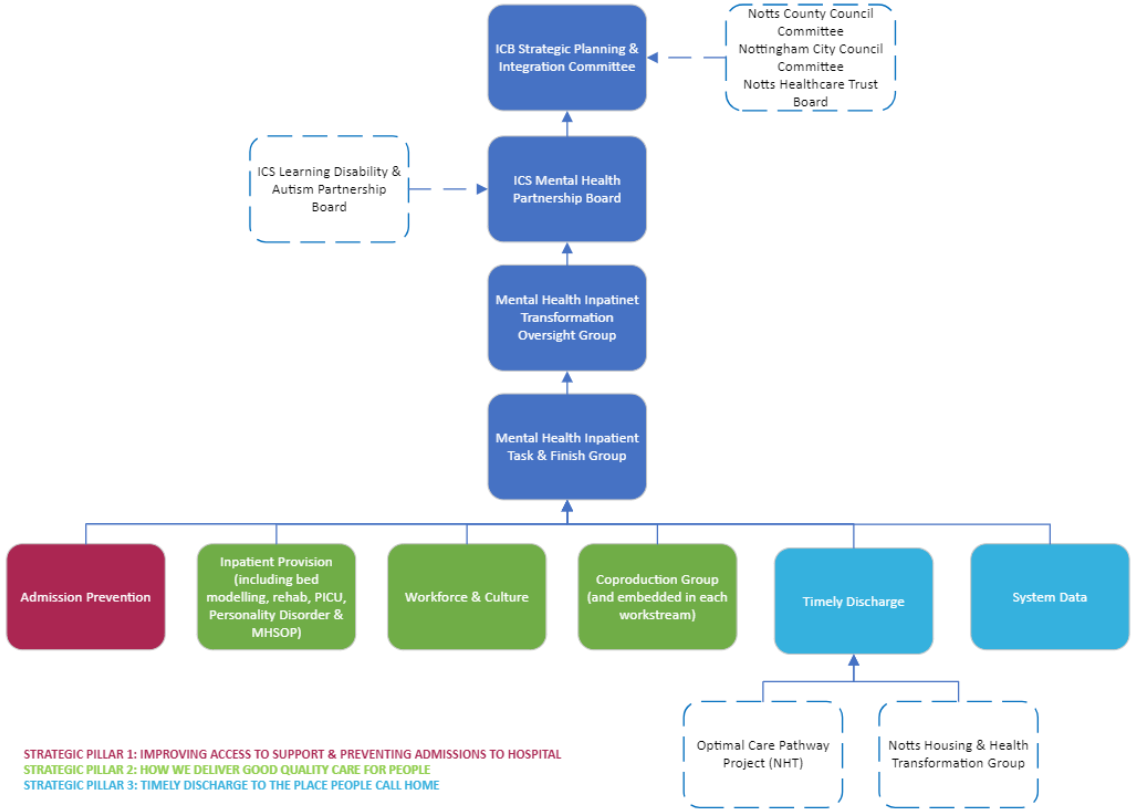
Integrated Care System
Nottingham & Nottinghamshire

The governance structure for overseeing delivery of the strategic plan focuses on a system approach with senior buy in and leadership shown by all key partners along with all key partners represented in membership. Programme infrastructure has been joint funded between health and local authorities and dedicated programme leadership and support is in place, along with partner support identified by key organisations.

The ICS Learning Disability and Autism Partnership Board will retain governance of transformation in relation to LDA, but the programme teams will work closely together to align priorities and deliverables, particularly in relation to those individuals with autism in a mental health inpatient environment.

The current governance arrangements are shown in the diagram. This will be reviewed in the next phase of delivery, to ensure sufficient oversight, assurance and support and will be aligned to the governance of the ICS Mental Health Partnership Board and Health and Wellbeing Boards. A series of working groups will be developed to provide subject matter focus on key areas of delivery. Governance will remain under review to monitor impact and productivity.

Financial support: An integrated system approach to commissioning and delivery of care and support services will maximise resources and support value for money approaches for the system. Commissioners from the ICB and local authorities will work together to gain maximum impact on outcomes and will work with people with lived experience to inform funding decisions. The Nottingham and Nottinghamshire system has been allocated £855,000 to support the delivery of the Mental Health Inpatient 3 Year Strategic Plan. This has been included in financial planning approved by the ICB Chief Financial Officer and aligns with ICS capital and revenue plans. System partners, including experts by experience, will determine the most impactful way to utilise the funding to achieve the best outcomes for people in Nottingham and Nottinghamshire, through addressing any identified gaps in care and support. Recommendations for funding use will be considered by the oversight group ahead of formal ICB governance routes.



System SRO: Chief Executive of Nottinghamshire Healthcare NHS Foundation Trust
ICB SRO: System Delivery Director – Mental Health & Children

Risks & Issues

Integrated Care System
Nottingham & Nottinghamshire

Overarching risks to the delivery of the strategic plan are included below. These will be addressed through the programme of transformation and will be managed through programme governance.

Risks		Mitigation
1	Different organisational cultures across the system poses a risk to achieving one system culture around the integrated mental health pathway	All system partners are actively engaged and are willing to work together to achieve our vision and aims. We will harness this collective ownership to work through any challenges relating to culture that we face.
2	Ability to transform with the current inpatient capacity challenge – inpatient beds full to capacity and increasing demand leading to use of out of area placements	We will work closely with Nottinghamshire Healthcare NHS Trust to align internal improvement activity with key partners work in relation to discharge support as a priority.
3	Challenging financial position may impact ability to align resources	The partnership will review what has already been invested and explore opportunities to maximise opportunities from the SDF programme allocation to develop case for change initiatives for future budget decisions.
4	Compatibility of partner data to support sharing of data and development of system reporting	Initial meetings in relation to data will focus on challenges and mitigations to establish meaningful data sharing options.
5	Pace and alignment with requirements/recommendations of CQC and other local investigations may influence the timing and delivery of the strategic plan	We will work closely with system partners to align deliverables and key delivery activity where possible and will understand at an early stage any potential impacts on delivery timescales to respond accordingly.
6	Ability to deliver on areas of focus that the system have been working on for a number of years and have not yet delivered (such as out of area placements)	We will build upon the foundations that have already been established, learn from previous attempts and maximise the potential of the current context and relationships. All system partners are engaged and supportive of the system approach to the integrated mental health pathway and are in a different place to previous attempts to deliver system change.
7	Ability to establish sufficient housing supplies to meet need due to ongoing housing supply difficulties	We will align with the work of the Notts Housing and Health Transformation Group to understand opportunities and influence housing decisions undertaken by district/borough housing authorities. We will explore opportunities for integrated commissioning opportunities for accommodation that are in the direct gift of commissioners.