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West Northamptonshire Council

West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Jeffrey Room, Guildhall, Northampton, NN1 1DN on Tuesday 26 March 2024 at 2.00 pm

Agenda

1.	**Apologies for Absence and Notification of Substitute Members**
2.	**Notification of Requests to Address the Meeting** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements** To receive communications from the Chair.
	Business Items
5.	**Minutes and actions from previous meeting 23rd January 2024 - Chair** (Pages 5 - 18)
6.	**NHS Northamptonshire Integrated Care Board Annual Report 2023/2024 - Naomi Eisenstadt** (Verbal)
7.	**NHS Northamptonshire Integrated Care Board 5 Year Forward Plan - Karen Spellman** (Pages 19 - 44)

8.	**West Northamptonshire Director of Public Health Annual Report 2023 - Sally Burns** (Pages 45 - 84)
9.	**Northamptonshire All Age Autism Strategy - Louise Kirby** (Pages 85 - 200)
10.	**Better Care Fund Quarter 3 Report** (Pages 201 - 214)
	Thematic Session
11.	**Live Your Best Life ambition 2: Access to the best available education and learning - Ben Pearson** (Presentation) • SEND Partnership
12.	**Live Your Best Life ambition 7: Connected to families and friends - Sally Burns** (Presentation) • Introduction to the ambition, for more focused discussion at the next meeting on the 14th May.
13.	**Voluntary Spotlight: Connect Northamptonshire - Claire Neilson** (Presentation)
14.	**Any Other Business - Chair**
15.	**Close Public meeting**

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Councillor Fiona Baker
Dr Jonathan Cox
Sally Burns
Colin Foster
Russell Rolph
Colin Smith
Dr Andy Rathbone
Professor Jacqueline Parkes
Councillor Jonathan Nunn
Anna Earnshaw
Naomi Eisenstadt
Stuart Lackenby
Toby Sanders
Michael Jones
Councillor Wendy Randall
Wendy Patel

Dr Philip Stevens	Dr David Smart
David Maher	Heidi Smoult
Robin Porter	Miranda Wixon
Chief Superintendent Rachel Handford	Jonny Bugg

Information about this Agenda

Apologies for Absence
Apologies for absence and the appointment of substitute Members should be notified to Cheryl.Bird@westnorthants.gov.uk prior to the start of the meeting.

Declarations of Interest
Members are asked to declare interests at item 2 on the agenda or if arriving after the start of the meeting, at the start of the relevant agenda item

Local Government and Finance Act 1992 – Budget Setting, Contracts & Supplementary Estimates
Members are reminded that any member who is two months in arrears with Council Tax must declare that fact and may speak but not vote on any decision which involves budget setting, extending or agreeing contracts or incurring expenditure not provided for in the agreed budget for a given year and could affect calculations on the level of Council Tax.

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Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

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Or by writing to:

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WEST NORTHANTS
Health and Wellbeing Board
live your best life

WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 23rd January 2024 at 10.00 am
Venue: Council Chamber, The Forum, Towcester

Present:

Councillor Matthew Golby (Chair)	Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council
Anna Earnshaw	Chief Executive, West Northants Council
Colin Smith	Chief Executive, LMC
Councillor Wendy Randall	Labour Group Leader, West Northants Council
David Maher	Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
Dr David Smart	Chair Northampton Health and wellbeing Forum
Dr Philip Stevens	Chair Daventry and South Northants GP Locality
Gabriella Van Beek	Office Manager, Healthwatch Northamptonshire
Michael Jones	EMAS
Miranda Wixon	Co-Chair Daventry and South Northants Health and Wellbeing Forum
Naomi Caldwell	Chair, NHS Northamptonshire Integrated Care Board
Palmer Winstanley - substitute	Chief Operating Officer, Northampton General Hospital
Professor Jacqueline Parkes	University of Northampton
Robin Porter	Assistant Chief Fire Officer, Northants Fire and Rescue
Russell Rolph Via Teams	Chief Executive, Voluntary Impact Northamptonshire
Sally Burns	Director of Public Health, West Northants Council
Toby Saunders	Chief Executive, NHS Northamptonshire Integrated Care Board

Also, Present

Adam Eakins, Lead Pastor, Broadmead Church
Annapurna Sen, Public Health Physician Health Protection, West Northants Council
Ashley LeDuc, Assistant Director
Bonita Wallace, Senior Public Health Administrator, West Northants Council
Cheryl Bird, Health and Wellbeing Board Business Manager
Chloe Gay, Public Health Principal, West Northants Council
Chris Pallot, Deputy Chief Operating Officer, NHS Northamptonshire Integrated Care Board
Julie Lemmy, Director of Primary Care, NHS Northamptonshire Integrated Care Board
Karen Spellman, Director of Strategy, NHS Northamptonshire Integrated Care Board

Paul Birch, Assistant Director Population Health, NHS Northamptonshire Integrated Care Board
Rachael Page, South Northants Volunteer Centre
Roberta Borges-Stewart

01/24 Apologies

Carella Davies, Chief Executive, Daventry Volunteer Centre
Cllr Fiona Baker, Cabinet Member for Children and Families, West Northants Council
Cllr Jonathan Nunn, Leader, West Northants Council
Colin Foster, Chief Executive, Northamptonshire Childrens Trust
Dr Andy Rathborne, Primary Care Network
Rebecca Wilshire, Director of Childrens Services, West Northants Council
Staurt Lackenby, Director of People, West Northants Council

02/24 Notification of requests from members of the public to address the meeting

None Received.

03/24 Declaration of members' interests

None received.

04/24 Chairs Announcements

The Chair made the following announcements:

- Palmer Winstanley will be the Northampton General Hospital representative for the next few months.
- Gabriella Van Beek will be the Healthwatch Northamptonshire representative replacing Wendy Patel

05/24 Minutes and actions from the previous meeting 11th December 2023

RESOLVED that:

- **The minutes from the previous meetings held on the 11th December 2024 were agreed as an accurate record.**
- **The 2 actions assigned to Assistant Director Revenue and Benefits to be followed up by the Health and Wellbeing Board Business Manager.**

06/24 Health and Wellbeing Board Terms of Reference and Election of Vice Chair

The Chair presented the revised Terms of Reference for the Board and highlighted the following:

- The Terms of Reference were adopted by the Board at their meeting on the 24th June 2021.

- The following proposed additions are to be added to ensure the Board complies with regulations for Local Authority statutory committee meetings and to outline additional procedures for when a Board member joins virtually:
  - Paragraph 8.2 If a Board member joins the meeting virtually this will not be counted in the quorum of that meeting.
  - Paragraph 9.2 If a Board member joins the meeting virtually, they will not be counted as being in attendance or be permitted to vote.
- The following proposed amendment from quarterly to bimonthly meetings to clarify frequency of meeting arrangements:
  - Paragraph 10.1 The Board shall meet on a bi-monthly basis, but this may need to be reviewed if there is a change in the frequency of work the Board needs to address. The date, hour and place of meetings shall be fixed by the Board.

RESOLVED that:

- **The Board endorsed the revised Terms of Reference for presentation to West Northamptonshire Full Council for approval.**
- **The election of Vice Chair be postponed to a future meeting.**

07/24 Live your best life domains: Access to health and social are when needed

The Chair advised the Live Your Best Life (LYBL) ambition 9 thematic theme for this meeting is 'Access to health and social care when they need it'.

The Director of Public Health advised there is development work taking place on the delivery plan for this ambition, which currently contains 4 high level metrics. Scorecards showing the high level metrics against the ambitions are being developed and will be brought to a future meeting. These scorecards will show the thread from the key action down into Local Area Partnership (LAP) level and Parish Council level.

The Director of Strategy and Partnerships confirmed the work being completed by NHS Northamptonshire Integrated Care Board (ICB) around the 5 Year Forward Plan and the associated implementation plans support delivery of this ambition and other ambitions contained within the Joint Health Wellbeing Strategy.

07a/24 Urgent Emergency Care Strategy:

The Deputy Chief Operating Officer presented an overview on development of the Northamptonshire Urgent and Emergency Care (UEC) Strategy and highlighted the following:

- This strategy will underpin the 5 Year Forward Plan and algin with this LYBL ambition Access to health and social care when they need it.
- Currently an engagement process is underway on development of the Strategy.
- Each year the strategy covers will be underpinned by a delivery plan.
- There are 6 stages of UEC:
  1. Empowered self-care and active prevention – these are patients at a higher risk of conveyance to hospital, often diagnosed with multiple long term conditions. The commitment is to ensure all those living with multiple long term conditions are supported to live well and thrive in their communities, supported by services delivered at place-level. Each will have a comprehensive holistic care plan which is visible to all partners; increased use of remote monitoring; peer support groups and increased annual health checks.
  2. Rapid access to primary care and community care – living well with diagnosed long term conditions.

3. Rapid and co-ordinated urgent care and crisis response – working with patients to keep them well and at home for as long as possible, with more intensive support being provided. The commitment is to expand and embed a single point of access to respond to escalating needs and safely avoid a conveyance or admission to hospital, enabling the person to complete their recovery in their place of usual residence.
4. Sub-acute – the patient needs a level of intervention from more specialist services, to provide wrap around rapid diagnostics to enable patient to remain at home.
5. Emergency and acute care – a patient becomes ill and is unable to be treated at home and need hospital admission.
6. Recovering independence – to support patients to recover their independence following a period of illness. The commitment is to deliver periods of intensive rehabilitation or recovery without delay for those who can return home and support them to remain there. Those who transition to a permanent care setting will receive this without delay.

- Each of the 6 pillars will include a breakdown of a work on a yearly basis. For pillar one the intent is to expand our capacity so that by 2028:
  1. 10,000 persons with multiple long-term conditions have a care plan using consistent care plan format.
  2. 5,000 persons benefit from remote monitoring.
  3. Every LAP will have a minimum of one peer support group per month for each of the four long term conditions prioritised for support.
  4. We will extend the annual health check for all persons over the age of 50 to include full blood test and an extended review with a lead clinician.
  5. All partner organisations involved in the support for the named person will have access to the care plan and take part in Multi Disciplinary Teams reviews.
- For pillar 6 the intent is to strengthen our provision and approaches to:
  1. Ensure that patients do not wait for more than 48 hours in hospital from being ready for discharge to being at home.
  2. Provide longer term therapy where required through local community therapy services.
  3. Ensure any equipment or minor home adaptations required to support maximum independence of person are identified early in the patient journey and implemented to avoid delays.
  4. Utilise short term alternative (non 24 hr staffed) accommodation for persons to commence their out of hospital recovery if their own home is not yet available for them to return to.
  5. Maximise the use of Virtual Ward to enable the patient to return home for further recovery where they would otherwise have occupied a hospital bed where they are supported through outreach monitoring.
- The intent is also to reprofile to ensure that by 2025:
  1. Any person requiring general rehabilitation / reablement in a bedded unit will be able to access this provision within ten miles of their home.
  2. We will have a single specialist facility giving correct provision of specialist stroke recovery beds to meet demand and ensure patients do not remain in Acute bed for longer than benefits their recovery plan.
  3. For persons who require a bedded pathway to manage unresolved delirium or challenges from behaviour related to dementia before they can progress to next part of their recovery journey, we will provide beds within one of our units with additional on site, in and out-reach staff to support successful outcomes.
  4. We have achieved full approval for our plans from stakeholders including health and social care in North and West Northamptonshire.
  5. We have maximised the use of our best estate and reduced future estate liability costs.
  6. No more than 5% of recovery beds are occupied on any given day by a person who

no longer has reason to reside.

Following questions from Board members the Deputy Chief Operating Officer added the following:

- The Strategy will support the work Northampton General Hospital will undertake in redesigning services around A&E, with one option to co-locate some minor illnesses services and out of hours services.
- Part of the new Primary Care Strategy will look at opportunities for an urgent care response in partnership with primary care and community care.
- Communication and support will be key in informing and guiding patients to use correct pathways and not ask for emergency services.
- There are mental health triage cars in place working alongside Northamptonshire Police (Operation Alloy) to attend mental health related incidents, which has seen a decrease in presentations to mental health facilities and A&E departments.
- Engagement has already taken place with various organisations and groups. The Deputy Chief Operating Officer offered to attend meetings and community groups to discuss development of the UEC Strategy and obtain residents feedback.

The Board discussed the update and the following was noted:

- General Practice only have 10 minutes with a patient to Make Every Contact Count (MECC), whereas staff in acute settings have much longer with patients. Conversations with patients in hospital around the benefits of diet, physical activity and smoking are key components to living healthier for longer and have a better success rate when discussions begin whilst a patient is in hospital.
- There is evidence to show that if hospitals provide a bio-psycho-social approach this will improve outcomes for patients.
- There is a need to ensure that all partners are communicated with, so they have an understanding of the development work taking place across the health system.
- There is an ongoing issue with patients suffering with mental health conditions not receiving the appropriate care or support, resulting in this cohort being frequent users of emergency services. More investment in treatment plans for these patients would reduce their reliance on emergency services.
- Patients who attend an A&E Department suffering with mental health issues are referred to the Community Liaison Teams, but there is a need to ensure patients feel their needs are being met.
- Referrals from Primary Care into the Musculoskeletal Service has a waiting time of approximately 1 year, which inevitably leads to more presentations at A&E and primary care to control their condition whilst waiting to see a specialist. There is also a 6 month waiting time to see a specialist for a dementia referral.
- A third of patients living in the Daventry and South Northants area access secondary care outside of Northamptonshire.
- ONS data has shown that poor mental health and musculoskeletal issues are the 2 main reasons for economic inactivity for those who are of a working age. There are currently long waiting lists for these services, with Northamptonshire Healthcare Foundation Trust (NHFT) looking at a range of options such services in community settings.
- There is an opportunity for the LAPs to help communicate the right pathways to access care through their engagement work with communities.
- It would be beneficial to have data points included in the action plan to act as a baseline to assess whether progress in being made.

RESOLVED that:

- **Presentations from the meeting to be circulated to Board members.**
- **The Board noted the update.**

07b/24 Northamptonshire Primary Care Strategy

The Director of Primary Care gave an overview for development of the Northamptonshire Primary Care Strategy and highlighted the following:

- Currently residents are finding access to GP appointments and NHS dentistry services difficult. Communication and engagement with residents is a key driver in facilitating change.
- The national recovery plans for both primary care access and UEC services have driven the structure of our Operating Framework. NHS England and supporting policies has emphasised the importance of joined-up delivery plans across Integrated Care Systems to drive recovery and resilience across the system, so the transformations planned in secondary care will align with the development of the primary care strategy.
- The *Delivery plan for recovering access to primary care,* also builds on the Fuller Stocktake Report, and references system-wide responses to integrated urgent care and neighbourhood teams:
  - The plan is centred on two key ambitions for access – tackling the 08:00 rush to ensure patients can receive same-day support and guidance from their local practice, and enabling patients to know how their needs will be met when they contact their practice.
  - To do this, it focuses on four areas to alleviate pressure and drive greater access – building capacity, reducing bureaucracy, empowering patients and modernising GP access.
  - Delivery in these areas includes improving the information, functionality and interoperability of technologies available; expanding the role of community pharmacy; and driving capacity increases through enabling workforce and estates initiatives to better support primary care.
- A System Level Access Improvement Plan has been produced and presented to NHS Northamptonshire ICB Board. This plan has an emphasis on listening to patients concerns, supporting them and GP Practices.
- The Primary Care Strategy will include GPs, Pharmacists and Dentists and focus on the four main areas to alleviate pressure and drive greater access – building capacity, reducing bureaucracy, empowering patients and modernising GP access.
- The engagement approach will be informed by the primary care sector, system providers and communities. Engagement from previous consultations with residents will feed into the draft Strategy.
- The aim of the strategy is for residents to access NHS services, personal and social care when they need to. People are supported to live at home for as long as possible and only spend time in hospital to meet medical needs. Services to prevent illness (e.g. health checks, screening and vaccines) are good, easy to access and well used.
- There are opportunities to deliver more routine health care services through other avenues to release capacity within primary care to enable GPs to deal with the more complex patients.

The Board discussed the overview and the following was noted:

- AI technology in Welcoming Spaces could be used to promote health improvement messages and pathways to services. As well as providing information for volunteers to promote.
- Concerns were raised about the current restraints on the system and raising unrealistic expectations amongst residents.
- The Joint Strategic Needs Assessment (JSNA) is being refreshed at a LAP and Primary Care Network (PCN) level.
- All the LAPs have GP representation as members.

- The high workload of primary care impacts on secondary care services. The national share of funding by the NHS into primary care is at an 8 year low, this balance of resource needs to be shifted more into primary care to enable more prevention work to be undertaken.
- GP Practices do not have an access problem it is a capacity problem.
- GP Practices are seeing patients with more complex needs, with a significant amount suffering with poor mental health. GPs would like to be able to support more patients who have complex needs at home, rather than in the practices.
- IT connections and communications between primary and secondary care need to be improved, as well as out of county communications which continue to be in paper format.
- Behaviour change in residents enabling them to care for themselves will release a lot of pressure on primary and secondary care services.
- Psychosocial health services could be undertaken by voluntary and community groups, as if psychosocial health issues are left unresolved this will manifest into physical health issues.
- A goods public communication strategy is needed to deliver messages on new pathways to access services and approaches to living healthier.
- Behaviour change for the population needs to start within health and care organisations.

RESOLVED that:
- **Access Improvement Plan to be circulated to the Board.**
- **The Chair VCSE Assembly and Director of Primary Care to discuss using community and voluntary sector to promote health improvement messages.**
- **The Board noted the update.**

07c/24 Prevention Strategy

The Assistant Director for Commissioning Performance gave an overview of work around prevention and residents requiring adult social care support and highlighted the following:
- Statutory requirements of local authority adult social care teams are:
  - If a Care Act Assessment confirms eligibility for long term support, there is a array of providers that help support these people.
  - If a Care Act Assessment deems a person is not eligible for support, there is still a responsibility to prevent, reduce and delay.
- There is rehabilitation, reablement and recovery pathways already in place.
- Approximately 80% of people accessing reablement services have no need for long term support after 3 months of receiving the initial support.
- The recovery pathway is for those who need good neighbourhood type support services.
- There are contracts in place with equipment specialist and assisted technology to help keep people at home safely for as long as possible.
- All enquiries into adult social care will go through the adult social team to enable better support for those who are in a crisis, with particularly high flow through the Northampton areas. To help mitigate the risks associated with front door services, the web pages are being re-designed to provide information and advice of health and wellbeing services as well as referrals to services where appropriate.
- For those who need more support looking after themselves but not long term support, a community wellbeing team is being created, with a mix of Supporting Independence Staff and Adult Social Care Staff, focusing on maximising independence. This will be a 12 week process assessed with the outcome start at the beginning and end of the plan.
- There will be improved links to GP Practices to identify people at risk of losing their independence. Building on the strengths of Aging Well to maximise resource available to support prevention.

- The customer service centre will work with people helping to identify those who could benefit from the community wellbeing team support.
- The Adult Social Care Teams have been re-aligned with the LAPs to utilise the strengths of the community offer and build into the adult social care offer.
- Discussions will take place with NHFT on use mental health support teams and housing support services to develop a more integrated offer.
- The draft West Northamptonshire Carers Strategy will be ready by the end of February, this has been reviewed by experts by experience, including engagement with unpaid carers to gauge their feedback on the support offer that is currently available.
- A bid has been submitted to the Accelerating Reform Fund (ARF), which includes more provision for unpaid carers who support people living with dementia.

The Board discussed the update and the following was noted:
- Wellbeing of carers needs to be included in the assessment for those suffering with dementia.
- The voluntary and community sector are aligned with the Prevention Strategy particularly in building capacity, as well as Action for Happiness project.

RESOLVED that the Board noted the update.

7d/24 Health Inequalities

The Assistant Director Population Heath gave an overview on inequalities and access to planned hospital care and highlighted the following:
- There is a new legal duty that data should (where available) be disaggregated by age, sex, ethnicity and deprivation. The aim for Northamptonshire is for this to include reporting at a Place and LAP level. This reporting must also show links to JSNA and Health Equity Audits.
- Inequalities in elective activity:
  - The GP registers show more residents and more diversity than ONS data, this is due to the GP register kept more up to date than the ONS data.
  - Differences between groups:
    - There are 43% of "White British" aged over 50.
    - Black people twice as likely to live in most deprived areas.
    - The proportion of those needing elective surgery increases with age.
  - Key findings:
    - Those living in deprived communities have a longer length of hospital stay.
    - There is significant variation in standardised elective access rates by ethnicity categories.
    - The COVID recovery is not equal.
- The elective activities by deprivation decile DSR, 2022/23 show higher access rates in the deciles 1 and 5, there are also higher rates in decile 7, 8 and 9 which is falls into some of the least deprived areas.
- Access rates for cancer relative services shown in the Relative Index of Inequality (proportion) of Elective activity are higher in the least deprived areas and lower in most deprived communities. More research will be conducted to try and establish whether this is due to screening or late presentation and accessing treatment in emergency settings rather than elective settings.
- Change in the elective activity DSR by deprivation 2022/23 compared to 2019/20 shows that the reduction in access rates following Covid is heavily skewed to more deprived populations with the least deprived 20% of our population seeing access rates increase while all other deciles saw reductions.

The Board discussed the update and the following was noted:

- Child poverty has a longer-term impact, with the impact being felt for potential another 30-40 years and service design needs to consider this.
- Those in poverty tend to suffer more ill health.
- It would be beneficial to see if there is interplay between deprivation, ethnicity and life chances. The ICB is currently undertaking some work around race, health and inequalities.
- With Northampton being a University town, primary care access for young people should be investigated further rather than focusing on elective care. There is a greater impact of sickle cell sufferers due to a higher student population.
- Healthwatch Northamptonshire are inviting speakers from local sickle cell sufferers to share their lived experiences, including looking at health inequalities.
- The biggest inequalities being seen by general practice is with those who can afford private medical treatment and those who have to wait for NHS treatment. Referrals for private medical treatment is approximately 20% higher than pre COVID19 levels.
- NHS funded private medical treatment to reduce waiting times is accessed more in deprived communities.

RESOLVED that:

- **The Assistant Director Population Health to circulate data on non elective activity, along with mental health data.**
- **The Board noted the update.**

7e/24 COVID19 Impact Assessment

The Public Health Physician Health Protection gave an overview of the COVID19 Needs Assessment and highlighted the following:

- The COVID-19 Impact Assessment has been conducted to evaluate the effects of the pandemic on the population and services across Northamptonshire. The aim was:
  - To identify both direct and indirect implications on the health, well-being, and lifestyle of residents, additionally.
  - To examine the impact of the pandemic on service provisions and their ability to meet the needs of the community, with the intent of informing system partners in the planning of recovery programmes.
- A survey was sent to approximately 6000 randomly selected residents, families and organisations from across Northamptonshire and 2300 fully completed responses were received.
- Half of the respondents (51%) reported suffering from the COVID-19 Infection, with around a quarter (26.5%) of them experienced COVID-19 reinfections (more than two episodes).
- Less than a fifth (14%) of the individuals who tested positive for COVID-19, resulted in having symptoms of long-covid within and beyond 3 months of infection. Which resulted in these individuals experiencing difficulties with day to day activities.
- A tenth (12%) of respondents indicated being diagnosed with a new health condition during the pandemic, with a third of them indicating their diagnosis was because of COVID-19.
- Respondents who did not have any mental health issues before, over half (50%) of them have reported to experience some form of mental health issue, from anxiety to serious mental health conditions, including attempting self harm.
- Two fifths (38%) of the adult respondents completed the domestic abuse questionnaires, of these, around one fifth of those (18%) stated they experienced some form of domestic

abuse, and two thirds of them experienced two or more types of domestic violence (63%) affecting their physical and mental health.

- Around two thirds (**65%**) of the children and young adults had the covid-19 infection; out of those, around **(50%)** were not vaccinated or incompletely vaccinated.
- Over two thirds (**69%**) of parents indicated their child experienced some form of mental health difficulties, anxiety being the most experienced followed by low confidence and self-esteem.
- Thematic analysis identified that the primary issues parents faced was accessing healthcare services including dentists and GP's, with a long wait for a follow-up for existing conditions.
- Delays in up to 2 years for special education assessments to diagnose special needs and support affected behavioural and learning growth.
- Issues identified in maintaining and recruiting volunteers which were associated with financial burdens due to unemployment, reduced earning and significant increase in cost of living.
- To keep organisations in operation, services indicated that financially they relied most on the local community (45%), followed by 30% support from the national government and 25% support from the local government.
- The majority (82%) of businesses who responded indicated a decrease in turnover during the COVID-19 pandemic compared to pre-pandemic expectations.
- One tenth of the responding businesses indicated that post pandemic they are still only partially trading, whereas remaining businesses returned to full trade.
- According to respondents' opinions, the contributing factors that influenced turnover included Brexit (24%), manmade wars (34%), changes in European laws on importing and exporting (24%) and other environmental factors (33%).
- 80% of the adult respondents indicated issues in accessing healthcare, which was related to cancelled appointments, getting follow up as well as first appointments.
- 60% of the adult respondents stated waiting times for a virtual or telephone GP appointment was also a minimum around seven days, which was a factor affecting timely management of ill health. These delays in access have continued in the post pandemic phase as well.
- 41% of the respondents from the Children survey also stated issues in accessing medical appointments, as a result of cancellations and postponements.
- 32% of health care workforce who responded stated that the COVID-19 pandemic had an effect on their Mental Health, with 29% of the workforce said that their physical health was also affected, with 39% indicating higher number of absences had an impact on the service delivery and affected their quality of work due to overburdened responsibilities.
- Workforce reported experiencing increased anxiety, work induced stress, burn out and episodes of low mood and no respite.
- 61% of respondents indicated their residents had various health and social care appointments cancelled. 50% stated that as a result of the cancellations, health and wellbeing of the residents deteriorated.
- Thematic analysis indicated that as a result of the pandemic, access to GPs was difficult and inconvenient, Residents' physical and mental health declined and the isolation led to development of poor memory leading to higher levels of anxiety and deteriorating existing memory loss and cognitive functions.
- 83% of the respondents indicated that the pandemic negatively impacted their residents mental health. These were linked to feelings of loneliness, anxiety and low mood due to the lack of social contact and interactions.
- Mental Health demand is exceeding capacity due to pandemic toll, additional capacity is required to support increasing needs. Additional need to smooth Mental Health service transition from adolescent to adult.
- Demand on Primary care (GP and dental)
  - Care pathways to be appraised to triage patients to relieve knock on pressures.

  - Improvements required to increase availability of NHS Dental Health services and existing local pathway should be reviewed to improve access.
  - Improve engagement with the population and the community to improve uptake of preventative interventions with a targeted approach to address health inequalities.
- Focus is required for supporting children with confirmed or undiagnosed learning difficulties to ensure they have the best start in life by improving access to special educational needs assessments and creating additional capacity to facilitate educational establishments.
- More investment into voluntary sector is needed to ensure services are kept in operation to continue to support those in need.
- Local government should ensure that all COVID-19 government support provided through the Local Authorities are equitable and equal, ensuring that hidden vulnerable cohorts and small businesses or organisations are not left out. Local Authority departments including regeneration, housing and community should identify local needs and mobilise resources and fundings accordingly.
- Northamptonshire system leaders to be prepared with local plans and procedures and be resilient, with adequate resources and capacity for an immediate response to emerging infectious disease epidemics or a pandemic.

The Board discussed the update and the following was noted:
- A wider discussion is needed on how best to use the findings contained within the needs assessment and how the findings can help formulate a wider recovery plan.
- Need to consider at a community level how we prepare for a future pandemic, identifying potential issues and working in partnership to address those hidden needs.
- Young Healthwatch Northamptonshire are undertaking an in-depth study in conjunction with the ICB around waiting times for SEND, ADHD diagnosis waiting times and how this is affecting young people.
- This impact assessment will sit within the JSNA and some of the recommendations have already been accessed.

RESOLVED that the Board noted the update.

7f/24 NHS Dentistry Update

The Chief Executive NHS Northamptonshire ICB gave an update on the NHS dentistry provision within West Northamptonshire and highlighted the following:
- The ICB took over commissioning for NHS dentistry provision from NHS England in April 2023.
- Currently there are national and local issues in accessing NHS dentistry services, due to workforce challenges within dentistry and the national NHS contract for dentists to provide NHS services.
- In West Northamptonshire currently demand for NHS dentistry services outstrips demand, with this financial year seeing several dental practices withdrawing NHS dentistry provision.
- NHS Northamptonshire ICB Dental Team have been contacting local dental practices for expressions of interest to increase their NHS dental offer above their core contracted level. There have been a few positive responses with these practices offering some limited additional NHS provision.
- NHS Northamptonshire is working with the regional Public Health Team to commission a dental needs assessment for Northamptonshire to be completed at the end of the financial year. Once completed it would be beneficial for this needs assessment to come to a future Board meeting to enable a wider discussion on a longer term investment plan for the dental underspend.

RESOLVED that:

- **The Dental Needs Assessment be presented to a future Board meeting.**
- **The Board noted the update.**

08/24 Voluntary Sector Spotlight

The South Northants Volunteer Bureau (SNVB) provided an overview of their work and highlighted the following:

- SNVB support the voluntary and community sector by providing guidance, training and information to those looking to initiate community action and assist residents in enjoying healthy lives whilst strengthening the community/voluntary sector in West Northamptonshire.
- SNVB are supported by approximately 350 volunteers, benefiting over 3000 residents and deal with approximately 100 volunteer enquiries every quarter.
- SNVB Volunteer Car Service facilitates transportation for over 500 passengers to access health and social appointments and receives approximately 2000 bookings every quarter. The volunteer drivers provide over £40k of volunteering every quarter and has saved 8 lives due to interventions made by the volunteer drivers.
- The cost of living crisis has seen a dramatic increase in residents needing additional support.
- WNC Customer Outreach Team attend the Woodford Saints Community project on a monthly basis, also the Care Co-ordinator for Towcester and Brackley attends on a weekly basis.
- SNVB work in collaboration with VCSE's Older Persons Thematic Group and Integrated Care Northamptonshire in understanding the reasons behind health inequalities in the older communities. With the aim to co-produce interventions to promote the prevention agenda and reduce periods of ill health.
- SNVB has completed asset mapping within their area and how this contributes to enhanced social participation, improved wellbeing and independence.
- The community food larders have over 100 volunteers providing a service to over 12k members accessing these larders. The volunteers have provided 10k hours of volunteering per quarter to a value £127k.
- The garden buddy volunteers complete 300 jobs every quarter using volunteers serving 125 community members, equates to 400 hours per quarter valuing £5k. Those often attending the food larders tend to volunteer at these.

The Lead Pastor, Broadmead Church provided an overview of their work and highlighted the following:

- Broadmead Church formed in 1932, which was re-developed in 2019 to build a community asset including more suitable space for the day nursery.
- A community survey was undertaken to gauge residents views on services they would like to see provided, with the top 3 being:
  - Community café
  - Senior lunches
  - After School Drop in
- Post COVID19 a workshop was held with over 80 attendees, including residents, voluntary sector, representatives from education and statutory services. From these actions groups were formed to work on fly tipping, anti-social behaviour, wellbeing, mental health.
- An Eastfield and Headlands Community festival is held annually, in conjunction with St Albans, food banks, statutory services and the voluntary/community sector.

- Broadmead Church has a good working partnership with local social prescribers and is in partnership with Northamptonshire Sport (NSport) to run the Big Bike Revival and guided bike rides.
- Broadmead Church has partnered with NSport to offer table tennis club which is attended by 30-40 people, and helps in reducing social isolation.
- Good Companions run a fortnightly lunch club at the Church for single or isolated elderly people and a fitness group has just started for the less mobile.
- There are approximately 1k adults coming into the church every week, with 120 volunteers. The Church is helping those who have been economically inactive for a period, to come and volunteer which helps them get back into employment.
- A challenge for voluntary sector/community groups is having to constantly access grant funding.

The Board discussed the updates and noted the following:
- The work of community sector and voluntary groups is a fundamental part of the work of the LAPs.
- Community trust decreases the risk of long term conditions and thought needs to be given on how to evaluate and evidence this.

RESOLVED that:
- **The West Northamptonshire Asset mapping to be circulated to the Board once completed.**
- **The Board noted the updates.**

08/23 Local Area Partnership Terms of Reference

RESOLVED that the Board endorsed the Local Area Partnerships Terms of Reference.

09/24 Any Other Business

The Director of Strategy NHS Northamptonshire ICB gave an update on the Workwell Partnership Bid and highlighted the following:
- The Workwell bid was submitted on the 22nd January. There will be 15 pilot sites across the country.
- The bid is to set up a pilot service to support people with disabilities and health conditions to return to employment or stay in employment.
- The bid was a collaboration between North and West Councils, NHS, voluntary sector, DWP and health colleagues.
- The model focused on 5 LAPs across the county, for West Northamptonshire it is Northampton Central and Rural West.

Dame Carol Black visited the county to review work around substance misuse taking place in the county.

RESOLVED that the Board agreed for the Chair to have delegated access to sign off the Better Care Fund Quarter 3 submission.

There being no further business the meeting closed at 12.05 pm.

WEST NORTHANTS
Health and Wellbeing Board
live your best life

West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action
111223/01	Belinda Green to link in with the Population Health Board Prevention Subgroup.	Belinda Green	Asked for an update awaiting a response	
111223/02	Belinda Green to ascertain if there is any provision currently in place to help people with offsetting debts	Belinda Green	Asked for an update awaiting a response	
230124/03	Miranda Wixon and Julie Lemmy to discuss using community and voluntary sector to promote health improvement messages	Miranda Wixon/ Julie Lemmy		
230124/04	Paul Birch to circulate data on non elective activity, along with mental health data.	Paul Birch		

Actions completed since the 23rd January 2024

Action No	Action Point	Allocated to	Progress	Status of Action
230124/01	Presentations from the meeting to be circulated to Board members.	Cheryl Bird	Circulated 23rd January.	Completed
230124/02	Access Improvement Plan to be circulated to the Board.	Julie Lemmy	Circulated 24th January.	Completed

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

26th March 2024

Report Title	**Northamptonshire ICB Five Year Joint Forward Plan-Update 2024/25**
Report Author	**Karen Spellman, Director of Strategy and Planning, Northamptonshire ICB**

List of Appendices

Appendix A –Five Year Joint Forward Plan-Update 2024-25

1. Purpose of Report

The purpose of this paper is to set out the approach to revise the Northamptonshire ICB 5 Year Plan.

2. Executive Summary

In line with statutory guidance, ICBs and their partner trusts should review their Joint Forward Plan (JFP) before the start of each financial year, by updating or confirming that it is being maintained for the next financial year.

Our JFP strategic intent remains the same and we will continue to maximise the opportunities that true integration brings, working with our partners and communities across Northamptonshire to transform the way we provide health and social care.

Our focus in this updated summary JFP is therefore on the following;

- Summary of progress against our 24/25 priorities
- Development of our reporting metric dashboards

This approach contributes to the production of our detailed operational and financial plan for 24/25 which will be finalised by May 24 in line with NHS England national guidance.

The paper describes how our 5 year plan delivery priorities align to the Live Your Best Life ambitions and progress against the agreed ICN Outcomes Framework for the following three ambitions;

- Best Start in Life

- Opportunity to be fit, well and independent
- Access to health and social care when needed

Over the coming years, we will deliver our 5 multi-impact interventions at the same time as delivering progress on long term issues such as prevention and reducing inequalities. During 2024/25 as our ICS matures further, we will review our progress against delivery and further refine the strategic decisions to be made to best deliver improved outcomes for our population.

3. Recommendations

The Board are asked to note the ICB Five Year Joint Forward Plan updates for 2024/25 and endorse the JFP strategic direction of travel.

4. Report Background

4.1 The Northamptonshire ICB 5 Year Joint Forward Plan was published in June 2023. The JFP sets out how we will help deliver many of the ambitions outlined in the ICP Live Your Best Life Strategy, as well as setting out how we intend to deliver our statutory duty to provide health services in an integrated way.

4.2 During 2023/24, the ICB has worked collaboratively with West Northamptonshire County Council and all partners across the system in delivering our plans and ensuring we have aligned reporting and metrics to improve outcomes for our local population.

4.3 The Health and Wellbeing Board considered and endorsed the final JFP in June 2023.

5. Issues and Choices

5.1 The report sets out progress against our multi-impact priorities and the development of our reporting metric dashboards and alignment of these with the Live Your Best Life ambitions.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 This JFP contributes to the production of our detailed operational and financial plan for 24/25 which will be finalised by May 24 in line with NHS England national guidance.

6.2 **Legal**

6.2.1 There are no legal implications arising from the proposal.

6.3 **Risk**

6.3.1 There are no significant risks arising from the proposed recommendations in the report.

6.4 **Consultation**

6.4.1 The report has been developed in collaboration with system partners. Each of the specific delivery partnerships engage and consult with service users on co production of their transformation plans.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 This has not been revied by the Overview and Scrutiny Committee.

6.6 **Climate Impact**

6.6.1 No climate/impact assessment has been carried out. An ICB Green Plan has been published and a series of ambitions and actions are included i elements of the delivery partnership transformation plans.

6.7 **Community Impact**

6.7.1 Delivery Partnerships Include collaboration with Local Area Partnerships as appropriate.

7. Background Papers

7.1 ICB 5 Year Joint Forward Plan-June 23
7.2 Integrated Care Northamptonshire Live Your Best Life Strategy -January 2023

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NHS Northamptonshire Integrated Care Board Five-Year Joint Forward Plan: Updates for 2024-2029

NHS
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Integrated Care Board

This section is to be read alongside our full Five Year Joint Forward Plan published in June 2023. For 2024-2029 the update includes the progress made in 2024/25 and our summary delivery plans.

Introduction

In line with the statutory guidance, ICBs and their Partner Trusts should review their Joint Forward Plan before the start of each financial year, by either updating or confirming that it is being maintained for the next financial year.

The purpose of this paper is to set out the approach to revise the Northamptonshire ICB 5 Year Plan.

Our 5-year Joint Forward Plan (JFP) was published in June 2023 and sets out how NHS Northamptonshire Integrated Care Board (ICB) intends to work with partner NHS Trusts and Local Authorities to deliver its statutory duties to provide health services in an integrated way to the population over the 5 years from 2023/24 to 2027/28.

Our 5 Year Joint Forward Plan is directly linked to the Integrated Care Northamptonshire 'Live your Best Life' strategy published in January 2023 and the West Northamptonshire and North Northamptonshire Health and Wellbeing strategies developed throughout 2023. All our plans focus on improving a set of agreed outcomes for the health, care and wellbeing of local people. Throughout 2023/24 we have focused on developing our programmes and delivery plans to improve outcomes. As we develop as a System our plans will reflect more fully our wider partnership activities to achieve this.

Our JFP strategic intent remains the same and we will continue to maximise the opportunities that true integration brings, working with our partners and communities across Northamptonshire to transform the way we provide health and social care.

Our focus in the updated JFP is therefore on the following;

- Summary of progress and delivery plans for 24/25 for the Multi-Impact Interventions
- Development of our reporting metric dashboards

This approach contributes to the production of our detailed operational and financial plan for 24/25 which will be finalised by May 24 in line with NHS England national guidance.

NHS Northamptonshire Integrated Care Board

The Northamptonshire Integrated Care Partnership **10-year 'Live Your Best Life' Strategy** was published in January 2023

The NHS **Northamptonshire Integrated Care Board Five-Year Joint Forward Plan** was published in June 2023

Context

Northamptonshire Integrated Care Board

As we approach the end of the financial year 2023/24 and move onwards into 2024/25 Northamptonshire ends with a challenging financial position. The ICB recognises that its current financial position is not sustainable in the medium-term. To achieve the best outcomes for our population we have been collaborating across the system to develop our medium-term financial planning approach and to put a delivery framework around our joint financial strategy for the system. We will use a range of benchmarking data available to support and inform our approach.

For 2023/24, we originally planned to deliver a breakeven financial position which included a challenging efficiency target. We revised this position in January to reflect a forecast outturn deficit of £34.8m. It is important to note that the System is forecasting to deliver the planned efficiency target in full and that this movement away from plan is driven largely by uncontrollable pressures around inflation, demand and indistrial action. Our final position and forecast for 2024/25 will be included in our Operational and Financial planning submission due for completion by 2nd May 2024.

As a system we will need to build on the current multi-impact interventions and focus on transformation and efficiency that will support our long-term financial sustainability. As we move into 2024/25, with greater financial challenges and pressures across the system, we will need to make some difficult decisions about our key priorities for critical investment and efficiency.

We will deliver our 5 year JFP ambitions to improve health and care outcomes for our population through the changes outlined in our multi-impact interventions and delivery partnerships. Where our longer-term plans are dependent on investment in transformation to deliver care in better healthcare settings, we recognise we will need to drive productivity and efficiency in order to be able to achieve this.

From 1 April 2023 the commissioning of Pharmacy, Optometry and Dental services was delegated to ICBs from NHS England. This provided us with the opportunity to directly impact and influence the commissioning of these service for our population. This has allowed us flexibility in the way we commission services such as pharmacy and to continue to support our population to access advice and support closer to home.

The challenges faced in dental services capacity are not unique to Northamptonshire and our priority for 2024/25 will be to work regionally and nationally to develop our commissioning approach to reflect the needs of our population.

From 1st April 2024, 59 Acute Specialised Service Lines will be formally delegated to the ICB (subject to Board approval). We are committed to working together across the Midlands to achieve the best outcomes promoting pathway integration to drive improvements in population health. 2024/25 will be a transitional year to set out the practical ways in which we will work together to mitigate any potential risks and issues to develop a strong operating model.

Our Plan on a page

Our Plan on a page summarises our programmes and focus to deliver our ICS aims and the national and local priorities.

NHS Northamptonshire Integrated Care Board

Integrated Care Northamptonshire

Our shared 10-year vision

"We want to work better together to make Northamptonshire a place where people are active, confident and empowered to take responsibility for good health and wellbeing, with quality integrated support and services available for them when they need help."

Our ICS aims

Improve outcomes in population health and healthcare	Tackle inequalities in outcomes, experience and access	Enhance productivity and value for money	Help the NHS support broader social and economic development

Our delivery focus areas

National priorities	Local NHS 'Live Your Best Life' ambitions
• Recover our core services and productivity • Deliver the key ambitions of the NHS Long-Term Plan • Continue transforming the NHS for the future	• Best start in life • Opportunity to be fit, well and independent • Access to health and social care when needed

Multiple-impact interventions

Digital	Recovery of independence	Access to services	Children and young people	End of life

Our approach to creating the conditions for success

Integration	Health inequalities	Data	Quality improvement	Prevention

Our delivery partnerships

Maternity and neonatal	Children and young people	Primary and community care	Urgent and emergency care
Elective care	Cancer care	Mental health, learning disability and autism	Palliative and end-of-life care

Our enabling programmes

Our people	Research and innovation	Digital	Comms and engagement	Estates and environment	Finance

How our 5 year plan maps to the delivery of our ICN Live Your Best Life ambitions

NHS Northamptonshire Integrated Care Board

During 2023/24, we have ensured our delivery partnerships and programmes are aligned to the Integrated Care Northamptonshire Live Your Best Life ambitions. The ICB is working to support the delivery of all 10 'Live Your Best Life' ambitions, however, based on health inequalities data, the ICB has also prioritised driving improvement through three of the ambitions. Within these three ambitions the ICB has agreed nine priority outcome metrics. The table below shows how our delivery programmes map to the ICN priority ambitions.

ICN Ambition	Outcomes Framework Metrics	Our deliver partnerships and programmes	Oversight Board
Best Start in Life	• Percentage of children with a good level of development at age 2-3	• Children and Young people (including children and adolescent mental health, learning disability and autism) • Maternity and Neonatal	• CYP Transformation Partnership Board • Local Maternity and Neonatal Board
Opportunity to be fit, well and independent	• Reducing prevalence of adult overweight and obesity • Reducing prevalence of adult smoking • Reducing rate of emergency COPD admissions • Improving self-reported wellbeing score	• Inequalities and Prevention • Stroke, cardiovascular disease, respiratory and diabetes (Long Term Conditions) • Children and young people • Mental Health Learning Disability and Autism	• Inequalities and Prevention • Elective Collaborative • CYP Transformation Partnership Board • MHLDA Collaborative
Access to health and social care when needed	• Increasing proportion cancer diagnosed stage1/2 • Increasing Health Checks for Looked After Children and adults with Learning Disabilities and Severe Mental illness • Reducing rate of ED attendance for falls in those aged 65+ • People that return to their normal place of residence after discharge from hospital	• Access to services Multi-Impact Intervention • Primary Care • Supporting and Recovering Independence Multi-Impact Intervention • Urgent and Emergency Care • Elective Care • Cancer Care • Palliative and End of Life Care • Children and young people • Mental Health, Learning Disability and Autism	• UEC Board • Primary Care Operational Delivery Group • Elective Care Collaborative Board • Cancer board • CYP Transformation Partnership Group • MHLDA Collaborative • All Age End of Life Delivery Group
Supporting and Enabling delivery	Digital, Workforce, Quality Improvement, Safeguarding, Research and Innovation, Estates and Environment, Finance		

Live Your Best Life Ambition Outcome Metrics

The scorecard below summarises the progress against the Outcomes Metrics identified against the 3 main Live Your Best Life ambitions the 5 year JFP focuses on

NHS Northamptonshire

LYL Ambition	Metric	Responsible Programme	Good is..	Last Update	Current data		Trend	Previous Data	
					Period	outturn		Period	Outturn
1. Best Start in Life	Percentage of children with a good level of development at age 2-3	CYP Transformation	High	2022-23 NNC		75.4%	↑	2021-22	74.2%
				2022-23 WNC		76.9%	↓	2021-22	78.3%
3. Opportunity to be fit, well and independent	Reducing prevalence of adult overweight and obesity (OHID Fingertips)	Inequalities and Prevention (Population Health Board)	Low	21/22 (NNC)		68.3%	↓	20/21	69.2%
				21/22 (WNC)		69.4%	↑	20/21	68.9%
	Reducing prevalence of adult smoking (Smoking Prevalence in adults (18+) - current smokers (APS), OHID Fingertips) *(downward trend is positive)*	Inequalities and Prevention (Population Health Board)	Low	2022 (NNC)		14.6%	↓	2021	16.6%
				2022 (WNC)		12.0%	→	2021	11.5%
	Reducing rate of emergency COPD admissions	Access to Services MII	Low	Nov 23	Q3	47.5%	→	Q2	47.5%
	Improving self-reported wellbeing score*(No exact version of key system measure is available and a review of this metric and data source is under review with Public Health)	Children and young people Mental Health Learning Disability and Autism	-						
9. Access to health and social care when needed	Increasing proportion cancer diagnosed stage1/2	Cancer Board	High	2021 (NNC)		52.4%	↓	2019	55.3%
				2021 (WNC)		56.3%	↑	2019	55.5%
	Reducing rate emergency admissions for falls in those aged 65+ (Directly standardised rate per 100,000, OHID Fingertips	Inequalities and Prevention (Population Health Board)	Low	21/22 (NNC)		2,598		-	-
				21/22 (WNC)		1,958		-	-
	Increasing Health Checks for adults with Learning Disabilities and Severe Mental illness	MHLDA Collaborative	High	Dec 23	Q3	48.18%	↑	Q2	45.9%
	People that return to their normal place of residence after discharge from hospital	Recovery of Independence MII	High	Dec 23	Q3	94.5%	↓	Q2	95.5%

Our multiple-impact interventions

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In June 2023 we outlined our five multi-impact interventions which we agreed would have the greatest impact on our ability to meet our national and local priorities as well as ensuring the infrastructure is in place for longer term improvements.

Throughout 2023/24 we have further developed and begun to implement our delivery plans to provide clarity for our multiple impact interventions and delivery programmes. Further details of the delivery plans are in Appendix 1.

We have access to better data and insights and have developed outcome metrics and dashboards to support each Multi-Impact Intervention.

We have seen significant challenges across health and care over the past years, in particular with workforce challenges and cost pressures. Our priority for the coming year is to continue to deliver our multi-impact interventions. We have further developed these priorities to ensure we are focusing our collective effort on shared objectives where we can make a real impact.

By implementing integrated pathways to improve flow through our urgent and emergency care services we will support our population to maintain and recover their independence. We will support Primary Care to meet both urgent care needs and the maintenance of long–term condition care, we will do this through greater integration at Place and Local Area Partnerships.

During 24/25 we will further build on the successful delivery in elective and cancer care to implement improvements in pathways to increase productivity and delivery efficiencies, reduce waits and delivery better patient outcomes. This will include how we use our elective capacity across the ICS.

We continue to work with system partners to scope, evaluate and quantify the benefits of each of these interventions. As we develop our services and integration plans we will continue to engage with our stakeholders, communities and Local Area Partnerships to shape the care we offer.

Digital and Data

Access to high-quality, timely data, digital technology and innovation will have the greatest impact across all our partnership programmes and priorities to improve outcomes and reduce inequalities.

Supporting and recovering independence

Length of stay in health and care settings has a significant impact on patient experience, and we know patients would prefer to be helped to return home and regain their independence wherever possible. We have therefore prioritised reducing length of stay across all areas of care.

Access to services

Accessing care, particularly same-day care, is challenging for people in Northamptonshire. We are prioritising offering timely access to services and better supporting people in their communities to live healthier lives. This includes recovery of primary care and access to planned care

Children and young people

Having the best start in life prevents ill-health and helps identify the needs of our population earlier. We have identified two-to-three-year health checks and children and young people's mental health and wellbeing as key priorities which will have the greatest impact in this area.

End of life

While areas of Northamptonshire's end-of-life care service are exceptional, it is not always seamless, well-planned and coordinated. Our aim is for all individuals to have the best possible experience towards and at the end of their life.

Multi-Impact Interventions
Summary of achievements for 23/24

NHS Northamptonshire Integrated Care Board

	Summary of key achievements 2023/24
Digital and data	• NCR is now live, work towards digital ReSPECT forms to ensure all providers are aware of individuals end of life wishes is progressing at pace. Over 300 person days saved through use of NCR since October 23. • Investing in data tools to allow all partners to see and use data across the system including VUIT and NARP • Digital skills academy underway to enhance digital and data skills to support health and care pathways, 1st benefits review underway • Digital patient letters via a patient portal & the NHS App - Multiple languages, accessible screen reader technology for blind patients. 1st specialties due to go live in March 24
Supporting and Maintaining and Recovery of Independence	• Five-year strategy drafted with a focus on pre and post hospital care, Engagement underway, aim to publish April '24 • Plans to further develop the Single Point of Access and align with the System Co-ordination Centre • Focus on P2 and P3 pathways to reduce delays and improve flow • Plans to enhance services for those with dementia and delirium to improve outcomes and reduce delays
Access to Primary Care Services	• System Level Access Improvement Plan agreed by Board and published • GP Clinical strategy development working with the GP Federations and Super Practice to support the longer-term Primary Care Strategy. • Primary Care Strategy scoping is underway and will be aligned to the draft system clinical strategy
Children and Young People	• Supporting CYP Mental Health through CYP MH ARRs roles, embedding two MH Support teams in schools with a third planned for Sep '24, mental health champions in the hospitals and a self-harm pathway in place, facilitating collaboration between mental health services and the acute trusts • An innovative sport resilience model is in place to support young people on the CAMHS waiting list with low mood and social anxiety • We are de-medicalising the ADHD/Autism assessment pathway to manage capacity and demand. Lessons from a fast-track pilot in assessments are being shared and embedded. • The Key Worker service has supported aiding at-risk youth on the Dynamic Support Register with alternative mental health support, particularly for learning disabled/autistic children and has minimised unnecessary hospital admissions. • We have continued to provide maternal infant relationship support for families which will contribute to improving school readiness.
End of Life	• Providers commissioned to deliver Electronic Palliative Care Coordination Systems (EPaCCs) this will enable greater sharing of data. • Work is underway with the providers to scope compatibility with the Northants Care Record. • A bereavement task and finish group has been established, mapping existing local and national services completed with a gap analysis. • Respect is due to be launched Q1 2024/25 across the system including EMAS

Multi-Impact Interventions
High Level Metrics

Northamptonshire Integrated Care Board

Under development are scorecard products for each of the separate Multi Impact Interventions and Delivery Partnerships. These are to be incorporated into our overall performance framework and reported through each of the Collaboratives and Delivery Partnership programme boards. These scorecards include the headline metrics for each programme with the supporting detailed metrics reported at programme level. Below is the Multi-Impact Interventions scorecard summaries

Multi-Impact Intervention	Metric	Good is…	Last Update	Current data		Trend	Previous Data	
				Period	Outturn		Period	Outturn
Digital and data	Total NCR patient views	High	Jan 23	Up to end Jan 23	35k patient views	x	x	x
	Number of other (non End of Life) care plans in place	High						
	Reduce number of DNAs acute appointments	Low						
Supporting and Recovering Independence	A&E 4 hour performance (76%)	High	Dec 23	Q3	69.3%	↓	Q2	71.3%
	No of inpatients over 21 days	Low	Dec 23	Q3	135	↑	Q2	121
Access to Primary Care services	GP Access measure (same day appointments)	High	Nov 23	Q3	42,1%	↑	National average 2023	40%
	Number of patients accessing Pharmacy First services (service not commenced)	-						
Children and Young People	THRIVE outcome metrics under development	-						
	% of Initial Health Assessment sent to Independent Review Officer within 17 working days of receipt of notification all ages (85%)	High	Oct 23	Up to end of Nov 23	65%	↑	Sept 23	60%
	Northants children % of Review Health Assessment due to be completed in month that were completed within timescales (85%)	High	Oct 23	Up to end of Nov 23	55%	↓	Sept 23	60%
End of Life	Number of EPPACCs care plans in place (GP End of Life register)	High	Dec 23	Q3	604	↑	Q2	453
	People achieving their preferred place of death (reduce deaths in hospital proxy indicator)	Low	Dec 23	Q3	595	↓	Dec 22	644
	Reduction in the number of people receiving multiple admissions in the last 6 months of life(% of people dying in hospital who have 4 or more previous admissions- proxy indicator)	Low	Dec 23	Q3	6.9%	↑	Dec 22	5.4%

Creating the conditions for success

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To meet the needs of our population and deliver our locally agreed priorities we need to collectively agree how we work together across our integrated care system to deliver the outcomes we want to see. Our approach to creating the conditions for success prioritises working collaboratively in these five areas. During 2023/24 we have seen progress across all these we will strengthen our commitment as we move into 2024/25.

Our approach to…

Integration

Working collaboratively and using all available resources to deliver improved quality, remove unwarranted variation and improve outcomes for our local population.

Health inequalities

Driving forward work programmes that reduce inequalities, prevent poor health and improve people's opportunities for better health.

Data

Using integrated data from across the system to better understand the needs of our population and design services to better meet those needs.

Quality improvement

Delivering better health and healthcare outcomes through a culture of quality improvement, collaboration and oversight.

Prevention

Focusing on preventing ill health by supporting healthier lifestyles and development, detecting disease early and empowering people to remain independent through old age.

Our delivery partnerships

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- Our integrated care system has eight delivery partnerships working across organisations to provide health and care services to our communities
- These delivery partnerships have a central role in our ability to achieve our aims and deliver better outcomes for the people of Northamptonshire
- We have focused on improving access to services across urgent and elective care in our hospitals, mental health and community services. We have increased diagnostic capacity through our community diagnostic hubs and improved the number of patients being diagnosed with cancer within 28 days of referrals.
- We have reset our Children and Young people transformation programme with a clear aim and vision. We have co-produced a mental health local transformation plan.
- Other examples of progress this year include; 25% increase in advanced care planning for people with dementia and exceeding national targets for access to Specialist Perinatal Mental Health Services.
- Improved access to analytics is enabling us to develop our outcomes and reporting metrics. Our delivery plans for 2024/25 onwards will be completed in quarter 1 24/25 in line with the operational and financial plan submission.
- The role of our ICS programme groups and boards, is to lead and oversee the delivery of progress across Northamptonshire, including the 5 year Joint Forward Plan. The ICS programme boards and groups bring together partners across the system to set the direction for each of the programmes, ensure comprehensive delivery plans are in place and ensure monitoring of delivery. They are responsible for ensuring cross cutting themes such as addressing inequalities, a focus on prevention and quality improvement are embedded within the delivery programmes and the delivery and alignment of the programmes of work at Place and Local Area Partnerships are incorporated.

Key Achievements for 23/24

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Northamptonshire outperformed both national and regional percentage achievement in cancer constitutional measures

Northamptonshire has continued piloting lung cancer screening and working up plans for a county-wide rollout

37% increase in Community Health supported P1 packages (including those joint with ASC)

29 avoidable admissions to hospital were avoided for people with learning disabilities and/or autistic people (between Apr '23 – Jan '24)

60% increase in access to Employment Support for people with severe/ enduring mental health issues (between Jan '23 – Jan'24)

Exceeding national targets for access to Specialist Perinatal Mental Health Services

Delivered shared care record across primary and secondary care, community and mental health

Capacity increased from Local Authority Reablement Services including use of primary sub contractors able to meet quicker response times

Needs analysis for CVD risk factors, diabetes, elective and outpatient care

Across Northamptonshire we have launched the pharmacy first service approx. 96% of pharmacist have sign up to this service as at Feb 24

1,841 people reported that our Crisis Cafes provided an alternative using an emergency service (between Apr '23 – Dec '23)

£17m capital investment into Northants diagnostics – 88,000 more diagnostic tests for our patients each year

Next steps

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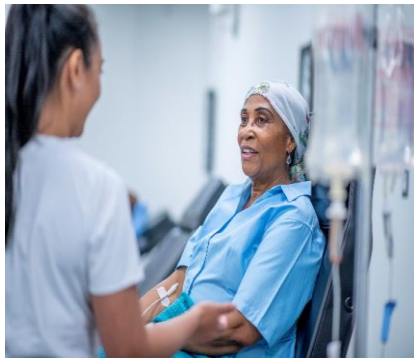
- Over the coming years, we will deliver our 5 multi-impact interventions at the same time as delivering progress on long term issues such as prevention and reducing inequalities.
- Whilst we have made progress in delivering our plan in 23/24, we recognise that as we move into 2024/25 there will be strategic decisions that we need to make together. As we conclude our operational and financial planning for 24/25, we will need to further define where we can best direct our resources to have greatest impact.
- We need clarity and focus on delivering our priorities. We will use data to inform our decision making with a constant focus on the needs of our population. We will continue to gather intelligence around our priorities to identify opportunities to shape and design our integrated service models.
- We will ensure strategic coordination of our 5 Year JFP delivery to ensure that co-dependencies are understood, aligned and integrated into our plans as they are further developed and implemented. This will include alignment with our Health and Wellbeing Strategies for the North and West Northamptonshire.
- Overall accountability for delivery of the 5 year plan sits with the ICB Board including all constituent members. Our delivery programmes and collaboratives have been established to have responsibility and accountability for leading, developing and overseeing delivery of programmes system wide and at Place.
- Overall strategic coordination of the delivery planning of the JFP and strategic alignment and integration of interdependencies across workstreams will take place at a quarterly Strategy Oversight Group and progress reported through our governance structures to the ICB Board and HWBBs.
- During 2024/25 as our ICS matures further, we will review our progress against delivery and further refine the strategic decisions to be made to best deliver improved outcomes for our population.

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Appendix 1
Multi Impact Interventions Delivery Plans Updates

Digital Multi-Impact Intervention Year 1 achievements

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What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will
The Northamptonshire Care Record	• Delivering joined up information to support patient care, improving efficiency, safety, and outcomes • Enabling system delivery of clinical priorities improving outcomes and equality, including systemwide care plans	• Delivering shared care record across primary and secondary care, community and mental health, adult and child social care • Enrich the shared care record by including results, documents and ambulance conveyance data	• Delivered shared care record across primary and secondary care, community and mental health. • Social care delayed due to local authority system change. • Plans under way for additional data sets • 300+ days saved so far	• Introduce care plans for end of life, learning disability and autism and mental health • Connect to other care records including EMAS • Deliver shared care record to community locations including care homes and pharmacies
The Northamptonshire Analytical Reporting Platform	• Provide our workforce with innovative tools and information to track and model historic and forward-looking health and care data; supporting active management of population health and care outcomes	• Deliver population health platform with embedded risk stratification • Deliver role-based access • Provide data to support redesign of care pathways • Deliver support for research using deidentified data	• Population health platform delivered, including risk stratification and John Hopkins ACGs. • VUIT also delivered to support comparison with other ICS's • Data available to support redesign • Data available to support research and investigations	• Drive data quality improvements • Incorporate additional data sources that will enrich the data and decision making • Work to connect data to our regional and national platforms • Engage with the national FDP programme
A single digital front door via NHS App	• Improved waiting list validation • reducing missed appointments and cancellations on the day of appointment or surgery • Improved accessibility • Reduced administrative costs	• UHN provide access to appointments, clinical letters and questionnaires to the NHS App • GP patient records made available to patients via the NHS App	• Health Care Comms portal deployed to both trusts • Appointment letters for 1st specialties in March 24 including to NHS App • Scaling across all specialties during 24/25 • Widening to clinical letters etc	• Scale acute programme • Patient/Carer led care plans for end of life, learning disability and autism and mental health once functionality available in NHS App • Connect community and mental health services to the NHS App once functionality available
A digital skills academy and accreditation programme for our workforce	• Strengthen our workforces capabilities to make the best use of digital and data to deliver the best care • Enhance our data and analytics capabilities to utilise data to redesign care pathways	• Full digital skills assessment across the ICS • First cohort of learners begin digital skills academy programme funded by apprenticeship levy	• Digital skills assessment across the ICS • 1st cohort of learners enrolled on to digital apprenticeships • Benefits review underway to inform cohort 2	• Benefits monitoring to identify further opportunities for learning • Further cohorts of learners join digital skills academy programmes • Incorporate other learning opportunities including Midlands Digital Skills Academy training

Supporting and Recovering Independence Multi-Impact Intervention Year 1 achievements

NHS Northamptonshire Integrated Care Board

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will subject to investment agreement
1) **Single Point of Access (SPOA) -** An improved Single Point of Access; integrated with services that support independence, available to all adults	An improved Single Point of Access; integrated with services that support independence, available to all adults. The right care at the right time by the right person for our population Easy access to preventative, intermediate and crisis response to prevent admission to hospital where possible Improved outcomes for our patients by remaining independent in the community Supporting and celebrating self-help and targeted professional support to improve health and social outcomes for patients Improved experience for carers	Scope completed: September 2023 Baseline completed: October 2023 Design completed: November 2023 Implementation completed: April 24	• Coproduction workshops completed to map current provision and future ambition and the steps towards that journey • Strengthened capacity within live handover to minimise call wait times during peak demand periods • Provision of additional GP and Palliative care time to support clinical decision making out of hours • Enabled electronic referrals from EMAS to SPOA for Cat5 from Jan 2024 extending to Cat3 by end of March • Work with EMAS to profile the shift in activity to move to SPOA and resultant alternative community interventions	• Embed the temporary solutions implemented in winter 23 and increase capacity the SPOA community response services • Implement duty Voluntary Sector model to ensure visibility of Voluntary Sector available capacity • Develop our system reporting portal • Evaluate changes made in order to inform next phase of implementation plan • Work with provider partners to ensure a seamless 24hr service is available for referral management and identify response capacity implications
2) **Pathway One -** Redesign hospital at home services and those which support patients to return directly home after a hospital admission	Single hospital at home service commissioned for the county Enhanced community support for patients (P1) being discharged to home 50% reduction in P1 delays in the provider sector	Scope completed: July 2023 Baseline completed: July 2023 Design completed: August 2023	• Opportunity scoping completed Q2 • Capacity increased from Local Authority Reablement Services • Decrease in daily number of patients waiting for P1 packages • Completed test and learn cycle on benefits of • 37% increase in Community Health supported P1 packages	• Maintain enhanced package capacity • Review our processes to support earlier identification of need and allocation of packages to providers • Work with our provider market to ensure ability to plan workforce capacity to respond to surges in demand • Review readmission rates and underlying thematic for pathway one
3) **Dementia and Delirium/Deteriorating Patient -** Review services for patients with dementia and delirium along with those for patients at risk of deterioration	Enhanced support services in-place across all providers Discharge delays reduced by 75% Rapid response service commissioned for out of hospital support	Scope completed: 31st July 2023 Baseline completed: 31st July 2023 Design completed: End August 2023 Implementation completed: In progress Sept 2023 Embed completed: November 2023	• Development of case for change for alternative pathway solution • Coproduction of 16 bed specialist recovery unit with associated staffing model including increased capacity for D&D team to manage admissions and achieve outcomes • Implement new proactive call helpline evenings and weekend for persons at risk of escalation • Increased the number of persons with dementia being supported through remote health monitoring	• Implement the recovery centre of excellence with environment preparation Q1 • Operational processes and standards agreed Q2 • Phased opening for patients Q3 • Increase the number of persons with Dementia and or Delirium who return home after unplanned hospital admission • Increase the number of persons with dementia using technology supported solutions to maintain independence and wellbeing

Supporting and Recovering Independence Multi-Impact Intervention Year 1 achievements

NHS Northamptonshire

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will
4) **Digital -** Improve digital services to join-up care along with dashboards to manage our unplanned care system across health and social care	Single countywide Urgent and Emergency Care (UEC) dashboard for all NHS, Social Care and Voluntary Sector partners Clinical decision-making support tools implemented NARP and UEC dashboard to improve long term planning and short-term flexing of plans and resource to respond to fluctuations of demand.	Scope completed: 23/6/23 Baseline completed: 7/7/23 Design completed: 28/7/23 Implementation completed: 25/8/23 Embed completed: 29/9/23	• Northamptonshire Shared Record testing phase complete and soft launch underway • Solution identified to ensure remote monitoring held data is visible to receiving clinicians through the NSR • Work with VitalHub SHREWD to ensure accuracy of data feeds and strengthening of 'one version of truth' • Enhance SHREWD to provide visibility of Virtual Ward position	• Agree the core metrics needed to give visibility of Urgent Community Response demand and capacity and create solution with partner • Utilise NARP and INUIT capabilities to segment population data to inform targeting of UEC solutions • Work with providers and NHSE to expand the range of areas assessed against OPEL criteria e.g. Mental Health, Children's Services
5) **Pathway Two -** Deliver an integrated service for patients requiring support following discharge from hospital, including rehabilitation, nursing care, and assessment for long term care.	Aligned services between the NHS and social care sector that manage the process Improved patient pathway for better patient outcomes Reduced length of stays in the acute hospitals Reduced length of stay in the P2 settings Release savings to the health community due to reduced reliance on the private sector to manage the process	Continued transformation to deliver a more integrated model across the system Develop speciality beds (stroke/complex D&D) Winter strategy for surge to be developed – costed model	• Overall Case for Change for Pathway Two created and presented to and supported by ICB Board and North and West Council Health and Scrutiny Committees • Operating model agreed to expand adult social care led P2 capacity in Corby with full occupancy achieved by end of Jan 2024 • Development of specialist P2 D&D pathway (see above for detail) • Increasing by 2 the number of stroke rehabilitation beds available to decrease waist for stroke P2 pathway • Opening of surge bed as part of system winter response	• Review medical models across the P2 bed provision and make recommendations for future model • Reduce number of lost days from patients without reason to reside in acute hospital awaiting P2 bed and awaiting care packages to commence • Identify the opportunity with partners for local primary care led pathways
6) **Integrated Brokerage -** Improve services for those needing discharge from hospital to a residential care setting	Improve processes within providers, 100% of referrals accurate and complete in 48-hours Integrate NHS and Social Care assessment processes Review county-wide bed stock for out of hospital care Commission equitable services north and west	Scope completed: April 2023 Baseline completed: April 2023 Design completed: May 2023 Implementation completed: In progress Embed completed: September 2023	• New integrated brokerage service within North and West operational in Q3 • Improvement in time taken for people to be placed within 14 days of receipt of referral • Work with market to identify gaps in commissioned provision • Escalation process established for system wide support and decision making where package needed is outside of core provision	• Develop process for early identification and tracking of potential complex discharge patients • Reduce number of lost days from patients without reason to reside in acute hospital awaiting P3 bed and for people in P2 beds without reason to reside awaiting 24hr care packages to commence • Increase through working with the EoL Transformation programme the number of people identified as EoL Fast Track who can die in place of their choosing

Access to Primary Care Services

NHS
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What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will
Empower Patients	• To manage their own health including using the NHS App, self referral pathways and through more services offered from community pharmacy i.e. pharmacy oral contraception and blood pressure services this year, to increase access and convenience for millions of patients, and launching Pharmacy First so that by end of 2023	• Establish all self-referral pathways (including MSK, audiology and podiatry) as set out in 2023/24 guidance, also ensure pathways are in place between community optometrists and ophthalmologists	• The NHS app is live and implemented across all practices. Practices are signposting patients and supporting patients to use the app. • Self-referral pathways have commenced • Pharmacy first service approx. 96% of pharmacist have signed up to this service (Feb 24)	• Continue to roll out and maximise the NHS app to benefit patients • Drive collaborative between community pharmacy and General Practice
Implement Modern Day General Practice	• To tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment • Supporting all practices on analogue lines to move to digital telephony, including call back functionality. • Providing all practices with the digital tools and care navigation training for Modern General Practice Access	• Sign up practices ready to move from analogue to digital telephony, and co-ordinate access to specialist procurement support through NHS England's commercial hub • Co-ordinate nominations and allocations to care navigator training, and digital and transformation PCN leads training and leadership improvement training.	• Successfully signed up 100% of practices for the new cloud-based telephony solutions (CBT) • Delivered a local Care Navigation training package in addition to the national Primary Care Access and Recovery Plan (PCARP) Care navigation offer and maximised the digital training support	• Develop the model for streamlined access to a universal same-day care offer, with the right intervention in the right setting and a responsive first point of contact • Continue to support the adoption of modern general practice principles
Build Capacity	• To deliver more appointments from more staff and add flexibility to the types of staff recruited • Expand GP specialty training • Encourage experienced GPs to stay in practice	• Develop system level access improvement plans to build capacity • Support PCNs to use their full Additional Roles Reimbursement Scheme budget	• Successfully developed the system level access improvement plan, this has helped co-ordinate the key actions from the primary care access recovery plan (published on ICB website) . • Continued uptake and maximisation of the PCN Additional Roles Reimbursement Scheme (ARRS) within budget.	• Further digital enabling of social prescribing, community pharmacy, care homes, and UEC. • Improved understanding of demand and capacity through digital tools • Further improvement of same-day services • Better understanding of inequalities at place and PCN level
Cut Bureaucracy	• ICBs to report progress on improving the interface with primary care, reducing requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat and streamlining the Investment and Impact Fund (IIF) from 36 to five indicators.	• Establish a local mechanism which will allow both general practice and consultant-led teams to raise local issues and to tackle the high-priority issues	• Completed system wide gap analysis against the national requirements and established a clinical led task and finish group	• Review the local concerns process and effectiveness. • Focus on improving the interface between Primary and Secondary Care to drive efficiencies through end to end pathway redesign.

Access to Primary Care Services

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will 24/25
Primary Care Strategy	• A Primary Care strategy that supports the delivery of our clinical model and delivery of system transformation plans to provide resilience and sustainability for the primary care sector. • To include models of care for same day access, complex care long term conditions and planned care. The strategy will agree the key principles of a clearly defined service offer, intuitive access points, the availability of self-care approaches, self-referral to community services, and innovative services in the community.	• Scoping and development of the Primary Care strategy • Review of current transformation programmes to identify system requirements of the primary care sector • Identify early opportunities for integrated clinical models of care	• An outline for developing a primary care strategy with alignment with draft clinical strategy	• Socialise and test with all relevant stakeholders the draft primary care strategy • Review transformation programmes to take into consideration delivery of the Primary Care strategy • Develop an operational plan describing the implementation plan • Review and develop commissioning plans in line with the strategy implementation • Support the development of Primary Care federations and super practice to deliver the strategy and integrated clinical models of care

Our delivery plan for CYP Multi-Impact Intervention

NHS Northamptonshire

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will
Promote early intervention and self-management of emotional wellbeing	• Support for CYP prior to a CAMHS referral, through additional support in primary care, community schools and digital. • Support the CYP at the right time, in the right place	• Pilot Children and Young People's Mental Health practitioners in three Primary Care Networks • Invest in digital options for mental health support, resources and participation • Expand Wellbeing Cafés and LGBTQ+ groups into rural areas • Support the expansion of Mental Health Support Teams (in schools)	• Children and Young People's Mental Health practitioners are embedded within three Primary Care Networks as a 12 month pilot • An additional 2 LGBTQ+ groups are funded and in progress to support rural communities • An additional 2 Wellbeing Cafes per week are funded and in progress • Expansion of the under 11's service in early intervention	• Continue and review the outcomes of the additional roles pilot, the additional LGBTQ+ groups and the wellbeing cafes • Launch the iDiscover online platform • Continue to provide an under 11's service working collaboratively with education
Ensure our children with the highest needs receive access to specialist services as soon as possible	• System integration to ensure the crisis team is accessible to those who need it • Shorter waiting times for specialist services, e.g. CAMHS	• Ensure the Child and Adolescent Mental Health Service (CAMHS) crisis team offers intensive home treatment as an alternative to acute inpatient admission • Facilitate formalised pathway development where a child presents at A&E with a mental health issue or an eating disorder • Reduce CAMHS waiting lists • Pilot new approaches and offer alternatives	• New escalation pathways in place across acute and mental health services • An innovative sport resilience model is in place to support young people on the CAMHS waiting list with low mood and social anxiety	• Continue reduction of CAMHS waiting times by supporting skill mix options and innovative practice • Explore additional opportunities to support children and young people on CAMHS waiting lists, such as the use of sport to build resilience • Progress work to better support parents and carers of the CYP supported by our mental health services
Ensure eating disorder services for children are best placed to support increases in demand and complexity	• Improved knowledge of Eating Disorders in, and support for, staff likely to see their earliest contact with services, e.g. GPs, Counsellors.	• Develop awareness of eating disorders to promote early identification and management • Develop a robust early intervention pathway, including universal and voluntary sector services • Invest in additional staffing and skill-mix opportunities using allocated funding	• Plans in place to support the development of children's eating disorder services including skill-mix opportunities • Additional capacity to support implementation of pre-assessment & early intervention workshops as well as eating, nutrition and body image workshops	• Embed robust early intervention pathway, including universal and voluntary sector services

Our delivery plan for CYP Multi-Impact Intervention

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1	23/24 key achievements	Year 2 we will
Work in partnership to increase the proportion of children who receive a 2 - 2 ½ year review in line with the Healthy Child Programme.	Early identification of developmental needs enables early intervention which supports a better start in life.	• Understand current position and any required improvement trajectories / action plans to meet this requirement • Scope analysis of sub-group data to determine baselines, inequalities and narrowing of gaps targets • Ensure appropriate pathways into specialist services are in place • Explore examples of innovative practice to address inequalities	• Northamptonshire-wide the proportion has increased from 43% (April 2023) to 70% (December 2023) (North Northants 52% to 76%, West Northants 35% to 66%). • Achieved through piloting new ways of working including the recruitment of Healthy Child Practitioners, who support the Health Visitors and strengthen the skill mix in the team. • Completed the 0-19 Health Needs Assessment • Continued provision of maternal infant relationship support for families which will contribute to improving school readiness	• Development of joint 2½ year checks in early years settings, such as family hubs to include greater number of parents • Ensure that best practice from across the country is used to inform future commissioning intentions for children's services • Continue to collaborate with key partners across the system to identify and address gaps in service provision • Explore examples of innovative practice to address inequalities
Improve access to assessments for CYP with potential ASD/ADHD	Improve the communication to families and seek to reduce waiting times through effective surveillance and triage.	• Implement lessons from the Fasttrack pilot • Undertake a community paediatric review to seek alternative models for diagnostics • Continue to work across the system to de-medicalise the pathway to reduce demand	• Undertook a Community Paediatric Review • Additional capacity to include; Neuro-diversity posts within MHSTs, Link nurses with 0-19 service, Saturday clinics, Carer/Peer support worker • Oliver McGowan Mandatory Training including 2000 primary care staff • System communications and management of medication supply	• Use the outcomes of the community paediatric review and research by young Healthwatch to improve community paediatric services • Seek routes to improve how we better meet the needs of children and young people with suspected neurodiversity • Implementation of the Partnership for Inclusion of Neurodiversity in Schools (PINS) to provide better support without the need of a diagnosis.

End of Life Multi-Impact Intervention Year 1 achievements

What we will do	Planned outcomes, what we are trying to achieve	Our Delivery Plans-how we want to do it		
		Year 1 Plan	23/24 key achievements	Year 2 we will
Replace the County DNACPR with ReSPECT Plan Implement the recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Launch ReSPECT across the system	To enable individuals to have the opportunity to create personalised recommendations for their clinical care in emergency situations, where they are not able to decide or communicate their wishes.	• System development until May 2024 • Implementation	• ReSPECT is launched and staff across the system complete the training. • Number of completed ReSPECT Plans increase and DNACPR Forms decrease • ReSPECT will be launched in May 2024 but will remain as ongoing engagement process across the system	• Evaluate impact and outcomes of the service and continue to embed within practice
Commission and embed an Electronic Palliative and Care Coordination System (EPaCCS) that meets national requirements and, locally, provides access to all system partners to enable them to update patient records contemporaneously which can be seen by relevant health and care professionals	Improve advance care planning conversations and the coordination of care for people approaching the end of life. Scope and develop mapping EPaCCS) options (reliant on Northamptonshire Care Record (NCR) being launched) To provide a communication platform which enables health and care staff from multiple organisations to work together through a shared patient record which gives them the ability to record and access key information about patients, 24/7	• Scoping • System Development • Implementation	• The platform is available to health and care staff across the system • Number of patients added to EPaCCS. • Reduction in admission to hospitals • Avoids delays to care and treatment	• Evaluate impact and outcomes of the service and continue to embed within practice
Review bereavement services to understand the demand, current provision and any gaps that need to be addressed and co-ordinate and develop a Countywide bereavement service.	Ensuring equitable bereavement services exist for all	• Scoping • Consultation • Develop proposal • Present proposal	• A bereavement task and finish group has been established, mapping existing local and national services completed. Existing gaps identified. A proposal has been drafted and external grant funding to be considered as an option.	• Implementation • Evaluate impact and outcomes of the service and continue to embed within practice
Undertake a scoping exercise for a 24/7 Palliative and End-of-Life Care Hub (P&EoLC)	To enable the provision of a 24/7 access to P&EoLC advice and guidance for local communities, families, and carers. Evidence shows from other systems that hospital admissions are reduced.	• Scoping • System Development • Implementation	• Scoping has been completed. • Task and Finish Group established to develop a local specification considering the feedback from the report completed and the groups opinions. • Capacity within NHFT SPoA has been extended to support non urgent referrals to ensure consistent and rapid access to clinical advice and alternative services, which will help to reduce unnecessary conveyance. This includes a Palliative/EoL advice line.	• Implementation • Evaluate impact and outcomes of the service and continue to embed within practice

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Health and Wellbeing Board
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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

26th March 2024

Report Title	**Director of Public Health Annual Report 2023**
Report Author	**Sally Burns, Director of Public Health, West Northants Council**

Contributors/Checkers/Approvers		
West S151	Martin Henry, Executive Director Finance, West Northants Council	08/03/2024
Other Director/SME	Stuart Lackenby, Deputy Chief Executive, West Northants Council	Approved at SLT on 01/03/2024

List of Appendices

Appendix A – Director of Public Health Annual Report 2023
Appendix B – Video link

1. Purpose of Report

1.1 To note the content of the annual Director of Public Health (DPH) statutory report for Northamptonshire.

1.2 To endorse the key recommendations made in the DPH annual report.

1.3 To note the requirement of the Health and Wellbeing Board to agree publication of the DPH annual report, which will then be disseminated to partners, stakeholders and residents in order to fully engage everyone in the Health & Wellbeing agenda.

2. Executive Summary

2.1 The focus of the DPH Annual Report for 2023 is around West Northamptonshire's place based approach to tackling inequalities. This ultimately means giving communities, the voluntary sector and other partners more opportunity to have an active involvement in shaping services to better meet their needs. This is important as each community has their own individual

barriers and challenges and this approach can therefore be tailormade. The annual report sets out why certain groups who are marginalised, such as the homeless, Gypsy and Roma travellers and sex workers for example, are at most risk of health inequalities and how some interventions such as direct collaboration with those groups, engaging with local voluntary organisations and utilising pre-existing community assets such as mutual aid and social networks for advice can really help to tackle specific issues in community groups.

2.2 Whilst we have begun to address the poor health outcomes for those living within marginalised groups or areas of deprivation, health inequalities remain a big concern and it is clear there is still more to do to address the needs of all of our residents across such a diverse area. This report and its accompanying video, will demonstrate how some of the work that has taken place, has started to address this issue and how the idea of taking a place-based approach embodies this way of thinking.

3. Recommendations

3.1 For the Health & Wellbeing Board to note the contents of the report and recommendations made.

3.2 For the Board to also note the progress made regarding the recommendations in the previous annual report.

3.3 For the Board to agree publication and distribution of the report.

4. Report Background

4.1 The core purpose of the Director of Public Health (DPH) is to be an independent advocate for the health of the population and system leader for its improvement and protection. DPH's across the country are required to produce an annual report and the Health and Wellbeing Board has a duty to publish their report. The DPH annual report provides an opportunity to:

- Raise awareness and understanding of the wellbeing of the county
- Identify key issues and challenges relating to the wellbeing of the local population
- Provide added value over and above intelligence and information routinely available
- Reflect on work already undertaken and the continued impact
- Identify recommendations for future courses of action to improve health and wellbeing locally.

5. Issues and Choices

5.1 Each year the Director of Public Health must produce an Annual Report, highlighting to key stakeholders and members of the public, the work that has been carried out over the last 12 months.

5.2 One recommendation, made in the previous Director of Public Health report, committed to taking a place-based and asset-based approach within West Northamptonshire's Local Area

Partnership areas, to try to tackle health inequalities. Tackling health inequalities is an extremely important area of focus within Public Health and the wider system and therefore this recommendation helped determine the direction of travel for this year's report.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 The production of an Annual Report is a statutory function that should be executed by the Director of Public Health. A budget is therefore put aside for this annually and comes from the Public Health Grant. There are no additional financial implications or Council resources required as a result of this paper.

6.2 **Legal**

6.2.1 There is a statutory obligation for the Health & Wellbeing Board to agree publication and distribution of this report.

6.2.2 There are no other legal implications that will result from carrying out the recommendations in this report.

6.3 **Risk**

6.3.1 Should this report not be agreed and published, the Council and the Director of Public Health would not meet the relevant statutory duties.

6.3.2 There would be a risk of reputational damage to WNC and the Public Health team.

6.3.3 There would be a lack of guidance to local communities/ organisations in relation to health and wellbeing in the county.

6.4 **Consultation**

6.4.1 Not applicable

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Not applicable

6.6 **Climate Impact**

6.6.1 Not applicable

6.7 **Community Impact**

6.7.1 Not applicable

7. Background Papers

Director of Public Health Annual Report 2022

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2023

TAKING A PLACE-BASED APPROACH TO ADDRESSING HEALTH INEQUALITIES.

West Northamptonshire Council

Wellbeing WEST NORTHANTS

FOREWORDS

Dear Reader,

It is with pleasure I welcome you to the 2023 Director of Public Health Annual Report for West Northamptonshire. This year, the report focuses on the Place Based Approach to a really important issue, tackling health inequalities.

Health inequalities is something that affects nearly all communities in some way. Bridging the gap in life chances and health outcomes between those in our more affluent communities and those in our poorest ones, is something that myself and my colleagues are all devoted to doing. We are committed to community involvement and ensuring that our residents can be involved in the way that services are delivered and our new place-based approach will enable us to achieve this.

I am really excited by all the work that is happening here in West Northamptonshire particularly in our Local Area Partnership initiative which you will hear more about in this report.

Cllr Matt Golby,
Cabinet Member for Adult Social Care, Public Health and Wellbeing

FOREWORD FROM THE DIRECTOR OF PUBLIC HEALTH

2023 has been another busy year with many impactful projects happening. It has been particularly significant for my Public Health team as it is the first full year where public health has sat solely within West Northamptonshire Council, working closely with partners to serve residents of West Northants.

In Public Health terms, 2023 has also seen a number of unsettling events continue; the cost of living crisis (which was the focus of my 2022 report), the humanitarian crisis resulting from the war in Ukraine, and now also in the middle east. Whilst globally being downgraded from its pandemic status, the threat of COVID-19 and the recovery from this prolonged pandemic still very much continues to play a big part in the world of Public Health.

However, there has been a huge response effort from partners, both internal and external, to the Council that has quickly mobilised together, to put in place the right support for our residents. And this is something I am incredibly proud of to all involved.

As well as this, the world has seen a number of medical breakthroughs, successful vaccines and treatments being developed for diseases and illnesses such as cancer, Alzheimer's and malaria. Positive steps have also been taken to tackle some of the most worrying climate and environmental issues the world currently faces and on a local level, we have also seen lots of exciting progress within West Northamptonshire itself, particularly around a place-based plan to develop our Local Area Partnership approach. Great strides have been taken to work with our partners across each local area to help residents achieve our shared aim to 'Live your best life'. More about this is featured within this report.

The last year has certainly demonstrated to me that working together with our systemwide partners, ensuring that our aims and outcomes are properly aligned, can and will make a real difference to people and their communities. This report gives real examples of how we have worked with our partners, voluntary sector and communities to start to embed our place-based and 'asset-based' approach, ultimately helping communities and individuals alike to have hands on involvement in being able to shape services to meet their needs.

Whilst we have begun to address the poor health outcomes for those living within marginalised groups or areas of deprivation, health inequalities remains a big concern and it is clear there is still more to do to address the needs of all of our residents across such a diverse area. Within this report and its accompanying video, you will see how some of the work that has taken place, has started to address this issue and how the idea of taking a place-based approach embodies this way of thinking.

The hope is that together we can start to break down these health inequities so everyone in West Northamptonshire can live a long and healthy life.

Sally Burns,
Director of Public Health

INTRODUCTION

The previous Director of Public Health report made the recommendation to take place-based and asset-based approaches linking with the work of the emerging Local Area Partnerships.

This report provides an update on the progress made in implementing this recommendation and embedding place-based and asset-based approaches across West Northamptonshire.

To stay healthy, people need good homes, good jobs, friends and an environment that makes healthy choices possible[i]. However, we know that not all people in society have the same chance to be healthy, due to not having good homes, good jobs, friends and healthy environments to live in. This results in health inequalities, and they are due to:

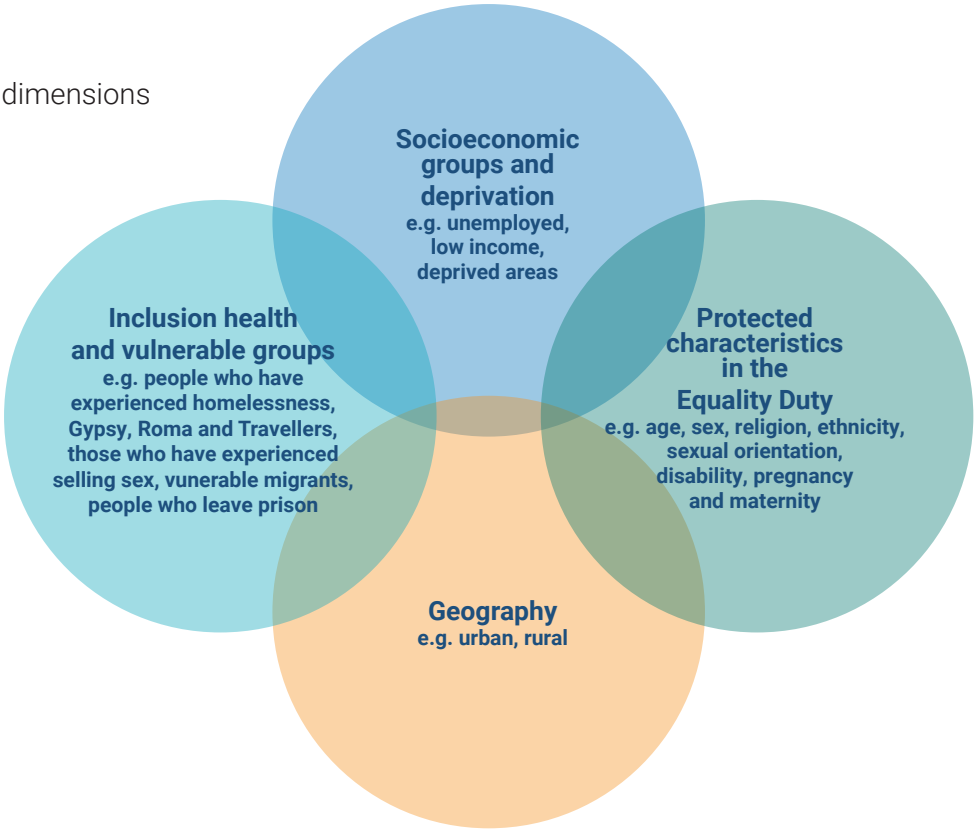
- wider determinants of health, eg quality of housing, employment, places people live
- behavioural risks to health, eg smoking rates and access to healthy food
- health status, eg health conditions
- access to care, eg treatments for ill health or advice on staying well
- quality and experience of care, eg levels of patient satisfaction[ii].

Health inequalities can be significantly reduced. The most effective way to do this is to improve the places people are born, live, work and age[iii]. Figure 1 shows the different groups that are most vulnerable to health inequalities and how these overlap. The different groups are:

- socioeconomic groups and deprivation i.e. people with low income / unemployment
- people living in deprived areas
- protected characteristics listed in the Equality Duty such as age, sex, ethnicity
- the places people live i.e. urban / rural areas
- inclusion health and vulnerable groups such as people experiencing homelessness, those w ho have experienced selling sex.

Many people fall into more than one of these groups and experience multiple disadvantages.

Figure 1
The overlapping dimensions of inequality



INTRODUCTION

Those described as inclusion health or vulnerable groups are particularly disadvantaged and excluded from society. In the UK, the concept of inclusion health has typically encompassed homeless people; Gypsy, Roma, and traveller communities; vulnerable migrants; and sex workers[iv] but other groups can be included. Social exclusion can be driven by unequal power relationships that interact across economic, political, social and cultural dimensions[v].

Inclusion health groups experience the poorest health outcomes and commonly have very high levels of morbidity and mortality, often with multiple and complex needs. This includes overlapping mental and physical ill-health and substance dependency, creating complex situations that health services are not always equipped to deal with and that traditional health and social care approaches generally fail to address[vi].

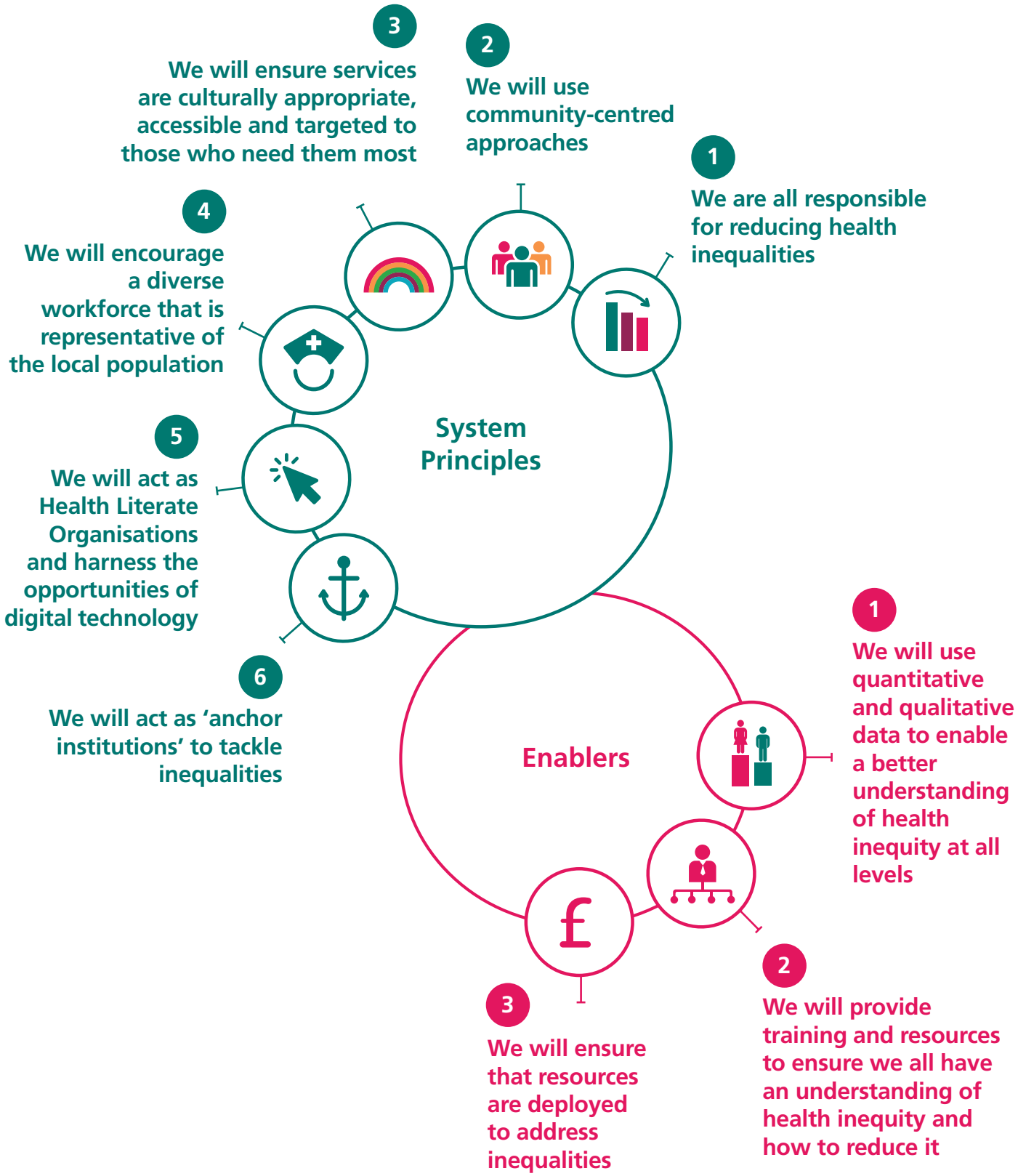
Common experiences cut across inclusion health groups. Most have been or are exposed to multiple, overlapping risk factors, such as adverse childhood experiences, trauma and poverty. Adding to this, many face multiple barriers in access to health services because of fear, language and communication issues or negative past experiences, such as being turned away[vii]. This results in overuse of some services, such as accident and emergency departments and underuse of others, such as primary and preventative care, resulting in poor health outcomes, inefficiencies and extra costs. Many of these populations are also highly mobile, making it difficult to ensure access and continuity of care from services that are typically designed for fixed populations[viii].

These groups frequently face stigma, discrimination and public misconception, and marginalisation can further be compounded by punitive social policies. Notably, inclusion health groups are not consistently recorded in electronic records, making them effectively invisible for policy and service planning purposes[ix]. These experiences can create a vicious cycle of health and social deterioration for those affected.

In 2021 NHS England developed the CORE20PLUS5 framework to better understand health inequalities and target services to those most vulnerable to them. CORE20 represents those living in the 20% most deprived areas and PLUS represents the other groups represented in figure 2, considering the specific communities within an area. The 5 element recommends focussing on 5 areas most considered to reduce health inequalities in healthcare. For adults this is early cancer diagnosis, physical health checks for people with serious mental health conditions, hypertension case finding, continuity of care for Black, Asian and minority ethnic groups in maternity services and chronic respiratory disease. For children and young people, the 5 areas are epilepsy, asthma, diabetes, oral health and mental health.

In July 2021 Integrated Care Northamptonshire published its Health Inequalities Plan, which describes how we will work with communities so that everyone has the chance to thrive and to access quality services providing excellent experiences and the best outcomes for all. The Integrated Care Northamptonshire Health Inequalities Plan sets out the principles which all partners working across the system need to adopt to address health inequalities, as shown below in Figure 2.

Figure 2
Summary of the ICN Health Inequalities Plan system principles and enablers



TAKING A PLACE-BASED APPROACH

While action on behaviours and conditions is a necessary part of the solution to reduce health inequalities, these need to be addressed within the context of their root causes in the wider determinants of health. Given the range of causes of health inequalities, a joined-up approach that focusses on specific places/ communities is necessary.

COMMUNITY CENTRED INTERVENTIONS

'Community' as a term, is used as shorthand for the relationships, bonds, identities and interests that join people together or give them a shared stake in a place, service, culture or activity. Distinctions are often made between communities of place or geography and communities of interest, identity or affinity, as strategies for engaging people may vary accordingly. Communities are dynamic and complex, and people's identities and allegiances may shift over time and in different social circumstances[x].

There is growing evidence which supports the case for a shift to more community-centred approaches to health and wellbeing[xi]. They involve:

- using non-clinical methods
- using participatory approaches, such as community members being actively involved in design, delivery and evaluation of services
- reducing barriers to engagement
- utilising and building on the local community assets
- collaborating with those most at risk of poor health
- changing the conditions that drive poor health
- addressing community-level factors such as social networks, social capital and empowerment
- increasing people's control over their health.

Actively involving residents in prevention of ill health and strengthening community assets is a key strategy in helping to improve the health of the poorest, in the fastest way. Community assets include:

- the skills, knowledge, social competence and commitment of individual community members
- friendships, inter-generational solidarity, community cohesion and neighbourliness
- local groups and community and voluntary associations, ranging from formal organisations to informal groups, or mutual aid networks such as babysitting circles
- physical, environmental and economic resources
- assets brought by external agencies including the public, private and third sector[xii].

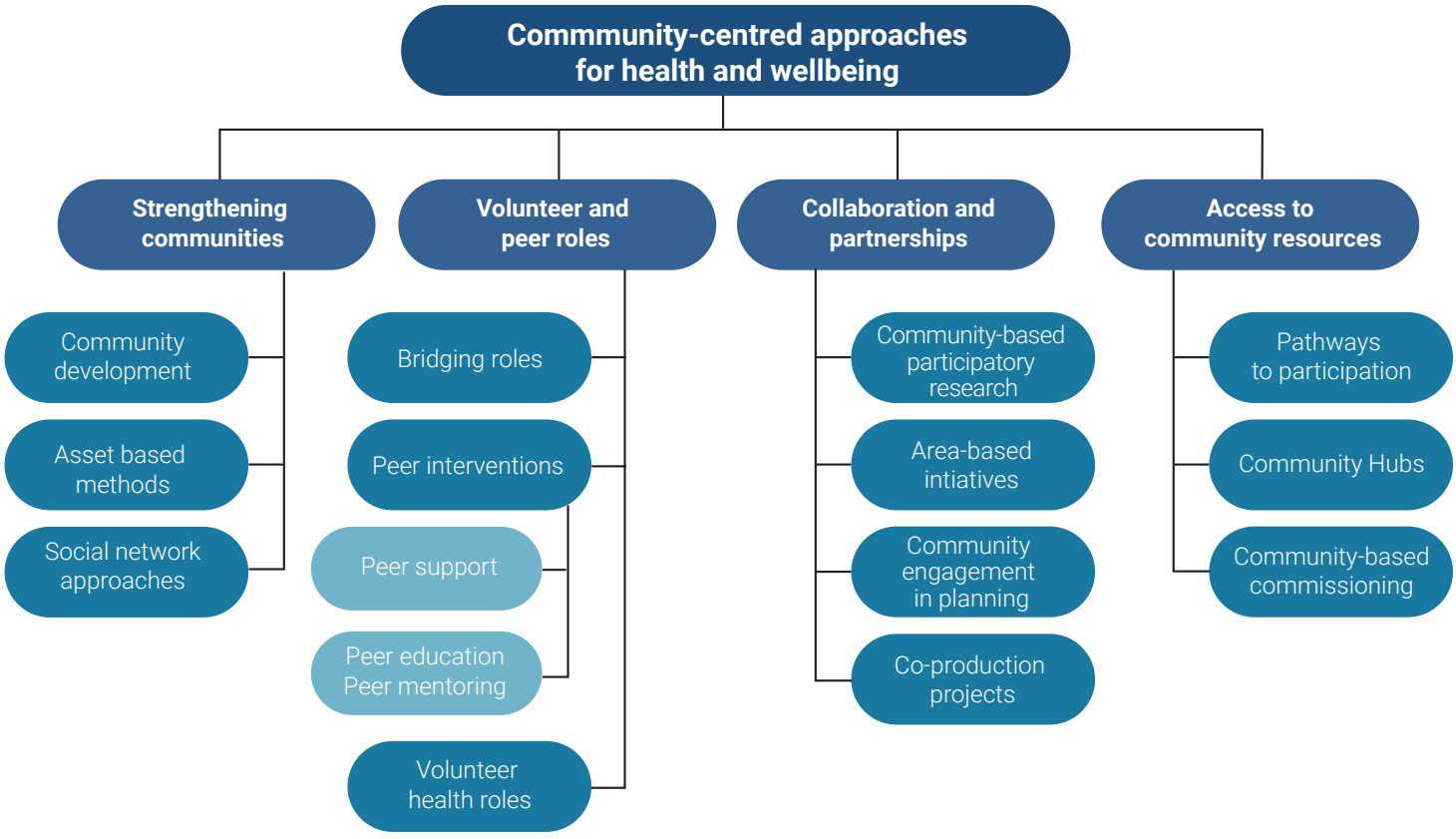
Community-centred approaches are about making the most of assets within communities, increasing people's control over their health and lives and ensuring everyone has the same opportunity to have good health and wellbeing. However, not all groups have equal access to community assets. Those who are socially excluded often do not have a voice in local decisions and are not given as many opportunities to participate in community life as others. Participatory approaches can directly address marginalisation and powerlessness that underpins this and can be more effective than professional-led services. Involving individuals and communities so that they define the problems and develop community solutions means we can shift power towards individuals and communities and address health inequalities.

COMMUNITY-CENTRED APPROACHES

PHE/OHID developed a 'family of community-centred approaches' as a framework to represent some of the practical options that can be used to improve community health and wellbeing. It includes four strands of community-centred approaches for health and wellbeing, including:

- strengthening communities: building on community capacities to take action together on health and the social determinants of health
- volunteer and peer roles: enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- collaborations and partnerships: approaches that involve communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation
- access to community resources: connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Figure 3:
Community-centred approaches
for health and wellbeing



WEST NORTHAMPTONSHIRE
POPULATION AND INEQUALITIES HIGHLIGHTS

429,013 people live in West Northamptonshire, an increase of 14.4% since 2011.

In 2022 there were 4,540 live births and 3,502 deaths.

13.7% of the population live in the 20% most deprived areas.

The proportion who are not White British (nWB) increased from 8.8% in 2001 to 24.9% in 2021. This is below the England average of 26.5%. Of this population a significant number, about 9.7% are from Eastern European countries. 3.4% are Black Caribbean; 2.3% are Bangladeshi; 1.1% Asian Indian; 0.9% Black African.

6.6% of households contain no one who has English as their main language. (England 5.0%)

19.9% of residents (aged 3+) who do not have English as their main language, either cannot speak English well or cannot speak English at all. (England 20.2%)

The proportion stating, they have no religion has shifted from 17.4% (2001) to 38.2%. (2021)

There is a lower-than-average proportion of residents following religions other than Christianity (6.2% v. 11.0% in England). Since 2011, the WN area has logged a 43% increase in persons of Muslim faith and a 27% increase in Hindus.

2.7% of the population over 16 have a sexual orientation other than heterosexual. (England 3.2%)

The Gypsy and Traveller population in West Northamptonshire in 2021 was 340. Gypsy, Roma and Traveller women live 12 years less and men 10 years less than the general population.

Between 2018 and 2023, 706 in total were recorded as having an accommodation at the time of application that was either Rough Sleeping or No Fixed Address (NFA), while a further 301 had a history of Rough Sleeping.

Most people sleeping rough have been male, averaging 78.8% across each of these cohorts. The average age at death of people who sleep rough is 44 years for men and 42 years for women.

20,369 households (11.6%) were living in fuel poverty in 2021. (England 13.1%)

287 people were killed or seriously injured on Northamptonshire's roads in 2022. (an increase from 215 in 2021)

WEST NORTHAMPTONSHIRE
POPULATION AND INEQUALITIES HIGHLIGHTS

Starting Well

- 21.4% (92,008) are children aged under 18.
- 19.8% of children live in relative low-income families. (England 19.9%)
- 9.7% of women smoked during pregnancy in 2022/23, significantly higher than England. (8%)
- 58.6% of babies were breastfed in 2022/23, (significantly higher than England 49.2%)
- 1.9% of term babies born in 2021 had a low birth weight, significantly lower than England. (2.8%)
- 3,504 children and young people have an EHC plan, 71.5% are boys, 32.9% have ASD.
- 8,167 have SEN Support, 62.9% are boys. 16.8% have social, emotional, or mental health needs.
- 68.6% of schoolchildren achieved a good level of development by the end of Reception in 2022/23. (England 67.2%)
- 19.9% of children in Reception and 34.3% in Year 6 were overweight or obese in 2022/23. Compared to England 21.3% and 36.6% respectively.

Living Well

- 60.8% (261,167) are adults aged 18 to 64.
- 69.4% of adults are classified as overweight or obese. (significantly worse than England at 63.8%)
- 65.3% of adults aged 19 and over were physically active (England 67.3%) and 24.0% were physically inactive in 2021/22. (England 22.3%)
- 12% of adults aged 18 and over were current smokers in 2022. (England 12.7%)
- 47.1% of adults do walking or cycling for any purpose at least 3 times a week in 2022. (England 45.8%)
- 83.2% of working-aged adults (16–64) were in employment in 2022-23 (England 78.6%); 2.9% were unemployed. (England 3.8%)
- The average annual salary for full-time workers was £31,776 per year in 2022 (England £33,106); for part-time workers, it was £12,203. (England £12,260)
- Average house prices were 8.4 times a person's average annual gross salary in 2022. (England 7.91)
- The average house price was £290,000 in Q1 of 2023. (England £277,732)
- 15.9% of households (27,457) did not have a car or van in 2021. (England 23.5%)

Ageing Well

- 17.1% (73,287) are aged 65 and over.
- 2.1% (8,957) of the resident population are 85 and over.
- Average life expectancy at birth for males was 79.4 years in 2021 (England 78.7) and 83.4 years for females. (England, 82.8 years)
- 1,293 people died before the age of 75 in 2021 (premature deaths); 641 people died before the age of 75 from deaths considered preventable.
- Estimated dementia diagnosis rate (aged 65 and older) was 62.3% for 2023. (England 63%)
- 1,343 Falls admissions for patients aged 65 and over.
- 34.9 percent excess winter mortality (% of extra deaths for all adults) in 2020/21. (37.5% nationally)
- The top 5 causes of death are cancer, dementia and Alzheimer disease, ischemic heart disease, chronic lower respiratory disease and cardiovascular diseases.

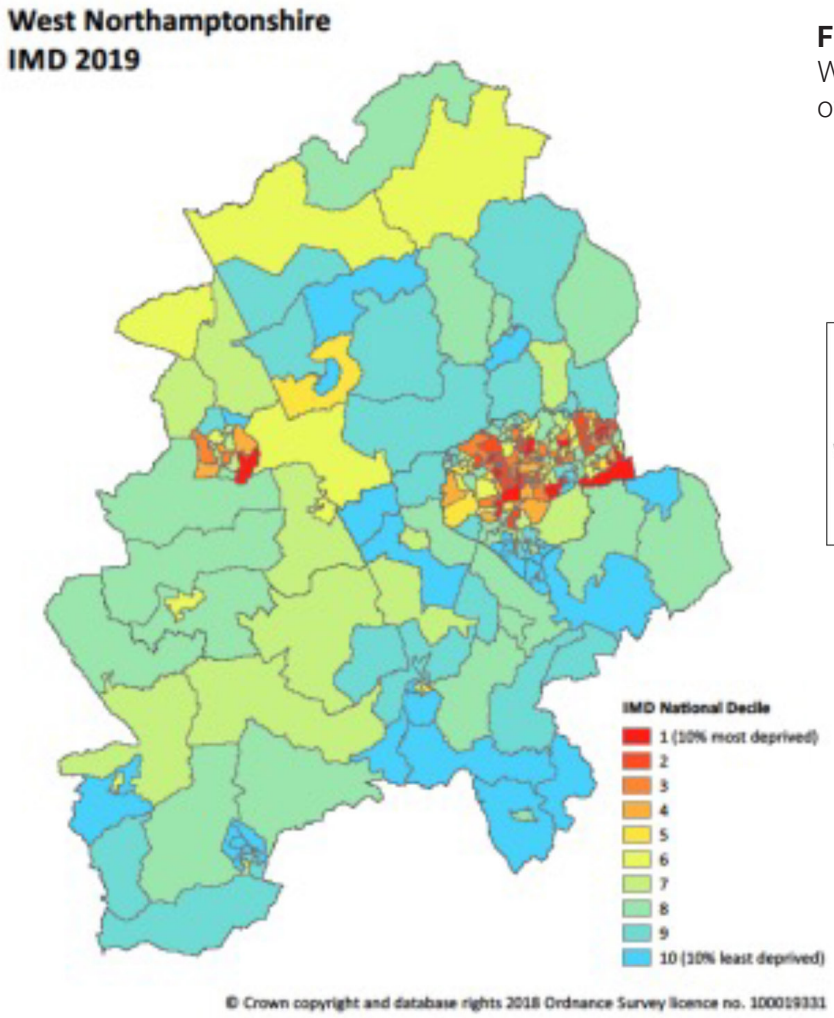
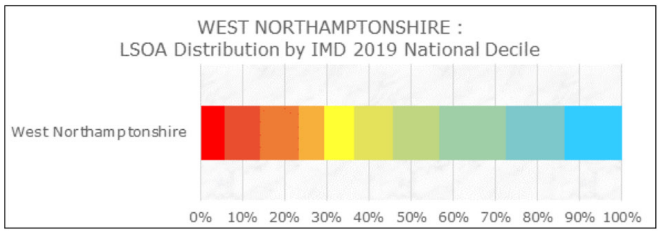
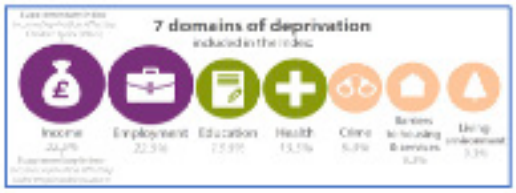


Figure 4:
West Northamptonshire Indices of Multiple Deprivation 2019





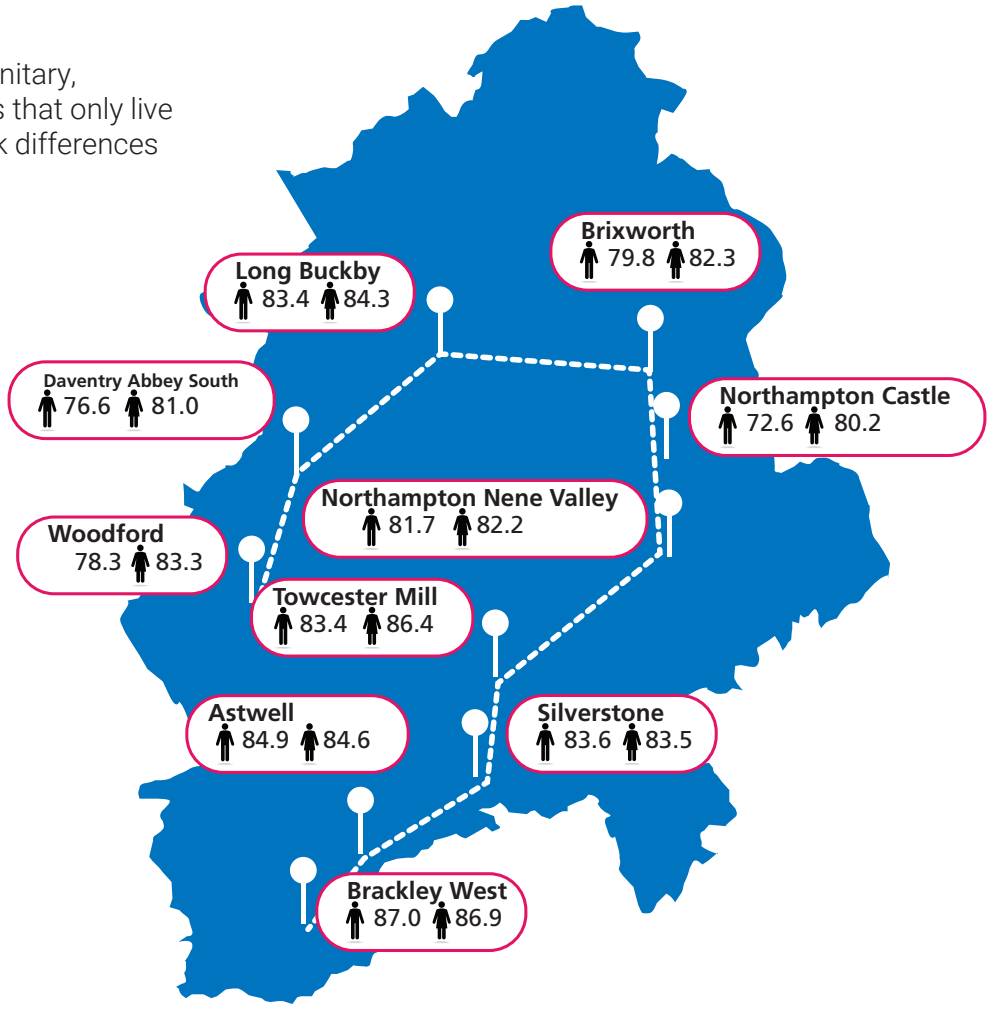
Deprivation Affected Population Counts based on the Index of Multiple Deprivation 2019 and the ONS Mid-Year Estimates 2018

WEST NORTHAMPTONSHIRE	Total Population	Aged 0-4	Aged 5-15	Age 16-17	Aged 18-24	Aged 25-44	Aged 45-64	Aged 65-84	Aged 85 & Over
West Northamptonshire Population Living in Top 20% most Deprived LSOAs Nationally IMD 2019	55779	4751	9554	1520	5361	16822	12016	5141	614
% of total population		8.5%	17.1%	2.7%	9.6%	30.2%	21.5%	9.2%	1.1%
West Northamptonshire Population Living in Bottom 80% LSOAs Nationally IMD 2019 (Not Deprived)	346366	20942	46887	7547	25285	86048	94969	56772	7916
% of total population		6.0%	13.5%	2.2%	7.3%	24.8%	27.4%	16.4%	2.3%

The table shows the approximate number of residents of West Northamptonshire (by age) who live in the top 20% most deprived LSOAs nationally based on 2018 mid-year estimates.

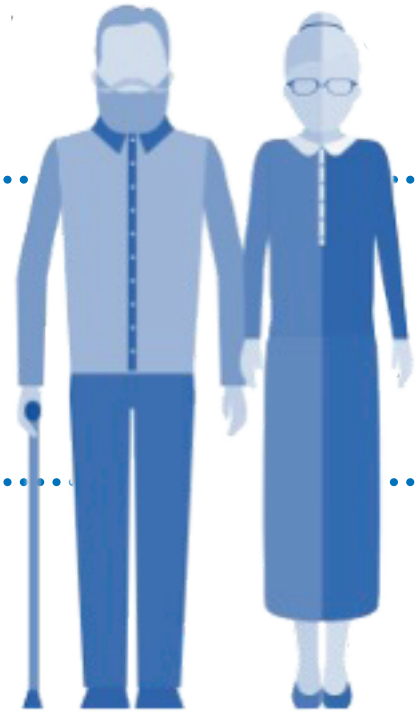
LIFE EXPECTANCY ACROSS WEST NORTHAMPTONSHIRE

Following a 'bus route' in each unitary, demonstrates that communities that only live a few miles apart can have stark differences in life expectancy.



Average life expectancy at birth for men is 79.4

Men living in the more affluent 20% of the West can expect to live 9 years longer than those in the 20% most deprived areas



Average life expectancy at birth for women is 83.4

Women living in the more affluent 20% of the West can expect to live 8 years longer than those in the 20% most deprived areas

CHILDREN IN RELATIVE LOW-INCOME FAMILIES IN WEST NORTHAMPTONSHIRE

In 2021-22, 19.8% of children aged 0-15 in West Northamptonshire were living in relative low income. This was just short of the England average (19.9%).

This number has increased by 42.1% compared to two years ago, compared to an increase of 1.2% across England as a whole.

50.3% live with lone parents above the England average (44.5%) - 70.9% increase in children in two years. 72.7% live in working families 2% above the England average.

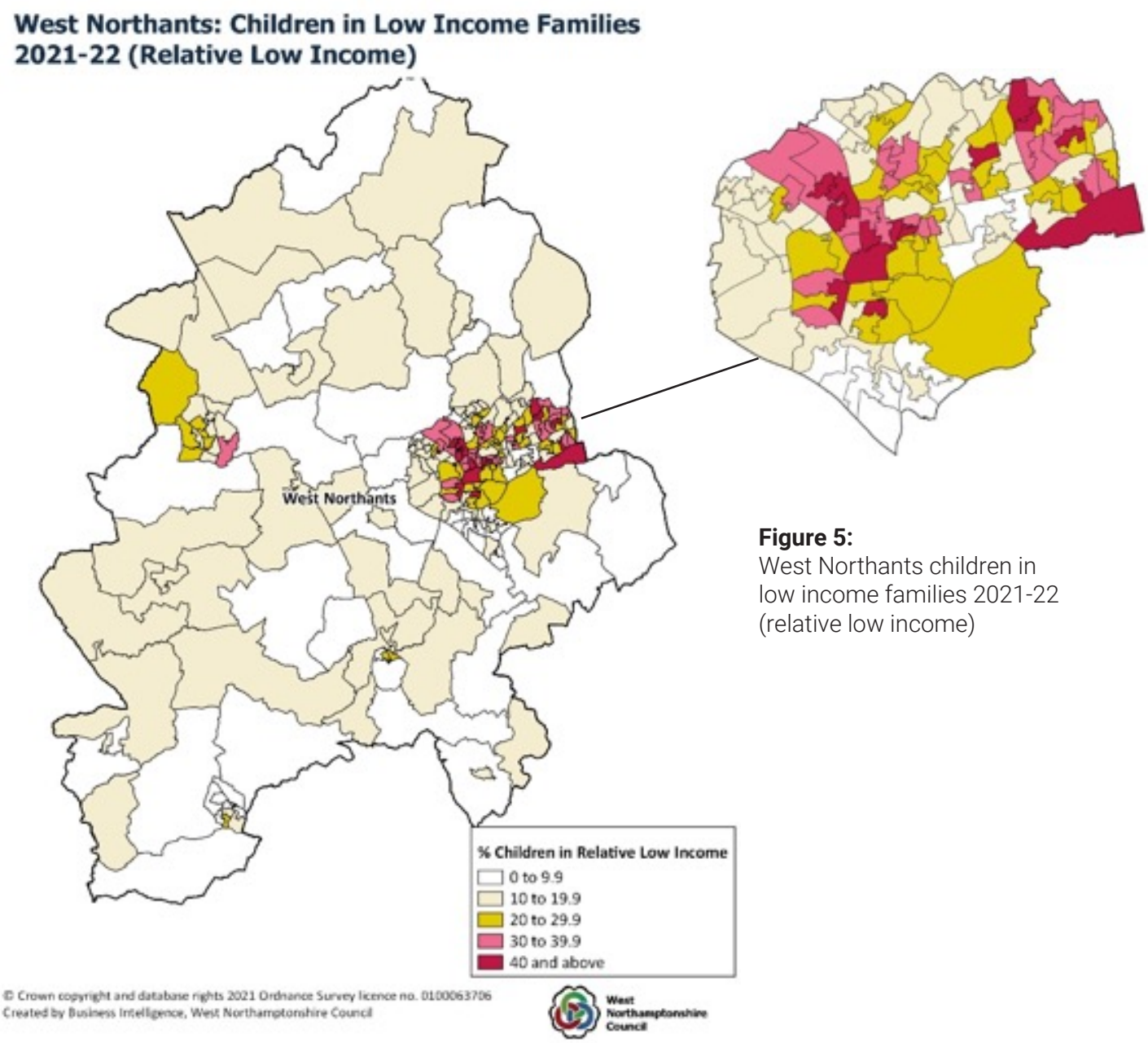


Figure 5:
West Northants children in low income families 2021-22 (relative low income)

Dependent Children in Low Income Families (CinLIFs) are those under 16 years or aged 16 to 19 in full-time non-advanced education or in unwaged government training, living in families with a gross income before housing costs of less than 60% of the median income. A family must have claimed one or more of Universal Credit, Tax Credits or Housing Benefit at any point in the year to be classed as low income in these statistics. Relative CinLIF measures children in low-income families before housing costs, in the reference year.

WEST NORTHAMPTONSHIRE'S PLACE-BASED APPROACH

In June 2022 the new Integrated Care System was adopted across Northamptonshire. Partners in the system committed to working towards the delivery of 10 ambitions and a set of common metrics. West Northamptonshire's Health and Wellbeing Board, Joint Health and Wellbeing Strategy 2023-28 sets out the actions all partners working in West Northamptonshire will take to deliver these ambitions, recognising the importance of place-based approaches. Outcomes will be improved through collaboration, integration and listening to the needs of local people.

Figure 6:
Summary of ICN ambitions, outcomes and system measures

Ambition	Key outcomes	Available system priority metrics
Best start in life	Women are healthy and well during and after pregnancy. Children are healthy from birth. All children grow and develop well so they are ready and equipped to start school. Children in care are healthy, well and ready for adulthood.	% achieving good level of development at age 2-3
Access to best education and learning	Children and young people perform well at all key stages. SEND education meets the needs of children locally. Schools serve all children and young people well and nobody misses out on learning. Adults have access to learning opportunities which supports employment and life skills.	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	Adults are healthy and active, and enjoy good mental health. People experience less ill-health and disability due to lung and heart diseases.	% of adults currently smoke (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps you and your families out of poverty	More adults are employed and receive a 'living wage'. Adults and families take up benefits they are entitled to.	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Good access to affordable, safe, quality, accommodation and security of tenure. The local environment is clean and green with lower carbon emissions.	Number of households owed a prevention duty under Homelessness Reduction Act
Safe in your homes and when out and about	People are safe in their homes, on public transport and in public places. Children and young people are safe and protected from harm.	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to families and friends	People feel well connected to family, friends and their community. Connections are helped by public transport and technology. Improving outcomes for those who are socially excluded.	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Homeless people and ex-offenders are helped back into society. People have good access to support for addictive behaviour and take it up.	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	Timely access to all health and social care services when it is required, life course from conception to end of life. People are supported to live at places of their residence and only spend time in hospital to meet medical needs. Services to prevent illness (all health screening and vaccinations) are easy to access with quality service provision. People are treated with dignity and respect in all care provisions including end of life.	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible adults with learning disability/ severe mental illness receive annual health check
To be accepted and valued simply for who you are	Diversity is respected and celebrated. People feel they are a valued part of their community and are not isolated or lonely. People are treated with dignity and respect.	Metrics to be developed

During 2023 the new Place Operating Model was rolled out across West Northamptonshire. The model is underpinned by targeting local needs and improving outcomes for local communities, adopting the community-centred approaches to health and wellbeing. It is delivered through nine Local Area Partnerships (LAPs), which are now in place, and they include local membership from a wide range of system partners who know their local population. The key to success of the LAPs is the range of agencies and services working in partnership at a very local level to reduce organisational barriers and drive integration. This provides focus, reduces duplication and improves efficiencies. A diagram illustrating the geography of the nine LAPs is shown below.

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

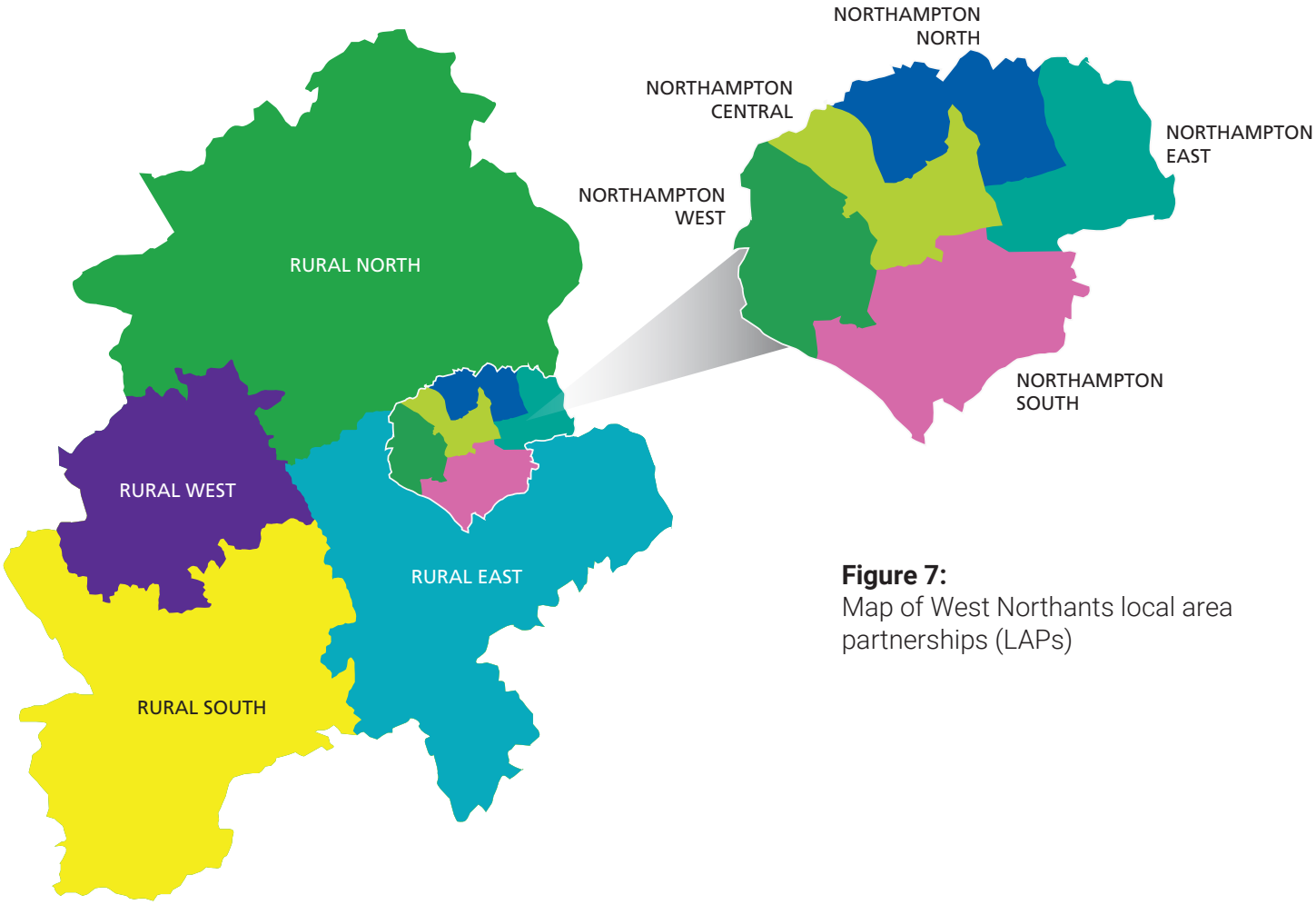
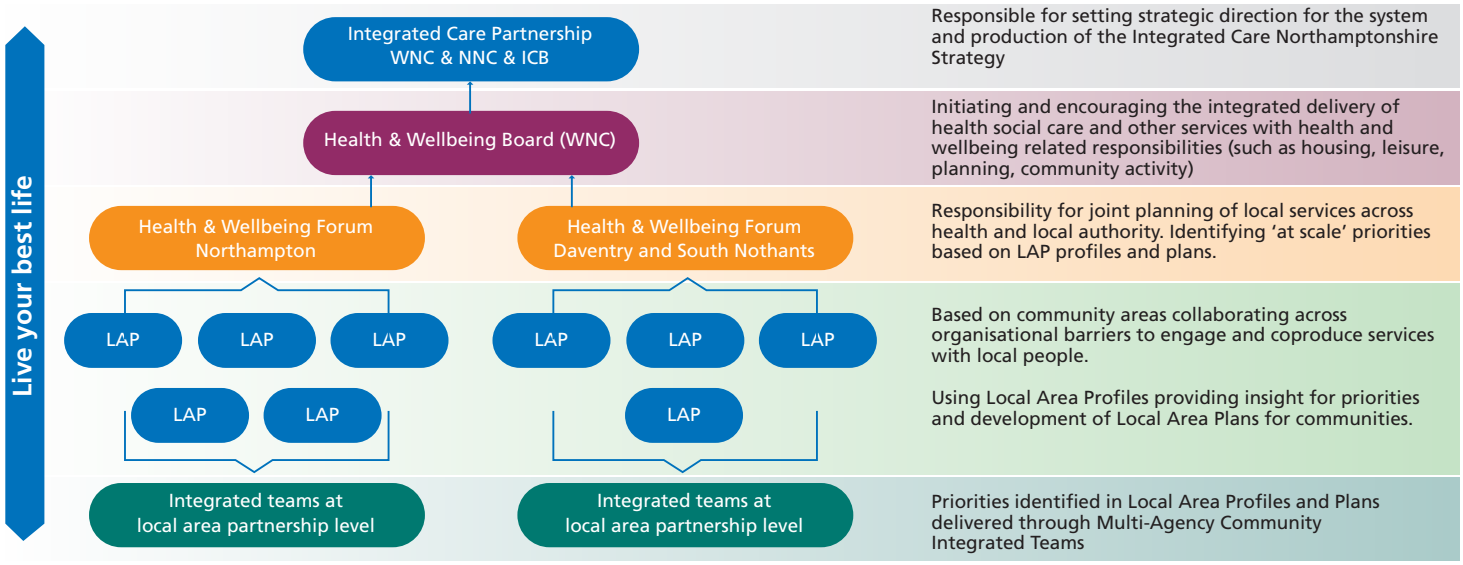


Figure 7:
Map of West Northants local area partnerships (LAPs)

The diagram below illustrates how the local community approach influences the decisions of the Integrated Care System and contributes to the 10 LYBL (Live Your Best Life) ambitions.

Figure 8:
West Northants Place governance structure



WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

LAPs are the focus of how partners within local communities co-design activities and services to improve outcomes, reduce health inequalities and contribute to the 10 LYBL ambitions.

The LAPs aim:

- To represent local areas and give a voice to residents.
- To empower residents to co-produce new services and solutions for their local area.
- To ensure local services are appropriate and delivered in a way that will meet the needs of the community.
- To contribute to West Northamptonshire priorities by utilising evidence-based information and local insight from frontline services and communities.
- To empower local leaders to take accountability for local action.

The LAP membership includes representation from a wide range of local partners including West Northamptonshire Council (WNC), Public Health, Adult Social Care, Police, Fire and Safety, Voluntary, Community and Social Enterprise (VCSE), GPs, local Elected Councillors, Northamptonshire Children's Trust and others.

As the LAP local leadership team their role is to:

- Determine two to three priorities that need addressing to reduce inequalities and oversee development of groups to take action to address these.
- Oversee the development of the LAP communications, engagement with communities and local websites.
- Escalate any areas of concern to the local Health and Wellbeing Forum.

Through discussions and agreements many partners have aligned themselves to the local areas including Adult Social Care aligning services to the LAP areas based on need, Northamptonshire Police aligning all their beats to the LAP areas, VCSE colleagues identifying representatives for all the LAPs based on the LAP priorities.

Partnership working in the LAPs provides the opportunity to share data and insights at a very local level which in turn means that the LAP leadership is able to identify meaningful specific priorities for the local population.

The majority of LAPs are focusing on children and young people, with others targeting the needs of older people and social isolation. The high level priorities are included in the figure in the next page.

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Rural West

Children & Young People:

- 20% of population are 0-16 yrs. old
- Mental health issues high with self-harm higher than average
- 5.6% youth unemployment higher than England average 4.9%

Families:

- 49.1% of families on relatively low incomes
- High proportion of obesity in adults
- Lower levels of achievement in education
- Development in EYFS (0-5 yrs.) falling below regional and national averages

Social Isolation:

- Connection to secondary schools for some is poor
- Low satisfaction scores for belonging.
- Some areas in Daventry town have high levels of income deprivation
- 7.7% of pensioners living in poverty

Rural North

Older People:

- High population age 65+ (21%)
- Higher life expectancy
- Poor mental health indicators

Carers:

- 8.5% of the population are providing unpaid care for others
- Almost 26% of carers deliver more than 50 hours per week.
- Majority of care is for older people

Social Isolation:

- Highest number of rural aging residents of all LAPs
- Furthest to travel for secondary education
- High food vulnerability index score
- High numbers attending Welcoming Spaces

Rural South

Older Population:

- 20.06% of population is aged 65+
- Highest proportion of persons 75+ of all LAPs
- Highest loneliness index score

Children and Young People:

- Average travel time to facilities and amenities is higher than England average.
- Prevalence of depression is high at 13.2%••
- Percentage of children (15+) smoking is high at 8.7%

Rural East

Older People:

- Higher proportion of population is aged 65+ (20%) & 75+ (8.8%) greater than England averages
- Number of pensioner households is rising, up to 23.7%

Families:

- High proportion of children in relative low-income lone parent families (51.1%)
- Percentage of children (15+) smoking is high at 8.6%

Transport & Services:

- High number of people living in rural location (31.1% compared to England average (10.5%)
- Higher levels of depression than England average

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Northampton North

Older People:
- Highest numbers of people aged 65+ of all LAPs
- Higher than average proportion of Pension Credit claims 12.2% compared to England average 11.3%

Anti-Social Behaviour & Youth Provision:
- High levels of neighbourhood level incidents of anti-social behaviour
- A higher-than-expected number of children live in relative low-income families

Children & young people:
- High levels of mental health needs

Northampton West

Youth Provision:
- Highest proportion of Children 0-16 of all LAPS
- High proportion of children smoking
- Nearly a third of children obese in Yr. 6
- High than average number seeking help for depression
- More UC claimants from single parent households

Multi-Agency Education Team:
- Suspensions is 2nd highest in WNC
- Seven-fold increase in exclusions relating to drugs and alcohol. High numbers of exclusions for disruptive behaviour and other reasons

Digital Information (Safeguarding):
- There is a need to improve the customer experience and communication routes across social care

Northampton South

Supporting families & pupils where English is not their first language:
- 30% identify as non-white British, 22.3% born outside the UK
- 8% of households have no English Speakers
- Significant increase in numbers from ethnic minorities

Early Years:
- Area of high levels of deprivation some wards in the 20% most deprived areas of England
- High numbers of lone parent families

Active Travel:
- Highest Carbon footprint of all the LAPs
- High average number of vehicles per household 35.6% compared to England average 26.1%
- Lowest average walking distance to key services
- Highest proportion of LAP populations that are of working age

Northampton Central

Multi-Agency Education Team:
- Suspensions and exclusions mean a loss of 12.5yrs of education
- Highest suspension rates in West Northamptonshire
- High numbers of exclusions for disruptive behaviour or for inappropriate use of social media

Access to Community Space for Youth Provision:
- 33.7% of children live in relative low income
- High youth involvement in anti-social behaviour; drugs weapons crimes
- Higher than average number of reports of feeling unsafe

Comprehensive COPD Programme:
- Significantly higher rates of COPD related illnesses
- 30% of residents smoke
- Of those with diagnosed COPD just 25% access services

Women's Health Inequalities:
- Life and health expectancy of women lowest in Northants.
- Largest non-white population in West Northants.
- Women have fewer years of healthy life due to poorer reproductive and gynaecological health.

Northampton East

Community Safety:
- High level of recorded crime over a 12-month period
- Violent crimes are higher than national average
- High numbers of burglaries and anti-social behaviour reports
- Low level of satisfaction score

Anti-Poverty/Cost of Living
- LAP area is ranked in the 20% most deprived areas of England
- 30% of children live in relative low-income families.
- Largest % of people claiming Disability Benefits
- Higher than average number of homes have no central heating
- Youth unemployment is higher than the national average

Youth Provision:
- Highest proportion of 0–16-year-olds of all the LAPS
- 4 in 10 children in Year 6 are overweight or obese
- High Proportion of lone parents
- Greater Socio-Cultural barriers such as beliefs and traditions

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Partners work together on the emerging issues to bring about positive impact on wellbeing, using a range of different approaches. An example is included below.

Central Northampton LAP

When compared with the West Northamptonshire LAPs, this LAP has:

- A total population of 59,083, with the lowest proportion of persons aged 75 and over
- The highest proportion of non-white British residents (50%)
- 5.8% that do not speak English at all or do not speak it well
- 17.7% households where no one speaks English as their main language
- The highest proportion of residents working in elementary occupations (25%)
- The highest proportion of no qualifications (19%)
- The highest proportion of deprived households: 50% of households living with 1 deprivation dimension; 5.2% of households living with 3 or more deprivation dimensions
- Highest number of people with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and high rates of emergency admissions, for both all ages and those under 75 years.

Based on the data, Northampton Central LAP identified poor respiratory outcomes as a priority. We have worked with partners across the NHS, VCSE and local authority to develop a test and learn programme to test a place-based approach to addressing inequalities in respiratory outcomes in this area.

It included reviewing the pathway for respiratory care, looking at the factors that influence respiratory health, starting with the wider determinants of health (the places people live and work), the opportunities to live healthy lives through to the opportunities to access support for people with respiratory conditions, considering both children and young people and adults. The model was developed in partnership with a range of stakeholders through a process of engagement, which was initiated at a Health and Wellbeing Board development workshop (attendees included elected members, local authority, NHS, VCSE partners) and refined through an iterative process in discussion with stakeholders.

The programme uses a number of approaches from the family of community approaches and is working with a number of partners across West Northamptonshire:

- Working with community organisations to conduct community engagement work to better understand experiences of respiratory conditions and identify opportunities for action.
- Develop a 2-year community health champions programme to recruit volunteers that represent local communities who will be trained and supported to be a link into communities and share information on health-related matters and signpost to services and support.
- Deliver a targeted outreach offer to bring health improvement services into the community, including a Stop Smoking Service, health checks, immunisation and screening.
- GPA recruited Health and Wellbeing Coaches, to engage with and offer 1:1 support for over-looked groups in the local community who are not currently accessing support to manage their COPD diagnosis.
- Engage with existing service providers to support and develop services currently available for people with a COPD diagnosis, such as Pulmonary Rehab and Breathing Space.
- Develop a digital exclusion project to increase access and improve engagement on the myCOPD self-management app.
- Develop an air quality project to increase awareness and reduce poor air quality in and around schools.
- Develop a children and young people with asthma project to support them, parents/carers and schools with effective asthma action plans and develop an Asthma Friendly Schools programme.
- Working with an evaluation partner to evaluate this place-based programme of work.

AN ASSET-BASED COMMUNITY DEVELOPMENT APPROACH

Through the LAPs, West Northamptonshire Council want to build community capacity to enable people to come together to identify local issues, devise solutions and build sustainable local action on health and the determinants of health. Well Northants uses an asset-based community development (ABCD) approach, targeting specific groups who are most vulnerable to health inequalities.

Well Northants

Asset Based Community Development's premise is that communities can drive the development process themselves by identifying and mobilizing existing, but often unrecognised assets. This means that communities are able to respond to challenges and create local social improvement and economic development.

Through the 'Well Northants' programme, community development workers are embedded within local communities with high deprivation (St David's Kingsthorpe, King's Heath, Blackthorn in Northampton and Southbrook in Daventry) or shared experiences (currently Gypsy Roma Traveller Community and Sex Workers) to better understand local needs and assets and to coproduce interventions to improve individual and community wellbeing.

AN ASSET-BASED COMMUNITY DEVELOPMENT APPROACH

The overall outcome it seeks to achieve is improved health, wellbeing and resilience. The model adopted for this work is the Well Communities Programme developed by the University of East London. The figure below shows the process taken to achieve this outcome, starting with engagement and capacity building, developing local projects and integration of work to build community involvement, empowerment, self-esteem and community cohesion. This results in improved access to services and better health and wellbeing outcomes.

Figure 9:
Well Communities model

WEST NORTHANTS LOCAL AREA PARTNERSHIPS (LAPs)

Community and Stakeholder Engagement, Assessment and Design (CSEAD)

This engagement uses the Community and Stakeholder Engagement in needs assessment (CSEAD) process which leads to local programme co-design. This begins with talking directly to residents through street interviews, ensuring that their views are heard and that they are involved from the outset. Intelligence gathered from residents is then used to conduct a needs assessment, followed by a coproduction workshop with the community and stakeholders to develop an action plan.

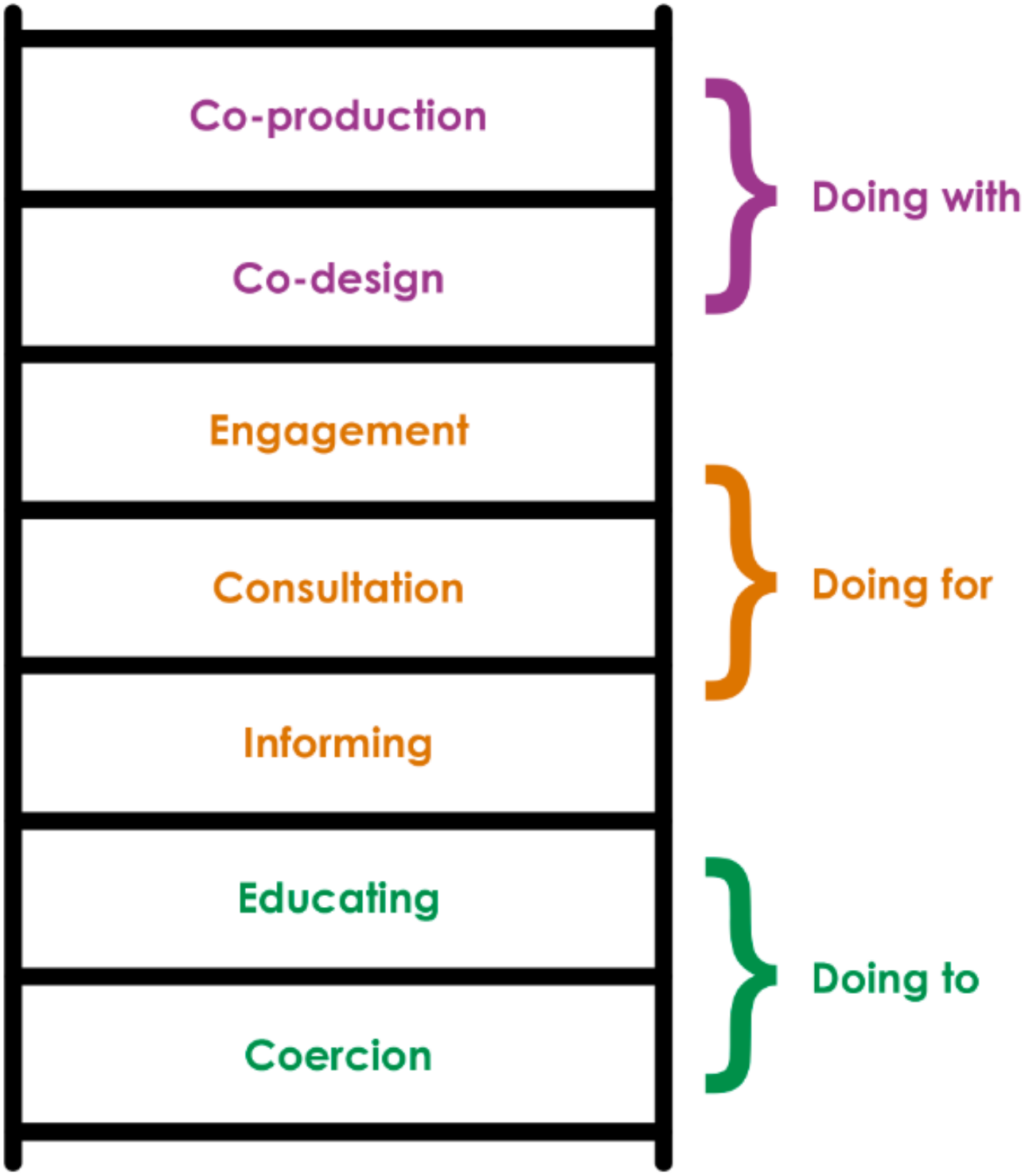
Community development workers have been working with local people and partners to develop neighbourhood, action plans and to implement the actions and monitor progress. Residents, groups and organisations from each community have been invited to bid for funding for an idea that addresses a theme identified through the feedback and insight received from residents. Inviting them to be involved in making decisions about how to spend public money, based on ideas from people who live in their neighbourhood can help achieve involvement. All bids for funding have been voted on by residents in the neighbourhood to choose the ideas they would like to see happen, with the proposals with the most votes receiving funding until the allocated budget is used.

For the long-term impacts of this programme, it is important to build social capital and community resilience. The ambition is for local needs to be met, with improved social connections and networks that reduce risk factors like smoking, obesity, drug and alcohol use and psychological stressors. Due to the nature of the programme targeting, we expect these outcomes will reduce health inequalities in those groups and ultimately result in an increase in life expectancy and healthy life years.

One of the local activities moving forward include the empowerment of a group of vulnerable women, some of whom are involved in sex work, to set up their own peer led beauty and support session, with a team of volunteers accessing training on a pathway to employment. The aim was to provide a safe space for vulnerable women to come together and feel good about themselves, and to provide an opportunity to get to know other people with the same lived experiences. The volunteers involved reported this has had a positive impact on their wellbeing, confidence and self-esteem and provided them with opportunities previously unavailable to them. This has also resulted in a recommendation by the women to develop a harm reduction pack to be given to vulnerable women by health professionals, with training to enable professionals to be able to support sex workers to reduce risk of harm.

ENSURING COMMUNITIES HAVE A VOICE

The Integrated Care Northamptonshire (ICN) and WNC are developing a set of principles for engagement, to ensure that all partners working in West Northamptonshire agree to working in partnership with communities to inform everything we do, based on the ladder of coproduction to move towards coproduction of services. WNC have also developed a coproduction charter to embed coproduction in everything we do and these principles were used to develop the Special Educational Needs (SEND) Strategy.



WEST NORTHANT'S CO-PRODUCTION CHARTER

West Northants Co-production Charter

'Together we are stronger'

This Co-Production Charter outlines the shared values that all partners have agreed to adhere to when working with children, young people and their families.

What is Co-production?

Co-production means working with people who use services as equal partners, to make a decision or shape a service that works for them.

Why co-produce and how do we know it makes a difference?

- Everyone feels equally valued and listened to.
- It leads to better services that improve people's lives.
- It is a legal requirement for all agencies to co-produce with children, young people and families.

This co-production charter outlines the 5 values that all parties will use to work together.

Communication

We will make our communication clear, consistent informative and timely.

Transparency

We will be open and honest as we make decisions.

Accountability

We will take responsibility, find solutions and regularly review to ensure we make a real difference.

Respect

We will listen to and empower people and treat them as equal partners.

Working together

We will work together and recognise that everyone has valuable contributions to make.

West Northamptonshire Council · Northamptonshire Children's Trust · Integrated Care Northamptonshire · NPFG

CASE STUDY: COPRODUCING THE SPECIAL EDUCATIONAL NEEDS (SEND) STRATEGY

- 3,504 CYP aged between 3 and 25 years have an EHCP plan
- 50.5% attend a mainstream school and 38.% attend a special school
- 32% have autistic spectrum disorder
- 22.6% have a speech, language or communication difficulty
- 18.6% have a social, emotional or mental health need
- 14.1% have a moderate learning difficulty

A multi-agency working party was established to scope the task of developing a partnership SEND and Alternative Provision Strategy that will improve the outcomes for children and young people; improve the lived experiences for families, reducing the current adversity and frustration they face; and deliver financial sustainability. Over a 4-month time frame a series of partnership co-production events and discussions took place across West Northamptonshire. Children, young people and their families and all partners across Education, Health and Social care, engaged in robust discussions about past, present and future needs. This included elected members, early years providers, mainstream and special schools, alternative providers, further education colleges, the University of Northampton, local voluntary/community organisations and employers. Mentimeter was used to capture views. The resulting strategy emerged from 21 drafts developed through an iterative process and reflects the aspirations of more than 800 people and more than 3,200 individual inputs. More than 50% of comments came from children, young people and their parents, supported by Northampton Parent Forum Group and other parent groups. The final SEND and Alternative Provision Strategy is the partnership's ambitious vision, aims and priorities co-produced with and by the community to ensure that system change can happen.

CASE STUDY: COMMUNITY WELLBEING FORUMS

As part of the engagement framework, WNC have a number of community forums, which provide a safe, accessible space to engage our communities, particularly our seldom heard communities, who we know may not ordinarily engage. The community forums are aligned to various protected characteristics including disability, gender, sexuality, age, religion, faith and ethnicity. Members can be individuals who live, work or are otherwise involved in community life in West Northamptonshire, or may attend on behalf of a business, community, voluntary or faith organisation. Each forum has a councillor co-chair appointed by the Council and a community co-chair, elected from its members.

The priority, aims and objectives of the forums are to:

- Give people a way to have a dialogue with WNC and its partner organisations
- Provide feedback on issues of concern
- Pass on ideas for future plans for West Northamptonshire and services provided locally, including those provided by the Council and its partners
- Help improve the quality of life for the community they are representing in West Northamptonshire
- Help community groups identify, develop and support people in the community
- Support community groups to raise awareness and educate people about related health and discrimination issues.

The forums seek to monitor the effectiveness of our services in relation to equality by:

- Providing information about services and how to access them
- Identifying and removing barriers to ensure access to services
- Promoting dialogue about issues of concern between us, our members and officers and other people in the community
- Identifying the specific requirements of the people the forums represent.

The forums meet at least every eight weeks and are part of our wider community engagement strategy and network.

The Diverse (Ethnicity and Faith) Communities Forum is an important networking, coordinating and information sharing platform for professionals, partnering organisations and community groups. The forum engages and has representation across a wide range of faith and ethnic groups, providing a mechanism to bring forward issues and barriers to accessing services, exchanging information, developing events, projects and programmes, resulting in it being a first point of contact for many services and organisations wanting to engage with specific communities.

This forum also supports community events that bring our communities together to foster good relationships and celebrate diversity. Including Black History month, Windrush, Independence Day celebrations and faith events such as Diwali and the Ukrainian flag raising event. Recently this forum has been used as a focal point by both the police and fire service in their recruitment to help increase diversity within both organisations. By having constant representation at the meeting, they are able to provide updates, share new information, and seek new advice and perspectives.

The LGBTQ and Allies Forum brings together partners from local LGBTQ+ services, volunteers and community members, marking events such as International Day Against Homophobia, Biphobia and Transphobia and World Aids Day.

Recent forum discussions include:

- The care of LGBTQ+ people in older age groups
- Social care staff, care providers and LGBTQ+ organisations
- Improving services for LGBTQ+ people
- Domestic Abuse and Sexual Violence and support services for the LGBTQ community
- A review of policy providing an LGBTQ+ lens

CASE STUDY: WORLD SUICIDE PREVENTION DAY 2023

In the UK, 115 people die by suicide every week – with 75 percent of those deaths being male (ONS), 1 in 5 people have suicidal thoughts (NHS Digital) and 1 in 14 people self-harm (NHS Digital). ONS figures report that there were 36 suicides in West Northamptonshire in 2022, which is a reduction from 43 in 2021.

World Suicide Prevention Day takes place annually, and this year's theme was 'Creating Hope Through Action'. For World Suicide Prevention Day on 10 September 2023, a sofa travelled around Northamptonshire giving people the opportunity to sit and chat about their mental health. The 'Take a Break' campaign encouraged passers-by to stop, sit and talk, to help to raise awareness of suicide prevention and the services that can provide support, as well as reducing stigma around suicide and self-harm. It provided a relaxed environment for people to chat, share any concerns and find out how to get help.

The brown leather two-seater sofa was transported to different locations across Northamptonshire, over six days at varying times, with different organisations supporting at each place.

The campaign was run by Northamptonshire Healthcare NHS Foundation Trust (NHFT) with support from West Northamptonshire and North Northamptonshire Public Health teams.

In West Northamptonshire, the sofa visited Brackmills Industrial Estate, Becket's Park and The Amazing Northampton Run 2023.

CASE STUDY: A PARTNERSHIP APPROACH TO WORKING WITH ROUGH SLEEPERS

Individuals and families experiencing homelessness are more vulnerable to health inequalities and have disproportionately poor health outcomes and as a result, people experiencing homelessness and rough sleeping have a greatly reduced life expectancy (44 years for men vs. the national average of 79.4 and 42 years for women vs. national average of 83.1). This is underpinned by poor health outcomes, with 73% of people experiencing homelessness suffering from a physical health problem and 80% from a mental health problem (UKHSA, 2019). According to the British Red Cross (2021 in NHSE, 2022) homeless people are significantly less likely to be registered with a GP meaning preventable healthcare needs are not treated in a timely fashion, making hospital attendance more likely. Therefore, public health services play a pivotal role in enhancing the wellbeing of these vulnerable individuals and communities by preventing diseases and injuries, detecting health issues early, and responding promptly to avoid the development of severe illnesses. While public health may not always be at the forefront of our minds, it is crucial in maintaining a healthy society, and increased life expectancy. Unfortunately, individuals experiencing acute homelessness and hardship face unique challenges in accessing healthcare, including barriers related to transportation and lack of structure to their lives.

WNC worked in collaboration with The Northampton Hope Centre and Bridge Substance Misuse Programme to organise a range of successful Health and Wellbeing events, benefiting those who are homeless, rough sleeping and in temporary accommodation within our community. This initiative aimed to provide crucial public health services to the community, with a focus on preventive healthcare measures. The team worked with providers to offer a range of essential services, including COVID-19 and flu vaccinations, NHS health checks, sexual health consultations, drug and alcohol support, hepatitis C testing, stop smoking services, smear testing and access to optical care.

Alex Copeland, the CEO of Northampton Hope Centre, emphasized the importance of easy access to public health services, especially given the increasing numbers of individuals experiencing homelessness in Northampton. He stated, “With the numbers of individuals presenting themselves as homeless at Hope, now often into the 50’s and 60’s daily, it is crucial that we work together on initiatives like this to make access to public health services as easy as possible to the most in need.” Copeland added, “Collaborating with Public Health with events like this will be important as we tackle homelessness head-on, particularly as we head into winter and need to avoid deaths on the street.”

Karl McGuiness from the Hepatitis C Trust said “Really well planned and executed, great number of people tested, and a lot of people also educated about transmission routes and risks.”

Bridget Carroll, a Director of the Bridge Substance Misuse Programme, commented that “the whole day was a success. Having all the providers in one room meant it was a relaxed and comfortable environment and welcoming to their clients. The service users who attended have been telling others about the day and are looking forward to attending the next event with the Public Health Team”.

These initiatives have received positive feedback from service users and our team are committed to continue working in partnership with settings to provide similar interventions throughout the year.

PROVIDING COMMUNITIES WITH A MEANS TO DRIVE POSITIVE CHANGE

Community funding is the way the council supports the local voluntary and community sector with grant awards to help them deliver projects and services within our communities. During the first six months of this financial year, we have awarded just short of £1.4m in community funding grants.

Demand for community grant funding, post-covid and with the cost-of-living increases, is exceptionally high, so it is not possible to satisfy all requests. But the Community Funding Grants team has introduced a framework which targets funding towards projects and services that support the delivery of the council's strategic aims and priorities and crucially, where there is the greatest need within the population or local community.

Community funding grants offer a wide range of benefits that contribute to the wellbeing and development of our communities and residents. Grants empower local organisations and residents' groups to take ownership of projects that matter to them. After all, they know their communities needs and aspirations best.

Grants can be tailored to address specific needs, targeting issues within a community whether it's youth engagement, money advice, food support, arts and cultural opportunities or other priorities.

They are also a great way to strengthen local communities, with people coming together to achieve a shared ambition, and many of the projects that receive funding focus directly on improving people's lives and generating a positive social impact. Whether it's access to mental wellbeing support, food banks or community fridges or youth clubs, grants contribute to the overall wellbeing of a community as a whole.

Participatory budgeting

Participatory Budgeting (PB) is a process that has co-production at its core. Working within the targeted communities, it puts local people at the heart of prioritising need. It enables the community to set their own criteria, and encourages them to have their say, through a Community Voting process. The process enables the community to select the projects and initiatives that they believe will best deliver their outcomes.

As a successfully developed methodology, the PB engagement process seeks to raise awareness and interest from both traditionally engaged sectors of the community, as well as those who are seldom heard. It involves encouraging all those connected to use their formal and informal local networks to spread awareness of the opportunity.

Where there is interest and potential in the community, additional support will be given to capacity-build parties to be deliverers of projects and initiatives. Existing local organisations are encouraged to become sponsor organisations to monitor progress, provide 'umbrella' governance and support burgeoning groups and individuals to pilot projects.

From the outset, the key message is 'You decide!' making it clear that local residents are in charge of deciding the priorities, as well as which projects get funded to deliver. This results in:

- a range of projects addressing community identified health needs
- a more engaged and connected community, empowered to create solutions to health needs.
- improved access to, and communication of, health interventions and improvement opportunities.
- strengthening of the voluntary and community sector in local communities.

Well Northants used participatory budgeting to provide funding to local areas. To ensure ease of community understanding, the term 'Community Voting Day' (CVD) was adopted to replace the term Participatory Budgeting, as it emphasises in simpler terms what the project is about.

The initial community voting days were delivered in the style of a 'Dragons Den" in which applicants bid for funding by pitching their project ideas to the community. A list of projects to be funded, would then be decided via a voting process, with the pitches with the highest scoring votes prioritised first. The results were then announced and applicants informed of the outcome.

PROVIDING COMMUNITIES WITH A MEANS TO DRIVE POSITIVE CHANGE

In 2023, Well Northants successfully delivered funding to the value of £60,784 to enable 31 community projects to be delivered in Well Northants communities.

Feedback from participants included:
"Amazing to see the community coming together to support each other – THANK YOU!!"

"A truly lovely day. Fantastic new opportunity for community groups to meet and hopefully work together in future"

"Great to connect with so many organisations and people trying to improve the community, I feel more part of community and curious about all the things that are happening. I now have information to share with people who complain that nothing happens/no-one cares!"

"Good to meet the organisations – inspiring to hear about the groups and learn that so much is available in my community"

The team listened to what people said about the community voting day and adapted how it was delivered on the day to increase reach, make the events easier to access and engaging. The latest community voting day was less of a dragons den and more of a market place. Overall attracting more residents in a more informal way, this was an opportunity for people to meet, learn about projects and talk about how they can get involved.

Examples of some projects funded:

- Fruit trees for the new community orchard at Bradlaugh Fields and Barn
- Discover yourself workshops for children and young people delivered by Lemon Pop
- Resources for the Keep Ever Young (KEY) club, supporting friendships and reducing isolation amongst older people.
- Gardening after school club at Blackthorn Primary school so children can grow their own and learn where their food comes from.
- Parenting workshops delivered by Free2Talk, helping to build confidence.

DEVELOPING COMMUNITY HUBS

The cost-of-living crisis created unprecedented pressures on people already in poverty, and despite central government support, many people in West Northamptonshire have been unable to afford to heat their home. Working with parish and town councils and partners in the voluntary and community sector we created a network of 96 Welcoming Spaces - non-judgemental, safe and welcoming places where people can come together to stay warm, and perhaps enjoy a hot meal or a cup of tea and a biscuit.

WNC offered grants of between £500 to £1,500 to support the creation and development of these spaces, and during the winter of 2022/23 the grant-funded spaces had 58,600+ attendees, referring over 3,500 clients on to wrap-around support services.

Below are a number of testimonials from different settings that host welcoming spaces:

Brackley Library

"One of our customers has been struggling with his electricity. Through coming to the library, we've been able to talk to him and signpost him to the Citizens Advice Bureau (CAB), who come on Fridays. With their support, he has been in contact with other council teams and charities that have helped him. We always check in to see how he is doing when he visits, and recently he said how grateful he is that the library, CAB and charities have offered him support. The help alleviated his stress, and he is finally getting to a point where he feels he is more financially settled."

Broadmead Church

"We have a lady who comes in every week from work, she has a break of four hours and can't afford to travel home so she comes and sits in the café, and we serve her drinks and food."

Bugbrooke Parish Council

"One of our regular visitors is elderly and partially sighted. His wife died last year so he now lives alone. He really enjoys coming to the Warm Space to chat to friends. He's sometimes tearful, but his friends are very supportive. He is determined to learn to cook for himself and has been getting advice from some of the other attendees."

The Hope Centre

"One client used the Warm Space to simply keep warm and avoid the cost of putting his heating on. When he first came, he wouldn't talk to anyone and sat quietly in the corner. Over the week his confidence grew, and he began talking to other clients and staff. He became interested in helping in the café and after chatting with the team it was agreed that he could begin working there. He later told staff: 'I wouldn't be here if it weren't for Hope'. Before finding the Warm Space, he'd tried to take his own life, but supporting the Warm Space has given him purpose and a reason to carry on."

The team at the Hope Centre are currently working on a plan to deliver sustainable services in these local trusted settings, where local people need them the most. They are working with partners to provide outreach for money and debt advice, mental health support, housing and employment, public health services and training for frontline workers and volunteers through the Community Training Partnership.

Welcoming Spaces form part of our Anti-Poverty Strategy, which sets out how the council will work with partners to support people who are struggling financially and what can be done to help prevent people falling into poverty. These spaces continue to develop, and are part of the WNC programme to develop one-stop shops, that bring together a range of services within a community to improve access to services.

VOLUNTEER AND PEER ROLES

Another strand of the family of community-based approaches are volunteer and peer roles, which enhance individual capabilities to provide advice, information and support or organise activities in their own or other communities – community members use their life experience and social connections to reach out to others. Common models include:

- peer support
- peer education
- health trainers
- health champions
- community navigators
- befriending and volunteer schemes such as health walks

Recognising the value of these approaches, WNC commissioned Grow! Cook! Eat! to build community capacity for healthy living in our communities through growing and cooking in West Northamptonshire. It is a collaborative project run by The Northampton Hope Centre and Health Works. The project has coined the phrase, 'A community that grows together, cooks together, eats together, stays together'. The programme recruits and trains community champions to grow and cook healthy food and share their new knowledge and skills to those around them, and provides small grants (£500 - £3000) to enable this to happen. An example is C2C Grows – Gardening for Wellbeing, which was established during lockdown (Autumn 2020) when they acquired a double plot at the Kingsthorpe Park Allotments. As a charity C2C has a proven track record of working with women on the fringes of society. The majority of the women who attend the allotment sessions have had some life changing challenges either with the criminal justice system, the impact of neglectful lifestyle choices, abuse through alcohol, drugs or violence, and some struggling with loss and bereavement. C2C Grows is a social and therapeutic gardening project that offers wellbeing gardening sessions for women and aims to build women's confidence in growing food and giving them a safe space to do this.

Prior to being involved in Grow!Cook!Eat! C2C struggled to get women up at the allotment consistently but with the grant funding and offering to cover transport this has been a game changer. C2C have been running weekly gardening for wellbeing sessions on Thursdays for women since April 2023. They focus on a different topic of gardening each week and aim to incorporate aspects of wellbeing into the sessions, such as looking at the healing properties of plants e.g., lavender to aid sleep. They always offer the women attending a chance to learn a new gardening skill – e.g., seed sowing, pricking out, pruning and plant care/ maintenance. The main focus of the project is to offer the vulnerable women a safe, green space to garden, grow a variety of fruit, vegetables, herbs and flowers, and gain a sense of meaningful purpose to their day. C2C used April and May to plant and sow a wide range of vegetables and fruit including runner beans, broad beans, peas, potatoes, lettuce, parsnips, beetroot, chard, carrots, cucumbers, tomatoes, pumpkins, sweetcorn, radishes and butternut squash. Fruit currently growing includes plums, apples, redcurrants, gooseberries, blackcurrants, strawberries, raspberries and cherries. The women harvested all of this produce to take home, alongside cooking sessions on site using as much of the vegetables as possible.

C2C have received positive feedback from the women attending the sessions so far, with one woman saying that coming to the sessions really lifts her mood and another saying that she leaves her troubles at the gate and can forget about everything else whilst being at the sessions. The project is providing a unique safe, green space for vulnerable women in the local community. C2C are now taking referrals from local GP surgeries who are offering the project as a green prescription.

New Life Amalgamation is another organisation who have received training and a community grant from

VOLUNTEER AND PEER ROLES

Grow!Cook!Eat!. New Life Amalgamation was established after Amanda Tandoh saw the need for both the spiritual and physical needs of her community to be met. Since its conception Amanda has been running weekly church services, a weekly foodbank, support groups and recently health heart checks. There is a mixed group of people who come along to the various sessions put on at the church, both men and women, young and old. After attending the champions training, Amanda established a session to teach participants to grow, cook and eat healthy on a budget. It is called 'cooking with a twist' because it teaches people to cook even with food they have been cooking before but in different and interesting ways. Amanda encourages participants to come with recipes and to teach the group how the meal is made. One of the ladies was amazed at how easy it was to prepare a healthy meal using simple ingredients. She said she would come back for more of the cooking sessions. The classes also provide an avenue to meet other people and foster a sense of community around food.

WNC also commission the Bridge Substance Misuse Programme, which is a Lived Experience Recovery Organisation (LERO). LEROs are organisations led by people with lived experience of drug and alcohol recovery, for the benefit of the recovery community. We believe in the therapeutic value of one addict helping another.

Bridge recruit, train and supervise volunteers who have had drug or alcohol problems themselves, or close contact with people who have. They act as mentors or support workers to clients with drug or alcohol problems. The aim is to help Bridge members deal with their substance misuse by providing practical support in relation to social aspects which impact negatively on their lives.

People who have experienced substance misuse problems have a role to play in helping others. Their experience and understanding should not be wasted when it can be used to support people trying to recover from their own substance misuse. The experience and learning that mentors gain should be a valuable aid to them in their personal or career development.

As well as offering members the opportunity to engage with a mentor, Bridge have developed, and constantly review, a programme of physical and other activities that are available to members. Many of these sessions are led by peer mentors.

Coproduction is an important part of their offer and ensures that the service user's needs are heard. Bridge regularly host members meetings. These are service user meetings that provide the opportunity for members to provide feedback on the service, and to make suggestions and requests. Bridge also use suggestion boxes for the same purpose. They regularly implement requests from service users – such as event days, or activities for the timetable.

CONCLUSIONS

This report has provided an update on how WNC has adopted the new place operating model, utilising the range of approaches in the family of community-centred approaches to addressing health inequalities. As this way of working becomes more embedded across the council, we expect more services to be utilising these types of interventions to improve the health and wellbeing of residents and to support delivery of the 10 Live Your Best Life ambitions. Below are a number of recommendations to help us further address health inequalities.

RECOMMENDATIONS FOR THE 2023 REPORT

1. We will ensure that the Joint Strategic Needs Assessment considers the needs of the CORE20PLUS groups, including developing community fact sheets for diverse ethnic communities and inclusion health groups and this is used to inform further actions to address health inequalities in West Northamptonshire.

2. Produce a Community Cohesion Action Plan for West Northamptonshire.

3. Develop a set of systemwide principles for community engagement and coproduction, ensuring that all staff adopt the recommended principles and practices.

4. Build, expand and promote our community engagement network across the system.

5. Develop a system inclusion health strategy and action plan.

6. Refresh the ICN Health Inequalities Plan.

7. Ensure appropriate training is provided and carried out and guidance and toolkits are provided to foster a consistent approach to community-based models of work.

8. Ensure training and tools are developed to enable staff to better understand health inequalities and their role in addressing these.

RECOMMENDATIONS FROM 2022 DPH ANNUAL REPORT

The DPH Annual Report for 2022 looked at the effects of the cost of living crisis for resident's of West Northamptonshire. Below are the recommendations from that report and updates of the actions taken to address each recommendation.

	Recommendation	Action taken
1	Continue to deliver urgent support to those struggling right now – ensuring good access to rights advice and easy access to hardship support.	• Funding for debt and money advisors in the VCSE sector in place • Transformation of WNC revenue and benefits team underway • Community Training Partnership launched with ongoing training offer for front line staff • Continuation of energy support and advice service for winter • Roll out of Household Support Fund 4 • Preparation of welcoming warm spaces for winter
2	Ensure that the impact of financial stress on mental health is understood and addressed.	• Implementation of an all-age mental health and suicide prevention training framework aimed at frontline workers and volunteers across the system as well as the general public. Key elements include increasing knowledge in relation to what can have a negative influence on our mental health and wellbeing, signs to look out for in relation to poor mental health, and strategies and approaches to support their own and the mental wellbeing of those they support. Training also includes understanding of what is available to support mental health, signposting and referral to appropriate support. • System-wide alignment of messaging related to the promotion of positive mental health and wellbeing underpinned by the A4H 10 Keys to Happier Living. This includes a campaign starting in early 2024 aimed at working age men, using the 10 keys to happier living to promote actions to support positive mental health and wellbeing.
3	Continue to build on the collaborative working to ensure partnership working is at the centre of anti-poverty action including the wider Integrated Care System constituent organisations.	• Anti poverty oversight group continues to meet with representation across statutory services and voluntary sector • Upstream anti-poverty actions including supporting employment and economy discussed at a system level by ICP Board and with West Northamptonshire Health and Wellbeing Board. Recognition at these meetings of the importance of the wider social and economic impact of the ICS partners (4th aim of Integrated Care Systems as set out by Integration White Paper)
4	Take place-based and asset-based approaches linking with the work of the emerging Local Area Partnerships.	• Wrap-around support at welcoming spaces delivered in close collaboration with LAP teams

RECOMMENDATIONS FROM 2022 DPH ANNUAL REPORT

	Recommendation	Action taken
5	Develop longer-term strategic approaches to reduce and prevent poverty and its impacts, focusing on: • Fuel poverty and warm homes • Sustainable food • Skills and access to employment •Homelessness and rough sleeping.	• Housing partnership board subgroup focussing on quality and sustainability of homes • Support for food banks through HSF4 to improve sustainability and community food larder offer • Working group established to look at spend of UKSPF people and skills and prepare for work well partnership bid to support employment opportunities Homelessness and rough sleeping needs assessment published and work underway on the homeless and rough sleeping strategy
6	Keep learning and reflecting and ensure that evaluation results in improved outcomes.	• Outputs and outcomes of activity closely monitored to ensure progress of projects • In addition to hard data, qualitative feedback from service providers and service users sought to be able to understand impact of interventions.

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

26th March 2024

Report Title	**Northamptonshire All Age Autism Strategy**
Report Author	**Louise Kirby, Helen Gregson-Holmes, David Loyd-Hearn**

List of Appendices

Appendix A – Northamptonshire All Age Autism Strategy
Appendix B – All Age Autism Strategy Action Plan
Appendix C – All Age Autism Strategy ppt
Appendix D – Autism JSNA

1. Purpose of Report

1.1. The Northamptonshire All Age Autism Strategy is a co-produced strategy across the Northamptonshire Integrated Care System and has been endorsed by our Autism Champions, our Autism Advisory Panel, the Young Autistic Advisory Project, the Children and Young People's Transformation Partnership Board and the Mental Health, Learning Disabilities and Autism Programme Board. al Health, Learning Disabilities and Autism Programme Board.

1.2. The All Age Autism Strategy dovetails with the West Northamptonshire SEND strategy, the West Northamptonshire Co-Production Charter and the Northamptonshire ICB Long Term Plan with a focus on our population needs and intersectionality through the autistic lens.

1.3. The Autism Strategy was enabled by the development our first Autism Joint Strategy Needs Assessment (JSNA), a significant undertaking we believe is largely unique in the UK.

1.4. There is an Action Plan that is proposed to be used as a framework across our children and young people and adult governance.

1.5. This strategy and supporting documentation are being presented to the West Northants Health and Wellbeing Board for endorsement and assent to commit to improve the lives of our Autistic Community and to ensure there is "no decision about us, without us"

2. Executive Summary

2.1. The Northamptonshire all age autism strategy builds on the preceding local autism strategy published in 2018 and will be reviewed again in 2026 in line with the National strategy for autistic children, young people and adults: 2021 to 2026. It explains the main things we want to work on over the next two years towards the vision for Autistic people to be recognised, heard, valued, able to thrive and reach their full potential in our county.

2.2. The focus of the strategy has been informed by national government themes and co-produced in partnership with the local autistic community, both adults and children. The development of the strategy was also supported by colleagues from partner organisations.

2.3. This strategy aims to address the diverse and complex needs of autistic individuals and their families in Northamptonshire. The focus on a life-course approach underscores the commitment to supporting autistic people at every stage of their lives. It recognises autism affects people differently and touches many aspects of their lives.

2.4. The three-year timeframe aligns with the government's national strategy and emphasises the importance of continuous review and evaluation, ensuring that the strategy remains responsive to evolving needs and challenges. The involvement of a diverse group of stakeholders, including the autistic community, in the development and review process is a key strength that promotes inclusivity and ensures that the strategy remains person-centred.

2.5. The emphasis on joint ownership and leadership across multiple organisations underscores the collaborative nature of the strategy, recognising that addressing the needs of autistic individuals requires a unified and concerted effort from various sectors. Furthermore, the strategy's co-production with the Autism Advisory Panel, Young Person Autism Advisory Panel, Autism Enabler Group, and Autism Champions underscores the commitment to the principle of "Nothing About Us Without Us," ensuring that the voices and perspectives of the autistic community are at the forefront of decision-making processes.

2.6. There is an emphasis on collaboration and partnership with various organisations and stakeholders demonstrating a concerted effort to ensure comprehensive support and inclusivity. The holistic approach outlined in the strategy, encompassing various aspects such as health services, education, employment, independent living, and the criminal justice system, reflects a comprehensive understanding of the multifaceted challenges faced by autistic individuals. This approach is poised to create a more supportive and inclusive environment that fosters the well-being and empowerment of the autistic community in Northamptonshire

2.7. The West Northamptonshire Wellbeing Board are being asked to sign off the Autism Strategy and promote the work across the partnership ensuring inclusive practice that makes our communities and services within, more accessible to our autistic people.

3. Recommendations

3.1 Request sign off and endorsement of the Northamptonshire All Age Autism Strategy

4. Report Background

4.1 Please refer to the appendices for supplementary information

5. Issues and Choices

5.1 This suite of documents have been produced as a partnership undertaking throughout 2022/23 and 2023/24

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1. Endorsement requires officer capacity to ensure the strategy is embedded in our work through the agencies across the local authority area.

6.2 **Legal**

6.2.1. The Autism Act 2009 and the 2021 National Strategy for Autistic Children, Young People and Adults recommends local strategies and plans.

6.3 **Risk**

6.3.1 There are still bodies of evidence nationally and locally that services are not inclusive and accessible, the All Age Autism Strategy and Action Plan are mechanisms to improve inclusion. If the strategy is not endorsed, this would represent a risk for inclusion.

6.4 **Consultation**

6.4.1 This Strategy is the culmination of 2 years worth of work to co-produce with our Autistic community across the Northamptonshire.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 No.

6.6 **Climate Impact**

6.6.1 N/A

6.7 **Community Impact**

6.7.1 This will improve inclusion for the autistic community of West Northamptonshire, though the inclusive practice is also likely to be beneficial to people with a learning disabilities, dementia, English as a second language and people with communication, emotional wellbeing and social needs.

7. Background Papers

All Age Autism Strategy
All Age Autism Strategy Action Plan
All Age Autism Strategy ppt
Autism JSNA

Integrated Care Northamptonshire

Northamptonshire All Age Autism Strategy

2024-2026

ACTING TOGETHER FOR AUTISM NORTHAMPTONSHIRE

Image by Otto Morrison – Young Person

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Where are we now?

Graphic: Amber Miller

The words autistic individuals associate with autism. (Difference, overload, transitions, frustrated, misunderstood, time blind, theory of mind, outcast, human, communication, neurodiversity, brilliant, incapable, care, anxiety, minority, stress, invisible, isolation, confusion, slow, angry, behaviour, language, bullied, sensory processing, unique, emotional, gifts, dysregulation, central coherence, structure, monoprocessing, vulnerable, planning, fluctuating, immature, dramatic, aggressive, sensitive, control freak, weird, prove ourselves, not normal, not listened to, not believed, lost, useless, lonely, hard, emotionless, difficult, naughty, stubborn, lazy, left out, time consuming, manipulative, boring, selfish, gullible, super powers, stupid, obsessive, sensitive, disabled, struggle, smart, struggle, dumb, vulnerable, high expectations.)

The strategy

This strategy aims to address the diverse and complex needs of autistic individuals and their families in Northamptonshire. The focus on a life-course approach underscores the commitment to supporting autistic people at every stage of their lives. It recognises autism affects people differently and touches many aspects of their lives.

The three-year timeframe aligns with the government's national strategy and emphasises the importance of continuous review and evaluation, ensuring that the strategy remains responsive to evolving needs and challenges. The involvement of a diverse group of stakeholders, including the autistic community, in the development

and review process is a key strength that promotes inclusivity and ensures that the strategy remains person-centred.

The emphasis on joint ownership and leadership across multiple organisations underscores the collaborative nature of the strategy, recognising that addressing the needs of autistic individuals requires a unified and concerted effort from various sectors. Furthermore, the strategy's co-production with the Autism Advisory Panel, Young Person Autism Advisory Panel, Autism Enabler Group, and Autism Champions underscores the commitment to the principle of "Nothing About Us Without Us," ensuring that the voices and perspectives of the autistic community are at the forefront of decision-making processes.

There is an emphasis on collaboration and partnership with various organisations and stakeholders demonstrating a concerted effort to ensure comprehensive support and inclusivity.

The holistic approach outlined in the strategy, encompassing various aspects such as health services, education, employment, independent living, and the criminal justice system, reflects a comprehensive understanding of the multifaceted challenges faced by autistic individuals. This approach is poised to create a more supportive and inclusive environment that fosters the well-being and empowerment of the autistic community in Northamptonshire.

Vision Statement

“Autistic people are recognised, heard, valued, able to thrive and reach their full potential”.

Our vision statement was created with the input of autistic people embodying out commitment to ‘Nothing About Us, Without Us’ principle.

Mission

Our work, goals and achievements are guided by our vision to make Northamptonshire a better place for autistic people and encourage others to follow our lead. Our mission describes how we plan to achieve this and was developed by the Autism Champion Network.

A	Across organisational boundaries.
U	Understanding of autism improved.
T	Thoughtful processes and pathways developed.
I	Improving collaboration.
S	Sharing knowledge.
M	Making experiences better for autistic people.

Priority Outcomes

The strategy demonstrates a clear commitment to addressing the priorities and needs of the autistic community in Northamptonshire. By co-producing the strategy with the Autism Advisory Panel, Young Autistic Advisory Panel, Autism Enabler Group, and Autism Champions, the voices and perspectives of the autistic community have been incorporated into the Priority Outcomes and high-level goals.

Aligned with the national government themes, the strategy's Priority Outcomes reflect a comprehensive approach to addressing various aspects of the lives of autistic individuals. These outcomes, along with the corresponding high-level goals and action plans, are designed to deliver meaningful and sustainable improvements in the quality of life and well-being of autistic people and their families.

They are: -

1. **Planning and Governance that delivers improved outcomes.**
2. **Involvement, information and access that delivers results.**
3. **Increase service training, development and collaboration between services which, improves understanding and acceptance of autism within society.**
4. **Improving autistic children and young people's access to education and supporting positive transitions into adulthood through assessment, early intervention and planned support for key transition stages**
5. **Supporting more autistic people into employment and to retain employment.**
6. **Reduce health and care inequalities for autistic people.**
7. **Have the right support in the community and inpatient care.**
8. **Improved support within the criminal and youth justice systems.**

Image: A group of people with signs calling for better support for the disabled community.
By Cheryl Stafford – Adult

The emphasis on planning and governance to deliver improved outcomes signifies a commitment to effective coordination and management of resources to ensure the successful implementation of the strategy. Furthermore, the focus on involvement, information, and access underscores the importance of promoting inclusivity, accessibility, and transparency in all aspects of support and services for the autistic community.

The strategy's focus on reducing health and care inequalities, ensuring appropriate support in the community and inpatient care, and improving support within the criminal and youth justice systems highlights a commitment to addressing systemic challenges and promoting equity and fairness for the autistic community across various Sectors.

Overall, the strategy's comprehensive approach, in conjunction with the involvement of the autistic community in its development, positions Northamptonshire to make significant strides in improving the quality of life and well-being of autistic individuals and their families.

What is Autism?

My Kaleidoscopic Perspective
By C.R. Eede

May this poem offer an insight into my personal experience of living with autism.

Through a different lens, I perceive,
An array of thoughts, I've come to believe,
Sensory concertos, both tender and noisy,
Autism's canvas, a gentle pillow ever so cosy.

A wondrous journey, glowing in my delight,
Autism's embrace, unfolding with great might,
I see, I hear, I feel, I touch,
Surrounded by life, it becomes too much.

Through routines and structure, there is comfort I find,
A sanctuary of composure, a safe and serene mind,
Empathy and understanding, deep and profound,
Understanding emotions, innate echoes resound.

I wish to be heard, to be loved, to be seen,
Not treated as lesser, or even a machine,
I deserve to be happy, live a good quality of life,
Must my mind balance on the tip of a knife?

Embracing the details, such beauty they hold,
Autism's masterpiece, my story untold,
I struggle to navigate a world of feelings,
As people use metaphors, applying different meanings.

Communication, a slow dance of its own,
Words may escape me, but connection is shown,
Expressions and gestures are all so true,
My autistic language, an inner bond that grew.

Inclusion and acceptance, the path I must tread,
Shattering barriers, too many times I have fled,
Equality and understanding, it's all I seek,
But the world around me views me as weak.

I am a raging phoenix, revolutionary and fiery,
No one can obscure me, not people, not society,
In love and acceptance, more people unite,
Autism's message, my beacon of light.

This is my epilogue, I say to you,
Look into my eyes; with life I pursue,
I see colours and words, swirling as a collective,
Inside my mind, a kaleidoscopic perspective.

This poem serves as a powerful reminder to embrace the kaleidoscopic perspectives that shape our world, recognising the richness that lies within each unique experience. It invites readers to pause, reflect and appreciate the profound depth of emotion and understanding that exists within the journey of autism. Thank you for sharing your poignant reflection.

Definition

The definition of Autism changes as our knowledge continues to expand. The National Autistic Society currently defines Autism as “a lifelong developmental disability which affects how people communicate and interact with the world”. Autism, sometimes known as ‘Autism Spectrum Condition’ (ASC) or ‘Autistic Spectrum Disorder’ (ASD) is considered a neurodivergence, signifying a different functioning of the brain. While it is recognised as a lifelong developmental disability, it’s important to acknowledge that not all individuals with autism view themselves as disabled.

For diagnostic purposes, Northamptonshire refers to the World Health Organisation’s (WHO) International Classification of Diseases 11th edition (ICD11 2019) Framework and the 2013 American Psychiatric Association released the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

With an estimated 700,000 autistic adults and children in the UK, it is likely that most people have some connection with someone who is autistic. Additionally, there are around 3 million family members and carers of autistic individuals in the UK, as reported by the National Autistic Society. Autistic individuals experience the world in a distinct manner, perceiving, hearing, and feeling differently compared to others. Autism's wide-ranging effects have led to its characterisation as a spectrum condition, with varying levels of support needed throughout individuals' lives.

Autism is neither a learning disability nor a mental health condition however mental health issues are more prevalent among autistic individuals. Although autism is not a learning disability, around 4 in 10 autistic individuals have a learning disability.

Diagnosis

Autism is a relatively ‘modern’ diagnosis; the term ‘autism’ only came into common clinical use in the 1960s and whilst most diagnosis now occurs in childhood; many adults remain undiagnosed. Demand is increasing as there is a greater awareness of neurodiversity.

Getting a diagnosis can be a crucial milestone for autistic people; many have felt different and unable to “fit in” for all of their lives.

Decisions as to which terms to use with regard to someone who has a diagnosis of autism, identity first (autistic individual) or person first (individual with autism) are always difficult as they have subtle differences in meaning and can elicit strong feelings. There is no single universally accepted description that is agreed upon in the UK. We use the identity-first language preferred by many autistic individuals (Kenny *et al*. 2016).

By Cheryl Stafford – Adult

Impact

Autism, while a medical diagnosis, encompasses a range of challenges that individuals with this condition may encounter. These challenges **can** include:

• Camouflaging or masking behaviours to conform and fit in.

• Identification as a social minority group, highlighting the need for understanding and acceptance.

• Living with a lifelong and complex condition, requiring ongoing support and accommodation.

• Managing an invisible disability, leading to potential misunderstandings and misconceptions.

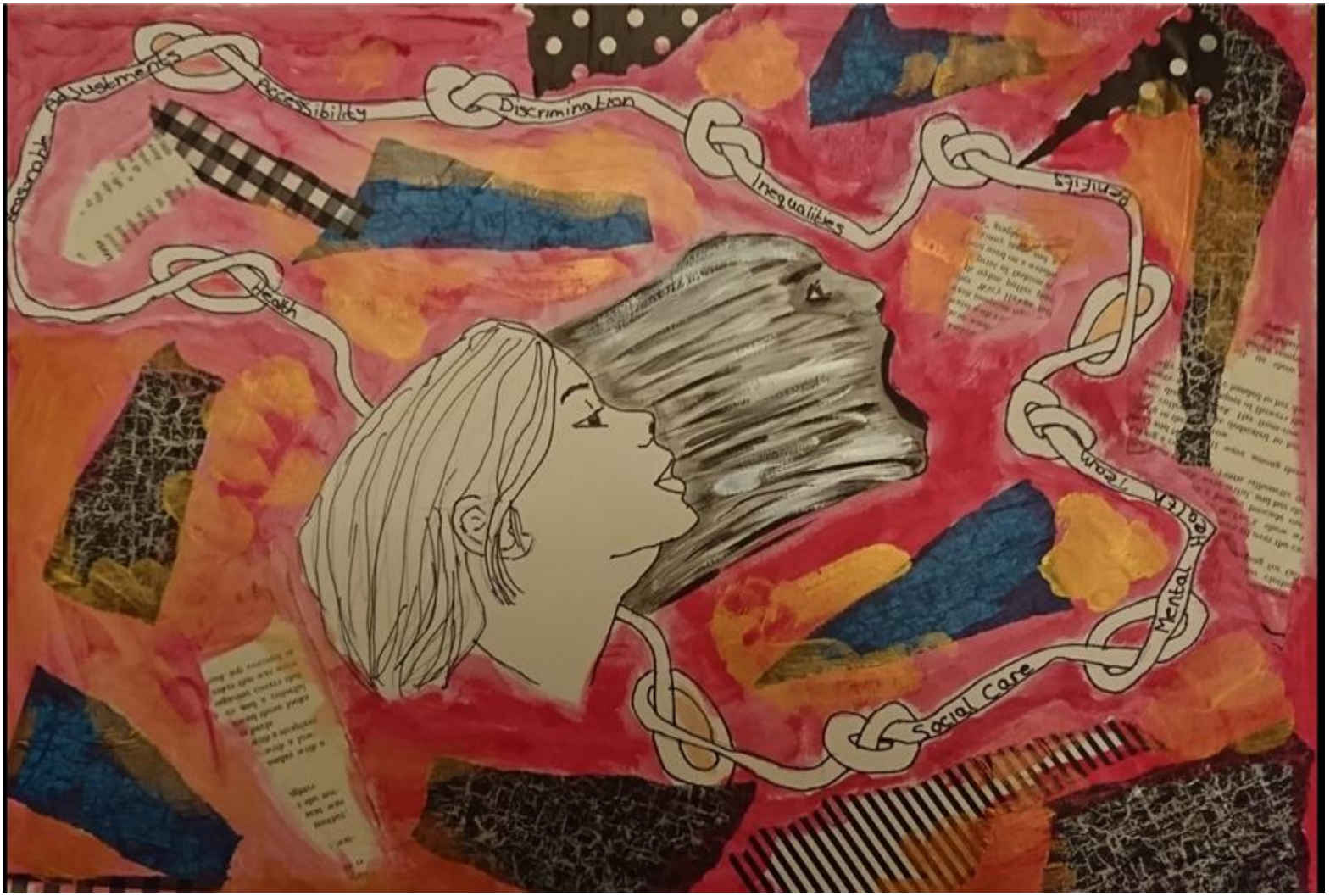
It is crucial to recognise that autism presents with diverse profiles and support needs. Each autistic individual is unique and their requirements may vary. Autism is a spectrum and not linear, influenced by factors such as the environment and stress levels. While some autistic individuals may require minimal or no support, others may rely on daily assistance from a parent or caregiver.

Support needs can encompass a wide range of aspects, including establishing friendships, navigating educational settings, adapting to the workplace, and participating in community activities. This strategy emphasises the concept of neurodiversity, which recognises the different ways the brain can function and

process information, highlighting the importance of accommodating and embracing diverse cognitive processes.

By Cheryl Stafford – Adult

Covid



Artwork Cherl Stafford

The COVID-19 pandemic and previous pressure on the NHS have had a profound impact on various aspects of healthcare services, including those for individuals with autism. As a result, several challenges have emerged, contributing to a notable shift in the landscape of autism support and diagnosis. Some of the key impacts include:

1. **Waiting List Surge**: There has been a staggering increase in the number of individuals on the waiting list for autism assessments, with a reported rise of 200% for children and young people and 500% for adults. This surge has resulted in extended waiting times, leading to delayed access to crucial diagnostic evaluations and subsequent support services.
2. **Shortage of Practitioners**: The pandemic has exacerbated the existing shortage of healthcare practitioners specialising in the autism pathway. The reduction in available professionals has further compounded the challenge of managing the surge in service demand, contributing to longer waiting times and delays in accessing essential support.
3. **Extended Waiting Times for Diagnosis**: The substantial increase in waiting times for autism diagnoses has created additional stress and anxiety for

individuals and their families. Prolonged delays in accessing timely assessments and interventions have implications for early intervention strategies, potentially impacting the overall well-being and development of those on the waiting list.

4. **Hospital Admissions and Support**: The pandemic has also seen fluctuations in the rates of hospital admissions for individuals with autism, potentially due to the challenges in accessing necessary support services and disruptions in routine care. Navigating hospital environments during the pandemic has posed additional difficulties, especially for individuals with sensory sensitivities or specific support needs.

To address these challenges, it is imperative to adapt and innovate in the delivery of autism support services, ensuring that individuals on the waiting list receive adequate support and care. Developing support services, streamlining assessment processes, and prioritising high-risk cases can help mitigate the impact of the pandemic on autism care and support services. Moreover, investing in training programs and initiatives to expand the pool of practitioners with knowledge of autism care and support, can help alleviate the strain on the Diagnostic Pathway and improve access to timely assessments and interventions.

Where are we going?

Graphic: Amber Miller

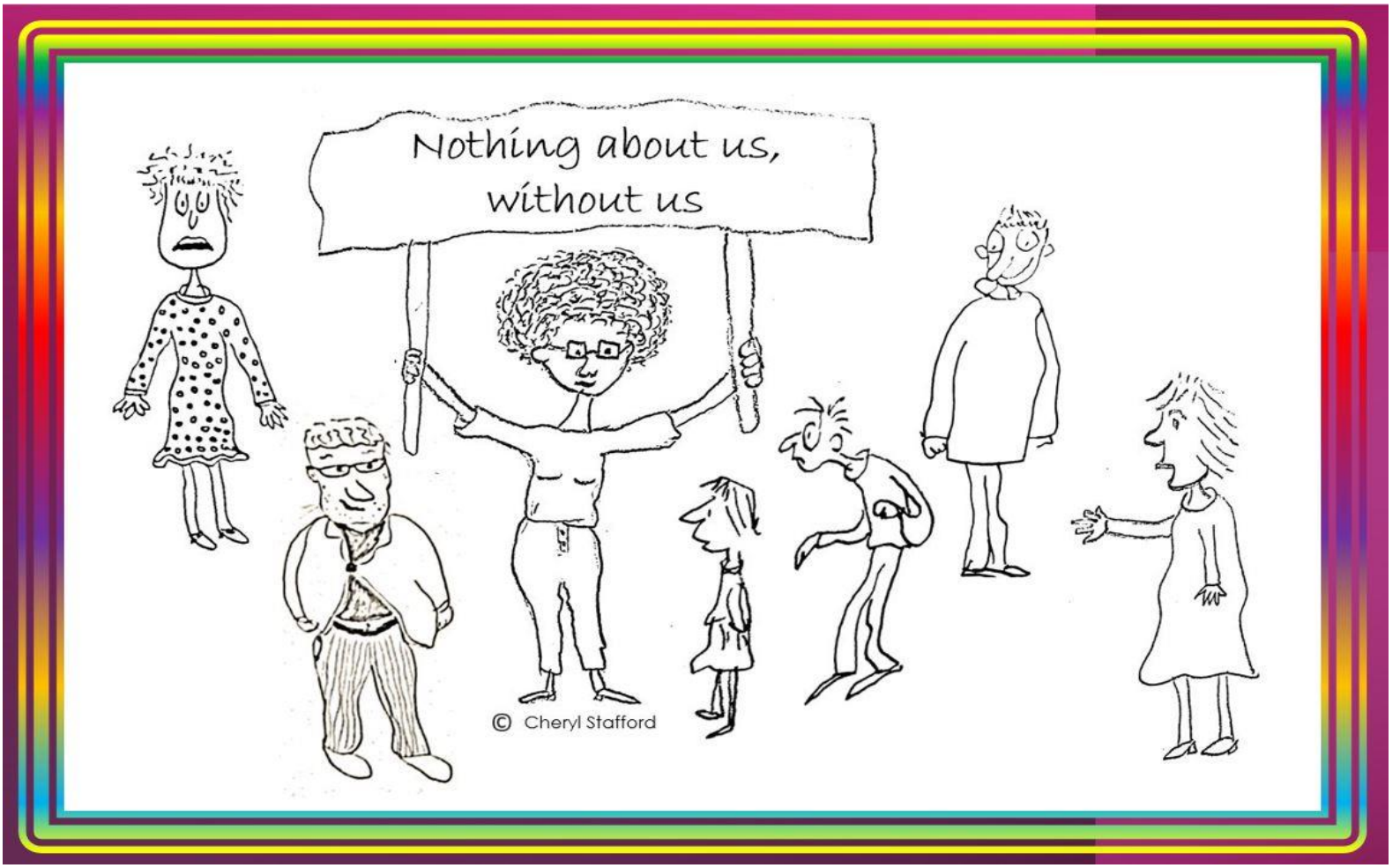
Words used by autistic individuals to describe how they feel they want to be viewed. (Empowered, life chances, trail blazers, reach full potential, heard, quality of life,
thrive, empathy, respect, equality, diversity, validated, connected, understood,

compassion, proactive, positive, lasting, safe, valued, visible, included, fulfilled, accepted, wellbeing, hope, supported into adulthood, believed, good, supported, seen, recognised, strong, creative, understood, different- not less, observant, thoughtful, worthy, outside the box, gifted, resilient.)

Core Values and Guiding Principles

In pursuit of Northamptonshire's vision to become an autism-inclusive community, the strategy emphasises the importance of fostering a supportive and inclusive environment that promotes equal opportunities for autistic individuals. To achieve this local vision, the following key principles and initiatives have been identified:

1. **Collective Responsibility**: Recognising that supporting autistic individuals is a shared responsibility, the strategy advocates for collaborative partnerships among various agencies and stakeholders, foster a collective approach to addressing complex challenges.
2. **Early Support and Intervention**: Prioritising early identification and intervention for autistic children, young people, and adults, the strategy emphasises the need for a skilled and confident workforce equipped to identify and provide timely support for individuals displaying autistic traits.
3. **Inclusion and Localisation**: Ensuring access to universal services with reasonable adjustments, the strategy underscores the importance of creating an inclusive environment where autistic individuals can participate fully in their local communities, accessing relevant services tailored to their needs.
4. **Personalisation of Support**: Adopting an individualised approach that emphasising choice, control, and reasonable adjustments, the strategy aims to empower autistic individuals by providing tailored support that respects their preferences and autonomy.
5. **Co-production and Partnership**: Encouraging active participation and decision-making by autistic individuals, the strategy promotes the principle of "Nothing about us without us," advocating for the inclusion of their perspectives in the developing and shaping of services.
6. **Integration and Coordination**: Emphasising the importance of collaborative integration, joint commissioning, and coordinated approaches, the strategy seeks to facilitate improved outcomes for autistic children, young people, and adults through cohesive and integrated service delivery.
7. **Cultural Shift and Flexible Approaches**: Encouraging a shift in cultural perspectives and the adoption of flexible delivery methods, the strategy advocates for innovative and adaptable approaches to better support the diverse needs of autistic individuals, fostering a more inclusive and responsive environment.



By Cheryl Stafford – Adult

Identification of Needs/ Population Data

Understanding the prevalence and impact of autism within the community is crucial in shaping effective strategies and support systems. Current estimates suggest that Between 1.5 and 1.76% of children and young people and 1 and 1.3% of adults are autistic. We estimate there to between 8,514 and 11,032 people with autism in Northamptonshire, although variations may exist due to different diagnostic criteria, service availability, and public awareness. The experience of autistic individuals, particularly in educational and social settings, underscores the need for comprehensive support and understanding. Some notable statistics from the National Autistica's research highlight the challenges faced by autistic individuals:

- 34% of autistic children report experiencing bullying at school.
- 70% of autistic adults express dissatisfaction with the support provided by social services.

- A significant portion of autistic individuals experience mental health conditions, with high rates of anxiety and depression and other comorbidities.
- Employment opportunities for autistic adults remain limited, with only 16% in full-time paid positions.
- There is a significant underdiagnosis of autism in females compared to males.

The National Institute for Health and Care Excellence (NICE) estimates that around 70% of autistic people have an additional condition, which is “often unrecognised”. The main conditions that co-occur more frequently in autistic people compared with the general population include:

- Mental health conditions Research suggests that 70% of autistic people have a mental health condition and that 40% have two or more.
- Autistic people are up to four times more likely to have anxiety disorder and twice as likely to have depression.
- Research has shown that autistic people are more vulnerable to negative life experiences, which may also impact mental health.
- Compared to the general population, autistic people report having a lower quality of life.
- Research indicates that suicide is a major cause of early mortality in autistic people.

In Northampton, data on the autistic population is gathered from various sources, including the Joint Strategic Needs Assessment (JSNA), national prevalence figures, and submissions to Public Health England. Co-occurring conditions, including mental health disorders and neurodevelopmental challenges, are prevalent among autistic individuals, often posing additional hurdles to well-being and quality of life.

Involvement

By Cheryl Stafford – Adult

To ensure a comprehensive and inclusive approach, the strategy emphasises the active engagement and participation of all members of the community, aiming to foster positive and empowering outcomes for everyone involved. Various forms of involvement, including engagement, consultation, participation, and co-production, have been crucial in developing this strategy, with a dedicated effort to ensure that the perspectives and needs of autistic individuals are at the forefront of decision-making processes.

Throughout the strategy's development, a priority has been placed on meaningful community involvement to establish clear and effective outcomes, goals, and actions that are responsive to the o communities diverse needs. Respect for the unique needs of autistic individuals has been a guiding principle, leading to the adaptation of approaches and the provision of reasonable adjustments to facilitate their full and confident participation in a manner that best suits them.

In pursuing a comprehensive and well-informed strategy, information has been gathered from various stakeholder events conducted during the post-COVID period, ensuring that the strategy reflects the diverse voices and experiences within the community. This commitment to inclusive participation and collaboration underscores the strategy's dedication to creating a supportive and empowering environment for all individuals, including those with autism.

Gratitude is expressed for the courage shown by autistic individuals in sharing their experiences and stories, acknowledging the vulnerability inherent in such sharing. This recognition underscores the importance of creating a supportive and understanding environment that values the contributions and perspectives of every individual involved in the strategy development process.

Legal Background and Obligations

This strategy is being developed in parallel to legislation, Strategies and Guidance that impact the lives of children, young people and adults with autism and their families. These include:

- NHS Long Term Plan (2019)
- The National Strategy for Autistic Children, Young People and Adults: 2021 to 2026
- Department of Health in 2010 (Fulfilling and Rewarding Lives; the strategy for adults with autism in England)
- National Institute Of Health & Care Excellence (NICE) Guidelines
- Special Educational Needs and Disability and Childrens and Families Act 2014
- The Autism Act (2009)
- Strategy for Adults with Autism 2010
- Learning Disability Mortality Review (LeDeR/ learning from lives and deaths)
- Think Autism 2014 and Statutory Guidance 2015
- Care Act 2014
- Equality Act 2010
- The Health and Care Act 2022
- Core Capabilities Framework for Supporting Autistic People 2019. The Department of Health and Social Care

How do we get there?

To ensure the continued relevance and effectiveness of this strategy, an annual review process will be implemented, engaging a diverse group of individuals, stakeholders, partners, and, significantly, autistic individuals of all ages, along with their families. Effective implementation of the strategy requires active participation and leadership at senior levels within various partner organisations, including West Northamptonshire Council, North Northamptonshire Council, Northamptonshire Health Care Trust, Northamptonshire Integrated Commissioning Board, NHFT, Northampton General Hospital, GH, Kettering General Hospital, Northamptonshire Police, and Voluntary Sector Partners.

By Cheryl Stafford – Adult

Given the multifaceted nature of the priorities outlined in this strategy, successful implementation hinges on shared ownership and collaborative leadership across all relevant organisations. The collaborative efforts of these diverse stakeholders will be instrumental in ensuring the strategy's meaningful impact and the effective delivery of its outlined objectives.

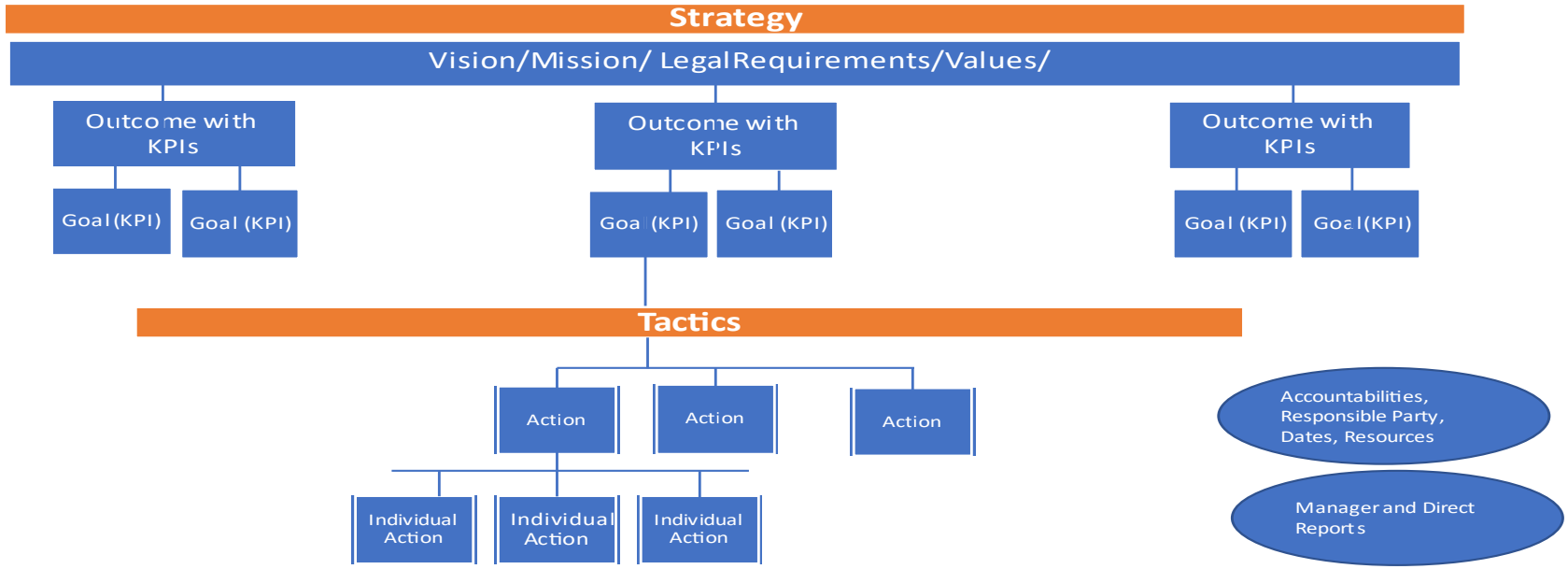
To effectively manage the progress of this strategy, a comprehensive monitoring and evaluation system will be established. The following measures will be implemented to ensure the strategy's success and its impact on the community:

1. **Establish Clear Metrics of Success:** Develop specific and measurable indicators aligned with the strategy's objectives to assess its progress and effectiveness.
2. **Regular Progress Updates:** Share timely updates and progress reports with stakeholders, partners, and the community to maintain transparency and accountability in the implementation process.
3. **Annual Review and Evaluation:** Conduct an annual review process to assess achievements, challenges, and necessary adjustments required to meet the evolving needs of the community effectively.

4. **Action Plan Development:** Work closely with designated action leads to develop a comprehensive action plan reflecting the strategy's priorities and initiatives, providing a clear roadmap for achieving the set objectives.
5. **Collaborative Approach:** Emphasise a collaborative approach to encourage effective communication and engagement among all stakeholders, ensuring that diverse perspectives are considered in the decision-making process.
6. **Effective Communication:** Implement a robust communication strategy to ensure that all relevant parties are well-informed and engaged throughout the implementation process.
7. **Flexibility and Adaptability:** Maintain a flexible approach to accommodate necessary adjustments and changes based on feedback received during the review process, ensuring that the strategy remains responsive to the evolving needs of the autistic community and their families.

By implementing these measures, the strategy's progress will be effectively managed, ensuring tangible and positive outcomes for the benefit of the autistic community in Northamptonshire.

Draft Action Plan



Need to add timeline and responsibilities when agreed.

Outcome 1 Planning and Governance that delivers Improved outcomes.			
Goal	Recommendation	Actions	Measures of success
Multi-Agency Strategy Group Leadership	Establish/Identify a multi-agency strategy group to lead the service organisation and delivery of care, fostering effective governance arrangements that oversee the implementation of the strategy and ensure comprehensive partnerships are in place to deliver high-quality local services and support, in line with NICE and Statutory Guidance.		
Strengthened Partnerships and Communication:	Enhance communication between departments on commissioning and funding, fostering effective partnerships with service providers to ensure outcome-based commissioning and best value for all partners, promoting a collaborative and transparent approach to financial management and resource allocation.		
Co-Design and Co-Production:	Actively listen to and engage with individuals with disabilities and their families, ensuring their central participation in decision-making processes at both individual and strategic levels, fostering a culture of co-design and co-production that values the insights and experiences of the autistic community.	**1.Develop a Participation, Engagement Strategy utilising the definitions below.** • **Engagement**: An active and participative process enabling individuals to shape and influence policies and services, involving diverse methods and techniques to foster inclusive participation.	

		• **Consultation**: A formal process that solicits the views and input of interested groups and individuals, facilitating open communication between policy makers and service providers. • **Participation**: Active involvement of individuals in collaboration with policy makers and service planners at the early stages of policy and service development and review, fostering a sense of ownership and inclusion. • **Co-production**: A collaborative relationship where professionals and citizens share decision-making power in planning and delivering support, recognising the vital contributions of all stakeholders in enhancing the quality of life for communities. This approach emphasising meaningful engagement at all stages, emphasising the value of inclusive design, delivery, and evaluation. **2. Facilitating Support Networks:** • Establishing support networks and forums where caregivers, professionals, and individuals on the autism spectrum can come together to share experiences, exchange knowledge, and contribute to the development of a more inclusive and responsive support system. **3. Collaborative Solutions:** • Facilitate collaborative solutions among different service providers, promoting interdisciplinary collaboration and a shared vision for a more integrated and cohesive support system that addresses the diverse needs and challenges of individuals on the autism spectrum.	

Continuous Learning and Innovation	Foster a culture of continuous learning, innovation, and positive risk-taking, actively seeking opportunities for improvement and transformation within the support system, learning from best practices and experiences of other authorities, and actively involving the community in building on existing assets and successful initiatives.	**1. Establishment of Learning Communities:** • Create learning communities comprising professionals, caregivers, and individuals with autism to facilitate knowledge sharing and collaborative problem-solving. • Encourage open dialogue and the exchange of ideas to foster a culture of continuous learning and mutual support within the community. **2. Research and Development Initiatives:** • Allocate resources for research and development initiatives focused on exploring innovative approaches and best practices in autism support and intervention. • Foster partnerships with research institutions and universities to stay updated on the latest advancements in the field of autism research and incorporate evidence-based practices into the support system. **3. Regular Training and Professional Development Programs:** • Organise regular training programs and workshops for professionals and support staff to enhance their skills and knowledge in the field of autism support and intervention. • Encourage participation in conferences, seminars, and webinars to facilitate the exchange of new ideas and approaches among professionals in the field. **4. Pilot Programs for Innovative Interventions:** • Launch pilot programs to test innovative interventions and support strategies aimed at improving the overall well-being and quality of life for individuals with autism. • Collaborate with local authorities and community organisations to assess the feasibility and effectiveness of	

		these initiatives and gather feedback for further refinement and expansion. **5. Integration of Technology and Digital Solutions:** • Explore the integration of technology and digital solutions, such as virtual therapy platforms and assistive communication tools, to enhance the accessibility and effectiveness of support services for individuals with autism. • Foster partnerships with technology companies and startups to leverage cutting-edge innovations in the development of user-friendly and inclusive tools for the autism community. **6. Community Engagement and Co-Creation:** • Involve the community in the co-creation of support programs and initiatives, fostering a sense of ownership and collective responsibility for the well-being of individuals with autism. • Organise community forums and focus groups to gather input and feedback on existing support services and to identify areas for improvement and innovation. **7. Monitoring and Evaluation of Innovations:** • Implement a robust monitoring and evaluation framework to assess the impact and effectiveness of innovative interventions and initiatives within the support system. • Utilise data-driven insights and feedback from stakeholders to refine and scale successful innovations, while discontinuing practices that prove to be less effective or sustainable.	

Financial management	Implement a comprehensive financial management strategy that prioritises outcome-based commissioning, fosters strategic partnerships with service providers, and encourages innovation and positive risk-taking. Navigate the challenges posed by limited resources and evolving demographics, fostering sustainable and impactful support services for individuals on the autism spectrum.	**1. Outcome-Based Commissioning:** • Establish clear and measurable outcomes for individuals within the autism support system, ensuring that commissioned services align with these defined goals and contribute to the overall well-being and development of individuals on the autism spectrum. • Emphasise the importance of delivering tangible and impactful outcomes that reflect the needs and priorities of the community. **2. Strategic Partnerships and Value Optimisation:** • Foster strong partnerships with service providers and stakeholders, emphasising the delivery of best value for all partners involved. Encourage collaborative initiatives that prioritise cost-effective solutions, resource optimisation, and the efficient allocation of financial resources to maximise the impact of support services and ensure sustainable outcomes for individuals with autism. **3. Innovation and Change Management:** • Embrace a culture of innovation, continuous improvement, and transformation within the support system, acknowledging the evolving financial pressures and demographic challenges faced by Northamptonshire.	

		• Encourage the exploration of new approaches, technologies, and service models, drawing inspiration from successful practices implemented by other authorities and embracing principles of positive risk-taking to drive meaningful and sustainable change within the autism support system.	
	Data and intelligence	• Further research should use secondary and/or local datasets to understand the most common causes of hospitalisation, criminalisation, employment and other adverse health or service utilisation outcomes. – JSNA recommendation • Where possible, appropriate and legal consider recording data relating to autism for service users, customers and patients. For example, whether an individual is autistic and what the outcomes were for that individual. – JSNA recommendation • Alongside quantitative data, ensure lived experience knowledge, participation and engagement is embedded into reports and reviews to provide qualitative information. – JSNA recommendation	

Outcome 2 Involvement, information, and access that delivers results.			
Goal	Recommendation	Actions	Measures of success
More joined up advice and information	Establishing Clear Communication Channels: Implementing clear and accessible communication channels that allow for effective dialogue and information sharing between autistic people caregivers, professionals, and service providers.	1. Ensure people and families are fully involved at all levels in both individual planning and planning for wider service developments. 2. Better access to information about services and support networks (relating to social and health care, education, low level support/advisory services and autism friendly facilities in the community e.g. autism shopping events etc 3. More effective use of social media to keep people informed. 4. Ensuring all public bodies to consider how people with autism may better access their service.	
Information and accessibility Children and Young People	That Local Authorities publish a Local Offer, setting out in one place information about provision they expect to be available across education, health and social care for children and young	**1.** Improved/better signposting and information for families and young people in children's services who will not meet eligibility criteria for adult social care **2.** Clearer pathways and advice for young people moving into post 16 provision and education.	

	people in their area who have SEN [Special Educational Needs] or have a disability, including those who do not have an Education, Health and Care (EHC) Plan (Special Educational Needs and Disability and Childrens and Families Act 2014)		
Reasonable Adjustments	Make reasonable adjustments to accommodate autistic people when accessing information, services, locations or employment. – JSNA Recommendation		
Equality Impact Assessments	Embed and monitor Autism into Equality Impact Assessments – JSNA Recommendation		

Outcome 3.
Increase Service training, development and collaboration between which improves services understanding and acceptance of autism within society

Goal	Recommendation	Actions	Measures of success
A skilled, competent, and compassionate workforce that is equipped to provide consistent and effective support for individuals on the autism spectrum, fostering a more inclusive, responsive, and person-centered approach.	Enhancing Professional Training for professionals to enhance their communication and interpersonal skills, ensuring they can effectively engage with and validate the insights shared by caregivers and individuals on the autism spectrum.	1. **Comprehensive Training Programme:** Develop comprehensive and standardised training programmes that provide in-depth knowledge about autism, its diverse presentations, and effective intervention strategies, ensuring all professionals and service providers have access to consistent and quality training. 2. **Professional Mentoring and Support:** Establish mentoring programs and peer support networks that enable professionals to learn from experienced practitioners and specialists, fostering a culture of continuous learning and knowledge sharing within the workforce. 3. **Specialised Workshops and Seminars:** Organise specialised workshops, seminars, and training sessions led by experts in the field of autism, providing professionals with opportunities to enhance their skills, deepen their understanding, and stay updated on the latest research and best practices.	Improved access to specialised support and resources, emphasing the importance of continuous professional development and access to specialist training programs to enhance their understanding and competence in addressing the diverse and evolving needs of individuals on the autism spectrum. - Oliver McGowan Mandatory Training -Learning Disability and autism awareness training will be mandatory for all NHS staff (NHS 10 Year plan -Ensuring awareness training is available to staff across the public sector -Ensuring education staff have appropriate autism awareness training -

		4. **Collaborative Learning Initiatives:** Encourage collaborative learning initiatives that promote interdisciplinary collaboration and knowledge exchange among healthcare professionals, educators, and social service providers, fostering a shared understanding and a holistic approach to supporting individuals on the autism spectrum.	
Outcome 4. Improving autistic children and young people's access to education, and supporting positive transitions into adulthood through assessment, early intervention and planned support for key transition stages.			
Goal	Recommendation	Actions	Measures of success
Access to Education	• A stronger focus on high aspirations and on improving outcomes for children and young people. (Special Educational Needs and Disability and Childrens and Families Act 2014) • Improving educational professionals' -understanding of autism and inclusive cultures within schools (The national strategy for	1. **SEND Self-Assessment:** • Implement a robust system for self-assessment of Special Educational Needs and Disabilities (SEND) within educational settings. • Regularly review and assess the effectiveness of existing support structures. 2. **SEND Improvement Plans:** • Develop and implement targeted improvement plans based on the outcomes of the SEND self-assessment. • Ensure that improvement plans are dynamic and responsive to the evolving needs of children and young people with autism. 3. **Reasonable Adjustments:** • Advocate for and enforce the provision of reasonable adjustments in educational settings to accommodate the diverse needs of children and young people with autism.	To increase the number of Children and YP who have school placements and an increase in the use of reasonable adjustments.

	autistic children, young people and adults: 2021 to 2026) ○ Improving how the SEND system supports autistic children and young people (The national strategy for autistic children, young people and adults: 2021 to 2026)	• Raise awareness among educators and staff about the importance of implementing and respecting reasonable adjustments. 4. **Access to Education for Those Without School Placements:** • Develop strategies to ensure that children and young people without a school placement due to establishments' inability to meet their needs still have access to quality education. • Explore alternative education options, such as online learning, to facilitate access for those who may not thrive in traditional school settings. 5. **Alternative Learning Options:** • Consider and promote alternative learning methods, including online education, to provide flexibility and adaptability for children and young people with autism. • For those educated at home consider the development of support groups and activities together to support their socialisation. • Collaborate with online education platforms to ensure that their resources are accessible and inclusive for individuals with diverse learning needs. 6. **Increasing School Placements:** • Work towards increasing the number of children and young people with SEN who have suitable school placements. • Collaborate with schools and educational institutions to enhance their capacity to accommodate students with a range of special educational needs. 7. **Promoting Reasonable Adjustments:** • Encourage and incentivise the adoption of reasonable adjustments in educational settings to create an inclusive learning environment.	

		• Provide training and resources to educators and school staff to effectively implement and monitor reasonable adjustments.	
Transitions	Supporting key transitions from preschool to employment and future life plans and make a successful transition to adulthood (Special Educational Needs and Disability and Childrens and Families Act 2014)	1. **Better Planning and Transitions Support:** • Enhance planning processes for individuals with autism, starting from preschool years and continuing through their educational journey. • Allocate resources to transition workers to 0 2. **Improved Pathways for Social Care Eligibility:** • Review and refine the eligibility criteria for social care services to better accommodate the needs of young people with autism. • Ensure that individuals who meet social care eligibility criteria receive the necessary support and services during their transition to adulthood. 3. **Collaboration and Multi-Agency Approach:** • Facilitate collaboration among relevant agencies, including education, healthcare, social services, and employment support, to create a holistic and coordinated approach to transitions. • Encourage joint planning meetings to address the diverse needs of individuals during key transition points. 4. **Individualised Transition Plans:** • Develop individualised transition plans for each young person with autism, considering their unique strengths, challenges, and aspirations. • Involve individuals and their families in the development of transition plans to ensure they align with the individual's goals. 5. **Employment Preparation and Support:**	

		• Integrate vocational training and employment preparation programs into the transition process for young people with autism. • Foster partnerships with local businesses and organisations to create inclusive employment opportunities for individuals with diverse abilities. 6. **Mental Health and Well-being Support:** • Prioritise mental health and well-being support during transitions, providing access to counselling services, peer support, and community resources. • Ensure that mental health needs are addressed within the context of the overall transition plan.	
Local	Create a more inclusive and supportive employment environment for autistic individuals, addressing specific challenges in the interview process, fostering educational and workplace inclusivity, and promoting equal opportunities for career development.	**Improved Pathways and Support:** 1. **EHCPs with Employment Focus:** • Advocate for more consistent reference to employment in Education, Health and Care Plans (EHCPs) for autistic individuals. • Work with education authorities to ensure that transition planning includes a strong focus on employment pathways. 2. **Advice and Support for Adults:** • Improve advice and support systems for adults seeking employment. • Collaborate with national and local organisations to provide targeted resources and guidance for adults on the autism spectrum. 3. **Engaging Employers in Northamptonshire:** • Develop effective advice and support systems for engaging with employers across Northamptonshire.	

		• Collaborate with local businesses, chambers of commerce, and industry associations to foster inclusive hiring practices. 4. **Supported Internships:** • Increase the number of supported internships available for individuals with autism. • Collaborate with educational institutions and businesses to create internship opportunities tailored to the needs of autistic individuals. 5. **Improving Interview Processes:** • Work with partner Human Resources (HR) departments in organisations to improve interview processes, making them more inclusive and accommodating. • Provide training and resources for HR professionals to better understand and support autistic job candidates. 6. **Mentorship Programs:** • Develop mentorship programs to provide employment support for individuals with autism. • Encourage businesses to establish mentorship initiatives that facilitate the integration and success of autistic employees in the workplace.	

Outcome 5. Supporting more autistic people into employment and to retain employment.			
Goal	Recommendation	Actions	Measures of success
National Strategies	To improve employment support for autistic individuals, consider the following strategies aligned with the goals outlined in The National Strategy	1. **Awareness and Knowledge for Employers:** • Collaborate with national initiatives to raise awareness and promote knowledge about autism among employers. • Develop campaigns and resources to educate employers on creating inclusive work environments.	

	for Autistic Children, Young People, and Adults (2021 to 2026):	2. **Fit-for-Purpose Job Interviews:** • Work with national initiatives to advocate for job interviews that are fit for purpose when interviewing individuals with autism. • Provide guidelines and resources for employers to conduct inclusive and supportive interviews. 3. **Educating the Workforce:** • Collaborate with national initiatives to design and implement educational programs for the workforce on supporting autistic individuals and their families. • Include training modules that cover understanding autism, communication strategies, and creating inclusive workplaces. 4. **Training for Employers:** • Develop and deliver training programs for employers on how to conduct interviews specifically tailored to autistic individuals. • Include practical tips and insights to enhance the interviewing process. 5. **Individualised Work Positions:** • Encourage employers to create individualised work positions for autistic employees, taking into account their strengths, preferences, and support needs. • Advocate for flexible job roles that accommodate the diverse skills of individuals with autism. 6. **Communication Considerations:** • Promote awareness about communication preferences among autistic individuals, emphasising the importance of putting questions in the correct order and recognising challenges with small talk. • Develop resources for employers to enhance communication in the workplace. 7. **Measuring Success:**	

		• Work with national initiatives to explore and establish meaningful ways for employers to measure success in employing autistic individuals. • Develop metrics that go beyond traditional performance indicators to capture the unique contributions of neurodiverse employees. 8. **Suitable Employment Content:** • Advocate for employment content that is suitable for individuals with autism, considering accessibility and clarity in job descriptions and expectations. 9. **Addressing Unemployment Disparities:** • Collaborate with national initiatives to address the disparities in employment rates for individuals with autism, particularly those with third-level qualifications. • Advocate for policies and initiatives that promote equal opportunities and reduce barriers to employment.	

Outcome 6. Reduce health and care inequalities for autistic people.			
Goal	Recommendation	Actions	Measures of success
Improved support for Parent/ Carers	Support for parents and carers of autistic individuals is crucial for the well-being of both the caregivers and the individuals with autism.	Here are some ways in which support can be improved: 1. **Education and Information:** • Provide comprehensive and accessible information about autism spectrum disorders (ASD) to parents and carers. This includes information about the characteristics of autism, available therapies, and strategies for managing challenging behaviors. • Offer workshops, webinars, and training sessions to educate parents and carers about the latest research, therapies, and interventions in the field of autism. 2. **Peer Support Groups:**	

		• Establish and promote support groups for parents and carers of autistic individuals. Connecting with others who share similar experiences can provide a sense of community and understanding. • Encourage the formation of both in-person and online support groups to cater to different preferences and circumstances. 3. **Counselling and Mental Health Support:** • Offer counselling services specifically tailored for parents and carers to address the emotional and psychological challenges they may face. • Provide access to mental health professionals who have expertise in working with families affected by autism. 4. **Respite Care Services:** • Implement respite care programs to give parents and carers a break from their caregiving responsibilities. This can help prevent burnout and ensure the well-being of both the caregivers and the individual with autism. 5. **Advocacy and Legal Support:** • Assist parents and carers in navigating legal and educational systems to ensure that their child receives appropriate support and accommodations. • Advocate for policies that promote inclusivity, understanding, and support for individuals with autism and their families. 6. **Flexible Work Arrangements:** • Encourage employers to provide flexible work arrangements for parents and carers of autistic individuals. This may include flexible working hours, remote work options, or other accommodations to better balance work and caregiving responsibilities. 7. **Financial Support:**	

		• Explore financial assistance programs or grants specifically designed for families with autistic individuals. Financial support can help cover the costs associated with therapies, interventions, and other necessary resources. 8. **Accessibility and Inclusivity:** • Ensure that public spaces and services are accessible and inclusive for individuals with autism and their families. This includes sensory-friendly environments, autism-friendly events, and trained staff who understand the needs of individuals with autism. 9. **Continuous Communication:** • Establish open lines of communication between schools, healthcare providers, and parents. Regular updates on a child's progress, challenges, and strategies can help parents stay informed and involved in their child's development. 10. **Research and Innovation:** • Support and invest in research that focuses on improving the quality of life for individuals with autism and their families. This includes research on effective interventions, assistive technologies, and innovative support services. 11. **Carers assessments** • Ensure all Parents and carers have access to Carers assessments which take into account the areas above.	
Improved diagnostic pathways. Move away from reliance on medical models.	Key areas to address. **1. Identifying Weaknesses and Strengths:** Understand the strengths and weaknesses within the diagnostic pathway and pinpoint areas that require	1. **Identifying Weaknesses and Strengths:** • Conduct an in-depth analysis of the current diagnostic process to identify specific areas of strengths and weaknesses.	

– JSNA recommendation	improvement and recognising successful aspects that can be replicated or built upon. **2. Stakeholder Engagement:** Meaningful engagement with various stakeholders can provide valuable insights into the challenges faced within the diagnostic pathway and help in developing a more comprehensive understanding of the lived experiences of those involved. **3. Streamlined Processes:** The goal of implementing efficient diagnostic procedures is essential for reducing waiting times and ensuring equitable access to services. By promoting a coordinated and timely approach to assessment and support, the aim is to minimise the burden on individuals and their families and to improving the overall experience for those involved. **4. Early Intervention Framework:** Creating a comprehensive early intervention framework is crucial for providing families with the necessary support and guidance from the early stages of the diagnostic process. **5. Empathy and Understanding:** Is crucial for creating an inclusive and	• Gather data and feedback from various stakeholders, including individuals on the autism spectrum, families, and healthcare professionals. 2. **Stakeholder Engagement:** • Organise regular focus groups and forums to facilitate meaningful engagement with stakeholders. • Create links with the Autism Enabler Group to provide ongoing insights and recommendations. **3. Streamlined Processes:** • Review the current diagnostic procedures that reduce waiting times and identify opportunities for streamlining the process. ensure equitable access to services and promote a coordinated and timely approach to assessment and support, minimising the burden on individuals and their families. • Implement digital solutions for appointment scheduling, information dissemination, and data management to reduce waiting times and ensure equitable access. • Implement a centralised intake system for initial assessments, ensuring a swift and efficient entry into the diagnostic pathway.	

	supportive environment. The emphasis on. Active listening, compassionate care, and personalised support reflects a commitment to providing holistic care that considers the emotional and psychological well-being of individuals and their families. **6. Consistency in Skills:** Consistent and standardised training among professionals to ensure they possess the required knowledge and skills for effective engagement and support. This emphasis on professional development is vital for maintaining a high standard of care and ensuring that individuals on the autism spectrum receive the best possible support from knowledgeable and skilled professionals. **7. Continuous Improvement:** The establishment of a framework for continuous evaluation and improvement is crucial for monitoring progress, identifying areas for further development, and ensuring ongoing enhancements to the diagnostic pathway. This focus on data analysis, regular feedback mechanisms, and stakeholder consultations enables adaptability and the ability to respond to evolving needs and challenges.	• Establish clear protocols for information sharing and communication among different healthcare providers and professionals involved in the diagnostic process. **4. Early Intervention Framework:** • Develop a comprehensive early intervention framework that provides families with immediate access to support services upon receiving a preliminary diagnosis. • Collaborate with community organisations and support groups to offer tailored assistance and guidance for families during the early stages of the diagnostic journey. **5. Empathy and Understanding:** • Develop a comprehensive training program focused on cultivating empathy and understanding among healthcare professionals and service providers. • Implement communication workshops and seminars to emphasise the importance of active listening and compassionate care. **6. Consistency in Skills:** • Establish a standardised training curriculum for healthcare professionals and service providers involved in the diagnostic process.	

		• Collaborate with educational institutions and professional organisations to ensure the delivery of consistent and up-to-date training programmes. **7. Continuous Improvement:** • Implement a feedback mechanism to regularly gather input from stakeholders and evaluate the effectiveness of the changes made. • Establish a review committee to monitor progress, identify areas for improvement, and implement necessary adjustments to the diagnostic pathway. • Establish development and continuous evaluation and improvement, incorporating regular feedback mechanisms, data analysis, and stakeholder consultations to monitor progress, identify areas for further development, and ensure ongoing enhancements to the diagnosis pathway.	
	Care, assessment and support should be delivered by specialised children and young people and adult autism teams, which consist of professionals from a range of disciplines; (National Institute Of Health & Care Excellence (NICE) Guidelines)	1. **Specialised Autism Teams:** • Form specialised children and young people, as well as adult autism teams, comprising professionals from various disciplines to ensure comprehensive care and support.	A more effective, person-centred, and holistic approach to the care, assessment, and support of individuals with autism. With an emphasis on the importance of collaboration, timely intervention, and addressing the diverse needs of individuals with autism throughout their lives.

		2. **Timely Diagnostic Assessments:** • Initiate diagnostic assessments within three months of receiving a referral to expedite the process and provide timely support. 3. **Assessment for Coexisting Health Problems:** • Conduct assessments for coexisting physical health and mental health problems in addition to the diagnostic assessment to address the individual's overall well-being. 4. **Collaborative personalised Plans:** • Develop and implement personalised plans in collaboration with individuals with autism, their families, and the autism team, ensuring a person-centred approach. 5. **Named Key Worker:** • Assign a named key worker to individuals with autism to coordinate and facilitate the care and support outlined in their personalised plan. 6. **Psychosocial Interventions:** • Discuss opportunities for age-appropriate psychosocial interventions with individuals to address the core features of autism. 7. **Assessment of Challenging Behaviours:**	

		• Assess individuals with autism who exhibit challenging behaviours for possible triggers, considering physical health conditions, mental health problems, and environmental factors. 8. **Needs-Based Support:** • Provide support based on individual needs rather than solely focusing on the diagnosis, recognising the unique requirements of each person with autism. 9. **Lifelong Planning:** • Adopt a whole-life approach in future planning, ensuring that considerations for lifelong needs are integrated into care plans. 10. **Interdepartmental Collaboration:** • Enhance collaboration between different departments involved in the care and support of individuals with autism to ensure a cohesive and integrated approach.	
		• Personality disorder • EUPD • Diagnostic overshadowing	

		• i-mprove understanding of autism and all its profiles, including recently identified forms such as pathological demand avoidance (PDA)	
Mental Health	Improving systems of autism identification and diagnosis for older children, adolescents and adults, including appropriate post-diagnostic mental health assessment and treatment	1. **Specialised Training for Mental Health Professionals:** • Provide specialised training for mental health professionals to enhance their knowledge and skills in recognising and diagnosing autism in older children, adolescents, and adults. 2. **Raise Awareness:** • Increase public and professional awareness about the diverse presentation of autism across the lifespan, emphasing that it can be identified and diagnosed at any age. 3. **Accessible Diagnostic Services:** • Ensure that diagnostic services are accessible and available for individuals of all ages, with a particular focus on reducing waiting times for assessments. 4. **Tailored Assessment Tools:** • Develop and utilise assessment tools that are tailored to the unique characteristics and challenges of autism in older individuals, considering the developmental differences compared to younger children. 5. **Integration of Mental Health Assessment:** • Integrate mental health assessments as a routine part of the diagnostic process for individuals with autism, addressing coexisting mental health conditions. 6. **Multidisciplinary Approach:** • Implement a multidisciplinary approach to diagnosis and post-diagnostic care, involving professionals from	

		psychology, psychiatry, neurology, and other relevant fields. 7. **Transition Support:** • Provide targeted support during transitions, especially for adolescents and adults newly diagnosed with autism, including access to mental health services. 8. **Community Outreach Programs:** • Establish community outreach programs to reach older individuals who may not have previously received a diagnosis or support for autism. 9. **Advocacy for Mental Health Services:** • Advocate for increased availability and accessibility of mental health services tailored to individuals with autism, considering their specific needs and challenges. 10. **Culturally Competent Services:** • Ensure that mental health services are culturally competent, taking into account the diversity of experiences and backgrounds among individuals with autism. 11. **Research and Innovation:** • Support research initiatives to better understand the mental health needs of older individuals with autism and to develop innovative approaches for assessment and treatment. 12. **Collaboration with Adult Services:** • Facilitate collaboration between autism services and adult mental health services to create a seamless transition and continuity of care for individuals as they age. 13. **Peer Support Programs:** • Establish peer support programs for older individuals with autism, allowing them to connect with others who share similar experiences and challenges.	

Risk of suicide	Collaboration between researchers, clinicians, autistic individuals, and advocacy groups is essential to ensure that these strategies are informed by a deep understanding of the unique challenges faced by autistic individuals in relation to suicide risk. Adopt the recommendations from Autistca's 'Suicide and Autism: A National Crisis' and their action briefing on health checks. – JSNA recommendation	Alongside NHS England work 1. **Identify Barriers to Help-Seeking:** • Conduct research to identify specific barriers that autistic individuals face when seeking help for mental health concerns. • Develop targeted interventions and support systems to address these barriers, such as sensory sensitivities, communication challenges, or social anxiety. 2. **Risk and Protective Factors:** • Investigate the unique risk and protective factors for suicide in autistic individuals across different stages of life. • Tailor prevention strategies to address these factors, taking into account the diversity of experiences within the autistic population. 3. **Believability of Distress Reports:** • Examine and raise awareness about the phenomenon where autistic individuals may not be believed when reporting the severity of their distress. • Develop training programs for healthcare professionals to enhance understanding and empathy toward the subjective experiences of autistic individuals. 4. **Development of Suicidality:** • Investigate the development of suicidality that is not associated with other mental health symptoms across the lifespan in autistic individuals. • Develop early intervention strategies that specifically target the unique pathways to suicidality in this population. 5. **Assessment of Suicidal Thoughts:**	Reduce the number of suicide by improving prevention, intervention, and support strategies for the autistic population.

		• Research and identify the most effective ways of assessing suicidal thoughts and behaviours in autistic individuals in both clinical practice and research settings. • Develop assessment tools that are sensitive to the communication styles and preferences of autistic individuals. 6. **Adapted Interventions:** • Explore how existing interventions for suicide prevention can be adapted to better meet the needs of autistic individuals. • Involve autistic individuals and their families in the development and evaluation of suicide prevention interventions. 7. **Understanding Suicidality Experience:** • Conduct qualitative research to understand the unique experiences of suicidality in autistic individuals compared to the general population. • Use this understanding to inform targeted intervention strategies. 8. **Help-Seeking Behaviour:** • Examine how autistic individuals seek help when they are in crisis, considering potential communication challenges and preferences. • Develop communication tools and support networks that align with the needs and preferences of autistic individuals. 9. **Applicability of Existing Models:** • Evaluate how well existing models for understanding suicide apply to autistic individuals. • Adapt or develop new models that better capture the complexity of suicide risk in the autistic population. 10. **Impact of Poor Sleep:**	

		• Study the impact of poor sleep on suicide risk in autistic individuals. • Develop and implement interventions that target sleep disturbances as a potential risk factor for suicide.	

Outcome 7. Have the right support in the community and in inpatient care			
Goal	Recommendation	Actions	Measures of success
Strengthening collaboration, supporting individuals with autism and learning disabilities, and improving the quality of care,	**Create Inclusive Services**	1. **Strengthen Collaboration Between Child and Adult Services:** • Facilitate regular collaboration and communication between child and adult services to ensure a seamless transition for individuals with autism as they age. • Develop joint protocols and transition plans to avoid duplication of efforts and enhance continuity of care. 2. **Promote Joint Work Between Health and Education:** • Foster collaboration between health and education professionals to create a holistic support system for individuals with autism. • Develop joint training programs for health and education staff to enhance their understanding of neurodiversity and improve the quality of support. 3. **Utilise the National Toolkit for Neurodiversity:** • Implement the National Toolkit for frontline staff on neurodiversity developed by the government to ensure that services are informed by best practices and tailored to the needs of individuals with autism. 4. **Equip Health and Social Care Professionals:**	

		• Provide training for health and social care professionals to enhance their knowledge and skills in supporting individuals with autism and learning disabilities. • Emphasise the importance of providing support regardless of an official diagnosis.	
	Support Services Based on Presenting Need	1. **Meeting Presenting Needs:** • Ensure that support services are available based on the presenting needs of families and individuals at a particular point in time. • Conduct regular assessments to identify evolving needs and adjust support services accordingly. 2. **Reasonable Adjustments in Public Services:** • Advocate for the consideration of reasonable adjustments in public services to accommodate the diverse needs of individuals with autism. • Collaborate with service providers to create an inclusive environment that supports neurodiversity. 3. **Awareness in Benefits Agencies:** • Raise awareness among benefits agencies about autism and the need for understanding when assessing autistic individuals. • Provide training to agency staff to ensure a more informed and supportive assessment process. 4. **Access to Support and Information:** • Establish accessible ways for individuals to access support and information if they suspect they might be neurodiverse. • Develop awareness campaigns to reach out to the community and reduce stigma around seeking support. 5. **Holistic Support for Families:**	

		• Provide a comprehensive range of support services for the whole family, acknowledging that individuals with autism may have additional disabilities. • Ensure that families are aware of available support options and resources. 6. **Post-Diagnostic Support and Signposting:** • Offer post-diagnostic support for individuals and their families, including signposting to relevant services and resources. • Consider the needs of those who may not meet eligibility under the Care Act 2014 but still require support.	
	Improve Inpatient Care and Crisis Prevention	1. **Enhance Quality of Inpatient Care:** • Implement measures to improve the quality of inpatient care for autistic individuals. • Ensure that inpatient settings are equipped to provide individualised and neurodiverse-friendly care. 2. **Facilitate Timely Discharges:** • Develop protocols to facilitate timely discharges from inpatient care, considering the specific needs and preferences of individuals with autism. • Provide community-based support to prevent unnecessary and prolonged stays in inpatient settings. 3. **Crisis Prevention Strategies:** • Invest in crisis prevention strategies to reduce avoidable admissions into inpatient settings. • Develop community-based crisis intervention teams and resources to support individuals during times of crisis.	
	Pre and Post-Diagnostic Support:	1. **Comprehensive Pre-Diagnostic Support:** • Provide pre-diagnostic support to individuals and families, including information, counselling, and resources.	

		• Ensure that the diagnostic process is accompanied by adequate support services. 2. **Post-Diagnostic Support Programs:** • Establish post-diagnostic support programs that cater to the diverse needs of individuals with autism. • Include peer support, counselling, and skill-building programs in post-diagnostic support services.	
Reduce homelessness.	**To ensure consistency in support, plan, and address housing challenges for autistic individuals**	1. **Consistency in Support:** • Develop and implement standardised guidelines or protocols to ensure consistency in the level of support offered to autism communities. This can involve creating clear service standards and training programs for professionals working with autistic individuals. 2. **Early Planning:** • Encourage early planning for the future needs of autistic individuals, especially in terms of housing and support services. This can involve collaboration between education, healthcare, and social services to create transition plans that address housing considerations. 3. **Connecting Strategy to Operational Realities:** • Align the next strategy with operational realities, acknowledging challenges such as the demand for housing outstripping supply. Develop strategies that are practical, taking into account the current state of housing resources and identifying potential areas for improvement. 4. **Define Supported Housing/Living:** • Clearly define what is meant by supported housing or living, ensuring a common understanding among stakeholders. This definition should encompass the necessary accommodations and support services that cater to the unique needs of autistic individuals.	

		5. **Innovative Housing Solutions:** • Explore and develop meaningful and innovative housing solutions that go beyond traditional models. This may involve partnerships with housing developers, community organisations, and local government to create inclusive and accessible housing options. 6. **Person-Centred Approach:** • Understand and adopt a genuine person-centred approach by involving autistic individuals and their families in decision-making processes. Recognise and respect individual preferences, needs, and aspirations when developing housing and support plans. 7. **Preventing Homelessness:** • Collaborate with homelessness services, local authorities, and housing agencies to develop and implement strategies aimed at preventing homelessness among autistic individuals. • Address the specific risk factors associated with autism that may contribute to homelessness, such as difficulties in interpersonal interactions, isolation, and susceptibility to mate crime. • Conduct research or collaborate with existing research initiatives to gather accurate and comprehensive data on the representation of autistic individuals in homeless populations, as well as the specific challenges they face. **8. Access to Housing and Housing Advice:** • Ensure that housing agencies provide accessible housing advice and support services for autistic individuals, recognising their unique needs and challenges. • Implement autism awareness training for staff in housing agencies to enhance their understanding of autism and improve interactions with autistic individuals seeking housing assistance.	

		• Develop and promote supported housing strategies that cater to the diverse needs of autistic individuals, providing an environment that supports their independence and well-being. • Ensure that staff in specialist provision, including supported housing, are suitably trained in Positive Behaviour Support (PBS) techniques to create a positive and enabling living environment. • Encourage collaboration between housing agencies and autism support organisations to facilitate a coordinated and informed approach to housing support. 9. **Enabling Department for Housing:** • Advocate for the Department for Infrastructure to function as an enabling department, improving equality of access to housing for independent living with reasonable adjustments. This can involve policy changes, awareness campaigns, and training initiatives. 10. **Inclusive Housing and Planning:** • Incorporate housing and planning considerations for autism at the earliest stage of development. Work with architects, urban planners, and developers to ensure that housing designs are inclusive and accessible, considering the sensory and support needs of autistic individuals. 11. **Data Collection and Research:** • Work with relevant authorities, such as the homeless team in the council, to collect accurate figures on the representation of autistic individuals in homeless populations. Use this data to inform targeted interventions and support services. 12. **Training and Development:**	

		• Ensure that staff in housing agencies, specialist provision, and other relevant services receive autism awareness training. Additionally, provide training on Positive Behaviour Support (PBS) techniques to create supportive environments.	
Outcome 8 Improving support within the criminal and youth justice systems.			
Goal	Recommendation	Actions	Measures of success
To improve support within the criminal and youth justice systems for autistic people, it's crucial to focus on several key areas as outlined in The National Strategy for Autistic Children, Young People, and Adults (2021 to 2026)	**Community Safety, Anti-Bullying, and Life Skills:**	**1. Life Skills Programs:** • Develop and implement life skills programs within the community to empower autistic individuals with tools to avoid intimidation and coercion. • Collaborate with local organisations and educational institutions to integrate life skills education into curricula. **2. Anti-Bullying Initiatives:** • Launch anti-bullying campaigns that specifically address the needs of autistic individuals. • Provide resources and training for educators, community leaders, and law enforcement personnel on recognising and preventing bullying involving autistic individuals. **3. Community Safety Education:** • Implement community safety programs that educate autistic individuals on personal safety and how to navigate potential threats. • Collaborate with local law enforcement agencies to facilitate community safety workshops.	
	Identifying and Referring for Support	**1.Health and Justice Partnerships:** • Establish close collaborations between health and justice partners to streamline access to assessments and	

		referrals for support for autistic individuals in contact with the criminal and youth justice systems. • Develop joint protocols for timely and appropriate interventions based on assessment outcomes. 2. **Training for Justice Personnel:** • Provide training for justice personnel to enhance their ability to identify signs of autism and understand the unique needs of autistic individuals. • Collaborate with mental health professionals to ensure that assessments are conducted in a sensitive and informed manner.	
	Improving Understanding of Autism:	1. **Training for Criminal and Youth Justice Professionals:** • Implement mandatory training programs for criminal and youth justice professionals to improve their understanding of autism. • Include training modules that cover communication strategies, sensory needs, and de-escalation techniques when interacting with autistic individuals. 2. **Awareness Campaigns:** • Launch awareness campaigns within the criminal and youth justice systems to promote understanding and acceptance of autism. • Utilise various communication channels, including online platforms, workshops, and informational materials, to reach a wide audience.	
	Improving Access to Services:	1. **Tailored Support Services:** • Work with service providers to tailor support services that specifically address the needs of autistic individuals within the criminal and youth justice systems. • Ensure that interventions are individualised and consider the unique characteristics of autism.	

		2. **Community Outreach:** • Implement community outreach programs to inform autistic individuals and their families about available services and support within the criminal and youth justice systems. • Collaborate with advocacy organisations to amplify outreach efforts. 3. **Advocacy for Legal Protections:** • Advocate for legal protections that safeguard the rights of autistic individuals within the criminal and youth justice systems. • Collaborate with legal experts and advocacy groups to address systemic issues and promote inclusivity.	

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The Strategy

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

- This strategy sets out our plan to achieve our vision for Northamptonshire and takes a life-course approach, encompassing all autistic children, young people and adults, and taking into consideration the needs of families and carers. It recognises autism affects people in different ways and touches many aspects of their lives. As such, we have taken a holistic view
- Our ambition is to work in partnership to address the wide range of areas in which autistic people might be supported, including in health services, education, preparing for adulthood, employment, independent living and the criminal justice system.
- Covers 2 years to align with Government Strategies but could be extended to include any new areas identified in future Government Strategies. The priority areas are likely to remain similar, the action plan has been designed to allow for change.

How did we get here – the draft strategy

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

Pulled together information from: -

- Research
- JSNA
- Legislative requirements
- Government Plans and Strategies
- Surveys (local and national)
- Events
- Workshops
- Reports
- Data analysis
- Face to face meetings with lived experience and those who support them.

Who are the Partners

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

- Local Authority – North & West
- Health
- Housing
- Education
- Police
- Transport
- VCSE
- Youth Justice Service
- Employment Services
- Probation/Criminal justice
- Housing/Homelessness
- Transport

The Vision

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

"Autistic people are recognised, heard, valued, able to thrive and reach their full potential".

What is the Mission.

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

The mission describes how we aim to achieve the Vision:

Across organisational boundaries

Understanding of autism improved

Thoughtful processes and pathways developed

Improving collaboration

Sharing knowledge

Making experiences better for autistic people

Developed by the Autism Champion Network

What are the Priority Outcomes

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

1. Planning and Governance that delivers improved outcomes.
2. Involvement, information and access that delivers results.
3. Increase Service training, development and collaboration between services which improves understanding and acceptance of autism within society.
4. Improving autistic children and young people's access to education, and supporting positive transitions into adulthood through assessment, early intervention and planned support for key transition stages
5. Supporting more autistic people into employment and to retain employment.
6. Reduce health and care inequalities for autistic people.
7. Have the right support in the community and inpatient care
8. Improved support within the criminal and youth justice systems.

The words autistic individuals associate with autism.

Words used by autistic individuals to describe how they feel they want to be viewed.

Action Plan

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

- The actions reflect good practice and do not necessarily capture everything that is happening.
- Some areas will already have begun or finished work on them – need to reflect this when developing further actions so that we build on and not duplicate.
- Need to agree what can be done in the next two years – by whom and when and the performance/ impact data that will evidence if they are making a difference. Autism Enabler Group is undergoing a refresh to enable it to be fit for purpose to quality monitor the Strategy and Plan.

Feedback from those autistic people, and their parents and cares

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

- “At last, we have defined Goals and the life -course approach is brilliant”
- “Please make this vision come true “
- “Would like it to clearly state that lived experience and coproduction is vital to achieving outstanding services .”
- Carers found that points 3 and 4 and 7 were the most important, especially for those with additional mental health difficulties .

Next Steps

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

JSNA

- Finalised Feb 2024 and sent to Department Public Health (DPHs) for approval to publish.
- Published in public domain by end of Feb.
- The version shared today is a final draft .

Draft Autism Strategy

- Signed off by the MHLDA and sought from the Health and Wellbeing Boards.

Next Steps:-

Mental Health, Learning Disability and Autism Collaborative Northamptonshire

Action Plan -Feb 2024

1. A small group of people will get together to agree/understand if the actions are correct for the priorities – should they be different/ timelines/organisational responsibilities.

2. Workshop to be arranged to capture what is already happening /individual responsibilities/ review timelines and layers.

Autism JSNA

LOUISE KIRBY, HELEN GREGSON-HOLMES, JASON KENT

West Northamptonshire Council

Integrated Care Northamptonshire

North Northamptonshire Council

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1 Introduction

Autism is a lifelong developmental disability that affects how people perceive, communicate and interact with others. However, it is essential to recognise that there are differing opinions on this and not all autistic people see themselves as disabled. With an estimated 700,000 autistic adults and children in the UK, approximately 1% of the population, most people probably know someone who is autistic. In addition, there are an estimated 3 million family members and carers of autistic people in the UK. The latest research from the USA suggests that the prevalence could be over 2.5%.

The numbers of people affected by autism are not dissimilar to the number of people with dementia. The Department of Health, in 2010, indicated that it is a source of social, economic and health inequality in England.

Autistic people of all ages, ethnicities and genders. Inequalities experienced because of disability may interact with discrimination and barriers based on ethnicity, beliefs, sex, gender, sexual orientation, age, pregnancy and maternity, marital status and socio-economic disadvantage. There is an Equalities Impact Assessment to sit alongside this Strategy to summarise how we aim to address these issues.

Autistic people see, hear and feel the world differently from other people. Autism varies widely and is often referred to as a spectrum condition because of the range of ways it can impact people and the different levels of support they may need across their lives. Autism is not a learning disability, though around **4 in 10** autistic people have a learning disability.

Some autistic people will need little or no support in their everyday lives, while others may have co-occurring conditions and need high levels of care, such as 24-hour support in residential care. People may need to be empowered with various things to form friendships, cope at school, manage at work, or get out and about in the community. Wider communities and society should adapt to be inclusive of autistic people.

In this strategy, we also talk about neurodiversity, which refers to how the brain works and interprets information. Neurodiversity uses the social model of disability and considers autism a natural variation rather than a disorder that leads to different ways of thinking and behaving that can be advantageous in some circumstances and disadvantageous in others.

There are no definitive numbers regarding the number of autistic people, either adults or children. Any information about the possible number of autistic people in the community is based on epidemiological surveys. The website offers some interesting data and facts about autism:

- **34%** of children on the autism spectrum say that the worst thing about being at school is being picked on.
- **63%** of children on the autism spectrum are not in the kind of school their parents believe would best support them.

- **17%** of autistic children have been suspended from school. **48%** had been suspended three or more times; **4%** had been expelled from one or more schools.
- **70%** of autistic adults say that they are not getting the help they need from social services. Seventy per cent of autistic adults also told us that with more support, they would feel less isolated.
- At least **one in three** autistic adults is experiencing severe mental health difficulties due to a lack of support.
- Only **16%** of autistic adults in the UK are in full-time paid employment, and only **32%** are in some paid work
- Only **10%** of autistic adults receive employment support, but **53%** say they want it
- Around a **third of people with a learning disability may also be autistic**
- Between **44 and 52%** of autistic people may have a learning disability
- **Five times** as many males as females are diagnosed with autism. There is increasing evidence that there is a significant underdiagnosis of autism in females

The estimated number of autistic people in Northampton is derived from several sources:

1.1 Joint Strategic Needs Assessment (JSNA)

- National prevalence figures
- Data from adult and children's social care
- The Schools Census
- Data submitted to Public Health England as part of the 2018 Autism Self-Assessment

1.2 Co-occurring conditions

The National Institute for Health and Care Excellence (NICE) estimates that around **70%** of autistic people have an additional condition, which is "often unrecognised". The main conditions that co-occur more frequently in autistic people compared with the general population include:

- Mental health conditions Research suggests that **70%** of autistic people have a mental health condition and that **40%** have two or more.
- Autistic people are **up to four times** more likely to have anxiety disorder and twice as likely to have depression.
- Research has shown that autistic people are more vulnerable to negative life experiences, which may also affect mental health.
- Compared to the general population, autistic people report having a lower quality of life.
- Research shows that suicide is a major cause of early mortality in autistic people.

1.3 Neurodevelopmental conditions

These are caused by differences in early brain development and affect how a person processes information, thinks, or learns. Autism is one such condition, and it is common for autistic people to have other neurodevelopmental conditions. These include:

- General learning disabilities (affecting between **15%** and **30%** of autistic people).
- Specific learning difficulties (such as dyslexia and attention-deficit hyperactivity disorder).
- Other conditions such as epilepsy.

Language development delays are common in autism, and up to **30%** of autistic people are non-speaking (completely, temporarily, or in certain contexts).

Historically, autism, both within adults and children, has been seen as being a specialist area requiring input from (often) specialist health, education and social care provision. The reality is very different; in respect of both NHS and Local Authority provision, a person with autism is as likely (or more likely) to require support from and come into contact with day-to-day services, library staff, front-line Local Authority staff, receptionists in health centres, GPs, staff in A&E than with specialist staff within social and health care. Whilst this strategy looks at some areas that relate to the need for specialist input and provision, it also highlights that this is not a strategy relating solely to social care or specific areas of health care. Still, it is a Northamptonshire-wide strategy that needs to be supported by all public services in Northamptonshire.

1 Artwork by Cheryl Stafford

2 National Context

2.1 National strategy for autistic children, young people and adults: 2021 to 2026

The recently published national strategy replaces "Think Autism", extending the scope of the strategy to autistic children and young people. This sets out the ambitions of the national government and actions for local government, the NHS, and other public institutions on how to improve the lives of autistic people in the next five years.

Around £75 million in funding and an implementation plan have been announced for year one of the strategy.

The strategy covers the following six priority areas, though similar to the areas outlined under "Think Autism, including:

- Improving societal understanding and acceptance of autism.
- Improving access to education and supporting positive experiences of transition.
- Improving employment outcomes for autistic people
- Addressing healthcare inequities.
- Ensuring the right support is available for autistic people to live well in the community.
- Enhancing and improving available support for autistic adults and youth in the criminal and youth justice systems.

2.2 NHS Long Term Plan

The NHS Long Term Plan outlines six priority areas of action (and associated actions) to improve the health, longevity and quality of life of autistic people and people with learning disabilities.

There has been a **40%** increase in referrals for people waiting for an autism assessment between June 2022 and June 2023. One hundred forty-three thousand people are waiting, and **82%** have been waiting for over 13 weeks. There are around **4,000** new referrals each month.

Since March 2015, there has been a **96%** increase in autistic people without a learning disability entering inpatient Mental Health services.

3 Local Context

3.1 Demography

At the time of the 2021 Census, Northamptonshire was home to **785,241** people**. 359,522** people live in North Northamptonshire. **425,725** people live in West Northamptonshire.

The gender split of the population in both North and West Northamptonshire is **49%** male and **51%** female.

For more demographic data, please visit the Local Insight web pages for North Northamptonshire and West Northamptonshire.

We estimate there to be somewhere between **8,500** and **11,000** people with autism, diagnosed and undiagnosed, in Northamptonshire, **4,000** and **5,000** in North Northamptonshire and **4,500** and **6,000** in West Northamptonshire. These figures are examined in more detail in the next section.

4 Level of Need

4.1 Prevalence of Autistic Spectrum Disorders

- **Estimates suggest that between 1.5 and 1.76% of children and young people and between 1 and 1.3% of adults are autistic.**
- **We estimate there to be between 8,514 and 11,032 people with autism in Northamptonshire.**
- **We estimate there to be between 4,048 and 5,054 people with autism in North Northamptonshire.**
- **We estimate there to be between 4,465 and 5,979 people with autism in West Northamptonshire.**

2 Artwork by Otto Morrison

5 Children and Young People

- **We estimate there to be between 2,444 and 3,154 children and young people with autism in Northamptonshire.**
- **We estimate there to be between 1,124 and 1,455 children and young people with autism in North Northamptonshire.**
- **We estimate there to be between 1,320 and 1,700 children and young people with autism in West Northamptonshire.**

5.1 Northamptonshire Schools Census

According to the School Census of 2022, **2,262** children have an autistic spectrum disorder. This figure represents an increase of **27%** over the total recorded in 2020 (**1,776**) and **62%** over the number in 2017 (**1,396**). Research has found that this increase is due to increased autism awareness and a better understanding of what to look for. Please note that the categorisation within this census is not a formal diagnosis:

Need	2017	2020	2022
MLD (Moderate Learning Difficulty)	3,014	2,715	2,594
SPLD (Specific Learning Difficulty)	1,908	2,349	2,790
SLD (Severe Learning Difficulty)	459	482	508
PMLD (Profound & Multiple Learning Difficulty)	124	142	110
SEMH (Social, Emotional & Mental Health)	2,675	3,110	3,401
SLCN (Speech, Language & Communication Needs)	2,330	2,887	3,428
ASD (Autistic Spectrum Disorder)	1,396	1,776	2,262
OTH (Other Difficulty / Disability)	643	889	1,008
NSA (No Specific Assessment)	583	530	840
PD (Physical Disability)	426	472	519
HI (Hearing Impairment)	256	332	379
VI (Visual Impairment)	164	198	199
MSI (Multi-Sensory Impairment)	20	96	82

Table 1 Northamptonshire School Census 2017, 2020 and 2022

5.2 OHID Known Numbers

The Office for Health Improvement and Disparities statistics show there are **1,781** children in Northamptonshire known to have autism by their school (2020). This represents **1.5%** of the school population. That figure of **1.5%** is statistically significantly lower than the national average of **1.8%.** The regional average in the East Midlands is **1.77%**. If we were to apply those proportions to the 2021 Census population aged 5 to 18, that would produce figures of **820** children in North Northamptonshire and **960** in West Northamptonshire.

If we apply that **1.5%** figure to the whole population of Northamptonshire aged between 5 and 18, that gives us an estimate of **2,026**, a difference of **245—937** in North Northamptonshire and **1,089** in West Northamptonshire.

5.3 Children aged 0 to 4

There are no published figures for very young children aged 0 to 4 years, so we have used the above prevalence estimates and applied them to the 0 to 4 population of Northamptonshire at the time of the 2021 Census to produce an estimate. This suggests that between **663** and **777** young children could have an autistic spectrum disorder in Northamptonshire. In North Northamptonshire, the estimate is between **303** and **356**; in West Northamptonshire, the estimation is between **360** and **422**.

5.4 Further studies

A 2021 survey of children by Newcastle University found that autism was most prevalent in black schoolchildren (**2.1%**) and lowest in Roma/Irish Traveller children (**0.85%**). It also noted that children with an autism record in schools were **60%** more likely to come from a disadvantaged background and **36%** less likely to speak English.

Applying the **1.76%** prevalence to the population of Northamptonshire aged 5 to 18 gives us an estimate of **2,377**. **1,099** in North Northamptonshire and **1,278** in West Northamptonshire. This estimate is **33%** higher than the number of children known by their schools to be autistic in the OHID statistics.

6 Adults

- **We estimate there to be between 5,800 and 7,985 adults aged 18 and over with autism in Northamptonshire.**
- **We estimate there to be between 2,655 and 3,645 adults aged 18 and over with autism in North Northamptonshire.**
- **We estimate there to be between 3,145 and 4,340 adults aged 18 and over with autism in West Northamptonshire.**

6.1 POPPI and PANSI

POPPI and PANSI predict there to be around **5,800** adults with autistic spectrum disorders living in Northamptonshire. **1,320** of whom are aged 65 and over—**2,655** in North Northamptonshire and **3,145** in West Northamptonshire.

6.2 Adult Psychiatric Survey

POPPI and PANSI use the estimated prevalence of autism from the 2007 Adult Psychiatric Survey. This survey found rates of prevalence of autism of **1.1% in 14 to 44-year-olds**, **0.9% in 45 to 74-year-olds** and **0.8% in over 75s**. The lower prevalence rates in the older populations are most likely due to under-diagnosis and lack of recognition of the condition in older cohorts. Overall, the rate for all adults was found to be **1%**. Using these three prevalence rates for the population aged 18 and overproduces an estimated **6,005** adults with Autism in Northamptonshire. **2,733** in North Northamptonshire and **3,271** in West Northamptonshire.

A follow-up estimated the prevalence of autism to have increased to **1.1%**. This rate of prevalence produces an estimated **6,757** autistic people aged 18+ in Northamptonshire. **3,085** in North Northamptonshire and **3,672** in West Northamptonshire.

A further study in 2016 used experimental statistics to estimate the prevalence of autism at **0.8%** but noted that it could be as high as **1.3%**. Details of the limitations of these experimental statistics are contained within the published report. Using these prevalence estimates, this gives us an estimate of between **4,914** and **7,985** adults aged 18 and above with Autism in Northamptonshire. For North Northamptonshire, this estimate is between **2,243** and **3,645**; in West Northamptonshire, this estimate ranges between **2.671** and **4,304**. Given the evidence and analysis described previously, we will discount the lower figure and use the POPPI/PANSI estimate as the lower estimate.

Whilst autism is known to impact both males and females, girls and women are disproportionately less likely to receive a diagnosis and are considerably more likely to receive a 'late diagnosis', even in the presence of symptoms of equal severity. Current UK

and international evidence reflect that the rate of males diagnosed with autism is **three to five times** higher than for females. **90%** of the adults predicted to have autism by POPPI/PANSI are male.

Please note that people aged 18 have been counted twice in the children/adult breakdown but only once in the total, so as a result of this and rounding up/down, adding these totals will not produce the result at the top of this section.

7 Projected need

7.1 Children and young people

The following projections result using the **1.5** and **1.78%** prevalence estimates mentioned earlier and applying these estimates to the latest Office for National Statistics Population Projections.

1.5% prevalence	2020	2025	2030	2035	2040
0 to 4	693	664	664	681	714
5 to 17	1,919	2,025	1,981	1,918	1,920

Table 2 Autism projection estimates in Northamptonshire for ages 0 to 4 and 5 to 17 using 1.5% prevalence.

1.78% prevalence	2020	2025	2030	2035	2040
0 to 4	823	788	788	808	847
5 to 17	2,277	2,403	2,531	2,276	2,279

Table 3 Autism projection estimates in Northamptonshire for ages 0 to 4 and 5 to 17 using 1.78% prevalence.

The following two tables show the percentage change compared to the 2020 estimate for 2025, 2030, 2035 and 2040:

% change from 2020 (1.5%)	2025	2030	2035	2040
0 to 4	4%	-4%	-2%	3%
5 to 17	6%	3%	0%	0%

Table 4 Percentage change in autism prevalence ages 0 to 4 and 5 to 17 in Northamptonshire compared to 2020 using 1.5% prevalence.

% change from 2020 (1.78%)	2025	2030	2035	2040
0 to 4	-4%	-4%	-2%	3%
5 to 17	6%	11%	0%	0%

Table 5 Percentage change in autism prevalence ages 0 to 4 and 5 to 17 in Northamptonshire compared to 2020 using 1.78% prevalence.

The final two tables in this section show the percentage change compared to the last data point, for example, the change between 2020 and 2025, then between 2030 and 2025 and so on:

% change from previous (1.5%)	2025	2030	2035	2040
0 to 4	-4%	0%	-2%	3%
5 to 17	6%	-2%	-3%	0%

Table 6 Percentage change in autism prevalence ages 0 to 4 and 5 to 17 in Northamptonshire compared to the previous data point using 1.5% prevalence.

% change from last (1.78%)	2025	2030	2035	2040
0 to 4	-4%	0%	3%	5%
5 to 17	6%	5%	-10%	0%

Table 7 Percentage change in autism prevalence ages 0 to 4 and 5 to 17 in Northamptonshire compared to the previous data point using 1.78% prevalence.

7.2 Adults

POPPI and PANSI project an increase in the number of people with autism in Northamptonshire to rise by almost **1,000** or by **17%** over the next 20 years. As we've seen earlier, autism prevalence estimates can vary by **30%** over the POPPI/PANSI analysis.

7.3 Autistic Spectrum Disorders

Northamptonshire	2020	2025	2030	2035	2040
18-24	540	546	625	648	614
25-34	921	922	885	920	1,005
35-44	985	1,051	1,076	1,067	1,024
45-54	1,077	1,034	1,063	1,025	1,143
55-64	954	1,057	1,060	1,025	1,058
65-74	759	760	870	961	967
75+	561	701	779	856	974
Total	5,797	6,071	6,358	6,502	6,785

Table 8 Autistic Spectrum Disorder Estimates 2020 to 2040

The most significant increases in adults living with autism are expected to be in older cohorts, most notably people over the age of 75. The following table shows the percentage change from the 2020 estimate.

% change from 2020	2025	2030	2035	2040
18-24	1%	16%	20%	14%
25-34	0%	-4%	0%	9%
35-44	7%	9%	8%	4%
45-54	-4%	-1%	-5%	6%
55-64	11%	11%	7%	11%
65-74	0%	15%	27%	27%
75+	25%	39%	53%	74%
Total	5%	10%	12%	17%

Table 9 Autistic spectrum disorders estimate percentage increase from 2020 prediction.

The fastest increase rates are expected within 5 to 10 years of the 2020 predictions. The number of older people will likely increase between 2020 and 2025. The last table in this section shows the percentage change from the previous data point, for example, the change between 2020 and 2025, then between 2030 and 2025 and so on:

% change from previous	2025	2030	2035	2040
18-24	1%	14%	4%	-5%
25-34	0%	-4%	4%	9%
35-44	7%	2%	-1%	-4%
45-54	-4%	3%	-4%	12%
55-64	11%	0%	-3%	3%
65-74	0%	14%	10%	1%
75+	25%	11%	10%	14%
Total	5%	5%	2%	4%

Table 10 Autistic spectrum disorder estimates increase on the previous five-year estimate.

8 Population characteristics

8.1 Common comorbidities

Autistic children, young people and adults are considerably more likely to–develop a physical or mental health condition than those who are not autistic.

Notably, no source examined health conditions in autistic older adults; this constitutes a major gap in the evidence, given that the burden of many health problems and the need for support both increase with age.

While not exhaustive, this review identified several groups of conditions which have been confirmed to co-occur with autism across independent studies, including:

- physical health conditions (tooth decay and gum disease; epilepsy; hypertension and high blood cholesterol; allergies; reproductive system diagnoses).
- mental health or other neurodevelopmental conditions (anxiety, depression, ADHD, alexithymia, eating disorders).
- Evidence of potential gender disparities in the risk for certain health conditions may be considered when planning and commissioning preventive health services.
- Hypermobility has high co-morbidity

Particularly concerning is the considerable burden of mental health conditions faced by autistic people and high rates of suicide relative to the general population.

Even more so when coupled with findings from elsewhere in this review, which indicate substantial disparities in access to health and care services (particularly for mental health services) and a lack of support after diagnosis for children, young people and adults.

Themes around a lack of access to mental healthcare, the ability of mental health services to tailor to autism needs, and a lack of post-diagnostic support services were consistent across published academic and grey literature.

Concerningly, robust evidence also suggests a considerably higher rate of suicide and self-harm in autistic people.

8.2 Camouflaging and masking

The emerging literature on camouflaging or masking behaviours (i.e., strategies to mask the symptoms of autism in social situations) has potential implications for how autism is understood and recognised within health and care settings.

While empirical studies on the health risks of camouflaging have not yet been conducted, qualitative literature has explored the consequences, including physical and emotional exhaustion, as reported by autistic interviewees.

There is an emerging body of evidence concerning autistic adults' (particularly females) use of conscious or unconscious strategies to minimise the appearance of autistic traits within social settings or 'camouflaging'.

Examples of these "behavioural coping strategies to conceal symptoms" given by a recent narrative review include mirroring facial expressions or other non-verbal gestures in conversation. This concept has been proposed as one candidate explanation for lower rates of diagnosis in autistic women and girls.

The narrative review referenced earlier outlines that this area of research is emergent and has largely explored developing methods to measure this concept, and qualitative investigations of camouflaging behaviour among autistic women and girls.

There is also an emerging body of qualitative evidence around the potential physical and emotional consequences of maintaining this camouflage.

The summary of this report notes that *"Consequences […] included physical and emotional exhaustion, often requiring time alone to recover; issues around identity and authenticity […] and difficulty accessing support and diagnosis."*

8.3 Quality of life

Systematic and narrative reviews show that autistic adults may experience lower scores on quality of life (QoL) measures.

Widespread use of QoL measures that have not been validated for autistic adults may give 'misleadingly low or high scores'. A crucial need is to develop appropriate measures to understand what matters to autistic people regarding QoL.

8.4 General health and mortality

Population studies show poorer general health and health status in autistic children and young people, and there is limited research which directly assesses autistic adults' physical health.

Evidence from more recent cohort studies shows higher mortality levels in autistic people.

8.5 Family, carer and sibling outcomes

Evidence shows lower Quality of Life (QoL) (subjective mental and physical health) for parents/ carers and siblings of autistic children.

8.6 Employment and education

There is considerable evidence of disparities in education and employment outcomes for autistic adults (by gender, socioeconomic status and ethnicity.

Several grey literature sources show poorer post-secondary education outcomes and high un-and-underemployment for UK autistic graduates.

We spoke with local stakeholders who told us that supported employment provision is often based on pan-disability, except for IPS and IAPT, which focus on mental health. Whilst mainstream employment support is available to people who are autistic, it is believed that specific provision is necessary and would support many more people to achieve their learning and employment potential. To achieve this, we would first need to understand how many people need this support and with data of limited value, predicting support needs is difficult, so the proper support for the right person at the right time cannot happen. Capturing condition-specific data and details would help us understand what support could and should look like and the more appropriate allocation of funds and support.

8.7 Criminal justice system (CJS) and related settings

Conflicting findings were identified across sources as to whether autistic people are over-represented within the CJS, though autistic people are overrepresented in secure psychiatric settings. There is also a lack of gender-sensitive autism screening tools for identifying autism in CJS.

UK-based surveys highlight discrepancies in the experiences of autistic people, carers and policing professionals in levels of satisfaction reported.

Qualitative evidence examining the contributory factors reported by autistic people leading up to their arrest points to the "accumulation of unmanageable stress and a lack of understanding and access to wider support".

8.8 Barriers and facilitators

Several common barriers to accessing health and care services (including diagnostic services) were identified, including sensory sensitivities, communication difficulties, lack of autism knowledge, and waiting times.

8.9 Access

There is considerable evidence that autistic people experience disparities in access to health and care services.

Several sources describe disparities in access to transition-related services and diagnosis and support services by ethnicity and socioeconomic status.

Access to mental health services appropriately tailored to autistic peoples' needs emerged as a major area of concern for both children and young people and adults.

8.10 Autism diagnostic services

A recent systematic review highlights, "The evidence supporting racial, ethnic, and economic disparities in ASD diagnosis and service access is strong and has been replicated across multiple studies.

Wider qualitative research has also highlighted the need to tailor diagnostic services to be more culturally and linguistically sensitive in light of barriers to access.

8.11 Post-diagnostic support services

Available evidence points to a lack of post-diagnostic support services. Locally, there is limited support directly after diagnosis, and independent voluntary community social enterprises offer peer support.

8.12 Gender

A 2021 survey of children by Newcastle University suggests the prevalence of autism to be **1.76%**, **2.8%** in boys and **0.6%** in girls.

Whilst autism is known to impact both males and females, girls and women are disproportionately less likely to receive a diagnosis and are considerably more likely to receive a 'late diagnosis', even in the presence of symptoms of equal severity. **76%** of autistic patients accessing inpatient mental health services between 2022 and 2023 aged under 18 were female; by age 18 to 24, this falls to **46%**, and over 25 falls further to **22%**.

Current UK and international evidence outlined below reflects that the rate of males diagnosed with autism is three to five times higher than for females.

- Of **25,063** individuals with a recorded autism diagnosis, only around 20% of those were female. Follow-up analyses also reflect a **3:1 male-to-female ratio** in prevalence rates at ages 10 and 11 (**4.4%** for boy's vs **1.1%** for girls).

- Rather than reflecting an increased incidence of autism in men relative to women (i.e. that autism is more common in men than women), it is thought that the signs of autism in women and girls may be under-recognised and under-diagnosed.

8.12.1 Gender identity and sexual orientation

Available evidence indicates that there is currently no reliable estimate of the relative proportion of autistic individuals who identify as LGBTQ+. This is because this kind of data is seldom collected in a way that enables robust comparisons, as many large population-based studies do not collect information on autism gender identity or sexual orientation.

While this area of research is emergent, an earlier systematic review covering articles published between 1966 and 2015 indicates that autism may be more prevalent in children and adolescents experiencing gender dysphoria compared to the general population. However, there is limited research concerning adults.

More recently, researchers at the Autism Research Centre in Cambridge have conducted the largest analysis to date concerning gender identity and autism.

Compared to those who identify as cisgender (someone whose gender identity matches the sex they were 'assigned' at birth (Stonewall)), people who identify as transgender or gender-diverse are between three and six times as likely to be autistic.

8.13 Ethnicity

While evidence on the association between ethnic background or ethnicity and autism prevalence is somewhat conflicting, it appears that across the international evidence base, there are differences in the prevalence of autism between ethnic groups.

Specifically, some studies indicate that non-white children are less likely to receive an autism diagnosis, which may indicate disparities in access to diagnostic services or under-identification. In the UK and globally, there is also a lack of research concerning the experiences of ethnically diverse populations who are autistic.

Findings from several population-based studies point to differences in how prevalent autism is among different ethnic groups:

- One study conducted in Scotland found that children and young people with autism were more likely to be of Caucasian ethnicity.
- US-based work by Christensen et al in 2017 also highlighted lower autism prevalence in children from a Black or Hispanic ethnic background.
- Magen-Molho et al. identified strong associations between ethnicity and autism prevalence; specifically, autism prevalence was around three times lower in those whose ethnic background was Arab or non-Israeli in 2020.

Findings from the largest case-control cohort study concerning autism and ethnicity to date (using data from the Spring School Census National Pupil Database) show consistent differences in prevalence rates across ethnic groups. Specifically, in a large sample of children and young people, two ethnic groups were identified as being more likely to have an autism diagnosis recorded in the educational system compared to white pupils:

- Black pupils were **26%** more likely to be recorded as having an autism diagnosis and had the highest prevalence rate overall (**2.11%**).
- Chinese pupils were **38%** more likely to be recorded as having an autism diagnosis.

Several groups were also indicated to have a lower prevalence of autism or be less likely to have an autism diagnosis recorded:

- Roma/Irish Traveller pupils were around **60%** less likely to be recorded as having an autism diagnosis and had the lowest prevalence rates of autism overall (**0.85**).
- Asian pupils and pupils from any other ethnic group were less likely to have autism compared to White pupils.
- This conflicts with US and international evidence showing lower prevalence rates of autism in Black and other minority ethnic groups.

9 Physical health conditions and disabilities

9.1 Children

Available evidence highlights a higher burden of physical disabilities, sensory conditions and physical health conditions in autistic children and young people compared to non-autistic children and young people.

For example, a whole country population observational study conducted in Scotland found that compared to the general population, conditions such as deafness/ partial hearing loss, blindness/ partial sight loss and other physical disabilities were between **5 and 16 times more prevalent** in autistic children; mental health conditions were **16 times more prevalent** in autistic children and young people.

9.2 Adults

Several secondary sources highlight a lack of literature related to the physical health of autistic adults. A 2016 scoping review by Cashin et al outlines that very few primary research studies assess the health status and physical health of autistic adults. A 2020 study by Kassee et al also reflects this as the first scoping review to examine the physical health of autistic women and girls.

Multiple sources also point to a clear need to conduct further research to understand how physical health changes across the lifespan for autistic adults, particularly for older adults. Notably, very few studies have shown this.

9.3 Mental health conditions

A meta-analysis of 96 prevalence studies highlights that common mental health conditions are highly prevalent in autistic people, more so than in the general population.

9.3.1Alexithymia

Autism has also been found to co-occur frequently with alexithymia (defined as difficulties in identifying, describing or expressing, and distinguishing between different emotions and internal or bodily sensations).

9.3.2 Depression

Several published academic secondary sources indicate considerably elevated prevalence rates of depressive disorders and symptoms of depression in autistic adults and young people.

9.3.3 Anxiety

Several sources suggest a higher rate of anxiety disorders in autistic children, young people and adults.

Specifically, Autistica points to previous research to suggest that anxiety is one of the most common mental health issues, affecting four of every ten autistic children.

A more recent meta-analysis by Lai et al in 2019 shows the pooled prevalence of anxiety disorders in autistic adults at around 20%.

The prevalence rate of anxiety disorders in autistic people is concerning, as co-occurring anxiety may reportedly worsen or exacerbate core autism symptoms such as social challenges and sensory sensitivity.

10 Employment and workplace outcomes

10.1 Published academic literature- secondary sources.

An early narrative review by Chen et al. in 2015 highlights several aspects of poorer employment outcomes that are consistent with findings from international sources:

- Unemployment: High rates of unemployment (ranging from **40 – 80%**) are indicated across several international studies.
- Underemployment: Autistic individuals who are employed tend to be paid less and may have limited weekly working hours or work in part-time or voluntary roles. For example, a longitudinal study highlighted by the authors followed 66 autistic adults for ten years, finding that only six per cent of individuals had 'competitive jobs', while no adults worked in full-time roles. Other longitudinal research cited (n=68) mirrors this, with only two participants working on full-time salaries.

10.2 Grey literature

Findings from a series of focus groups and a UK survey (n=2,080 autistic adults or proxy responses), conducted as part of the National Autistic Society's (2016) work to understand the employment gap, suggest disparities in outcomes and experiences around:

- Employment or getting a job. The full-time employment rate for autistic people is around **16%**; combined with the rate of part-time employment (**16%**), only **32%** of adults in this large survey were employed. About **40%** of respondents reported having never worked. These figures are considerably lower than the rate of adults without disabilities in full-time employment (**80%**).
- Getting a job matching the person's skills and desire to work. Around **40%** reported part-time employment and wanting to work more hours; about **51%** of those in employment also reported being overqualified for their job.
- Employers assumed autistic people would want jobs that do not involve social interaction or that they favour jobs that require technical skills and attention to detail. This is not the case for all autistic people, as this survey showed that for **11%** of respondents, their ideal industry was the arts industry, and **10%** wanted to work in IT. In contrast, smaller proportions indicated administrative or office work (**9%**), research development or library (**7%**) or museum-based roles (**7%**).

11 Barriers and facilitators to healthcare access

11.1 Published academic literature- secondary sources.

A 2019 UK-based systematic review by Mason et al identified six studies relevant to barriers to accessing physical health services.

- Patient-provider communication. Five studies highlighted communication as a barrier; difficulties included registration, communication with the GP, and providers not adopting the patient's preferred mode of communication.
- Executive functioning and planning difficulties. Several studies described individual-level factors related to the autistic person's level of information processing and memory or ability to carry out and plan complex and day-to-day tasks (e.g., taking medication, remembering to prepare for and attend an appointment).
- Sensory sensitivities. Five studies reported different sensory sensitivities as barriers, including waiting room environment, unpredictability (of sensory environment and waiting times), and travelling to the appointment.

11.2 Published academic literature- primary sources.

These barriers and facilitators dovetail with categories of different reasonable adjustments (and their importance) reported by autistic adults in two large cross-sectional UK surveys.

Three themes were identified concerning necessary reasonable adjustments:

- Sensory environment.
- Clinical and service context.
- Clinician knowledge and communication.

Survey findings indicate that reasonable adjustments were perceived as necessary in supporting healthcare access, but these adjustments are seldom offered as **69%** of autistic adults were not provided mental health service adjustments, though this was slightly lower for physical health service adjustments (**56%**).

11.3 Grey literature

As part of a national inquiry into access to healthcare for autistic people in England, the Westminster Commission on Autism surveyed 863 autistic people, family advocates and professionals, contributing to understanding and informing how to reduce barriers to access. Several key barriers to healthcare access were identified:

- Lack of training for health professionals and lack of accountability. A high proportion (**88%**) stated they felt healthcare professionals did not always understand autism. In 2014, only **29%** of local areas surveyed rated themselves green for having autism training available to all staff (Self-Assessment Framework).

- Sparse data collection and reasonable adjustments. The inquiry notes that a lack of data collection on autism has been seldom collected in England at a general-practice and national level. **Three-quarters** of autistic and parent advocates stated that their doctor does not make any changes or adjustments to meet their needs, which may suggest that health professionals may struggle to identify and make adjustments for autistic people proactively.
- Even when access barriers are surmounted, autistic people may receive poorer healthcare services than those without autism. Around **74%** of autistic parents and professionals surveyed said they felt autistic people receive 'worse' or 'much worse' healthcare than non-autistic people.

11.4 Adult mental health services

A UK-based cross-sectional mixed-method study examined the experiences of autistic young adults between 16 and 25 years of age living with mental health and accessing mental health services, using a community-based participatory research approach with an online survey and in-depth interviews. Key survey findings include:

- While a high proportion (**90.1%**) indicated having sought help from mental health services previously, comparatively fewer suggested that this support was 'extremely' (**13.7%**) or 'very useful' (**23.2%**).
- **Around a quarter** of respondents felt comfortable disclosing or discussing their mental health issues with professionals (**23.5%** felt 'very' or 'extremely' comfortable admitting).

Findings from in-depth qualitative interviews highlight several common themes relating to access and mental health services:

- Stigma: Experiencing stigma related to mental health concerns was a major barrier to seeking help, particularly for psychosis or personality disorder-related diagnoses. The stigma around mental health from family members was also reported; respondents felt it was important for clinicians and professionals to address issues such as stigma.
- Barriers to accessing mental health services: Several barriers were reported as prominent, including lack of available services for both autism and mental health needs; mental health problems being deemed "[not] severe enough for support"; lengthy waiting times for access; mental health services not being tailored to autism; and poor transition to adult services ("*you hit 18 and all your services just go "poof" and just disappear.*").
- Quality of care: The authors report that "*Overall, interviewees were generally unhappy about the standard of the services they accessed: 'I wasn't very happy with any way that my mental health was handled my whole entire life really*."- reflecting that some interviewees reported a pressure to show gratitude for support they felt did not go far enough: *"I just felt like a burden 'cause I didn't get as much as I wanted to but I was made to feel that that was more than I deserved."*

11.4.1 Grey literature

Several quotes from this briefing highlight the interaction between the increased burden of mental health difficulties in autistic adults and systemic barriers to accessing both timely and sufficient mental health support.

11.5 Children and young people's mental health services

11.5.1 Grey literature

Autistica has produced a resource outlining key findings from recent research concerning autistic children and young people's mental health. Many themes highlighted echo Autistica's briefing on adult mental health, outlining the high burden of mental health conditions in autistic children and systemic challenges in accessing timely and appropriate support.

12 Local and National Services

The Local Offers in Northamptonshire can be found by clicking here for North Northamptonshire and here for West Northamptonshire.

Integrated Care Northamptonshire have a directory of health and care services.

En-Fold is a local information hub offering direct services and an autism online web resource for information, services, and support within Northamptonshire. The National Autistic Society also has a service directory.

Northamptonshire Healthcare NHS Foundation Trust (NHFT) have a Children and Young People ADHD and ASC service and an Adult ADHD, Autism and Tourette's Team within their Mental Health, Learning Disability and Specialty Services department.

NHS England has a webpage of useful autism resources and training.

Autism Central provide resources, events and one-to-one support for family members and carers of children and adults with autism.

Neurodiverse Connection is a Community Interest Company (CIC) created to improve support and outcomes for neurodivergent people. Neurodiverse Connection has also recently launched a black and autistic support group.

13 Quality and outcomes

NHS Digital published 'Autism Statistics' in November 2019. Data for Northamptonshire Healthcare NHS Foundation Trust (NHFT) is incomplete. Still, we can see here that in quarter 3 of 2018/19, the average waiting time for a first appointment for suspected autism patients was ten weeks compared to a national average of **48**.

SystmOne, the NHS's electronic patient record system, can record autism. The autistic community chose the green letter A as the icon on this system to record an autism diagnosis. Registering autism allows the NHS to plan their service provision, recognise and improve the experience for autistic people and allow NHS staff to identify patients and service users as autistic and adapt accordingly.

This system links with a 'Reasonable Adjustment' dialogue box template that NHFT have worked with NHSE/I to develop, where individual instructions can be recorded to allow the authority to create highly individualised bespoke adjustments.

13.1 Reasons for poor mental health in autistic people

- Communication differences not being understood.
- Unhelpful support.
- Sensory differences.
- Negative sense of self.
- Lack of understanding in society.
- Trauma.
- Not being listened to and not being believed.
- Protective factors.
- Understanding self.
- Listened to and accepted.
- Trusting relationships.
- Understanding how others can support.
- Environmental factors.

The Autism Act 10 Years On document, which informed the National Strategy for autistic children, Young People, and Adults: 2021 to 2026, reported that only **32%** of autistic adults rated mental health professionals' understanding of autism as good or very good. Only **10%** of autistic adults said that social workers had a good sense of autism.

13.2 Bullying

Autistic children are more likely to experience bullying, and both children and adults with autism are at heightened risk of post-traumatic stress disorder as a result of bullying and other maltreatment and abuse.

13.3 Employment

The employment rate for working-age adults with autism between July 2020 and June 2021 was **29%**. In the six months preceding this, January to June 2020, the rate was **22%**. The rate for the whole working-age population has been between **72%** and **76.6%** over the last decade.

The employment rates for working-age males with autism were **21.2%** between January and June 2020 and **30.4%** between July 2020 and June 2021. The employment rate for working-age females with autism was **22.8%** between January and June 2020 and **25%** between July 2020 and June 2021.

Autism is not included separately in the data publications before January 2020.

13.4 Life expectancy

Autistic people die on average 16 years earlier than the general population due to a multitude of medical conditions.

13.5 Access to healthcare

Autistic adults experience significant disparity in healthcare, relating to issues including verbal communication skills, sensory sensitivities, challenges with body awareness, slow processing speed, atypical non-verbal communication, and difficulties with organisation.

Tackling health inequalities for autistic individuals is a national priority, with a training programme on autism for health and care staff made statutory.

Alternative paradigms than the medical model, such Burchardt in 2004, are gaining traction, advocating difference rather than impairment (Mac Cárthaigh, 2020; O'Dell *et al.* 2016) and the importance of relationships and quality of life.

14 Evidence of what works.

14.1 Current policy, legislation and guidance

14.1.1 NHS Long Term Plan (2019)

The NHS Long Term Plan outlines six priority areas of action (and associated actions) to improve the health, longevity, and quality of life of autistic people and people with learning disabilities. Owing to this review remit, this overview focuses on autistic people:

- Enhance community-based support for autistic people, moving care into the community.
- Ensure all NHS services provide a good standard of care and treatment for autistic people and their families.
- Increase investment in intensive, crisis, and community forensic services for autistic people.
- Reducing waiting times for specialist services.
- Reducing health inequalities.
- Improving understanding of autism across the whole NHS and working to improve the health and wellbeing of autistic people.

Since the publication of the Long-Term Plan, the NHSE/I national autism team has been established to oversee the delivery of the commitments set out, aiming to achieve a clearer focus on autistic children, young people and their families.

Specific areas of focus include:

- Reducing waiting times and increasing the quality of autism diagnostic pathways (assessment waiting times; pre-and–post support).
- Develop and pilot annual health checks.
- Ensuring health services put reasonable adjustments in place for autistic people.
- Expanding programmes which aim to reduce and stop the overuse of psychotropic medications in autistic people.
- Working with primary care partners to expand sight, hearing and dental checks to autistic children and young people in residential settings.
- Helping autistic people with complex needs to access personal health budgets and ensuring access to a designated key worker.
- Working with local service providers to reduce avoidable inpatient admissions and plan high-quality person-centred inpatient services that may be accessed as close to home as possible.
- Increasing awareness of the importance of employing autistic people.

14.1.2 Learning Disability Mortality Review (LeDeR/ learning from lives and deaths)

Starting in 2015, the Learning Disability Mortality Review (LeDeR, or learning from lives and deaths, as it is now known) is a formal process for reviewing the lives of individuals aged 4 and over with learning disabilities who have died.

Reviews such as these are conducted to understand the health and care services the person who died has received throughout their life. And to inform how healthcare services can be improved to address health inequities and prevent further early deaths. Clinical Commissioning Groups (CCGs) currently hold responsibility for conducting these reviews.

One of the most notable changes is including autistic people in these reviews.

The focus of planned changes to LeDeR governance and processes is to ensure that local health and care systems act upon the findings of such reviews.

For example, NHS England notes that from September 2021, LeDeR will be incorporated into quality reporting arrangements for local ICSs. This mechanism for accountability is intended to improve local learning from these reviews, leading to clear steps for how this learning is translated into tangible service improvements for autistic people.

14.1.3 Annual health checks for autistic people

Annual health checks were previously offered to people with learning disabilities or people with learning disabilities and autism, but not to autistic people without a learning disability. This is despite this group's higher burden of health problems than the general population.

Based on this, one of the key commitments of the NHS Long Term Plan (2019) is to pilot annual health checks for autistic people and extend this more widely if successful. However, there needs to be more information available about what this might entail. The degree to which existing screening tools or areas of the learning disability annual health checks might be adapted is also unclear.

Relevant national guidance for population screening of autistic people and people with learning disabilities has recently been published by Public Health England in 2021, and research funded by Autistica (in collaboration with academic partners and NHS England) to design and test such health checks is due to enter its third phase in Autumn 2021. It culminates in a randomised controlled trial to understand the feasibility, acceptability, and effectiveness of health checks for autistic people.

Autistica outlines several recommendations for action regarding annual health checks, including:

- Integrate autism health checks into CQC inspections for general practices (assessing how prepared local practices are to deliver this).
- Regulatory organisations should collaborate with primary care IT system providers to ensure GPs can access relevant information they need to invite individuals for

annual health checks; this might also ensure that appropriate data is accessible to the individual and that it becomes part of the health record.

- Regulatory organisations, health education providers and Royal Colleges should collaborate to understand how clinicians in primary care might be supported and incentivised to offer annual health checks for autistic people.
- Health education providers and Royal Colleges should come together to develop ways of recognising professionals who have developed specialist knowledge and expertise in the health of neurodivergent people (this might include accreditation of a General Practitioner with Extended Role).
- To improve inconsistent coding of autism diagnoses across GP records, regulatory organisations should collaborate with Royal Colleges and autistic community stakeholders to simplify clinical coding for autism diagnoses and audit local records.

14.2 Policy Overview

The focus of national policy related to autism has been fairly consistent across the last decade with several priority areas related to:

- Increasing societal and professional understanding of autism.
- Developing consistent local diagnostic and wider support pathways.
- Developing the local and national governance required for policy implementation and monitoring.
- Moving care from hospital to community settings.
- Reducing inequities in health outcomes and access to services.
- Improving the consistency of local and national data collection.

The most recent national strategy, which extends the provision of previous policies to children and young people, states three core enablers related to improving research and innovation, improving data collection, and reporting and strengthening governance, leadership, and accountability.

14.3 Learning from lives and deaths and annual health checks

The inclusion of autistic people in learning from mortality reviews and the possible provision of yearly health checks for autistic people are potentially positive developments which may reduce health inequities. Evidence and guidance for local systems to anticipate how they might respond to these priorities is yet forthcoming.

Policy recommendations

Recommendations from national sources and other relevant organisations were synthesised across the following topic areas:

- Understanding, training and awareness, Governance leadership and accountability enhancing service provision and understanding autistic peoples' journey through services.

- Access to diagnosis and the diagnostic process, gender disparities, social care, and mental health.

This review identified a major gap in the existing evidence concerning autistic older adults, as reportedly, the literature on autistic adults has focussed on younger adults and those approaching middle age. Specifically, only a handful of papers identified mentioned autism in older adulthood, such as this from Heriot-Watt University.

14.4 Criminal Justice

Autistic people are overrepresented but are not more likely to offend.

14.5 Tackling Health and Care inequalities for autistic people

Autistic people die on average 16 years earlier than the general population.

14.6 Social Care

71% of autistic adult survey respondents from across England said they had unmet social care needs.

14.7 Suicide

Over the last seven years, the proportion of suicides where autism is recorded in Northamptonshire is a little over **0.1%.** However, around **14%** of cases don't have a record of whether the individual was autistic or not, so that figure could be much higher. Reports that adults with autism are **nine times more likely** to die by suicide than the general population, and children with autism are **28 times more likely** to contemplate suicide.

A paper published by Autistica by Sue Willgoss, Advisor for Suicide Prevention with Lived Experience, Norfolk and Suffolk NHS Foundation Trust Founder #LiftLoudForDanny, quotes some startling statistics:

- Suicide is the second leading cause of death for autistic people.
- Average life expectancy for autistic people is just **54 years old**.
- Up to **66%** of autistic adults have considered suicide.
- Suicide attempts tend to be more aggressive and lethal.
- One study showed that **15%** of autistic children had suicidal thoughts compared to **0.5%** of typically developing children.
- In the 86 days leading up to the first Lockdown and up to the 56 days after, **a quarter** of young people who died by suicide were autistic or had ADHD.
- Autistic people make up approximately **1%** of the population but **11%** of suicides.

The report includes recommendations and community priorities.

A Research (INSAR) provides further statistics relating to suicide and autism:

- The risk of death by suicide is even greater for autistic people without intellectual disability.
- It is also greater among autistic women, who are **13 times more likely** than non-autistic women to die by suicide.

This report contains the same recommendations and priorities as the Autistica paper.

A further report titled 'Personal tragedies, public crisis' looks further into the causes of premature mortality, including suicide, in the autistic population.

14.8 Mental Health Inpatients

Currently, autistic people have a shorter life expectancy than neurotypical people. Autistic adults experience a significant disparity in health care and are more likely to develop mental ill health but less likely than non-autistic people to get support.

There is an increased incidence of autistic adults in mental health wards compared to in the community.

14.9 Homelessness

Emerging research suggests that autistic people are disproportionately represented in homeless populations.

14.10 Training

Although it is promising in tackling explicit bias against autism, it has not been shown to reduce implicit bias.

The Health and Care Act 2022 required that all CQC registered service providers ensure their staff have training on learning disability and autism that is appropriate to their role. The Oliver McGowan Mandatory Training on Learning Disability and Autism is the Government's preferred and recommended training for health and social care staff to undertake.

15 Recommendations

Where possible, appropriate and legal consider recording data relating to autism for service users, customers and patients. For example, whether an individual is autistic and what the outcomes were for that individual.

Make reasonable adjustments to accommodate autistic people when accessing information, services, locations or employment.

Adopt the recommendations from Autistca's 'Suicide and Autism: A National Crisis' and their action briefing on health checks.

Adopt the synthesised recommendations referred to earlier in this paper and repeated here for convenience –

- Understanding, training and awareness, Governance leadership and accountability enhancing service provision and understanding autistic peoples' journey through services.
- Access to diagnosis and the diagnostic process, gender disparities, social care, and mental health.

Embed and monitor Autism into Equality Impact Assessments.

Further research should use secondary and/or local datasets to understand the most common causes of hospitalisation, criminalisation, employment and other adverse health or service utilisation outcomes.

Alongside quantitative data, ensure lived experience knowledge, participation and engagement is embedded into reports and reviews to provide qualitative information.

Move away from reliance on medical models.

The Autism Strategy Action Plan, a constantly evolving project, should reflect the work and the detail undertaken to produce this list of recommendations.

Nothing about us without us.

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WEST NORTHANTS
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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

March 26th 2023

Report Title	**BCF Quarter 3 Update**
Report Author	**Michael Hurt, BCF Service Manager, West Northants Council**

Contributors/Checkers/Approvers		
Other Director/SME	Stuart Lackenby, Deputy Chief Executive, West Northants Council	Provided by Ashley Leduc 18/03/24

List of Appendices

Appendix A – BCF Quarterly return

1. Purpose of Report

1.1. Health and Wellbeing Board to approve quarter 3 update (prior approval for submission 09.02.24)

1.2. To update the Health and Wellbeing Board on the progress of the Better Care Fund.

2. Executive Summary

2.1 The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB). These are joint plans for using pooled budgets to support integration, governed by an agreement under section 75 of the NHS Act (2006).

2.2 The policy framework, published on April 4th, 2023, confirmed the conditions and funding for the BCF for 2023/25. New guidance on 24-25 is due shortly.

2.3 The BCF plan and schemes for 2023/25 were submitted and approved as complying with the conditions of the 2023/25 grant on 28th June 2023. No date has been published for 24-25 yet.

2.4 The regional BCF lead asked to put forward the WNC BCF submission as a national exemplar.

2.5 The Health and Wellbeing Board are required to approve the BCF Quarter 3 Return (prior approval sought for submission on February 9th 2024).

3. Recommendations

3.1 It is recommended that the West Northamptonshire Health and Wellbeing Board:

a) Approve the Quarter 3 submission

b) Note the BCF update

4. Report Background

4.1 BCF national reporting for 2023/24

The national conditions for the BCF for 2023 to 2025 are:

1. a jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
3. implementing BCF policy objective 2: providing the right care, at the right place, at the right time
4. maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services

4.2 Two returns are submitted monthly to the national team to monitor progress against the plan. Each quarter, a further report with more detail is required. This report is for the quarter 3 submission. Quarter 3 included an additional sheet with activity and spend. The schemes were selected by the national team and it is likely that this will be in the end of year return also.

5. Issues and Choices

5.1 There have been some issues about timely and accurately recorded data. NHS brokerage is now being delivered by WNC in a joint approach. However the correct coding wasn't always being applied and therefore numbers were reported lower than anticipated. Thes issues have largely been addressed. Colleagues from brokerage attend the BCF reporting pre-meetings.

5.2 Hospital admissions due to falls improved in Q3 but remain a little more than planned at 500 actual vs 435 planned.

5.3 All other areas are on track.

5.4 Reviews of schemes are taking place and a Health Equity Assessment Tools (HEAT) are being completed for each scheme as it is reviewed. However, identifying scheme leads has been a challenge.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 Please see Q3 report

6.2 **Legal**

The council constitution makes provision for working groups to undertake activity on behalf of the Board.

6.3 **Risk**

6.3.1 None.

6.4 **Consultation**

6.4.1 No consultation was required.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 The report has not been considered by Overview and Scrutiny.

6.6 **Climate Impact**

6.6.1 There are no known direct impacts on climate because of the matters referenced in this report.

6.7 **Community Impact**

6.7.1 There were no distinct populations that were affected because of the matters discussed in this report, however those that access care and health services more frequently than the general population were impacted more by any improvements associated with activity undertaken.

7. Background Papers

7.1 Q3 report

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Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

1. Guidance for Quarter 3

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Hackney (due to a data breach issue) and Westmorland and Cumbria (due to a change in footprint).

5. Spend and Activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to the end of the third quarter (1 April to 31 December).

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	**Units**
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column I.** Enter the amount of spend from 1 April to 31 December on the scheme. This should be spend incurred up to the end of December, rather than actual payments made to providers.
- **Outputs delivered to date in column K**. Enter the number of outputs delivered from 1 April to 31 December. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns M and N.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column M and briefly describe the issue and planned actions to address the issue in column N. If you answer no in column M, you do not need to enter a narrative in column N.

More information can be found in the additional guidance document for tab 5, which is published alongside this template on the Better Care Exchange.

HM Government

NHS England

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	West Northamptonshire
Completed by:	Ashley Leduc
E-mail:	ashley.leduc@westnorthants.gov.uk
Contact number:	07912 891860
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: West Northamptonshire

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	Yes	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off		Yes

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: West Northamptonshire

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	220.0	220.0	220.0	220.0	241.5	229.4	On track to meet target	None identified	Delivery of packages desigend to avoid hospital admissions continues against plan. BCF investment has increased capacity which has offset demand from demographic demand	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	95.0%	95.0%	95.0%	95.0%	94.3%	94.8%	On track to meet target	None identified	Identfying these people and prioritising to speed up discharge and increasing support as necessary.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,739.7	541.2	500.8	On track to meet target	None identified	We have invested into additional training for Adult Social Care staff and provided lifting equipment supported by clinical decision making app to increase safe lifts reducing the number of falls long waits which occur	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				470	2022-23 ASCOF outcome: 431.2		On track to meet target	Please note: This indicator is cumulative Population within scorecard Q1 (79/77,713*100,000) = 102 Q2 (177/77,713*100,000) = 228 Q3 (273/77,713*100,000) = 351	Person is visited and their transfer of care is validated to ensure pathway 3 is the right pathway.	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				81.8%	2022-23 ASCOF outcome: 80.7%		On track to meet target	Q1 = 85.3% Q2 = 72.4% Q3 = 87.3%	Growth of the reablement team over the last 12 months to improve capacity and effectiveness. Daily huddle that reviews everyone daily.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: West Northamptonshire

Checklist	Yes	Yes	Yes

Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?
12	Home Based	Home-based intermediate care services	Rehabilitation at home (to prevent admission to	Local Authority Discharge Funding	£160,134	£126,781	39	62	Packages	No
11	Bed Based	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Local Authority Discharge Funding	£1,100,000	£828,767	58	31	Number of placements	No
18	Workforce	Workforce recruitment and retention		Local Authority Discharge Funding	£151,529	£77,463		3	WTE's gained	No
12	Home Based	Home-based intermediate care services	Rehabilitation at home (to prevent admission to	ICB Discharge Funding	£2,044,788	£1,618,902	498	376	Packages	No
18	Workforce	Workforce recruitment and retention		ICB Discharge Funding	£155,682	£79,586		3	WTE's gained	No
17	Residential Placements	Residential Placements	Care home	Additional LA Contribution	£580,000	£243,336	145	68	Number of beds/placements	No
18	Workforce	Workforce recruitment and retention		Additional LA Contribution	£680	£0		0	WTE's gained	No
1	Telecare and Assistive technology	Assistive Technologies and Equipment	Assistive technologies including telecare	iBCF	£448,000	£333,676	3,000	2,250	Number of beneficiaries	No
17	Demographic and care cost pressures	Residential Placements	Care home	iBCF	£5,065,165	£3,798,874	113	113	Number of beds/placements	No
8	Domiciliary Care	Home Care or Domiciliary Care	Domiciliary care packages	iBCF	£4,339,868	£3,254,901	219,000	164,250	Hours of care (Unless short-term in which case it is packages)	No
5	Disabled Facilities Grants	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£2,558,938	£2,130,379	352	245	Number of adaptations funded/people supported	No
3	Carers Support Services (CCG Contract)	Carers Services	Respite services	Minimum NHS Contribution	£381,089	£293,398	65,000	27,610	Beneficiaries	No
4	Intermediate Care Teams (ICT)	Home-based intermediate care services	Rehabilitation at home (to support discharge)	Minimum NHS Contribution	£5,093,930	£3,906,764	1,472	1469	Packages	No

1	Community Equipment (Health)	Assistive Technologies and Equipment	Community based equipment	Minimum NHS Contribution	£1,048,042	£1,314,476	9,020	8946	Number of beneficiaries	No
19	Residential Short Breaks	Residential Placements	Short term residential care (without	Minimum NHS Contribution	£469,426	£358,018	75	70	Number of beds/placements	No
3	Carers Support Services WNC Contract	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£424,508	£318,381	570	1,463	Beneficiaries	No
11	Specialist Care Centres (SCC) Step and Step Down	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with rehabilitation	Minimum NHS Contribution	£3,065,168	£2,451,442	328	175	Number of placements	No
12	Community Reablement Team	Home-based intermediate care services	Rehabilitation at home (to support discharge)	Minimum NHS Contribution	£3,408,926	£2,556,695	1,512	1,153	Packages	No
12	Community Occupational Therapy	Home-based intermediate care services	Reablement at home (to support discharge)	Minimum NHS Contribution	£1,138,110	£853,583	2,250	2,234	Packages	No
1	Community Equipment (Social Care)	Assistive Technologies and Equipment	Community based equipment	Additional LA Contribution	£1,447,731	£714,317	8,940	8467	Number of beneficiaries	No
11	Bed Based	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Additional NHS Contribution	£2,000,000	£1,509,000	106	57	Number of placements	No

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