WEST NORTHANTS
Health and Wellbeing Board
live your best life

# West Northamptonshire Health and Wellbeing Board

**A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Council Chamber, The Forum. Moat Lane, Towcester, NN12 6AF on Thursday 25 May 2023 at 1.00 pm**

## Agenda

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| **1.** | **Apologies for Absence and Notification of Substitute Members** |
| **2.** | **Notification of Requests to Address the Meeting**<br>The Chairman to advise whether any requests have been received to address the meeting. |
| **3.** | **Declarations of Interest**<br>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**<br>To receive communications from the Chair. |
| **5.** | **Minutes & Record of Decisions - Chair** (Pages 5 - 20)<br>To confirm the minutes and record of decisions from the previous Board meeting 23rd March |
| **6.** | **Action Log - Chair** (Pages 21 - 22)<br>Review outstanding actions |
| **7.** | **Progress update on the NHS Northamptonshire 5 Year Forward Plan - Karen Spellman** (Presentation) |

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| **8.** | **Director of Public Health Annual Report - Sally Burns** (Pages 23 - 42) |
| **9.** | **Better Care Fund End of Year Report 2022/2023 - Ashley Leduc** (Pages 43 - 90) |
| **10.** | **Integrated Care System PLACE development** (Pages 91 - 120)<br>• Joint Local Health and Wellbeing Strategy Update – Sally Burns<br>• Local Area Partnerships emerging priorities – Julie Curtis (presentation) |
| **11.** | **Live your best life domains: 'Thriving Childhood' and 'Access to the best available education and learning'** (Presentations)<br>• Children and Young Peoples Needs Assessment - Sally Burns<br>• West Northamptonshire Youth Services Peer Review – Stuart Lackenby<br>• N4 Local Area Partnership Education Subgroup – Ben Pearson<br>• Co-production Charter – Ben Pearson<br>• Emerging SEND Strategy – Ben Pearson<br>• West Northamptonshire Corporate Parenting Board - Rebecca Wilshire |
| **12.** | **Voluntary Sector Spotlight - Lowdown** (Verbal) |
| **13.** | **Any Other Business - Chair** |
| **14.** | **Close the meeting** |

Catherine Whitehead
Proper Officer
17 May 2023

**West Northamptonshire Health and Wellbeing Board Members:**

Councillor Matt Golby (Chair)

Sally Burns
Councillor Jonathan Nunn
Anna Earnshaw
Colin Foster
Stuart Lackenby
Toby Sanders
Councillor Fiona Baker
Dr Jonathan Cox
Naomi Eisenstadt
Assistant Chief Fire Officer Dr Shaun Hallam
Russell Rolph
Colin Smith

Neelam Aggarwal
Dr Andy Rathbone
Professor Jacqueline Parkes
Nicci Marzec
Dr David Smart
Superintendent Rachel Handford
Heidi Smoult
Michael Jones
Councillor Wendy Randall
Wendy Patel
Dr Philip Stevens
Dr Santiago Dargallonieto
David Maher

## Information about this Agenda

**Apologies for Absence**
Apologies for absence and the appointment of substitute Members should be notified to democraticservices@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

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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:

Tel: 0300 126 3000
Email: Cheryl.Bird@northnorthants.gov.uk

Or by writing to:

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One Angel Square
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Northampton
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**WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD**
**Minutes of the meeting held on 23rd March 2023 at 1.00 pm**
**Venue: Council Chamber, The Forum, Towcester**

Present:

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| Councillor Matthew Golby (Chair) | Cabinet Member for Adults, Health and Wellbeing, West Northamptonshire Council |
| Cllr Fiona Baker, | Cabinet Member, Childrens and Families, West Northants Council |
| Sally Burns | Interim Director of Public Health, West Northants Council |
| Anna Earnshaw | Chief Executive, West Northants Council |
| Naomi Eisenstadt | Chair, NHS Northamptonshire Integrated Care Board |
| Chief Superintendent Rachael Handford | Northamptonshire Police |
| Michael Jones | Divisional Director, EMAS |
| Jean Knight | Chief Operating Officer, Northamptonshire Healthcare Foundation Trust |
| Stuart Lackenby | Executive Director for People Services, West Northants Council |
| Cllr Jonathan Nunn, | Leader, West Northants Council |
| Professor Jacqueline Parkes | Professor in Applied Mental Health, University of Northampton |
| Cllr Wendy Randall | Opposition Leader, West Northants Council |
| Dr David Smart, | Chair Northampton Health and Wellbeing Forum |
| Heidi Smoult | Chief Executive, Northampton General Hospital |
| Dr Phillip Stevens | GP, Chair Daventry and South Northants GP Locality |
| Colin Smith | Chief Executive, LMC |

Also, Present

Cheryl Bird, Health and Wellbeing Board Business Manager
Julie Curtis – Via Teams, Assistant Director PLACE Development, West Northants Council
Rhosyn Harris, Consultant in Public Health, West Northamptonshire Council
Victoria Rockall via Teams, Head of Community Safety, West Northamptonshire Council
Steve Carroll, Service Director, BRIDGE
Miranda Wixon, Chair, VCSE Assembly
Sarah Bailey, Senior Criminal Justice Worker, Bridge

## 12/23 Apologies

Dr Andy Rathborne, Primary Care Network
Neelam Aggarwal-Singh, BAME representative
Colin Foster, Chief Executive, Northamptonshire Childrens Trust
Dr Shaun Hallam, Assistant Chief Fire Officer, Northants Fire and Rescue
Wendy Patel, Healthwatch Northamptonshire
Dr Santiago Dargallonieto, Chair, Northampton GP Locality
Nicci Marzec Director of Prevention, Office of Police, Fire and Crime Commissioner

## 13/23 Notification of requests from members of the public to address the meeting

None received.

## 14/23 Declaration of members' interests

None received.

## 15/23 Chairs Announcements

We are deeply shocked and saddened by the fatal incident in Kingsthorpe and our thoughts and condolences go out to the victim's family, friends and all those affected by this terrible tragedy. We are liaising with Northamptonshire Police, who are leading the investigation, and arranging support for those affected by the incident. We realise the profound impact that this tragic event will have on the local community, its schools and colleges and we are putting in place a package of measures to support them.

The Chief Operating Officer, Northamptonshire Healthcare Foundation Trust will be leaving her current role at the end of March. The Chair thanked Jean on behalf of the Board for all her work.

## 16/23 Minutes from the Previous meeting 23rd March 2023

**RESOLVED that the minutes from the previous meetings held on the 23rd March were agreed as an accurate record.**

## 17/23 Action Log

The Board reviewed the actions from the previous meeting:

- Ashley Tuckley and Stuart Lackenby to discuss a targeted workshop where representatives from Northants Police with some Board members consider what the next iteration of Community One would be. **Awaiting meeting date.**
- More information is to be circulated to the Board about off rolling. **Awaiting information from Ben Pearson.**
- Colin Foster to attend a Daventry and South Northants GP Locality safeguarding meeting. **Original meeting date postponed, awaiting confirmation of a new date.**
- **An update on the joint Health and Wellbeing Strategy will be brought to the next meeting.** On the agenda for discussion.

18/23 Community Safety Strategy

The Head of Community Safety gave the Board an overview of the West Northants Community Safety Partnership Strategy and highlighted the following:

- The West Northants Community Safety Partnership Strategy aligns with the Integrated Care Northamptonshire ambitions 'people feel safe in their own homes' and 'feeling valued for who they are'.
- The West Northamptonshire Community Safety Partnership (CSP) is an statutory partnership and had its inaugural meeting in April 2021. The CSP is tasked with creating a strategic assessment, strategy and action plan on how they plan to reduce crime and disorder, as well as anti-social behaviour (ASB).
- The structure of the CSP strategy will be launched on the 1st April 2023 an will be supported by performance data, updated on a quarterly basis to ensure the strategy is intelligence led.
- There will be a monthly CSP e-bulletin hosted on West Northamptonshire Council (WNC) website to ensure communities, partners and VCSE can receive regular updates.
- Strategic needs assessments will be used to formulate priorities.
- The current strategic priorities and agreed outcomes for the CSP include:
  1. **Work with our communities to ensure our neighbourhoods are safe spaces for everyone**
     - Support and influence the place-based approaches to our priority neighbourhoods and vulnerable locations.
     - Increased partnership outreach promoting wellbeing and safety in our communities
     - Environmental improvements that design out crime will be delivered.
     - Focus on early intervention and utilise the powers and legislation available to us as a partnership to reduce incidents of anti-social behaviour, youth violence, exploitation, and serious organised crime leading to improved victim satisfaction.
     - Improved awareness and reporting for hate crime.
     - Our protected and seldom heard communities engaged, ensuring a sense of belonging and improved community cohesion.
     - Safer Roads for use by all through supporting communities in the implementation of localised interventions.
  2. **Target those causing the greatest harm, tackling the causes of crime through prevention and early intervention**
     - Increased Early Intervention and Youth Offer - Diverting young people from opportunities to commit crime.
     - Improved education and awareness amongst young people in relation to online abuse, gangs, knife crime, criminal and sexual exploitation and hate crime.
     - improved understanding across the partnership of Serious Organised Crime and gang related activity.
  3. **Reduce incidents of serious violence including domestic abuse, sexual offences and knife crime.**
     - Reduce the number of high risk victims and offenders through referral, education and prosecution.
     - The Serious Violence duty will be delivered, including the development of a strategic needs assessment, strategy and action plan.
     - The Domestic Abuse Strategy and action plan will be delivered.
     - Improved public confidence in reporting violence, particularly for those disproportionally affected, i.e. women and girls.
     - Identify and target organised crime groups that cause harm to our communities by disrupting and dismantling them and bringing offenders to justice
  4. **Protecting vulnerable people, safeguarding those at risk of exploitation**

  - Develop and embed contextual safeguarding to ensure victims and their families get the right support when they need it most
  - Dismantled drug supply chains and effective treatment and recovery services through the delivery of the 10 year drug strategy, working closely with the Combatting Drugs Partnership.
  - Reduced opportunity for violent extremism through the delivery of the Prevent and Protect duties
- A governance structure has been mapped to the identified priorities and outcomes.
  - A Domestic Abuse Board delivers the Domestic Abuse Strategy.
  - The Serious Violence and Vulnerability Board looks at the structure and uses existing mechanisms to deliver this work.
  - There is a Serious Inquisitive and Rural Crime group.
  - Community One and series of neighbourhood working groups are aligned to the Local Area Partnerships.
  - The West Northants Anti Poverty Strategy is delivered through neighbourhood working.
  - Combatting Drugs Partnership and Youth Provision Board.
  - Case management meetings around individuals victims and offenders and is underpinned by community engagement networks and groups.
- A performance framework is in the process of being developed which aligns to the strategic priorities and Live Your Best Life outcomes framework.

The Board discussed the update and the following was noted:

- The Director of Communities and Opportunities chairs the CSP Board, and at the meeting held in February the new priorities and outcomes were approved.
- The CSP Board has the overarching responsibility of collaboration between key partners.
- The CSP Board uses key performance indicators that can demonstrate how effective the partnership is and the difference they are achieving and a performance report will be provided for scrutiny on a annual basis by this Board and WNC Full Council
- The CSP strategy is countywide and the LAPs will be a key element of neighbourhood working.
- Early intervention and prevention is important in rural areas as well as urban areas.
- The Sure Start Centres provided a secure place for women to report domestic violence. The WNC Communities Team has a Domestic Abuse and Sexual Violence Coordinator who is liaising with partners on progress against the violence against women and girls agenda.
- The Warm Welcoming Spaces provide opportunities to deliver community safety outcomes.
- Youth provision and youth offer in communities are needed as part of the early intervention and prevention.

**RESOLVED that:**

- **Jacqueline Parkes will liaise with Vicki Rockall around the work University of Northampton are completing around the Live Your Best Life ambitions.**
- **The Board noted the report and were assured that West Northants Community Safety Partnership are delivering against two of the Live Your Best Life ambitions; 'that people feel safe in their homes and when out and about' and 'that our communities are accepted and valued simply for who they are'.**

## 19/23 Combatting Drugs Partnership Needs Assessment

The Consultant in Public Health provided an overview of the Combatting Drugs Partnership (CDP) Needs Assessment and highlighted the following:

- As part of the National Drugs Strategy it is a statutory requirement for all local areas to set up a multi-agency partnership to tackle drugs and alcohol misuse, this partnership must oversee completion of a Drugs and Alcohol Needs Assessment and have a Combatting Drugs Strategy in place by end of March 2023.
- In Northamptonshire a Substance Misuse Needs Assessment was undertaken in 2022 and consisted of 4 workstreams:
  - **Quantitative**
  1. Analysis of local and national routine datasets and reports
  2. Northamptonshire Police Drugs Supply Report
  - **Qualitative**

  3. Harm reduction - system mapping completed by the University of Manchester

  4. Service users focus groups and 1:1 interviews – led by people with lived experiences of drug and alcohol misuse.
- Workstream 1 - Key findings during the analysis of routine data for children and young people:
  - **Alcohol -** Nationally, alcohol consumption in children and young people has been declining. Young people aged 16-24 have the lowest level of consumption of any age group, however, this age group is the most likely to binge drink. Northamptonshire schools survey of Year 8 and 10 pupils in 2022 reported 40% of children said they drink alcohol (more than just a sip). This has been a decrease since 2019, where the proportion was 45%. Locally, hospital admissions in <18's specific to alcohol have declined over the last decade. Admission rates in both North and West Northamptonshire are similar to the national average, with ¾ of hospital admissions being girls.
  - **Drugs -** Nationally, young adults have the highest rates of drug consumption of any age group. 1 in 5 adults aged 16-24 reported drug use in the last year (till June 2022). Since 2013 the overall drug use has been increasing in young people aged 16-24.
    - The Northamptonshire schools survey of Year 8 and 10 children in 2022 reported 7% of Year 10 pupils said that they have used cannabis, 2% of boys and 1% of girls in Year 10 have used solvents as drugs.
    - Hospital admissions due to substance misuse in Northamptonshire are significantly higher than England in 15-24 year old, with ¾ of admissions being young women.
    - There are approximately 100 young people in drugs alcohol treatment services, 2/3 being male with the peak age of 14-15 years.
      Nationally 8% of young people drug and alcohol treatment service is under 18, this is compared to 30% in Northamptonshire is and significant driver around exploitation and county lines crimes. In 2020-21, the main vulnerabilities in young people entering substance misuse treatment in Northamptonshire are detailed below.
      - anti-social behaviour (13%)
      - self-harm (14%),
      - domestic abuse (15%),
      - impact of other's substance misuse (26%).
      - NEETs (8%)
    - Mental health treatment needs at the time of entering young people's treatment services are high – 62% in Northamptonshire, slightly lower than 67% England.
    - Children with substance misuse tend have intergenerational substance misuse behaviour and the Family Link Service are hoping to work with the CPD to break this cycle.
    - Outcomes in 2020-21 were similar to **England rate** 81% of exits recorded as successful completion, with no representations within 6 months, with time in treatment slightly longer than the England average.

- There has been an increase in recent years of those young people in treatment having extremely complex and high risk substance misuse requiring significant multi agency work.

- Workstream 1 - Key findings during the analysis of routine data for adults. We are reaching approximately 540% of opiate users and only 20% of alcohol users. A key priority is getting more adults into treatment services.
  - **Alcohol -** Nationally, there has been a downward trend in the proportion of adults who drink. Rates were highest in more affluent households, men and those aged 55 to 64. Locally, an estimated 7,000 adults in Northamptonshire are dependent on alcohol and potentially in need of specialist treatment.
  - Around 21% of adults in Northamptonshire drink more than the recommended 14 units per week, similar to the England average of 22.8%. Fewer people abstain from drinking – 12.9% in Northamptonshire compared to 16.2% in England.
  - There are different ways of measuring deaths from alcohol, deaths can either be related or specific, with little change in the death rate from alcohol in either the North or West in recent years. Nationally, deaths from alcohol increased during the pandemic, with those already drinking high levels increasing their consumption, mainly occurring in men (65%).
  - Drugs - In line with national trends, the death rate from drug misuse has risen in Northamptonshire over the last decade. In the 3 years (2019-22), there were 134 deaths from drug misuse and understanding death data is a key action for the CDP :
    - Most deaths are in men (71%)
    - Average age: 44.3 years in men and 41.3 women
    - Concentrated in Northampton, Kettering and Corby
    - Deaths are concentrated in the most deprived areas.
  - In 2020-21, 3,165 adults were in treatment for substance misuse and 1,590 were new presentations in Northamptonshire. The adult drug treatment rate is lower than England but higher to similar areas (CIPFA).
  - Cohort of service users is ageing, fewer young people are entering the service and more over 50's. Age, sex, LGBT and religious profile mirror the national average.
  - Low rate access for disabilities - 18% locally compared to 28% in England and few ethnic minorities
  - Most treatment outcomes are comparable or better than England with the exception of successful completion of treatment for alcohol and the drop-out rate where outcomes are worse.
  - Substance misuse has a considerable impact on the use of NHS services. In the last year in Northamptonshire (Aug 21 – Jul 22) substance misuse was involved in
    - 20k attendances at urgent care
    - This involved around 6.4k individuals
    - 3.5k hospital admissions
    - Cost of urgent care was £3million

    Many urgent care attendances are related to injuries, 56% are accidental, 1 in 4 involving self harm and a further 15% are assaults. Hospital Admissions peak in in those aged 50-54.
- 87% of adults completing drug treatment and 89% completing alcohol treatment reported they no longer had a housing need in 2020-21. Comparable with England.
- Although most leave treatment without employment, in 2020-21, adults who are unemployed are 59% planned exit for drugs and 62% for alcohol
- In 2020-21, Northamptonshire had lower rates of completion of Hepatitis B vaccination, lower levels of acceptance for Hepatitis C vaccination, and a lower proportion of eligible adults provided with naloxone. Local data show that these figures improved considerably in 2022.
- Workstream 3 Harm Reduction System mapping

- Work was carried out by researchers at the University of Bath and Manchester Metropolitan University on behalf of Change Grow Live and the Public Health teams in North and West Northamptonshire Councils.
- Over two days of workshops with around 70 local stakeholders from a wide range of organisations in July and August 2022, the researchers facilitated sessions based on methods to understand complex systems to help understand harm reduction in the county and to identify opportunities to improve delivery.
- The output of the workshops were a stakeholder map and identification of factors affecting harm reduction delivery.
- Approximately 50 stakeholders reviewed these outputs and participated in the discussions to identify opportunities. These opportunities for improvement were grouped into themes.

- Workstream 4 – service users focus groups and 1:1 interviews
  - In 2022, the Northamptonshire Public Health teams commissioned a qualitative study to understand the views of adult services users in substance misuse treatment, those in recovery, and family and unpaid carers
  - The study looked at the needs of young adults and identified themes related to children but not include focus groups with interviews with children (under 18).
  - A total of 86 people took part in study, attending either focus groups or 1-2-1 semi-structured interviews conducted over 4 days. The interviews and focus groups were held in different geographical areas – Corby, Kettering, Northamptonshire and Wellingborough.
  - The themes explore were Harm reduction; Structured treatment ; Key workers and staff; Treatment and care planning; Safety and wellbeing; Joining up treatment with other services; Gaps in services and suggestions.
  - All those attending focus groups and interviews were asked to complete a consent form and provide demographic and characteristics information.
- Recommendations
  - Increasing intelligence in breaking drug routes and understanding vulnerable people to avoid exploitation and intelligence around night-time economy.
  - Get more people into treatment and reduce dropouts need to look at complexity of cases, ensure enough staff and ensure continuity of care, with people are aware of options and services appropriate to age groups and needs.
  - Ensure services are taking a psychologically informed environmentally informed approach.
  - Funding resources and reducing large caseloads would result in fewer dropouts.
  - Equity of harm reduction provisions and equity of access geographical for hard-to-reach groups.
  - Continue to strengthen the harm reduction offer provided by specialist treatment services, and knowledge of harm-reduction in other organisations.
  - Improve the treatment of those with both mental ill health and substance misuse.
  - Increase the capacity of specialist treatment and recovery services, addressing the increasing complexity of cases.
  - Improve the promotion and branding of treatment services to make them more visible and acceptable to those in need. Develop clear referral pathways for professionals.
  - Break the generational cycle by engaging with the whole family and community settings.
- The government has recognised better resource is needed for workforce retention and has provided a supplementary substance misuse treatment and recovery grant of £1 million for the county. This grant must be used to increase adult and child treatment workers, recovery workers and understand the gaps in treatments services.

The Board discussed the update and the following was noted:

- There are a large number of children in unrelated placements.

- The voluntary sector provide services for child substance misuse but these are not always known to children's services. Work is needed on how to join up services so organisations know where to signpost vulnerable children to.
- There will be a meeting with CAMHs, NHFT and children's services to discuss mapping a multi agency service pathway for children.
- A further multi agency workshop will be set up to try and identify ways of preventing children using substance misuse.
- The University of Northampton has a centre for health social sciences with a young person's theme.
- Substance and alcohol misuse tends to link with poor mental health, needing an integrated service and person centred approach is needed. Dual diagnosis and having a clear pathway is one of priority recommendations.
- There is a need to look at what additional community support is available to support people to build wholesome communities.
- The cost of living crisis has had a negative impact on residents mental health.
- Training should be given to staff in A&E departments to recognise the signs of potential triggers for substance/alcohol misuse.

**RESOLVED that.**
- **The need assessment action plan to be brought to the next meeting.**
- **A breakdown of the £1 million grant to be brought to the next meeting.**

20/23 Voluntary Sector Spotlight

The Service Director from Bridge gave an overview of their service and highlighted the following:
- BRIDGE is mainly based in Northampton, but also offers smaller outreach services based in Wellingborough and Corby.
- BRIDGE is a support service for those in recovery from alcohol and substance misuse. Drug and alcohol misuse treatment is provided by CGL and S2S, who refer people into BRIDGE.
- BRIDGE offers support with outreach workers by looking at why customers are misusing and identifying what are the barriers to accessing support. They also work on different areas affecting a person's recovery, which could involve housing, education, training or employment.
- BRIDGE can offer courses to improve their members self-esteem and confidence, as well as a wide range of therapies and recovery groups. Walking groups are organised to improve members physical and mental health, as well as social events to encourage members to socialise. There is also a litter picking group, self defence group and women only group.
- Members in recovery are encouraged to volunteer to help and support others in their recovery.
- BRIDGE has a working gym and table tennis tables and are currently completing a project with Northampton town football club. There is also a café providing nutritious meals.
- Bridge is a drop in service and use the parts of the service you want. Those in recovery need a good support network. There are currently 850 members across the county see with a daily footfall of between 50-100. Members are currently 2/3 male and 1/3 female.
- BRIDGE have a housing team called Phase with 20 properties across the county, they are semi-independent for those who are homeless or not in suitable housing.

- The police are visible at BRIDGE which is a positive step to break down barriers with members. For those who are offenders, the causes of what led to offending are identified, with the aim to reduce re-offending.
- BRIDGE are on a fixed funding contract so the cost of living crisis has had an impact their services.

The Board discussed the overview and the following was noted:

- The Mental Health Learning Disability and Autism Collaborative is reviewing drug and alcohol misuse as part of their work. NHFT to refer patients to BRIDGE and take referrals from BRIDGE for mental health treatment.
- There can be issues with access to services in the rural areas, BRIDGE is currently not in a financial position to be able to offer services in these areas, but do offer online groups and telephone contacts.

**RESOLVED that the Board noted the work completed by BRIDGE**

21/23 Joint Strategic Needs Assessment

The Consultant in Public Health advised there is a statutory requirement for this Board to publish a Joint Strategic Needs Assessment (JSNA), but there is no clear national guidance on the structure of the JSNA, other than it must be driven by the needs in a local area. There is an existing countywide JSNA process, but it has been recognised there is also a need for a separate West and North Northamptonshire view, with the chapters to be shaped by stakeholders. A steering group will be set up with members from across West And North Northamptonshire councils and NHS Northamptonshire Integrated Care Board to review the JSNA process and bring a proposal back to a future Board meeting on the format and structure of the future JSNA.

**RESOLVED that the Board support:**

**a) Development of a System JSNA for Northamptonshire, ensuring that the intelligence products specific to Place (North and West) are easily found.**
**b) Initiation of a JSNA redesign project to determine the scope of the JSNA in the context of plans for wider intelligence in Northamptonshire. Project to determine the vision for the JSNA, scope, format of the final product, governance and process for ongoing development and review.**
**c) Establishment of a project steering group for the JSNA redesign project to oversee the stakeholder engagement and development of recommendations to Health and Wellbeing Boards.**

22/23 Integrated Care System PLACE Development

The Assistant Director of PLACE gave an update on PLACE development taking place across West Northamptonshire and highlighted the following:

- There are 2 Health and Wellbeing Forums and 9 Local Area Partnerships (LAPs) in West Northamptonshire. Both Forums and the 9 LAPs are operational.
- There is a West Northants Executive Place Delivery board which oversees the operational delivery and has a wide range of stakeholders.
- Partnership engagement is key component of PLACE development, along with reviewing the Local Area Profiles and overlaying these with data from health, Northants Police, EMAS, Northants Fire and Rescue. This will provide evidence on where targeted interventions need to take place to reduce inequalities.
- The LAP has a core leadership team comprising of:

  - Elected members;
  - Local GPs;
  - VCSE;
  - Public Health;
  - WNC Director;
  - Police,
  - Northamptonshire Childrens Trust
- During the inaugural LAP meetings the Local Area Profile was reviewed, during April and May the LAPs will start to develop their priorities for their communities. Once identified these will be presented to the Board.
- Some of the emerging priority themes from across the LAPs are:
  - young families,
  - people feeling unsafe where they live,
  - drugs and crime,
  - online abuse
  - not feeling connected to the local community,
- The N4 LAP has identified priorities for has cardio vascular disease and school exclusions.
- Across the LAPs there is a common theme of young people's poor mental health.

The Board discussed the update and the following was noted:
- The University of Northampton held a Public Health event which looked at issues around the Live Your Best Life ambitions. During this event it was noted the LAPs will provide a good opportunity to evaluate community work.
- The priorities identified the LAPs will be aligned to the Live Your Best Life ambitions and Integrated Care Northamptonshire Outcomes Framework. The Health and Wellbeing Forums will be able to oversee that the priorities identified by the LAPs and ensure they align and deliver against these ambitions.

The Consultant in Public Health provided an overview of progress in developing the Outcomes Framework metrics and highlighted the following:
- The Live Your Best Life ambitions contained within the Integrated Care Northamptonshire strategy are all encompassing so specific priorities are needed to focus on as a system. Some of these will be shared across organisations.
- A prioritisation criteria has been applied to identify measurable metrics for a baselining progress against the priorities, which has produced recommendations for data collections and development of measures.
- Metrics need to be identified to assess children's mental health. A Children and Young Person Needs Assessment is currently being completed which will highlight the areas needed to focus on.
- There are GP representatives on the Strategy Development group working on the metrics.

**RESOLVED that the Board noted the progress.**

<u>23/23 NHS Northamptonshire Joint 5 Year Forward Plan</u>

The Chair of the NHS Northamptonshire Integrated Care Board (ICB) 5 Year Forward Plan and highlighted the following:
- It is a statutory requirement of the ICB and their partner trusts to produce a Joint 5 Year Forward Plan at the start of each financial year. Part of this requirement is that the ICB must consult with the Health and Wellbeing Board HWBB on whether the plan takes into

consideration the Joint Health and Wellbeing Strategy (JWBS). The HWBB must include a statement in the Plan as to whether it takes into consideration the JHWBS.

- The Plan must be informed by the Integrated Care Northamptonshire Strategy and the JSNA.
- There are 4 aims of an Integrated Care System
  - Aim 1 - Improve outcomes in population health and healthcare
  - Aim 2 - Tackle inequalities in outcomes, experience, and access
  - Aim 3 - Enhance productivity and value for money
  - Aim 4 - Help the NHS support broader social and economic development
- Inclusion of wider determinants is key to improving health and wellbeing of the local population as only 20% of work to improve residents health and wellbeing is completed by health partners.
- The Plan will include sections on:
  - What we know about the population of Northamptonshire?
  - What are priorities?
  - How do our programmes of work fit into these priorities?
- There are a large number of national priorities, but not enough resources to deliver against all of these. The ICB has chosen to take the lead on 3 Live Your Best Life ambitions, 'The Best Start in Life', Opportunity to be fit and well' and Access to health and Social Care when you need it'.

**RESOLVED that:**

- **Note that the draft plan is still in development at the time of this Health and Wellbeing Board**
- **Delegate submission of this statement for the ICB 5 Year Forward Plan to the Chair of the Health and Wellbeing Board in consultation with the Director of Public Health and Wellbeing and the Director of People, in order to ensure that required timescales are met.**

<u>24/23 NHS Northamptonshire Integrated Care Board Annual Report</u>

The Chair of NHS Northamptonshire ICB advised it is a statutory requirement of ICBs to produce an annual report. ICB's must outline in the report how they have contributed to the delivery of the JHWBS and must consult with HWBBs when preparing the Report. The draft Annual Report is still in progress.

**RESOLVED that the Board agreed to delegate consultation on the ICB Annual Report to the Chair in consultation with the Director of People and Director of Public Health to ensure timelines are met.**

There being no further business the meeting closed at 3.30 pm.

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**WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD**

**RECORD OF DECISION**

| | |
|---|---|
| Date Of Decision: | 23rd March 2023 |
| Title: | NHS Northamptonshire Integrated Care Board 5 Year Forward Plan |
| Is this a "Key Decision"? | Yes |
| Purpose: | The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards and their partner trusts (the ICB's partner NHS trusts and foundation trusts are named in its constitution) to prepare their 5 Year Joint Forward Plan (JFP) before the start of each financial year.<br><br>This guidance sets out a flexible framework for JFPs to build on existing system and place strategies and plans, in line with the principle of subsidiarity. It also states specific statutory requirements that plans must meet.<br><br>Part of these statutory duties are:<br>• ICBs must pay due regard to Joint Health and Wellbeing Strategies when developing their Joint Forward Plan.<br>• ICBs must consult with Health and Wellbeing Boards on whether their Joint Forward Plan takes into consideration the Joint Health and Wellbeing Strategy.<br>• Health and Wellbeing Boards must submit a statement to be included in the Joint Forward Plan as to whether it's the plan takes into consideration the Joint Health and wellbeing Strategy. |
| Board Member: | Naomi Eisenstadt |
| Decision Maker: | All Board members present. |
| Consultation and Scrutiny: | NHS Northamptonshire Integrated Care Board (ICB) has consulted with the Director of People and Director of Public Health during development of the 5 Year Forward Plan.<br><br>The Chair of the Health and Wellbeing Board, Director of People and Director of Public Health are satisfied that the 5 Year Joint Forward Plan aligns and pays due regard to the emerging Joint Health and Wellbeing Strategy.<br><br>The ICB Board oversees development and signs off the 5 Year Joint Forward Plan. The Chief Executive West Northants Council is a member of the ICB Board and also a member of the Health and Wellbeing Board. |
| Board Member Recommendations: | Delegate submission of required statement for the ICB 5 Year Joint Forward Plan to the Chair of the Health and Wellbeing Board in consultation with the Director of Public Health and Wellbeing and the Director of People. |
| Decision Taken: | The Board agreed for delegated authority to be given to the Chair. |

| | |
|---|---|
| Reasons For Decision: | The 5 Year Joint Forward Plan is still in development at the time of the Health and Wellbeing Board meeting. Delegated authority to the Chair has been requested to ensure statutory timelines are met. |
| Alternative Options Considered (Including Reasons For Rejection): | Delegated authority not to be given and the Health and Wellbeing Board are presented with the draft 5 Year Joint Forward Plan for consultation at a future meeting. This would result in the national timeline for submission not being met. |
| Declarations of interest: | None |

Authorised By the Chair/Director of People/Director of Public Health:

Name: .Cllr Matt Golby……

Signature: ……  ……

Date: ……16/05/2023……..…

Name: .. Stuart Lackenby……

Signature:  ……

Date: …16/05/2023 ……..…

Name: .. …Sally Burns……

Signature:  ……

Date: …16/05/2023 ……

WEST NORTHANTS Health and Wellbeing Board live your best life

**WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD**

**RECORD OF DECISION**

| | |
|---|---|
| Date Of Decision: | 23rd March 2023 |
| Title: | NHS Northamptonshire Integrated Care Board Annual Report 2022/2023 |
| Is this a "Key Decision"? | Yes |
| Purpose: | The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards submit an annual report.<br><br>This guidance states that Integrated Care Boards must consult with Health and Wellbeing Boards about whether when exercising its duties the Integrated Care Board has contributed to the Joint Health and Wellbeing Strategy. |
| Board Member: | Naomi Eisenstadt |
| Decision Maker: | All Board members present. |
| Consultation and Scrutiny: | NHS Northamptonshire Integrated Care Board (ICB) has consulted with the Director of People and Director of Public Health during development of their Annual Report 2022/2023<br><br>The Chair of the Health and Wellbeing Board, Director of People and Director of Public Health are satisfied that the Annual Report pays due regard to the emerging Joint Health and Wellbeing Strategy.<br><br>The ICB Board signs off their Annual Report. The Chief Executive West Northants Council is a member of the ICB Board and also a member of the Health and Wellbeing Board. |
| Board Member Recommendations: | Delegate reviewing on whether the ICB Annual Report has contributed to the emerging Joint Health and Wellbeing Strategy to the Chair of the Health and Wellbeing Board in consultation with the Director of Public Health and Wellbeing and the Director of People. |
| Decision Taken: | The Board agreed for delegated authority to be given to the Chair. |
| Reasons For Decision: | The Annual Report is still in development at the time of the Health and Wellbeing Board meeting. Delegated authority to the Chair has been requested to ensure statutory timelines are met. |
| Alternative Options Considered (Including Reasons For Rejection): | Delegated authority not to be given and the Health and Wellbeing Board are presented with the draft Annual Report for consultation at a future meeting. This would result in the national timeline for submission not being met. |
| Declarations of interest: | None |

Authorised By the Chair/Director of People/Director of Public Health:

Name: .Cllr Matt Golby…….

Signature: 

Date: ……16/05/23……

Name: .. Stuart Lackenby……

Signature: 

Date: ……16/05/23……

Name: .. …Sally Burns……

Signature: 

Date: ……16/05/23……

**West Northamptonshire Health and Wellbeing Board Action Log**

| Action No | Action Point | Allocated to | Progress | Status of Action |
|---|---|---|---|---|
| 151122/05 | More information is to be circulated to the Board about off rolling | Ben Pearson | | |
| 230323/02 | Combatting Drugs Partnership action plan and breakdown of grant to come to the next meeting. | Rhosyn Harris | Information to be circulated. | |

**Actions completed since the 23rd March 2023**

| Action No | Action Point | Allocated to | Progress | Status of Action |
|---|---|---|---|---|
| 230323/01 | Slides presented at the meeting to be circulated to the Board. | Cheryl Bird | | Completed |
| 230323/03 | Jacqueline Parkes will liaise with Vicki Rockall around the work University of Northampton are completing around the Live Your Best Life ambitions. | Jacqueline Parkes/ Vicki Rockall | | Completed |

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WEST NORTHANTS Health and Wellbeing Board
live your best life

**Item no: 08**

# WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

## 25th May 2022

| | |
|---|---|
| **Report Title** | **Director of Public Health Annual Report 2022** |
| **Report Author** | **Sally Burns, Director of Public Health, West Northants Council** |

**List of Appendices**

**Appendix 1 – DPH Annual Report 2022**

**Appendix 2 - Accompanying 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 DPH Annual Report for 2022 explores how the cost of living crisis currently being experienced nationally within the UK, has affected the health of residents of West Northamptonshire. This year the Annual Report is presented as both a physical report but also with a series of video clips to complement it.

2.2 The report sets out the evidence that links different aspects of poverty with health consequences, as well as the level of need across West Northamptonshire – showing our continued focus in delivering our Anti-Poverty Strategy for residents. Within the accompanying video we have also taken the opportunity to highlight some of the amazing projects such as Warm, Welcoming Spaces, Food Larders and Employment, Money and Debt Advice that have already been delivered

in partnership with the public sector, community voluntary sector and wider organisations as part of our Anti- Poverty Strategy work.

## 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 with regard to 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 DPH must decide on a topic that the annual report will cover in that period.

5.2 This year, due to the impact of the cost of living crisis and the emerging consequences that this has had on all areas of society, but in particular, for the poorer communities that already experience a plethora of health inequalities, it felt appropriate to explore the cost of living crisis and how this and other wider determinants of health, affect health outcomes for people.

5.3 West Northants Council has focussed its efforts in developing the Anti-Poverty Strategy and in turn, we have invested a proportion of our public health reserve into projects which support residents during this challenging time and will reduce the adverse impact on their health and wellbeing. It therefore felt timely to focus this annual report on the work that is being done to tackle poverty by showcasing the exemplary work being carried out and to highlight areas of continued development or areas of focus.

## 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

7.1 DPH Annual Report 2020-22

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# DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2022

## PUBLIC HEALTH EFFECTS OF THE COST OF LIVING CRISIS

West Northamptonshire Council

Wellbeing WEST NORTHANTS

# FOREWORD

COST OF LIVING SUPPORT

Welcome to this year's Director of Public Health (DPH) Annual Report. West Northamptonshire Council has strengthened its commitment towards helping people live their best lives by adopting a fresh approach towards tackling poverty and deprivation, as set out in our Anti-Poverty Strategy.

This Annual Report strengthens the case for action, documenting the challenges that still face our residents and identifying actions we need to take, not just as a local authority, but as a whole health and care system. In the video showcase that accompanies this report, highlights the many brilliant projects and examples of partnership working that are already underway to help prevent and mitigate against the effects of poverty across West Northants.

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

I'm very pleased to introduce this first Director of Public Health (DPH) Annual Report for West Northamptonshire. The last DPH Annual Report was for the whole of Northamptonshire and focused on the work of the previous two years that addressed the biggest public health emergency in generations – the COVID-19 pandemic. In the last year we have been facing a second major threat to health and wellbeing in the form of a cost-of-living crisis.

The drivers and impacts of health inequalities were made even more clear through the pandemic. We have seen the positive impact that good work, education and warm and secure housing has on our physical and mental health. We have also seen those with low incomes being most vulnerable to losing one or more of these key determinants of health.

This report sets out the evidence that links different aspects of poverty with health consequences, as well as the level of need across West Northamptonshire – showing our continued focus in delivering our Anti-Poverty Strategy for residents.

We have also taken the opportunity to highlight just some of the amazing projects that have already been delivered in partnership with public sector, community voluntary sector and wider organisations as part of our Anti- Poverty Strategy work.

I'd like to extend my heartfelt thanks to all of the groups who have worked so closely on this agenda in recent years. Only a very small selection of examples were able to be included in this report, but we do encourage readers to find wider information on our anti-poverty projects published regularly as Health and Wellbeing Board updates.

In the accompanying videos we show just some of the local work already undertaken to deliver the strategy. We hope this will further galvanise the system to deliver even better health and wellbeing outcomes for our residents.

**Sally Burns,**
Director of Public Health

# RELATIONSHIP BETWEEN POVERTY AND HEALTH

Poverty means not having enough money to meet basic living needs like food, clothing and warm shelter. This has a direct impact on people's physical health, as well as their mental health due to the stresses and strains of surviving without enough money.

The relationship between poverty and health is complex and works both ways – people who have poorer health are at greater risk of living in poverty.

We know that the longer someone lives in poverty, particularly in childhood, the worse their health outcomes are[1].

In communities where the percentage of households living in poverty is higher, healthy life expectancy is lower. An increase of 1% in the percentage of households living in relative poverty is associated with a 6-month decrease in male healthy life expectancy in that community.[2]

The national economic downturn has meant that the number of people struggling to make ends meet will have increased.

In West Northamptonshire we estimate as of 2019 that around 37,300 people (nearly 1 in 10 of our residents) were living in households receiving less than 60% of the average UK income; including 13% of children and 11% of older people aged over 60[3]. It's important to note that these figures may be falsely reassuring; as costs of goods increase faster than wages increase, we may see more people unable to afford basic goods, but the "relative poverty" numbers may not change.

Data from the 2021 Census found that 33.2% of households in West Northants were deprived on one factor of deprivation being either; education, employment, health or housing compared with 33.5% in England. In addition, 12.1% were deprived on two factors (14.2% England), 2.7% were deprived on three factors (3.7% England), and 0.2% were deprived on all four factors (0.2% England).[4]

1 Timing of poverty in childhood and adolescent health: Evidence from the US and UK - ScienceDirect
2 Relationship between poverty and healthy life expectancy by neighbourhood - The Health Foundation
3 Public health profiles - OHID (phe.org.uk)
4 2021 Census

# WHO IS MOST AT RISK OF LIVING IN POVERTY?

We know that certain groups are more likely than others to be living in poverty; families with children (particularly lone parents), people from certain ethnic minority groups, people with disabilities, people with long term conditions, carers and care leavers, those who are unemployed, those with irregular immigration status (vulnerable migrants) and other socially excluded groups including Gypsy Roma Travellers.[5/6]

**In West Northamptonshire:**

2.4% of people aged over 16 are unemployed which is equivalent to over 8,100 people; ranging from 5.2% unemployment in Northampton town centre to 1% in Clipston, Naseby and Yelvertoft.

The ethnic groups at greatest risk of living in poverty in the UK are Bangladeshi and Black African communities. Only 1.1% of the population of West Northants identify as Bangladeshi and 3.4% as Black African[7].

8.2% (ASP[8]) of the population (around 34,000 people) aged 5 and over provide some level of unpaid care to others weekly, compared to 8.9% (ASP) across England as a whole.

6.6% of households are lone parent households which is equivalent to 11,313 households, as opposed to 6.9% of lone parent households nationally. There has been very little growth compared to 2011.


19.1% of households in West Northamptonshire privately rent, which is almost a fifth of households (20.5% England average) which is a significant increase from 6.5% in 2001.

5.9% of residents (around 25,000) say their life is limited by a long term physical or mental health condition or illness, compared to 7.1% across England.

The Cost of Living Vulnerability Index (CLV Index) is a measure developed by the Centre for Progressive Policy, that seeks to identify parts of England experiencing particular hardship in the current economic climate. The CLV Index includes six indicators: fuel poverty, food insecurity, child poverty, claimant count, economic inactivity and low pay. [9] Compared with other local authorities in England, West Northants ranked around the middle in terms of overall cost of living vulnerability. Focusing only on the work-based indicator which includes rates of economic inactivity and low pay – West Northants was ranked 110 out of 307 (1=worst).


5 Anti-poverty strategy (8).pdf
6 Poverty in the UK: statistics - House of Commons Library (parliament.uk)
7 https://assets.website-files.com/61488f992b58e687f1108c7c/61bcc1c736554228b543c603_The%20Colour%20of%20Money%20Report.pdf
8 Age standardised proportion and therefore take into account age structures of different populations
9 Cost of Living Vulnerability Index

# FUEL POVERTY AND COLD HOMES

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TO WATCH THE VIDEO
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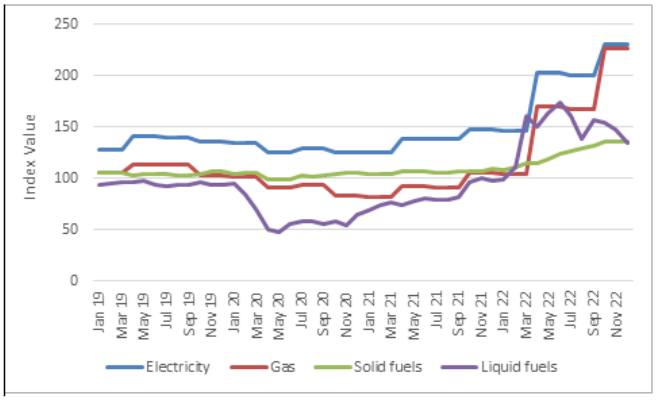
It was estimated that in 2020 approximately 12% of households were living in fuel poverty in West Northants, meaning that around 20,000 households were living in homes with an energy efficiency rating of D or lower and with a disposable income (after housing and fuel costs) that falls below the poverty line. Between January and December 2022, gas prices in the UK increased by 118% in real terms, therefore it is likely that the figure for those experiencing fuel poverty is a significant under-estimate. [10]

Fuel poor households and cold homes are linked to an increased risk of developing a wide range of health conditions, especially respiratory and cardiovascular, as well as poor mental health and unintentional injury[11].

In the winter, there are patterns of higher death rates which are likely linked in large part to the cold, often referred to as "excess winter deaths". In 2019–20 West Northants saw an estimated 210 excess winter deaths[12]. Estimates suggest that 10 per cent of excess winter deaths are directly attributable to fuel poverty[13].

In our most deprived communities, 27% of gross income is spent on housing and power only (July 2022, Source: ONS ), compared with 13% in the least deprived. Those most likely to be living in fuel poverty include; households living in privately rented accommodation (25% are fuel poor); those who are unemployed (37% compared with 13% general population); single parents of dependent children (27% are fuel poor compared with 10% of single people over 60).




**Fuel price indices in the UK (2019-2022)**

Homes that are cold and damp as a result of fuel poverty increase the risk of poor health and specific conditions such as lung and heart disease and in extreme conditions may lead to hypothermia.

## Example projects

The Northampton Whole House Retrofit Project helps tenants living in older homes such as 1920s and 1930s built, that are managed by Northampton Partnership Gomes (NPH). The Council was one of only 17 local authority areas to be awarded demonstrator funding from the Social Housing Decarbonisation Fund (SHDF) for this project.

This project has seen NPH work with leading domestic retrofit organisations to assess each home, taking a 'whole house approach' to understand which measures could make the most impact, such as external wall insulation, solar panels, loft insulation, changes to ventilation and new windows and doors.

All homes had a smart thermostat installed which is fitted with sensors that enable the project team to monitor the impact of these measures on internal air quality, temperature, and humidity levels. The device helps to identify households at risk of fuel poverty and has a clever function that allows NPH to communicate directly with the households.

This project won 'Most innovative retrofit/refurbishment scheme' at the Housing Digital Innovation Awards 2023. The energy efficiency improvements will help to protect households from the worst impacts of rising energy costs, saving them hundreds of pounds per year on heating bills, but will also have a huge impact on emissions - reducing the carbon footprint of the homes by up to 95% in some cases.

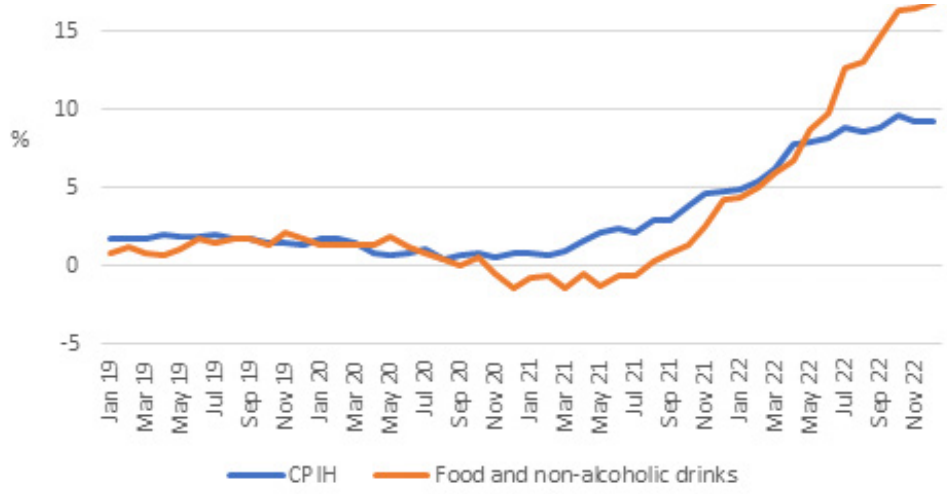
10 Domestic energy price indices
11 read-the-report.pdf (instituteofhealthequity.org)
12 Fingertips
13 read-the-report.pdf (instituteofhealthequity.org)
14 Fingertips

# FOOD INSECURITY

Food security means having access at all times to enough food that is both sufficiently varied and culturally appropriate to sustain an active and healthy life. In 2020/21, 9% of households in the East Midlands – equivalent to around 15,600 households in West Northamptonshire did not have food security[16]; around half of these households will have had members of the family who have missed meals or had to eat less due to a lack of money for food. [17]

The Consumer Prices Index measures the change in average prices paid by consumers for goods and services and from January 2022 to December 2022, it increased by 9.2%. During this time, prices for food and non-alcoholic drinks rose by 16.9%, and the annual rate of inflation for this category has risen for 17 consecutive months. It is suggested that the last time the rate was higher than this was in September 1977, when it was estimated to be 17.6%.[18]. In our most deprived communities, 18% of gross income is spent on food and non-alcoholic drinks, compared with 12% in the least deprived. Family Spending ONS research suggests that even the lowest-priced food items have increased in cost by around 17% over the 12 months to September 2022[19].

Consumer price inflation in the UK (2019-2022)




In 2021/22, 15% of schoolchildren in West Northants were eligible for free school meals (FSM), of which around 13% took up this offer. The proportion eligible for FSM across Northamptonshire has increased from 12% in 2015/16 to 16% in 2021/22, a pattern that follows the national and regional trajectory - though nationally there has been a greater rise in eligibility for FSM[15].

Those who access food banks are a relatively small proportion, compared to those experiencing food insecurity. However, the large increase in food prices in 2022 has had a significant impact with increased demand for emergency food aid. This is evident in West Northants, with an average of 3,600 food aid parcels per week distributed by 29 food aid providers in December 2022. This does not include the additional 2,700 individuals per week (approx) paying for subsidised food from food clubs/community larders.

Food insecurity impacts on health and wellbeing across a person's life, from risk of health problems in new-borns, to links with impaired childhood development, risk of chronic diseases in adulthood and frailty in older age. 12% of deaths in Northamptonshire in 2019 were attributable to poor diets[20]. Importantly, food insecurity means people going hungry, therefore potentially having low intake and low bodyweight, but it can also mean people only being able to afford poor quality processed foods which have high fat/salt/sugar, and can lead to higher rates of obesity.

15 (Source: Free School Meals)
16 Fingertips
17 Family Resources Survey: financial year 2019 to 2020 - GOV.UK (www.gov.uk)
18 (Source:Consumer Price Inflation).
19 Tracking the price of the lowest-cost grocery items, UK, experimental analysis - Office for National Statistics (ons.gov.uk)https://www.ons.gov.uk/peoplepopulationandcommunity/personalandhouseholdfinances/expenditure/datasets/familyspendingworkbook2expenditurebyincome
20. VizHub - GBD Compare (healthdata.org)https://vizhub.healthdata.org/gbd-compare/

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## Example projects

Food Aid Alliance West Northamptonshire (FAAWN) was established in 2020, bringing together a wide variety of food aid providers in the county in the midst of a pandemic. It was built on the success of the Northamptonshire Food Poverty Network, led by Northamptonshire Community Foundation (NCF) since 2005, but since this time the landscape of support has increased and now there are over 30 charities in West Northants alone that support people in financial hardship through the provision of food.

The charities and groups that are represented have a range of approaches to food aid provision including food banks, pantries/community fridges, food waste reduction schemes and food clubs. Although there are different models of delivery, there is a common purpose of intending to provide for those in financial hardship, and help them move towards greater financial stability.

FAAWN was established with the focus to bring together all food aid providers to work collaboratively, share good practice and training opportunities, share surplus resources and support with deficit and funding. The group meet together quarterly, and are governed by a Memorandum of Understanding which was agreed by FAAWN members in March 2023. This includes the process of appointing the FAAWN board and admission to the FAAWN.

The members of FAAWN work closely with other VCSE organisations to ensure that advice and signposting for welfare support is available for all accessing food aid. Many of the organisations provide additional support including life skills such as cooking or growing fruit/veg, budgeting or debt management, mental health and wellbeing support and advice/advocacy services to support with a wide range of socio-economic problems.

This wrap around support offer will only be enhanced by the Community Training Partnership, launching this summer, which will train front-line staff from across statutory and voluntary services in wellbeing and welfare rights issues.

21 https://www.nomisweb.co.uk/reports/lmp/la/1811939769/subreports/einact_time_series/report.aspx?

# GOOD WORK AND INCOME

Having a safe and secure job with good working hours and conditions ("good" work) can positively impact your health; having a purpose, regular social contact and feeling useful are all crucial for our wellbeing, as well as having an income that allows us to secure the material things we need for good health. Broadly, unemployment is a major risk factor for slipping into poverty, however in this current economic climate even working families are struggling to make household budgets stretch.

In Northamptonshire we have generally high rates of employment and low rates of unemployment. 62.9% of people aged over 16 in West Northamptonshire were in employment in 2021; among the top 20% of local authorities for high employment rates. However, despite high rates of employment we also have high rates of low paid employment with 14.7% in "routine occupations" which include HGV drivers, cleaners, porters, packagers, labourer and waiters (among the highest 40% of local authorities). In October 2022, 13.4% of adults aged 16 to 64 claimed Universal Credit in West Northants, which is a benefit that can be claimed for people on a low income or unemployed. In the area, there are also unequal access to jobs – in 2021/22 the employment rate for those with a physical or mental long term health condition (aged 16 to 64) was 7% lower than the overall employment rate.

Recent trends, exacerbated by COVID-19 has seen an increase of those who are of working age stop working and bcome 'econmoically inactive' by either taking retirement, some early retirement, or being unable to work due to long term sickness or caring responsibilities. The economic inactivity rate among adults aged 16-64 in West Northants has consistently been lower than the UK average until the start of the Covid-19 pandemic at which point it has risen similar to the UK average. In the financial year 2021/22, 18.8% of adults (nearly 47,000 people) aged under 65 were economically inactive in West Northants compared to 15.5% pre-pandemic (2018/19).)[21]

The average annual income after housing costs across West Northants is £30,509 (compared with England £28,248), however this ranges significantly across the area. In the Castle, Abington and Phippsville, St George and Dallington Spencer area the average annual income after housing costs is £24,702, compared to Silverstone, Middle Cheney and Brackley which is £36,681.


**Work status of West Northamptonshire Households**

Source: https://www.nomisweb.co.uk

The 2019 Index of Multiple Deprivation (IMD) is the official measure showing how deprived an area is relative to other areas in England[22]. It combines measures on seven different aspects of deprivation - income, employment, education, health and disability, crime, barriers to housing and services and the living environment.

This map focuses on income deprivation across West Northants and shows where neighbourhoods rank in terms of low-income households across England (red = neighbourhoods among the most income deprived 20% in England, dark green = among the least income deprived 20% in England). As shown in the map, in West Northants, the main areas of income deprivation were located around Northampton and Daventry.

21 https://www.nomisweb.co.uk/reports/lmp/la/1811939769/subreports/einact_time_series/report.aspx?
22 https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

# GOOD WORK AND INCOME

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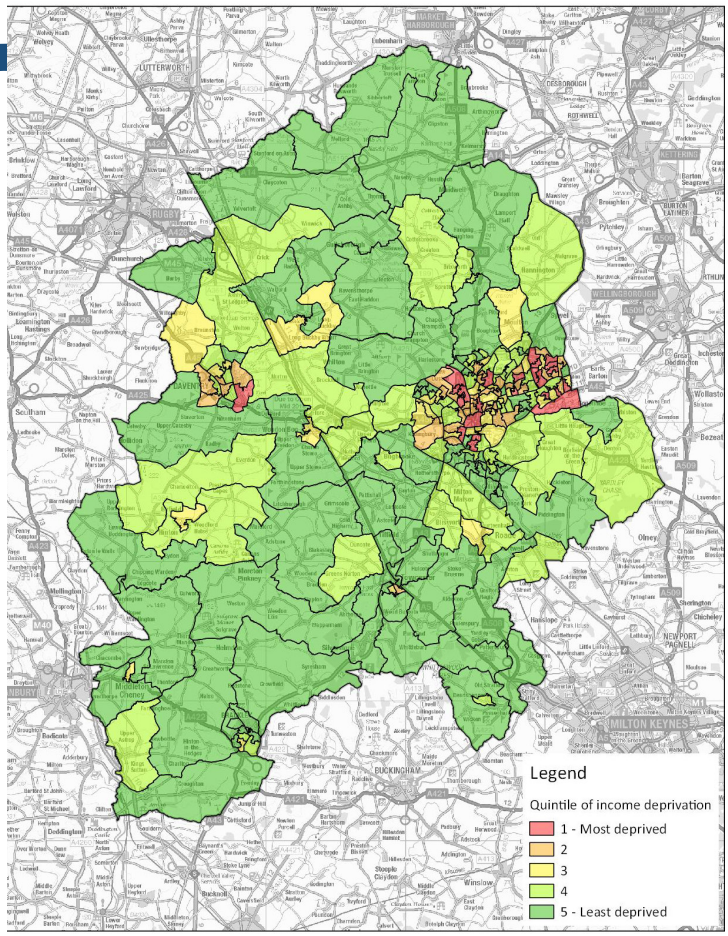
## Example projects

WNCs free Employment Support Service is available to every resident and employer in West Northamptonshire. The service is available to support finding a new job as easy as possible and includes a variety of support, including mental health, training, upskilling, volunteering, searching for suitable roles and transportation issues to name a few.

With the ambition to work with every resident to access the support and training needed to find local employment and enable employers to utilise the skilled local workforce to grow their business they are supported by expert partners such as Daventry Volunteer Centre. Daventry Volunteer Centre supports residents of West Northamptonshire and provides intensive 1:1 support for anyone 19+ thinking about or looking for work. As well as traditional employment support such as CV writing and help with training and development costs, they offer a range of tailored, supported volunteer opportunities to directly help residents on their employment pathway. As well as this, they help broker jobs between people and employers to help take some of the stress of job searching away.

In addition, our Anchor Institutions Network are some of the largest employers in Northamptonshire and have the potential to create significant opportunities for our local population and are committed to reducing unemployment. With the recent formation of a collective network, the Anchor Institutions are hoping to provide more opportunities for our residents to gain meaningful work with a focus on ensuring employment is accessible and sustainable to all groups of people with different backgrounds and needs.

# 2019 INCOME DEPRIVATION DOMAIN OF THE IMD IN WEST NORTHANTS



# HOUSING AND HOMELESSNESS

Housing conditions have a clear impact on a person's physical health, in addition to the availability and security of housing has on a person's mental health and wellbeing. A safe and settled home "is the cornerstone on which individuals and families build a better quality of life, access services they need and gain greater independence."[23]

The recent Census found that regarding housing tenure, 14.4% of households in West Northants had social landlords (17.1% England), 19.2% private landlords (20.6% England) and the remainder 66.4% were owner-occupied properties (62.3% in England). It is important to note that this varies hugely across West Northants, with 60% of households in the St Michaels MSOA of central Northampton privately renting (2021 Census).

Private rental prices paid by tenants in the East Midlands rose by 4.3% in the 12 months to June 2022, being the highest annual growth in private rental prices in the UK[24]. In West Northants, the highest monthly private rents were in South Northants in 2021/22 (£895), which was above both the Northamptonshire (£750) and England averages (£800) [25].

Summary of monthly private rental prices (1 October 2021 to 30 September 2022)

| Area | Lower range (£) | Median (£) | Upper range (£) |
|---|---|---|---|
| Daventry | 700 | 800 | 950 |
| Northampton | 670 | 750 | 870 |
| South Northants | 775 | 895 | 1,085 |
| Northamptonshire | 650 | 750 | 875 |
| England | 610 | 800 | 1,100 |

23 How does housing influence our health?
24 Index of Private Housing Rental Prices, UK - Office for National Statistics (ons.gov.uk)
25 https://www.ons.gov.uk/peoplepopulationandcommunity/housing/datasets/privaterentalmarketsummarystatisticsinengland

# HOUSING AND HOMELESSNESS

SCAN HERE
TO WATCH THE VIDEO
TO FIND OUT MORE

West Northamptonshire is also an expensive place to buy property with house prices nine times that of the average household incomes in 2021, which is similar to the England average of 9.1 but higher than the East Midlands average of 7.6[26].

Rising housing costs can lead to rent arrears and people being evicted from their property. People and households at risk of being evicted and made homeless or households currently unintentionally homeless are entitled to support from the local authority. In 2020/21 there were 2,045 households in West Northamptonshire that fit into this category – equivalent to 12 in every 1,000 households, the fourth highest rate in the region behind the three large cities of Leicester, Nottingham and Derby. In addition to the households that approach the council for support with homelessness we know there are many others experiencing having to sleep on friends' and family's sofas to get by, known as "hidden homeless". In 2018/19 it was estimated 1.2% of households in the region were supporting sofa surfers.[27]

A much smaller group of people but with often much more complex needs beyond those of poverty and homelessness, are those who are rough sleeping. Many people who experience rough sleeping have overlapping poor mental health, substance misuse needs and experience of the criminal justice system, as well as other traumas that are worsened by the experience of sleeping on the streets. This is the extreme end of poverty – destitution – and has an extreme impact on health and wellbeing; the average age of death of people who experience rough sleeping is 45 for men and 43 for women[28].

## Example projects

Poor housing, difficulty in obtaining and sustaining a tenancy, sofa surfing, homelessness and associated housing related matters have been identified as key factors in limiting people with a drug and alcohol misuse issue from entering or sustaining treatment or recovery programmes.

The Positive Housing and Safe Environments (PHaSE) project, delivered by Bridge Recovery Service in partnership with Orbit Housing, provides access to 20 properties across the county for people in recovery from substance misuse.

These properties are spread across communities, some are individual houses, and others are in blocks of general needs flats. There is nothing to indicate that these properties are any different from other properties, and the allocation of accommodation is not based on current town/district of current residence so that a person may choose to move between locations (within the county) to make a 'new start'.

PHaSE is not a forever home. Tenants are given an Assured Shorthold Tenancy valid for two years, with the aim that the people housed through the project are able to move into their own independent accommodation at some point within this period.

Once someone has moved in, Bridge's recovery staff and peer mentors will tailor any support that tenants may need. All new tenants will be helped to settle in, and then will get the individual support they need to successfully move on to the next chapter.

26 Fingertips affordability of home ownership 2021
27 English Housing Survey 2018 to 2019: sofa surfing and concealed households - fact sheet - GOV.UK (www.gov.uk)
28 Deaths of homeless people in England and Wales - Office for National Statistics (ons.gov.uk)

# PLACE-BASED APPROACHES

Actively involving citizens and strengthening community assets is a key strategy in helping to improve the health and wellbeing of the poorest residents and seldom-heard groups, reducing health inequalities. This year, our Public Health and Communities Teams launched the 'Well Northants' programme towards addressing this. Community development workers were embedded within local communities with high deprivation (using IMD data), or shared experiences through inclusion health groups, to better understand local needs and assets, and support them to develop interventions to improve individual and community wellbeing. The model adopted for this work is based on the Well Communities Programme, running in London. This uses a framework known as the CSEAD process: Community and Stakeholder Engagement in needs Assessment and 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 are working with local people and partners to develop neighbourhood action plans and to implement the actions and monitor progress. An example of a local activity underway is 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 is 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 have reported this has had a positive impact on their wellbeing, confidence and self-esteem and provided them with opportunities previously unavailable to them.

# RECOMMENDATIONS FROM 2020-2021 DPH ANNUAL REPORT

| | Recommendation | Action taken |
|---|---|---|
| 1 | The exploration and delivery of health-related messaging with a sense of inclusivity. | In 2022/23 there was a significant focus on achieving inclusive health-related messaging throughout all of our communications, i.e. with regards to the information that we provided, as well as the methods we used to share it. This was achieved through a broad programme of engagement with diverse communities (including those with shared ethnic identity as well as communities of shared interest e.g. those with a disability). This engagement work is helping us to ensure our future communications are tailored to the needs of these communities. |
| 2 | The continuation of collaborative working alongside other public and voluntary services to ensure the safety and wellbeing of the population in North and West Northamptonshire. | We have worked collaboratively with a range of partners to deliver health and social care interventions such as; vaccination, health screening, training, incident and outbreak management and wider support to extremely vulnerable groups who have been adversely affected during the Covid-19 pandemic. This has included distributing financial support to families of children who receive free school meals, household support fund and physical support to clinically extremely vulnerable people during lockdown. Partners include; local and regional health partners, voluntary agencies, faith groups, local businesses and workplaces, UK Health Security Agency (UKHSA) and other regional and national government agencies, community organisations, event organisers and other local authority teams. |
| 3 | The Health and Social Care system across North and West Northamptonshire should further utilise data and intelligence about the impact of Covid-19 and other health-related matters to inform services or initiatives and meet the needs of local communities. | Local surveillance on case rates, testing, incidents and outbreaks, vaccination, hospital admissions, mortality and staff absence, was benchmarked against regional and national intelligence, and used to inform local recommendations through briefing of multi-agency system partners of the LRF and forums, including the Contain Management Group, Covid-19 Health Protection Board, Strategic Coordinating Group, Tactical Coordinating Group, Oversight and Engagement Board and Cabinet briefings. Weekly briefings were also delivered to the local media informing them of the situation in Northamptonshire and included implementing improvements to address gaps identified. This helped to manage case rates in Corby, Kettering and Northampton when they featured in the top 20 areas with the highest case rate nationally and managing outbreaks in local settings in the national picture.<br><br>We are in the process of collating data to inform our local view on the effect of Covid-19, from local, regional and national benchmarking and county-wide surveys. The intelligence will be analysed and used to produce a comprehensive impact assessment, which will inform the delivery and development of services which will address the ongoing issues relating to Covid-19 and other health related matters during the recovery phase. |

# RECOMMENDATIONS FROM 2020-2021 DPH ANNUAL REPORT

| | Recommendation | Action taken |
|---|---|---|
| 4 | Priority should be placed on addressing the health inequalities exacerbated by the pandemic within and across the two unitary areas by ensuring access to services for all, particularly those who are rurally or socially isolated. | Addressing health inequalities is a priority set out in the Integrated Care Northamptonshire (ICN) Strategy. The strategy sets out 10 Live Your Best Life ambitions and the place-based approach we will take to achieve these. We are taking a joined-up approach across all the organisations and services involved in supporting our population and communities. This will be through a new very local approach with our communities central to our operating model – our Local Area Partnerships (LAPs').<br><br>The ICN finalised the Health Inequalities Plan in July 2022 which sets out the system ambition to address health inequalities and the approaches required to achieve that. A Health Inequalities sub-group of the Population Health Board has been established to coordinate and have oversight of the range of work across the system that will achieve this ambition. Health inequalities funding from NHSE has also been allocated to addressing health inequalities, and a process of identifying projects that align with the health inequalities plan is underway.<br><br>Other specific programmes of work with reducing inequalities at the core include:<br>• Well Northants programme - using an asset-based community development approach to work with communities most vulnerable to health inequalities to improve their health and wellbeing, using participatory budgeting processes to involve communities in decisions about how to allocate funding to projects<br><br>• the Northamptonshire Anchor Network brings businesses and public sector organisations together to commit to improving health and wellbeing outcomes for our local communities by empowering the next generation, providing employment opportunities and investing locally. |
| 5 | Investment in services which improve physical and mental health and wellbeing of the local populations which are key to supporting the recovery from the pandemic and the future health of the population. | Over the past year there has been increased investment in healthy weight programmes. In addition to the Public Health funded weight management services (offered by Slimming World, Northampton Town Football Club and Solutions 4 Health), a grant from OHID was used to offer grants to local organisations to deliver targeted weight management services to address inequities in access to existing services and reach people from minority ethnic groups, the most deprived parts of the county, men, people with mental health conditions and people with learning disabilities.<br><br>Public Health also funded a new service to promote growing and cooking healthy food, delivered through the Hope Centre in the West and Groundwork in the North. Public Health are also conducting a review of physical health pathways and services with a view to increasing physical activity levels and building it into treatment pathways.<br><br>Stop smoking services continue to increase their reach year on year, with 3056 quit dates set in 2021/22 and 62% of these achieving a quit at 4 weeks. Tobacco Dependency Advisors are now working in Northampton General Hospital and Kettering General Hospitals and maternity services using funding from NHSE as part of the Long Term Plan tobacco control priority. |

# RECOMMENDATIONS FOR THE 2022 REPORT

1. Continue to deliver urgent support to those struggling right now – ensuring good access to rights advice and easy access to hardship support.

2. Ensure that the impact of financial stress on mental health is understood and addressed.

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.

4. Take place-based and asset-based approaches linking with the work of the emerging Local Area Partnerships.

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.

6. Keep learning and reflecting and ensure that evaluation results in improved outcomes.

**ACKNOWLEDGEMENTS**

**Thanks to those that have particpated with the develeopment of this report:-**

Rhosyn Harris, Megan Denny, Victoria Rockall, Phil Veasey, Emma Brook, Emma Parry, Gareth Jenkins-Knight, Hannah Austin, Sadie Beishon, Simon Frost, Jamie Wooldridge, Chloe Gay, Julia Partridge, Annapurna Sen, Hannah Ellingham, Carolyn Howe and Paul Trinder.

To watch the videos that support this years Director of Public Health Report please scan the QR code or visit our YouTube channel: @WestNorthamptonshireCouncil

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www.westnorthants.gov.uk/cost-of-living

West Northamptonshire Council

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Wellbeing WEST NORTHANTS

WEST NORTHANTS Health and Wellbeing Board live your best life

**Item no: 09**

# WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

## 25th May 2023

| | |
|---|---|
| **Report Title** | **BCF Summary Report 2022/23** |
| **Report Author** | **Ashley Leduc, Assistant Director of Commissioning and Performance** |

| **Contributors/Checkers/Approvers** | | |
|---|---|---|
| **Other Director/SME** | Stuart Lackenby, Director of People | 17th May 2023 |

**List of Appendices**

**Appendix A – BCF 2022/23 West Northamptonshire Planning Template**
**Appendix B – BCF Narrative Plan West Northants 2022/23**
**Appendix C – 2022/23 Final BCF Return**

## 1. Purpose of Report

1.1. Health and Wellbeing Board to approve the Better Care Fund (BCF) 2022/23 performance template submitted to NHSE.

1.2. To update the Health and Wellbeing Board on the outline plan for the development of the Better Care Fund in 2023/24.

## 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 Commissioning 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 19th July 2022, confirmed the conditions and funding for the BCF in 2022/23.

2.3 The BCF plan and schemes for 2022/23 were submitted and approved as complying with the conditions of the 2022/23 grant.

2.4 The Health and Wellbeing Board are required to approve the 2022/23 Final BCF Return.

## 3. Recommendations

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

a) Approve the final return template for the Better Care Fund schemes (2022/23).

b) Note the proposed timelines for the Better Care Fund plan for 2022/23

## 4. Report Background

4.1 Funding 2022/23

4.2 The policy framework, published on 19 July 2022, confirmed the conditions and funding for the BCF in 2022/23.

4.3 For West Northants the total funding for 2022/23 was £50,442,297 (please see Appendix A for the full breakdown).

4.4 **BCF national conditions and metrics for 2022/23**

The national conditions for the BCF in 2022/23 were:

1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB.
2. NHS contribution to adult social care at HWB level to be maintained in line with the uplift to NHS minimum contribution.
3. invest in NHS-commissioned out-of-hospital services.
4. Implement the BCF Policy objectives.

4.5 National Condition 1

A jointly agreed plan between local health and social care commissioners and signed off by the HWB was submitted and approved by the HWB on 19th September 2022.

4.6 National Condition 2

The NHS contribution to adult social care at HWB level was maintained and increased in line with the uplift to NHS minimum contributions.

4.7 National Condition 3

The expenditure plans shown in appendix A demonstrates that schemes were put in place to support out of hospital services.

4.8 National Condition 4

This National Condition requires a joint plan to deliver Health and Social Care services that support the funds 2 policy objectives:

- Enable people to stay well, safe and independent at home for longer.
- Provide the right care in the right place at the right time

Expenditure plans in appendix A show the commissioned schemes from BCF funding resources to support this objective.

Appendix B shows the narrative approach to delivering these objectives locally and the integrated approach taken by Health and Social Care.

4.9 Metrics

4.10 Beyond this, areas had flexibility in how the fund was spent over health, care and housing schemes or services. This needed to be evidenced as to how this spending will improve performance against the following BCF 2022/23 metrics:

- Avoidable admissions to hospital
- Admissions to residential and care homes
- Effectiveness of reablement
- Hospital discharges that are to a persons usual place of residence

4.11 Further details of this are set out in appendix B.

4.12 Appendix C shows West Northamptonshire's performance against the defined metrics and outturn against the planned position for 2022/23.

4.13 **Avoidable admissions to hospital**

This metric is linked to the NHS Outcome Framework indicator. In 2022/23, planned performance of 4,160 avoidable admissions were planned, 4,136 were achieved. This is an average of 344.6 per month, which is an improvement from the 21/22 achievement of 309.

4.14 **Percentage of people who are discharged from acute hospital to their normal place of residence**

The planned outturn for 2022/23 was 94.7% and West Northamptonshire achieved 93.5% which is 1.2% below the outturn. This is also a reduction from 2021/22 where 95% outturn position was achieved. This is likely to a challenging winter and the residual affects of Covid, where patients

who could have been discharged on pathway 0 were supported to be discharged via pathway 1 & 2.

4.15 **Rate of admissions to residential care per 100k (over 65's)**

Significant over performance was achieved in 2022/23 where 479.37 residential care admissions took place (per 100k population) against a planned outturn of 549. This demonstrates the effectiveness of pathway 1 and 2 provision across Health and Social Care, and effective use of discharge resources.

4.16 Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

This metric is slightly above target, and is a significant improvement from 2021/22. 80.7% of people remained at home against a planned outturn position of 79.2%. This highlights the effectiveness of reablement services on pathway 1 and 2.

4.17 Planning and Assurance of BCF Plans 2023/23

4.17 The plan will be developed locally by the local authority and ICB. This will be aligned with other strategic documents and plans including those of the ICB/ICP and wider programmes such as Ageing Well. A report will be presented at the June Health and Wellbeing board.

## 5. Issues and Choices

5.1 As per the delegation from the previous board the discussions with local partners to determine financial allocations was agreed and approved by the Chair of the Health and Wellbeing Board and lead officers from both West Northants Council and the ICB.

5.2 The performance template for 2022/23 has been agreed in line with the National Conditions.

## 6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 Please see appendix A for the breakdown of schemes and the financial allocation.

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 As per appendixes

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# BCF Planning Template 2022-23

**1. Guidance**

**Overview**

**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, as below:

Data needs inputting in the cell

Pre-populated cells

**Note on viewing the sheets optimally**

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

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

**Checklist** (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund 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 submission.

**2. Cover** (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

**4. Income** (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

**5. Expenditure** (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

**6. Metrics** (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value:
https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

**7. Planning Requirements** (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

# Better Care Fund 2022-23 Template

**2. Cover**

**Version 1.0.0**

HM Government

NHS

*Please Note:*
*- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.*
*- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".*
*- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.*
*- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.*
*- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.*

| | | |
|---|---|---|
| **Health and Wellbeing Board:** | West Northamptonshire | |
| **Completed by:** | Anna Earnshaw | |
| **E-mail:** | Anna.earnshaw@westnorthants.gov.uk | |
| **Contact number:** | 07766 204789 | |
| **Has this plan been signed off by the HWB (or delegated authority) at the time of submission?** | No | |
| **If no please indicate when the HWB is expected to sign off the plan:** | Thu 08/09/2022 | << Please enter using the format, DD/MM/YYYY |
| **If using a delegated authority, please state who is signing off the BCF plan:** | Stuart Lackenby Executive Director for People | |

**Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):**

| | |
|---|---|
| **Job Title:** | Cabinet members for Adults Community and Wellbeing |
| **Name:** | Cllr Matt Golby |

| | **Role:** | **Professional Title (e.g. Dr, Cllr, Prof)** | **First-name:** | **Surname:** | **E-mail:** |
|---|---|---|---|---|---|
| ***Area Assurance Contact Details:** | Health and Wellbeing Board Chair | Councillor | Matt | Golby | matthew.golby@westnorthants.gov.uk |
| | Integrated Care Board Chief Executive or person to whom they have delegated sign-off | | Toby | Sanders | toby.sanders1@nhs.net |
| | Additional ICB(s) contacts if relevant | | Jan | Thomas | Jan.thomas@nhs.net |
| | Local Authority Chief Executive | | Anna | Earnshaw | Anna.earnshaw@westnorthants.gov.uk |
| | Local Authority Director of Adult Social Services (or equivalent) | | Stuart | Lackenby | stuart.lackenby@westnorthants.gov.uk |
| | Better Care Fund Lead Official | | Anna | Earnshaw | Anna.earnshaw@westnorthants.gov.uk |
| | LA Section 151 Officer | | Martin | Henry | martin.henry@westnorthants.gov.uk |
| *Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process --> | | | | | |
| | | | | | |
| | | | | | |

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

**Please see the Checklist below for further details on incomplete fields**

| | Complete: |
|---|---|
| 2. Cover | Yes |
| 4. Income | Yes |
| 5a. Expenditure | Yes |
| 6. Metrics | No |
| 7. Planning Requirements | No |


<< Link to the Guidance sheet

^^ Link back to top

# Better Care Fund 2022-23 Template

**3. Summary**

Selected Health and Wellbeing Board: West Northamptonshire

## Income & Expenditure

Income >>

| Funding Sources | Income | Expenditure | Difference |
|---|---|---|---|
| DFG | £2,558,938 | £2,558,938 | £0 |
| Minimum NHS Contribution | £29,346,053 | £29,346,053 | £0 |
| iBCF | £10,069,033 | £10,069,033 | £0 |
| Additional LA Contribution | £1,370,179 | £1,370,179 | £0 |
| Additional ICB Contribution | £7,098,094 | £7,098,094 | £0 |
| **Total** | **£50,442,297** | **£50,442,297** | **£0** |

Expenditure >>

**NHS Commissioned Out of Hospital spend from the minimum ICB allocation**

| | |
|---|---|
| Minimum required spend | £8,339,473 |
| Planned spend | £19,048,998 |

**Adult Social Care services spend from the minimum ICB allocations**

| | |
|---|---|
| Minimum required spend | £7,273,483 |
| Planned spend | £9,285,808 |

**Scheme Types**

| | | |
|---|---|---|
| Assistive Technologies and Equipment | £3,728,780 | (7.4%) |
| Care Act Implementation Related Duties | £609,479 | (1.2%) |
| Carers Services | £776,119 | (1.5%) |
| Community Based Schemes | £14,736,709 | (29.2%) |
| DFG Related Schemes | £2,558,938 | (5.1%) |
| Enablers for Integration | £274,223 | (0.5%) |
| High Impact Change Model for Managing Transfer of ( | £2,646,789 | (5.2%) |
| Home Care or Domiciliary Care | £4,339,868 | (8.6%) |
| Housing Related Schemes | £0 | (0.0%) |
| Integrated Care Planning and Navigation | £0 | (0.0%) |
| Bed based intermediate Care Services | £4,806,974 | (9.5%) |
| Reablement in a persons own home | £9,405,866 | (18.6%) |
| Personalised Budgeting and Commissioning | £0 | (0.0%) |
| Personalised Care at Home | £0 | (0.0%) |
| Prevention / Early Intervention | £1,210,000 | (2.4%) |
| Residential Placements | £5,065,165 | (10.0%) |
| Other | £283,387 | (0.6%) |
| **Total** | **£50,442,297** | |

Metrics >>

## Avoidable admissions

| | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan |
|---|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population) | | | |

## Discharge to normal place of residence

| | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan |
|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | | | |

## Residential Admissions

| | | 2020-21 Actual | 2022-23 Plan |
|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 321 | 549 |

## Reablement

| | | 2022-23 Plan |
|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 78.9% |

Planning Requirements >>

| Theme | Code | Response |
|---|---|---|
| **NC1: Jointly agreed plan** | **PR1** | No |
| | **PR2** | Yes |
| | **PR3** | Yes |
| **NC2: Social Care Maintenance** | **PR4** | Yes |
| **NC3: NHS commissioned Out of Hospital Services** | **PR5** | Yes |
| **NC4: Implementing the BCF policy objectives** | **PR6** | Yes |
| **Agreed expenditure plan for all elements of the BCF** | **PR7** | Yes |
| **Metrics** | **PR8** | Yes |

# Better Care Fund 2022-23 Template

**4. Income**

| Selected Health and Wellbeing Board: | West Northamptonshire |
|---|---|

| **Local Authority Contribution** | |
|---|---|
| Disabled Facilities Grant (DFG) | Gross Contribution |
| West Northamptonshire | £2,558,938 |
| | |
| DFG breakdown for two-tier areas only (where applicable) | |
| | |
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| | |
| | |
| **Total Minimum LA Contribution (exc iBCF)** | **£2,558,938** |

| **iBCF Contribution** | Contribution |
|---|---|
| West Northamptonshire | £10,069,033 |
| | |
| **Total iBCF Contribution** | **£10,069,033** |

| Are any additional LA Contributions being made in 2022-23? If yes, please detail below | Yes |
|---|---|

| Local Authority Additional Contribution | Contribution | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|
| West Northamptonshire | £1,370,179 | Community Equipment |
| | | |
| | | |
| **Total Additional Local Authority Contribution** | **£1,370,179** | |

| NHS Minimum Contribution | Contribution |
|---|---|
| NHS Northamptonshire ICB | £29,346,053 |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total NHS Minimum Contribution** | **£29,346,053** |

| | |
|---|---|
| Are any additional ICB Contributions being made in 2022-23? If yes, please detail below | Yes |

| Additional ICB Contribution | Contribution | Comments - Please use this box clarify any specific uses or sources of funding |
|---|---|---|
| NHS Northamptonshire ICB | £7,098,094 | ICAN, VHE, P2 Pilot & DTA beds |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |
| **Total Additional NHS Contribution** | **£7,098,094** | |
| **Total NHS Contribution** | **£36,444,147** | |

| | 2021-22 |
|---|---|
| **Total BCF Pooled Budget** | **£50,442,297** |

| **Funding Contributions Comments**<br>Optional for any useful detail e.g. Carry over |
|---|
| |

# Better Care Fund 2022-23 Template

**5. Expenditure**

Selected Health and Wellbeing Board: West Northamptonshire

<< Link to summary sheet

| Running Balances | Income | Expenditure | Balance |
|---|---|---|---|
| DFG | £2,558,938 | £2,558,938 | £0 |
| Minimum NHS Contribution | £29,346,053 | £29,346,053 | £0 |
| iBCF | £10,069,033 | £10,069,033 | £0 |
| Additional LA Contribution | £1,370,179 | £1,370,179 | £0 |
| Additional NHS Contribution | £7,098,094 | £7,098,094 | £0 |
| **Total** | **£50,442,297** | **£50,442,297** | **£0** |

**Required Spend**

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

| | Minimum Required Spend | Planned Spend | Under Spend |
|---|---|---|---|
| NHS Commissioned Out of Hospital spend from the minimum ICB allocation | £8,339,473 | £19,048,998 | £0 |
| Adult Social Care services spend from the minimum ICB allocations | £7,273,483 | £9,285,808 | £0 |

>> Link to further guidance

**Checklist**

Column complete:

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

**Sheet complete**

| | | | | | | Planned Expenditure | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Sub Types | Please specify if 'Scheme Type' is 'Other' | Area of Spend | Please specify if 'Area of Spend' is 'other' | Commissioner | % NHS (if Joint Commissioner) | % LA (if Joint Commissioner) | Provider | Source of Funding | Expenditure (£) | New/ Existing Scheme |
| 1 | Carers Support Services (CCG Contract) | This Service provides Carers health support ensuring that they can | Carers Services | Respite services | | Other | Northamptonshire Carers | CCG | | | Private Sector | Minimum NHS Contribution | £374,351 | Existing |
| 2 | Carers Support Services WNC Contract | Council Contracted Service hosted by North Northants on behalf of | Carers Services | Other | Assessment & Advice services | Other | Northamptonshire Carers | LA | | | Private Sector | Minimum NHS Contribution | £401,768 | Existing |
| 3 | Continuing Healthcare | LD Health care at home/CHC/domiciliary care | Community Based Schemes | Multidisciplinary teams that are supporting | | Continuing Care | | CCG | | | Private Sector | Minimum NHS Contribution | £9,348,114 | Existing |
| 4 | Hospital Discharge Programme | Nationally funded programme of services and Interventions reduce | High Impact Change Model for Managing Transfer | Home First/Discharge to Assess - process | | Social Care | | LA | | | Local Authority | Additional NHS Contribution | £659,394 | New |
| 5 | LD Service Delivery | LD service delivery-community based health support | Community Based Schemes | Integrated neighbourhood services | | Community Health | | CCG | | | NHS Community Provider | Minimum NHS Contribution | £3,978,595 | Existing |
| 6 | ICAN - community Resillience | Transformation programme - implementation of best | Community Based Schemes | Integrated neighbourhood services | | Other | Integrated programme & subject matter | LA | | | Private Sector | Additional NHS Contribution | £1,410,000 | New |
| 7 | ICAN - Flow & Grip | transformation of acute hospital patient management and reduce | High Impact Change Model for Managing Transfer | Early Discharge Planning | | Other | Integrated programme & subject matter | LA | | | Private Sector | Additional NHS Contribution | £1,210,000 | New |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | ICAN - Frailty, Escalation and Front Door | Transformation to support the development of the | Prevention / Early Intervention | Other | Admission avoidance and same day Care | Other | Integrated programme & subject matter | LA | | | Private Sector | Additional NHS Contribution | £1,210,000 | New |
| 9 | Integrated Discharge Teams | Social Care Hospital based teams supporting Integrated Discharge hub | High Impact Change Model for Managing Transfer | Multi-Disciplinary/Multi-Agency Discharge | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £777,395 | Existing |
| 10 | Specialist Care Centres (SCC) Step and Step Down | Specialist Care Centres (SCCs) x 52 beds with a mix of Nursing | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £2,900,974 | New |
| 11 | Telecare and Assistive technology | Assistive technology and call lifelines designed to help keep people safe in | Assistive Technologies and Equipment | Community based equipment | | Social Care | | LA | | | Local Authority | iBCF | £448,000 | Existing |
| 12 | Intermediate Care Teams (ICT) | Community health reablement team supporting discharge | Reablement in a persons own home | Reablement to support discharge - step down | | Community Health | | CCG | | | NHS Community Provider | Minimum NHS Contribution | £5,064,551 | Existing |
| 13 | Community Equipment (Health) | Jointing commissioned and funded Health and social care provision of | Assistive Technologies and Equipment | Community based equipment | | Social Care | | LA | | | Private Sector | Minimum NHS Contribution | £991,901 | Existing |
| 14 | Community Equipment (Social Care) | Jointing commissioned and funded Health and social care provision of | Assistive Technologies and Equipment | Community based equipment | | Social Care | | LA | | | Private Sector | Additional LA Contribution | £1,370,179 | Existing |
| 15 | Community Reablement Team | Team providing reablement support post discharge home or from | Reablement in a persons own home | Reablement service accepting community and | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £2,979,124 | Existing |
| 16 | Older People's Mental Health / Dementia | Holistic Intermediate Care Team (HICT) service - This is a specialist | Reablement in a persons own home | Reablement service accepting community and | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £285,047 | Existing |
| 17 | Community Occupational Therapy | Community Occupational Therapy Teams - The | Reablement in a persons own home | Reablement service accepting community and | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £1,077,144 | Existing |
| 18 | Disabled Facilities Grants | The DFG provides funding through local councils to make | DFG Related Schemes | Adaptations, including statutory DFG grants | | Social Care | | LA | | | Local Authority | DFG | £2,558,938 | Existing |
| 19 | Clinical cover for SCCs | GP & Pharmacy cover across the three specialist care centres to | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Social Care | | LA | | | Local Authority | iBCF | £216,000 | Existing |
| 20 | Safeguarding (Assurance) Teams | quality and safeguarding team responsible for monitoring the quality of | Care Act Implementation Related Duties | Other | Privider Quality, Advice and improvement | Primary Care | | LA | | | Local Authority | Minimum NHS Contribution | £609,479 | Existing |
| 21 | Commissioning & Intelligence Capacity | Provision of commissioning capacity and expertise to support | Enablers for Integration | Joint commissioning infrastructure | | Social Care | | LA | | | Local Authority | Minimum NHS Contribution | £274,223 | Existing |
| 22 | Demographic and care cost pressures | Ongoing underlying care cost pressures (volume, complexity and cost | Residential Placements | Care home | | Social Care | | LA | | | Local Authority | iBCF | £5,065,165 | Existing |
| 23 | Domiciliary Care | Additional Market Capacity to meet the ongoing additional | Home Care or Domiciliary Care | Domiciliary care to support hospital discharge | | Social Care | | LA | | | Local Authority | iBCF | £4,339,868 | Existing |
| 24 | Virtual Health Enviornment | Technology to support the extenson of Virtual Wards | Assistive Technologies and Equipment | Telecare | | Acute | | CCG | | | NHS Acute Provider | Additional NHS Contribution | £918,700 | New |
| 15 | Pathway 2 Intermedite care pilot | Staffing costs to support pilot for single integrated bedded intermediate | Bed based intermediate Care Services | Step down (discharge to assess pathway-2) | | Community Health | | Joint | 30.0% | 70.0% | NHS Community Provider | Additional NHS Contribution | £1,690,000 | New |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Contingency | Unallocated | Other | | Contingency | Other | Contingency | CCG | | | CCG | Minimum NHS Contribution | £283,387 | Existing |
| | | | | | | | | | | | | | | |

## Further guidance for completing Expenditure sheet

### National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

### 2022-23 Revised Scheme types

| Number | Scheme type/ services | Sub type | Description |
|---|---|---|---|
| 1 | Assistive Technologies and Equipment | 1. Telecare<br>2. Wellness services<br>3. Digital participation services<br>4. Community based equipment<br>5. Other | Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services). |
| 2 | Care Act Implementation Related Duties | 1. Carer advice and support<br>2. Independent Mental Health Advocacy<br>3. Safeguarding<br>4. Other | Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF. |
| 3 | Carers Services | 1. Respite Services<br>2. Other | Supporting people to sustain their role as carers and reduce the likelihood of crisis.<br><br>This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. |
| 4 | Community Based Schemes | 1. Integrated neighbourhood services<br>2. Multidisciplinary teams that are supporting independence, such as anticipatory care<br>3. Low level support for simple hospital discharges (Discharge to Assess pathway 0)<br>4. Other | Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams)<br><br>Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home' |
| 5 | DFG Related Schemes | 1. Adaptations, including statutory DFG grants<br>2. Discretionary use of DFG - including small adaptations<br>3. Handyperson services<br>4. Other | The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.<br><br>The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate |
| 6 | Enablers for Integration | 1. Data Integration<br>2. System IT Interoperability<br>3. Programme management<br>4. Research and evaluation<br>5. Workforce development<br>6. Community asset mapping<br>7. New governance arrangements<br>8. Voluntary Sector Business Development<br>9. Employment services<br>10. Joint commissioning infrastructure<br>11. Integrated models of provision<br>12. Other | Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes.<br><br>Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others. |
| 7 | High Impact Change Model for Managing Transfer of Care | 1. Early Discharge Planning<br>2. Monitoring and responding to system demand and capacity<br>3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge<br>4. Home First/Discharge to Assess - process support/core costs<br>5. Flexible working patterns (including 7 day working)<br>6. Trusted Assessment<br>7. Engagement and Choice<br>8. Improved discharge to Care Homes<br>9. Housing and related services<br>10. Red Bag scheme<br>11. Other | The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section. |
| 8 | Home Care or Domiciliary Care | 1. Domiciliary care packages<br>2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1)<br>3. Domiciliary care workforce development<br>4. Other | A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services. |
| 9 | Housing Related Schemes | | This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units. |
| 10 | Integrated Care Planning and Navigation | 1. Care navigation and planning<br>2. Assessment teams/joint assessment<br>3. Support for implementation of anticipatory care<br>4. Other | Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals.<br><br>Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams.<br><br>Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside. |
| 11 | Bed based intermediate Care Services | 1. Step down (discharge to assess pathway-2)<br>2. Step up<br>3. Rapid/Crisis Response<br>4. Other | Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types. |

| | | | |
|---|---|---|---|
| 12 | Reablement in a persons own home | 1. Preventing admissions to acute setting<br>2. Reablement to support discharge -step down (Discharge to Assess pathway 1)<br>3. Rapid/Crisis Response - step up (2 hr response)<br>4. Reablement service accepting community and discharge referrals<br>5. Other | Provides support in your own home to improve your confidence and ability to live as independently as possible |
| 13 | Personalised Budgeting and Commissioning | | Various person centred approaches to commissioning and budgeting, including direct payments. |
| 14 | Personalised Care at Home | 1. Mental health /wellbeing<br>2. Physical health/wellbeing<br>3. Other | Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type. |
| 15 | Prevention / Early Intervention | 1. Social Prescribing<br>2. Risk Stratification<br>3. Choice Policy<br>4. Other | Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being. |
| 16 | Residential Placements | 1. Supported living<br>2. Supported accommodation<br>3. Learning disability<br>4. Extra care<br>5. Care home<br>6. Nursing home<br>7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3)<br>8. Other | Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home. |
| 18 | Other | | Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column. |

## Better Care Fund 2022-23 Template

**6. Metrics**

Selected Health and Wellbeing Board: West Northamptonshire

### 8.1 Avoidable admissions

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Indirectly standardised rate (ISR) of admissions per 100,000 population<br><br>(See Guidance) | Indicator value | 995 | 954 | 1,038 | 928 | it should be noted that the denominator value for our population is incorrect as this still shows the whole county not west northants. This has been reported to Khalid and we are awaiting advice . We are unable to submit the plan figures in the first draft submission as we are still trying to ascertain the correct figures as many of | |
| | Denominator | 757,200 | 757,200 | 757,200 | 757,200 | | |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| | Indicator value | | | | | | |
| | Indicator value | | | | | | |
| | Denominator | | | | | | |

>> link to NHS Digital webpage (for more detailed guidance)

### 8.3 Discharge to usual place of residence

| | | 2021-22 Q1 Actual | 2021-22 Q2 Actual | 2021-22 Q3 Actual | 2021-22 Q4 Actual | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence<br><br>(SUS data - available on the Better Care Exchange) | Quarter (%) | 94.9% | 95.2% | 94.7% | 93.6% | We are unable to submit the plan figures in the first draft submission as we are still trying to ascertain the correct figures as many of the personnel previously involved have moved on, so it is taking some time to work out what was done last time and replicate it with confidence. we will send a revised template when we have this. | |
| | Numerator | 7,908 | 7,699 | 7,370 | 6,493 | | |
| | Denominator | 8,329 | 8,083 | 7,781 | 6,937 | | |
| | | 2022-23 Q1 Plan | 2022-23 Q2 Plan | 2022-23 Q3 Plan | 2022-23 Q4 Plan | | |
| | Quarter (%) | | | | | | |
| | Numerator | | | | | | |
| | Denominator | | | | | | |

## 8.4 Residential Admissions

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population | Annual Rate | 320.5 | 936.3 | 432.6 | 549.0 | '2021-22 estimated' estimated figures on the planning template based on our SALT returns population figures not the BCF ones. The figure for 8.4 (cell H48)has been adjusted due to the slight difference in population used for SALT and those built | we continue to focus on pathway 1 and 2 as the preferred options with the best outcomes for patients. Recent years have proved challenging though with a high incidence of hospitals discharging to care homnes and D2A places and the council |
| | Numerator | 443 | 699 | 323 | 418 | | |
| | Denominator | 138,216 | 74,657 | 74,657 | 76,142 | | |

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

## 8.5 Reablement

| | | 2020-21 Actual | 2021-22 Plan | 2021-22 estimated | 2022-23 Plan | Rationale for how ambition was set | Local plan to meet ambition |
|---|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | Annual (%) | 73.9% | 79.2% | 83.8% | 78.9% | Analysis was carried out but due to the erratic nature of this indictors monthly/quarterly % the forecasting used that relies on prior months/quarters figures creates a forecast that's very different to the prior year SALT return final | Our ambition based on the ICAN work to re-egineer and redesign pathways 1 and 2 is that 85% to 90% of people are still at home after 91 days, but this is currently challenging as flow in pathway 1 has been slowed by a lack of step down capacity and |
| | Numerator | 420 | 240 | 119 | 116 | | |
| | Denominator | 568 | 303 | 142 | 147 | | |

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

## Better Care Fund 2022-23 Template

**7. Confirmation of Planning Requirements**

Selected Health and Wellbeing Board: West Northamptonshire

| Theme | Code | Planning Requirement | Key considerations for meeting the planning requirement<br>These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR) | Confirmed through | Please confirm whether your BCF plan meets the Planning Requirement? | Please note any supporting documents referred to and relevant page numbers to assist the assurers | Where the Planning requirement is not met, please note the actions in place towards meeting the requirement | Where the Planning requirement is not met, please note the anticipated timeframe for meeting it |
|---|---|---|---|---|---|---|---|---|
| NC1: Jointly agreed plan | **PR1** | **A jointly developed and agreed plan that all parties sign up to** | Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted?<br><br>Has the HWB approved the plan/delegated approval?<br><br>Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan?<br><br>Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? | Cover sheet<br><br>Cover sheet<br><br>Narrative plan<br><br>Validation of submitted plans | No | All local partners and stakeholders leisted have been involved in the development of the plan and are engaged in all the ICAN work and programme as shown in page 1 of the narrative plan. | | THE West Northants HWBB meeeting is on 8th September where the draft plan and expenditure will be approved. |
| | **PR2** | **A clear narrative for the integration of health and social care** | Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:<br><br>• How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally<br><br>• The approach to collaborative commissioning<br><br>• How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include<br>- How equality impacts of the local BCF plan have been considered<br><br>- Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these.<br><br>The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. | Narrative plan | Yes | | | |
| | **PR3** | **A strategic, joined up plan for Disabled Facilities Grant (DFG) spending** | Is there confirmation that use of DFG has been agreed with housing authorities?<br><br>• Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home?<br><br>• In two tier areas, has:<br>- Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or<br>- The funding been passed in its entirety to district councils? | Narrative plan<br><br>Confirmation sheet | Yes | | | |
| NC2: Social Care Maintenance | **PR4** | **A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution** | Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)? | Auto-validated on the planning template | Yes | | | |
| NC3: NHS commissioned Out of Hospital Services | **PR5** | **Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?** | Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)? | Auto-validated on the planning template | Yes | | | |
| NC4: Implementing the BCF policy objectives | **PR6** | **Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?** | Does the plan include an agreed approach for meeting the two BCF policy objectives:<br>- Enable people to stay well, safe and independent at home for longer and<br>- Provide the right care in the right place at the right time?<br><br>• Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year?<br><br>•Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided?<br><br>• Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care?<br><br>• Does the plan include actions going forward to improve performance against the HICM? | Narrative plan<br><br>Expenditure tab<br><br>C&D template and narrative<br><br>Narrative plan<br><br>Narrative template | Yes | see page 10 of the narrative plan and demand and capacity template | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Agreed expenditure plan for all elements of the BCF | **PR7** | **Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?** | • Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated)<br><br>• Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box)<br><br>• Has the area included a description of how BCF funding is being used to support unpaid carers?<br><br>• Has funding for the following from the NHS contribution been identified for the area:<br>- Implementation of Care Act duties?<br>- Funding dedicated to carer-specific support?<br>- Reablement? | Expenditure tab<br><br>Expenditure plans and confirmation sheet<br><br>Narrative plan<br><br>Narrative plans, expenditure tab and confirmation sheet | Yes | | | |
| Metrics | **PR8** | **Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?** | • Have stretching ambitions been agreed locally for all BCF metrics?<br><br>• Is there a clear narrative for each metric setting out:<br>- the rationale for the ambition set, and<br>- the local plan to meet this ambition? | Metrics tab | Yes | We have been as ambitious on residential admissions given the past challenges we faced with an over reliance on bedded solutions post COVID and that we have less hospital | | |

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Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

## 1. Health and Wellbeing Board(s)

| |
|---|
| West Northants Council |

**Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)**

- West Northants Council Adults Services
- Northamptonshire ICB
- Northamptonshire Health Foundation Trust (NHFT)
- Northamptonshire Universities Group Hospital
- ICAN Patient Advisory Group – Voluntary sector and patient Group (including Healthwatch)
- West Northants Community and Opportunities (Housing services, DFG services, care and repair)

## 2. How have you gone about involving these stakeholders?

The BCF plan 2022-23 and ambitions for 2023-24 have been discussed, developed, and agreed through our shared joint weekly health and care Chief Executives group, Chief Operating Officers group and as part of extensive conversation across all the stakeholders listed above as part of the ongoing work that our ICS is doing on its development of collaboratives.

One of these ICS collaboratives is the ICAN (integrated Care Across Northamptonshire) which is overseeing all our transformation work on all of our BCF out of hospital services and to improve our performance in relation to BCF metrics and national conditions. Within the ICAN BCF activities we are bringing services together across our community partners, primary care, hospitals front and back door activity and intermediate care services to make major improvements in outcomes, flow and efficiency. These have all been redesigned with a focus on keeping **more people well at home for longer and ensuring over 65s get the right care in the right place**, aims aligned to the BCF national objectives.

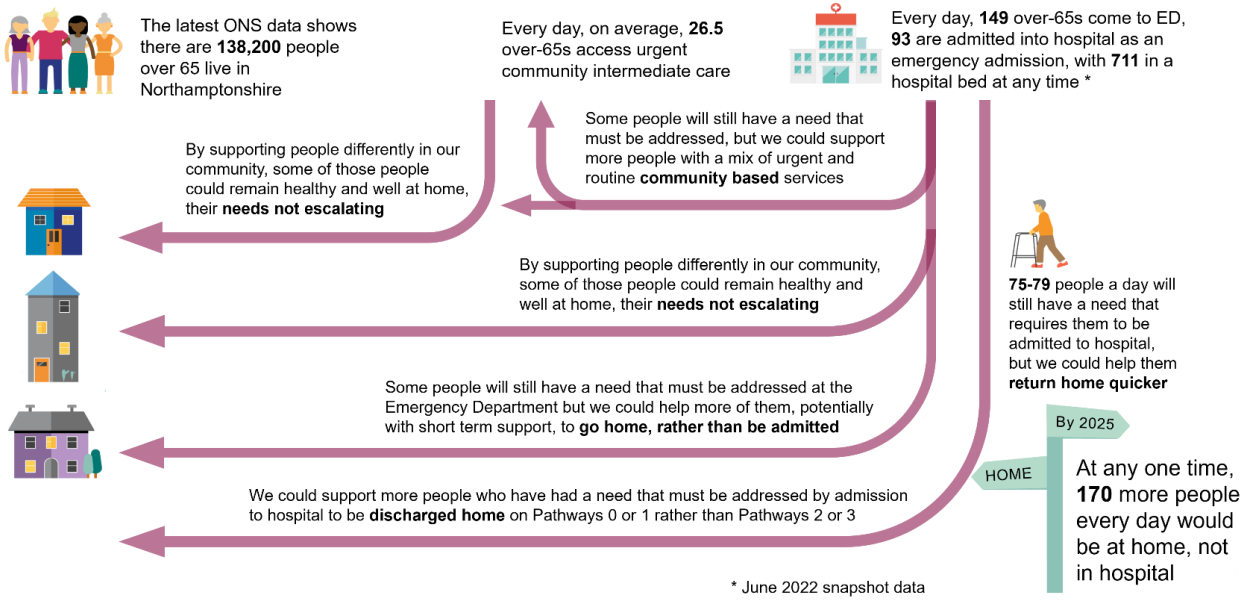
The ICAN BCF programme and budgets are overseen by joint health and care governance arrangements with all of the above partners engaged in monthly boards, weekly reviews and regular reporting to the ICB, HWBB and executives of all the partners listed. The programme is also working towards major improvement in KPIs across admission avoidance, reduced scalations, length of stay reduction, improved longer term outcomes and financial benefits, which are reported monthly and reviewed bi-monthly in a gateway review meeting attended system Directors of Finance and by NHSEI.

## 3. Executive summary

### Priorities for 2022-23 & Key changes since previous BCF plan

Our main objective in 2022-23 is to build on the transformation work done in 2021-22 and progress our integrated out of hospital delivery Model, described later in this plan. This will mean bringing together health and care and voluntary services, resources, assets and BCF and other funding sources into a single collaborative working within a single integrated delivery structure. In 2022-23 we continue to work towards this design through our ICAN programme which is targeting key improvement and transformation as well as formalising collaborative arrangements with delegated budgets and single outcomes contract for delivery. We have targeted several key and specific improvements in the over 65s cohort as part of ICAN BCF schemes and these are

- Reducing unplanned hospital admissions
- Reducing escalations to Acute care
- Reducing length of stay in Acute hospitals including reductions in patients with no reason to reside and stranded patients
- Reducing the Length of stay in community hospitals and rehab
- Improving our community offer & intermediate care
- Reducing the reliance on and use of long-term Care
- Delivering significant finance benefits to the system



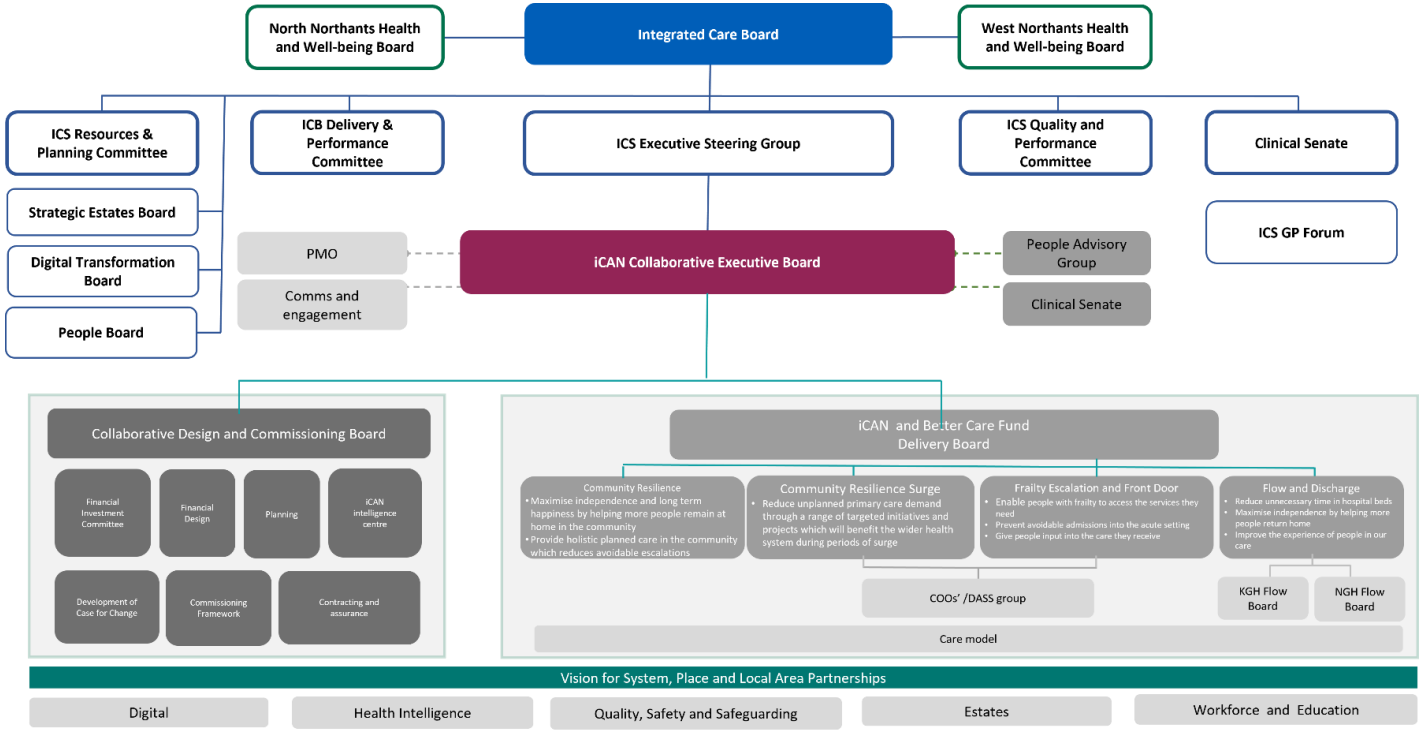

We are targeting over 65s within the BCF and ICAN and these specific improvements are designed to help us address our challenging demographic. Overall, the 2021 census showed that West Northants grew by 13% against a national average growth of 6%. But in the over 75s, West Northants saw growth of 58% compared to 37% nationally. Frailty increases with age, therefore having more people over 75 creates a disproportionate demand for support services.

We agreed as system that this cohort should be a priority for ICAN BCF schemes in order to mitigate the potential impacts of this growth on both cost and the quality and safety of care. While ICAN is a five-year programme we expect to make a significant difference against these priorities through these new ways of working and BCF schemes. The baseline we have and the improvements and changes we expect to see are summarised above.

While we are looking to bring in some additional services (like district nursing) into the 2023-24 BCF to align to our plans and remove some schemes (like mental health) where they are better aligned to other collaboratives, the BCF schemes for 2022-23 remain unchanged.

## 4. Governance

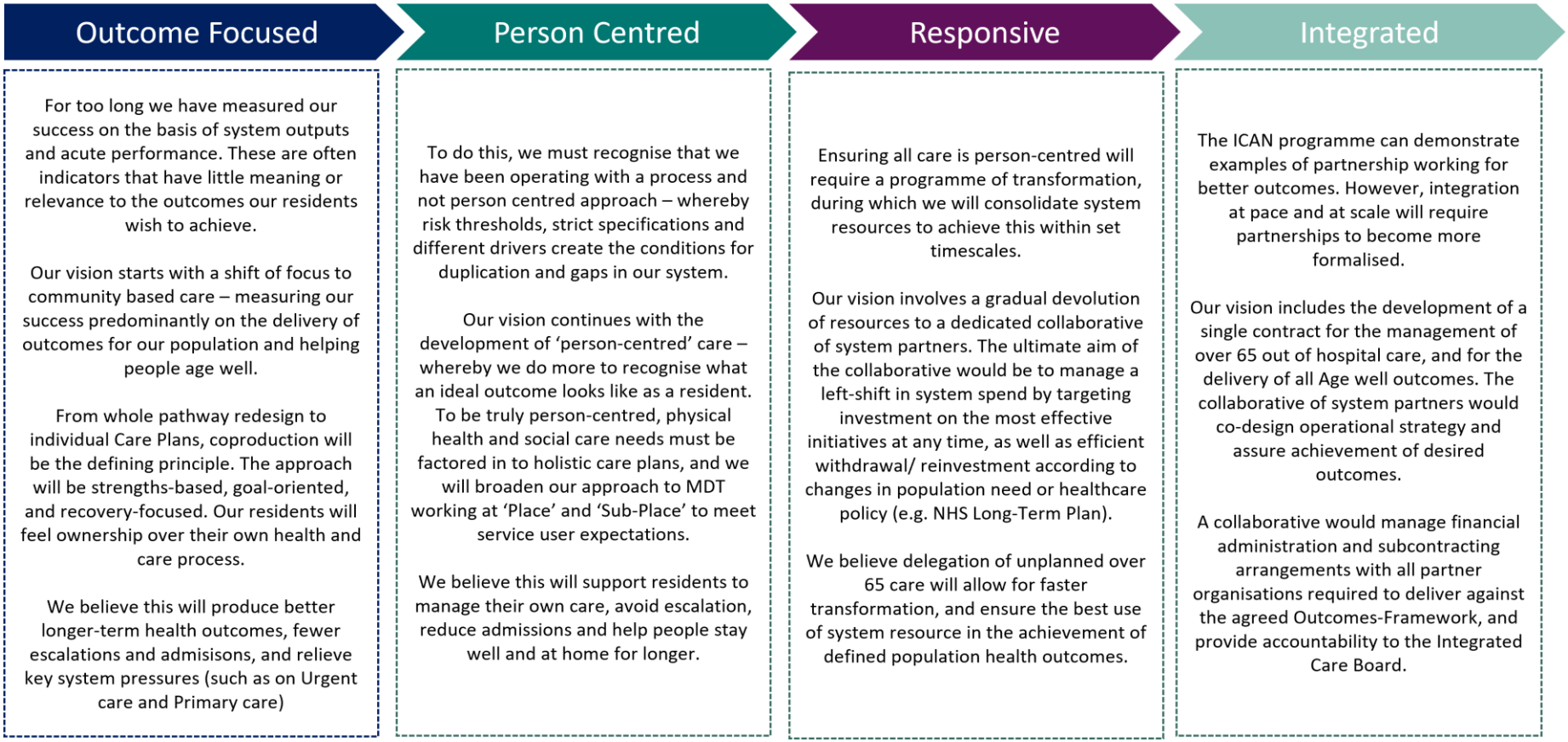
To deliver our ambitions, we have put in place the governance structure below that helps us oversee the BCF ICAN performance metrics and deliverables while also helping us transition ICAN from a transformation programme to an integrated service delivery model within a collaborative. This governance forms part of the ICB governance structures and ensures that the BCF performance is monitored via the ICS Planning and Resources Committee (for BCF finances) and through the Delivery & performance Committee (in terms of service delivery and BCF metrics)



## 5. Overall BCF plan and approach to integration

### 5.1 Outline of Joint priorities for 2022-23

Our priorities for 2022-23 builds on our work in 2021-22 and supports an overall move to more outcome focused and person-centred services that are both responsive and integrated. While we have immediate and significant challenges to reduce the occupancy levels in our Acute Hospitals and improve timely discharge, our ICAB BCF schemes are focused on a left shift of care to community-based care and away from increasing unplanned care. The changes we are making, the reason for those changes and the outcomes we are seeking are described below and involve moving to a truly integrated community offer.



The priorities for our 2022-23 ICAN BCF transformation programme funded through the PCF are:

## Reducing unplanned hospital admissions & escalations to Acute care by left shifting to more care in the community:

- **Community Resilience** - We are continuing to expand our work within the community through the use of community MDTs combining community health, social care, the voluntary sector and GP Age well teams to help people manage long term conditions and reduce the risks associated with frailty (for example falls). We now have frailty leads in all PCNs and are undertaking comprehensive care plan reviews using the MDTs and working with patients, carers and professionals to proactively prevent and mitigate the risks of frailty. Our work includes befriending services to reduce isolation, memory clinics and preventative support like balance classes (see further detail below). Multi-disciplinary and voluntary sector Welfare teams are also in place to support people stay well or follow up after a crisis or hospital visit and avoid readmissions.

"My mum would have ended up in a care home if it wasn't for her extended GP review" – Daughter of person who had a GP-led review

- **Remote Monitoring** – One our iCAN BCF objectives is to help older people stay well in the community, and remote monitoring will enable earlier identification of changes in presentation which could indicate an emerging issue. we have increased the level of remote monitoring instances both through the Virtual Ward programme for respiratory illness but also in peoples own homes. We have put in place the first large scale joint remote monitoring hub with combined council and nursing staff using an array of equipment to keep people safe. This project has introduced equipment to do the monitoring of patients' clinical observations and well-being remotely, by a team of senior clinicians. They then monitor and respond to the data that the equipment is feeding back. The Virtual Clinical Care Team is operating from 8am to 8pm daily and has the ability to respond within two hours to any significant abnormal data the system receives given clinical advice and guidance to manage the situation within the community.

- **Emergency Community Response** – our new Rapid Response pathways seek to increase the number of people using Rapid Response rather than attending hospital. As well as the success we have had in the community with an average of 35 referrals a day and 80% of calls needing a 2-hour response meeting targets, we are also now taking calls from the EMAS stack directly and from 111 more recently. At maximum throughput, this trajectory expects 6 additional EMAS referrals per day and 2 additional 111 referrals per day. One example of our successes is that 90% of long-wait fallers have already been supported to stay at home and the new pathway has saved an estimated 8.5 days of time where people would have been waiting on the floor.

Our first EMAS referral saved someone from waiting on the floor for 9 hours and inevitably avoided an attendance to hospital

### Reduced admissions as a result Frailty Escalation clinics and Front Door screening:

- **Frailty Units and Same Day Emergency Care** - our aim is to create a high performing and specialised team at the front door of our hospitals to support frail people to go home rather than be admitted into hospital. Both Hospitals now have frailty units in place with skilled teams who seek to screen, assess, and then discharge (with support if needed) and reduce the need to admit unnecessarily. It aims to discharge home 78% of patients referred. Despite a slow start with COVID the scheme is now meeting its target for referrals.

### Reducing Length of Stay In hospital through our flow and Grip work with:

*Great feedback from the clinical director for medicine: "We have seen improvement on this, it's working well... we're empowering the ward sisters "*

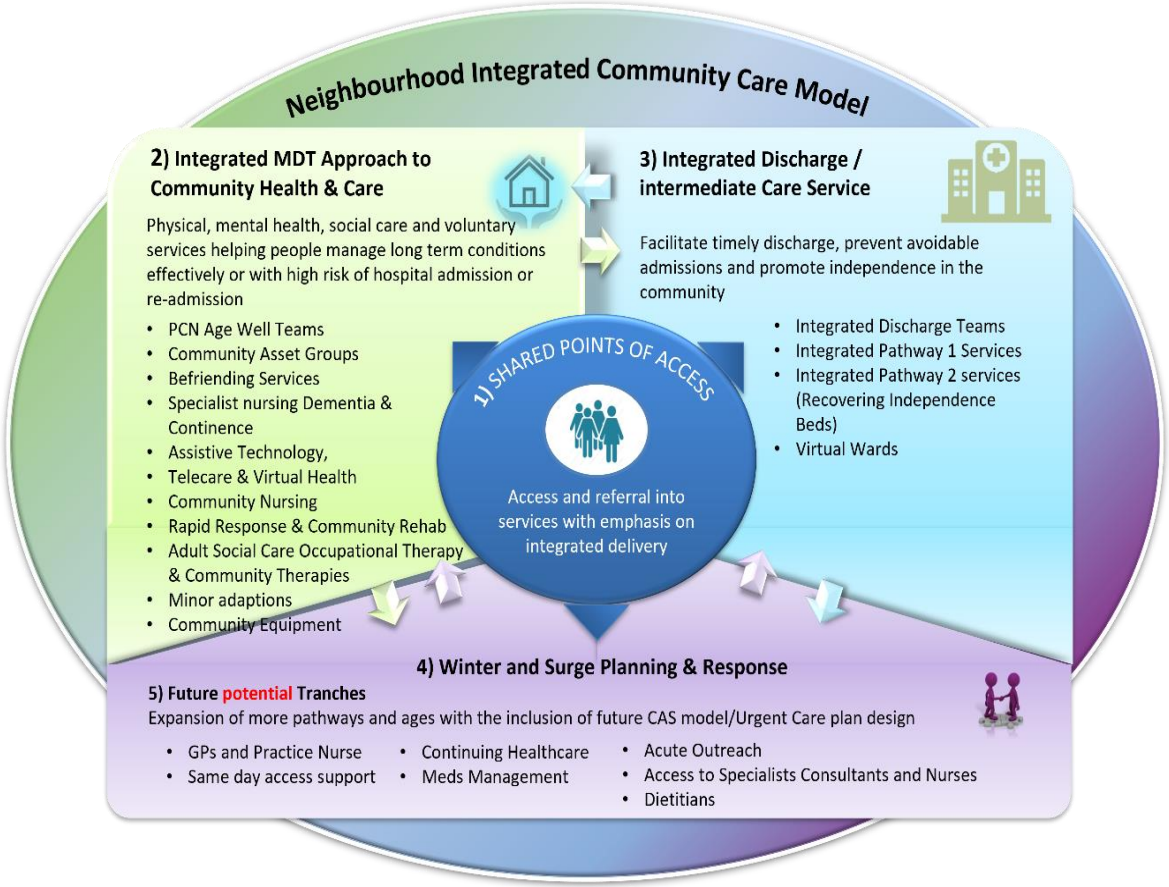
- **Board Rounds & Timely discharges -** Adopting new processes such as board rounds based on discharge best practice to enable a smooth and speedy flow through the hospital for our patients. The work here includes the development of an integrated Discharge Hub, improved early discharge expectations and a sustained focus on home first pathways.
- **Improved timeliness of diagnostics and use of community IV solutions –** past assessments have shown we over-use some diagnostic tests and delays occur when people wait for tests and during which time they decondition. We are now maximising the utilisation of all diagnostic systems and are now sending more people home with oral antibiotics or community IV rather than relying, as we have in the past, on hospital based IV solutions.
- **Trusted Assessments -** New forms are now being used in all wards replacing our PDNA forms that were over prescriptive and did not always represent the patient causing issues with Trusted assessments – the new 'What Matters to Me' focus creates a strength based, home first focus on all patients so they don't stay in hospitals when they no longer need acute care.

## 5.2 Approaches to joint/collaborative commissioning

The ICAN BCF programme and services are jointly commissioned by health and care and ICAN is one of the four Northamptonshire ICS priorities and collaboratives being developed. Investment in the ICAN BCF improvement programme has been provided by all partners and is monitored through the ICB governance arrangements. The ICAN collaborative will see all the services shown in the operating model below (funded by the BCF) placed into a formal collaborative in 2023-24 and we are acting in a shadow form currently. The ICAN BCF collaborative has just received ICB approval of its vision, scope and planned operating model and during the second half of 2022-23 we will be formulating and agreeing via the ICB, the outcome based collaborative contract

we will work to, with agreed KPIs and incentives for improvement and the final delegated budgets to be included. Delivery of out of hospital ICAN BCF services will be undertaken through a formally commissioned alliance contract covering services provided by the local authority, community health partner, Primary care age well teams and the voluntary sector.

The operating model for our collaborative will build on our ICAN BCF work to date with tranche 1 including all the services detailed in sections 1 to 4 of the diagram opposite to:




- **create formal commisioned integrated structures** and shared ownership of pathways
- **develop more trusted assessor approaches** with shared referral points in hospitals and from the community
- **operate an integrated intermediate care model** with Pathway 1 and Pathway 2 services with shared SLAs, less hand-offs and shared outcomes
- **increase avoided escalations to hospitals** with step up services to be developed working with GPs
- **develop a flexible shared workforces** that can respond to surges/Winter using data to inform joint interventions
- **expand ICAN pilots and integrate more prevention and wellbeing services** that can help avoid escalation for e.g. falls, supporting independence
- **work within the Neighbourhoods** and emerging Local Area Partnerships of our ICPs to join up wider services that effect the wider determinants of health and help prevent escalation, reduce unplanned care and improve population health outcomes.

## 5.3 BCF support for integration and changes to services commissioning through the BCF from 2022-23.

### The new shared remote monitoring hub

The hub went live in 2022-23 we have implemented a centralised monitoring hub that combines the existing response service provided by the local authority, monitoring lifeline responses and people with other assistive technology devices with the development of the use of telehealth across the county. This hub provides preventative and proactive engagement and response to people with low level assistive technology through to clinical decision making based on proactive monitoring of clinical data that people are providing from home.

We have rolled out the monitoring of telehealth in a number of care homes. The data is inputted by the staff from the care home and clinical team analyse the data, give advice and if necessary, seek further clinical input. The main objectives are to reduce GP input, admissions to hospital and to identify at the earliest opportunity any changes in clinical presentation to enable proactive intervention. Over the next 6 months the next areas of implementation are:-

- Virtual ICT ward of 20 patients. These are identified as having previous multiple admissions and re admissions to an acute setting.
- 600 people living in the community that are identified by GP's as having conditions/co morbidities that could be better monitored by telehealth equipment and the hub
- Utilising the hub team to proactively call all lifeline customers to identify where additional preventative support is required. This will be linked to the welfare teams in PCN's and the leads for the frailty clinics.
- Working with the MHLDA collaborative to see if the use of telehealth can improve health checks for people with an LD

Currently the service provides monitoring support to 5481 people plus the care homes monitored through telehealth.

### Redesigned intermediate care - pathway 1 services

Our ICAN BCF reablement services have faced significant challenges with demand and available capacity not aligned and as a result we have seen blocks in acute discharges and an overreliance on bed-based solutions that don't offer the optimum outcome for patients. The home care market challenges also effect the exit routes from Pathway 1. In 2022-23 the ICAN programme has been targeting significant improvements in performance and integration across the BCF pathway 1 services including working on local footprints to improve ICT/Reablement co-ordination and local improvement cycles to improve

capacity, the operating model and shift patterns of the workforce, process/Patient journey improvement and a harmonisation of ways of working – e.g., potential in assessment processes and on-going visit co-ordination / MDTs. During 2022-23 we ae specifically targeting:

- Capacity Improvement: Working through contracting and scheduling to align workforce to demand (see West reablement schedule variation right). Redesigned model in Reablement West would see weekly hours of care delivered increase from 491 to c. 1200.
- Length of Stay: Keeping a grip on length of stay and reducing days spent in service once optimised awaiting on-going packages of care – particularly a risk if taking more complex individuals into the services.

## New redesigned intermediate care - pathway 2 Pilot.

This ICAN BCF pilot aims to improve Pathway 2 step down service availability, supporting patients to be discharged promptly to the right intermediate care, and with the right wrap-around support to achieve their ideal long-term outcomes. We are moving towards a single integrated bed base of around 140 beds across the community hospitals, West Northants "Thackley Green" specialist care centre (SCC) and additional therapy based beds being set up in North Northants . We are calling these "**Recovering Independence Beds**" (RIB) because our focus will be to return people home. They will be overseen by a single management team led by our community health partners NHFT and will be staffed by joint health and care teams with a single point of access across the locations. The key elements of our model will be:

- **Single Point of Access** for referrals, with admissions seven days a week
- **Joint staffing model** of nursing, therapy and support staff allows flexibility of support around people as their levels of independence increase
- **Multi-disciplinary working** with joint plans, improving outcomes and reducing handovers and delays
- **Goals-based therapy focus**, allowing people to step out from RIBs at the appropriate point for them, not based on standard time periods
- **A culture of holistic support targeted at Recovering Independence**, with all staff members supporting the rehabilitation and recovery process
- **Beginning discharge planning from Day 1**, helping to reduce delays vs current settings
- Specialist Care Centre (SCC) sites include units with secure access, which is ideal for those with acute confusion/delirium
- Several rooms set up as individual flats –helping people achieve independence better than traditional hospital settings

We believe this will increase availability and flexibility of bed base and overcome the past challenges of underutilisation and blocks as the bed base available didn't exactly match the patients ready for discharge. We will also be targeting Length of stay improvements and P1/on-going care availability with smooth transitions.

**Who would the Integrated sites support?**

- **Medical/Nursing needs** - Those individuals who are undergoing reablement/rehabilitation but also have medical needs requiring nursing support. These patients would typically currently be supported in community hospitals (or some Nursing bed discharges e.g.. CHC pathways).
- **Residential Rehabilitation** - Those individuals who are undergoing reablement/rehabilitation who are not yet able to return home. These people are currently served by both community hospitals, SCCs and D2A residential beds.

Nursing and rehab cohorts would form most RIB bed patients – both cohorts could include step-up access as well as hospital discharges and potentially dementia and delirium patients. The pilot will run from September 2022 to March 2023 and will be closely monitored against range of KPIs including referrals, length of stay and returns home. The longer-term business case and funding model will be reviewed while the pilot is running and if successful the new model is likely to form part of ICAN BCF collaborative services in 2023-24.

## 6. Implementing the BCF Policy Objectives (national condition four)

### 6.1 Enable people to stay well, safe and independent at home for longer/Steps to personalise care, deliver asset-based approaches

In Northamptonshire we have implemented a holistic, strengths-based approach to creating care and support plans through the ICAN BCF and Age well plans. These are centred on 'what matters to me' principle rather than a traditional, often health led, 'what is the matter with me' desktop MDT approach. By placing the person at the centre, goals are created which are meaningful and achievable for the individual and their support network. We have adopted the 'no discussion or decision about me without me' core value from mental health and have embedded this into all our Ageing Well work.

*Patient testimonial from our asset groups: "In the past if I go to bed and do not wake up then it's okay really, now I have hope. The MDT was such a relief because someone cared. Now I go to be with a smile on my face"*

We utilise the framework of the Ardens Frailty Template but tailored for the individual situation; recognising that not every older person requires a full geriatric assessment but, by engaging with our population earlier in their ageing journey, we build a richness of shared information with the person. The baseline created enabled us to measure outcomes and changes in need over time. Our two key outcomes are improvement in person's self-reported wellbeing and how long their frailty level can be maintained at current (or better) level.

The power of social inclusion and peer support, especially amongst those with shared lived experience (person and carer), is recognised in Northamptonshire. Using our 2017 award winning community asset programme for people with COPD (Breathing Space) we have extended this to provide asset groups for Heart Failure, Diabetes and Dementia. These are all facilitated and run by our Voluntary Sector partners with specialist input and masterclasses provided on a rolling basis by a range of professional health, care and specialist advisors e.g. Financial Advisors, Bereavement Counsellors etc. Feedback from those attending and the staff delivering continues to be excellent reinforcing the oft heard view that small things make a massive difference to a person's wellbeing. "it's great to feel I am not alone and there are others just like me".

We have supplemented this with targeted strength and balance, fitness classes for those with frailty and / or cognitive impairment, identifying a gap in provision. These operate on a 'screen-in' rather than 'screen-out' attendance approach.

***It is our 2023/2024 ambition that every older person will have the opportunity to choose to, and the wherewithal to physically attend, an asset-based support group within their local area (five to seven miles).***

### 6.2 implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care

Whilst the themes we hear through coproduction are consistent around what good looks and feels like to age well, we know that the bespoke solutions are required to meet the diverse spread of the people we serve. Asset groups in town centre venues well serviced by public and voluntary transport are great but do not provide a viable option for the many older persons living in our rural areas where pop-up or rotating session programmes work better. We also ensure a choice in mix of face to face and on-line group support.

Our West Northamptonshire Public Health Team have, with the support of Optum this year, established learning sets helping us to use triangulated multi partner data sources to ensure our offers are both meeting identified need but are also engaging with all of our communities. As an example of this we chose to launch our Heart Failure Asset Group in Daventry this year as this was identified from our PHM analysis as a PCN with high ratio of older person registered population living with heart failure.

We work with our partners across all of our BAME and Protected Characteristic groups to ensure that solutions are meaningful. This can be fostering wider community integration e.g., having an older person fitness class for all delivered from a local Hindu Association Temple complex or by employing, through partnership with our Black Communities Together Group, staff who are recognised by communities and able to engage in first language where this isn't English as we are currently doing with our pathfinder work to support our Older Asian Communities in Northampton.

We review all of our activity data to test whether use of our new solutions is reflective of the population served e.g. are we seeing an expected share of persons from BAME communities in our GP Led Extended Review Clinics and our Group programmes and is their experience and outcomes comparable. Using our GP list demographic, we can triangulate and where a shortfall is identified we work with community groups and leaders to coproduce solutions.

Within our iCAN partnership team we have leaders from our LGBTQIA communities providing conduits for coproduction in the design and development of our Ageing Well Programme.

For 2023/2024 a priority focus for us is through our partnerships with Alzheimer's Society and Dementia UK to develop our support offer for persons with cognitive impairment associated with age, recognising the lower volume of persons from minority communities seeking timely help. Working with families to change our dialogue and our content where Dementia is not a recognised term or condition and helping to remove stigma will be essential as we know that early support can massively improve outcomes for many years, significantly reducing demand for long term care services.


Our ICAN BCF schemes and funding are supporting the rollout of new models of care and our June 2022 update showed that

- 128 patients had extended GP led reviews – with 854 patients cumulatively seen since we commenced the programme
- 14 of 16 of our PCNs are now delivering patient present multi-disciplinary team reviews of care plans
- A further 370 patients are now supported by PCN Age Well teams
- Attendance at community asset groups continues to grow, supported by roll out of Memory Hubs

### 6.3 multidisciplinary teams at place or neighbourhood level.

In 2018 we created our first PCN Integrated Age Well Team comprising team members from voluntary sector (Northants Carers, Age UK, Alzheimer's Society), Adult Social Care, Community Health and Primary Care. All staff, regardless of which organisation they are employed by, work under the day to day leadership of their team lead employed by the PCN and have same core training and skills development e.g. all can take basic patient observations, assess for, order and supply low level equipment, complete PQ9 and GAD mental health assessments, provide advice on benefits, attendance allowance etc

but most importantly all have been empowered to work with the individual person to sort what matters to them at that moment. The teams are able to fulfil the tasks that often fall into the gaps of someone's responsibility, but nobody knows whose.

During 2021 /2022 we have expanded to create eleven PCN Age Well Teams covering all sixteen of our PCNs. Age Well Teams cover circa 70,000 GP list size which is around 14,000 persons over 65 for each team.

Through our partnership ICAN BCF programme we have now secured a dedicated Frailty GP Lead(s) for every Age Well Team, supported by the PCN Pharmacist, Advanced Nurse Practitioner and other specialists including social care as needed are able to provide extended GP led reviews, the majority of which take pace in person's own home through Microsoft TEAMs call with the Age Well Coordinator being with the person. Our learning to date is that around 25% of new referrals require the extended clinical team input. Our Adult Social Care (AEW) team members are linked to their local ASC Teams and are able to identify from duty lists and low-level safeguarding concerns received, persons who would benefit from the Age Well Team input.

The Age Well Team approach adopted is of warm transfer and never cold onward referrals to another service which avoids leaving the person confused on what will happen next and unsupported.

All Age Well staff are trained and provided with NHS laptops and smartphones enabling them to directly update the person's health record providing the GP and primary care team with much greater awareness of the holistic person, their living circumstances, areas of confidence, causes of concern but also ensuring through our digital interoperability solutions that this same level of information is visible to those responding to the person at point of crisis or escalation.

Our 2022 /2023 priority is to extend the capacity of the team; at present there is limited resilience as no cover for leave or unplanned sickness and the volume of referrals is increasing and to further embed remote monitoring and assistive technology as core tools to aid independence and confidence of the person / carer.

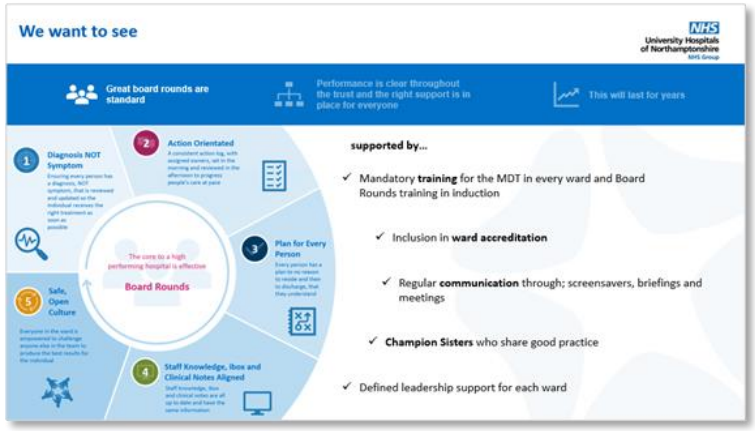
We are already seeing several of our PCNs moving to the next level of integration with their Care Home Coordinators attending shared team meetings with the Age Well staff and in some cases people with dual roles supporting people in their own home and a care home in their area. By having Age Well staff it has supported the PCNs to focus their Social Prescriber capacity onto those persons under 65.

Our learning has been shared with the NHSE/I team nationally leading on Anticipatory Care and has helped to inform the scope and ambition of the eagerly awaited Anticipatory Care Specification.

As part of the development of our Integrated Care Partnerships (ICPs) we are creating 9 local Area Partnerships (LAPs) across West Northants. These LAPs will be based on populations of between 30,000 – 50,000 and will be small enough to provide personal care through integrated neighbourhood teams, but big enough to make sure residents can use the range of services they need. Each LAP will provide support to neighbourhood teams by aligning additional services often related to health and wellbeing to the neighbourhood teams, this includes housing, debt advice, mental health services and leisure services.

**Provide the right care in the right place at the right time**

### 6.4 Support safe and timely discharge




As set out in section 5.1, we have made improvements across our discharge processes starting with the target that all patients will receive a letter on admission about their expected discharge expectations. In addition, we have moved to a best practice model of 'What Matters to Me' when discussing expectations with patients. This creates a strength based, home first focus on all patients so they don't stay in hospitals when they no longer need acute care

The ward referral and transfer of care hub processes to improve the speed of the discharge decision making processes. Most of our delays in discharge queues, for both bedded and home-based intermediate care, are either when patients are waiting for capacity to become available, or when a patient becomes not medically fit, but the referral process is kept open. As far as possible we try to avoid moving people to other bedded settings purely while they wait for the appropriate pathway to be available. Reducing the need for this is one of the raesns we have redesigned pathway 1 and 2 services as set out in section 5.3 abive to ensure that there is a graeter likelihood of people returning home and/or to independence.

Going forwards, we are improving the visibility of queues and wait times for each pathway, using data from both Transfer of Care Hubs and the Pathway Services. This will enable targeted continuous improvement and data-led decisions on capacity, and when to e.g., use spot purchase or alternative pathways as the best option to maintain hospital flow. We will continue to try to improve referral to discharge time, which will be most impacted by capacity improvements in services.

We can confirm that our approach addresses all the key criteria set out in the High Impact Change Model. The one area of the model where we require further work and workforce development is the **seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system**

### 6.5 Collaborative commissioning of discharge services to support this.

ICAN is an ICS system wide commissioned, funded and resourced programme supporting ageing well and admission avoidance but also timely discharges based on home first principles (where possible) and joint health, care and VCS "Welfare teams" who follow up on discharges to ensure we reduce the likelihood of readmissions. As set out in section 5.1 to 5.3 above this incudes jointly commissioned new intermediate care services using shared resources including:

**Pathway 1 capacity** – the council reablement service is currently undergoing significant HR and scheduling changes to improve the capacity of the service from providing c. 500 hours per week to a targeted 1100 hours. This increase will both cover the capacity currently delivered by the H2H service which was covered by D2A/ temporary funding, and then provide further starts capacity on top – aiming for the service to be able to move from c. 67 starts to c. 122 starts per month.

**Pathway 2 model** – Collaboration between NHFT and the two councils to pilot a new integrated care model in pathway 2 across 102 Recovering Independence Beds (RIBs) in the system over Winter. This would see a broader spectrum of staffing and people utilise the RIB beds, and with the right culture and holistic support to enable more people to return home and maximise their independence. Community Hospitals are also working on length of stay improvements to drive more capacity and starts per month – aiming for c. 10% improvement in length of stay through reducing equipment delays and implementing more goals-based discharge approaches.

## 7. Supporting unpaid carers.

As a system Health and Care invest over £1m of our BCF funding annually in Northamptonshire carers as the main provider of Care Act Carers assessments, support and advice for carers, respite breaks for both adult and child carers and wider services to help support unpaid carers in their key role. One in ten people on Northamptonshire is a Carer or Young Carer and they care for over another tenth of the population. We have commissioned services that seek to ensure carers are recognised and valued and that they can access the right support/advice/information at the right time, that they can enjoy a life outside their caring role and that carers own health and wellbeing is a priority

We aim achieve this by providing high quality, easily accessible information, advice and support which is timely and appropriate, delivering a range of preventative services that will delay, prevent or reduce the need for more intensive support for Carers and carrying out quality statutory Carers assessments to identify eligible support needs and a support plan that enables the Carer to maintain their caring role on a long term basis as required

Ensuring feedback is sought from Carers which is independent, impartial and meaningful is important to us and from the outset of the ICAN transformation that we engaged the view of patients and carers in our design and the development of our offer.

The PAG (patient Advisory Group) is led by No9rthamptonshire carers and gives the people group (including those who will benefit from the use of services or who care for people who use them) oversight of the developments that occur within the iCAN programme. Meeting monthly, the PAG also promotes, aids and helps to develop co-production of services. Membership is formed of patients, carers and service users, and includes key professionals and service leads will also on occasion be invited to present to, or update the group on key issues.

## 8. Disabled Facilities Grant (DFG) and wider services

The BCF DFG plans and approaches within the plan has been agreed by West Northants Council as a Housing Authority and brings together Housing, DFGs, occupational therapy and social care come to ensure that DFG funding is used effectively to help people stay I their own homes longer. From a housing and accommodation perspective our health, care and housing leads have worked together to increase the capacity we have across the county that can support independent living through several lenses. Our occupational therapy teams are now working alongside the housing DFG teams as part of plans to invest in improving accommodation earlier, removing waiting lists and considering more significant conversions that can support complex care and be used by future residents. While we saw backlogs for adaptions in 2021-22 we have cleared this and we are now utilising all of our budgets. We have also introduced some new elements of service including:

- Introducing a fast-track process
- Removing financial assessments for Disabled Facilities Grants under £5,000
- Maintaining a register of accessible homes for people to move into
- Introducing a new service to make minor repairs and
- Continuing our care and repair service to support discharges

We are working together with health across a range of housing services to ensure that people can remain independent longer, these include

- Extra Care – we have several extra care facilities supporting older people to stay independent and the CCG are also commissioning some of the flats as facilities for complex medical rehabilitation and step down for non-weight bearing patients leaving hospital.
- Supported living We have opened our first Learning disabled supported living village "Oak Rise" in 2021 which is based on a national best practice model and is jointly funding through the CCG and Councils to provide a community supported living facility for some of our most complex shared patients. This helps them remain independent and out of residential and hospital care for longer and live the best life they can, protected by on site care staff.
- Specialist living - We opened our community based complex Mental Health and Physical disability supported living facility, Morray Lodge in 2021 This has 20 flats equipped with assistive technology and equipment and provides a level of independence with on site specialist support and is our first shared step down facility for decades for these cohorts.

## 9. Equality and health inequalities

Since 2021-22 we have been working as a system on developing our population health outcome framework. This is designed to help us gauge the effects of interventions accurately and rapidly, and at a range of different population levels, allowing the tailoring of interventions and incentives to deliver both the highest impact and best use of resources. The main aims of the framework will be to Improve the health and wellbeing of the population and address health and care inequalities.

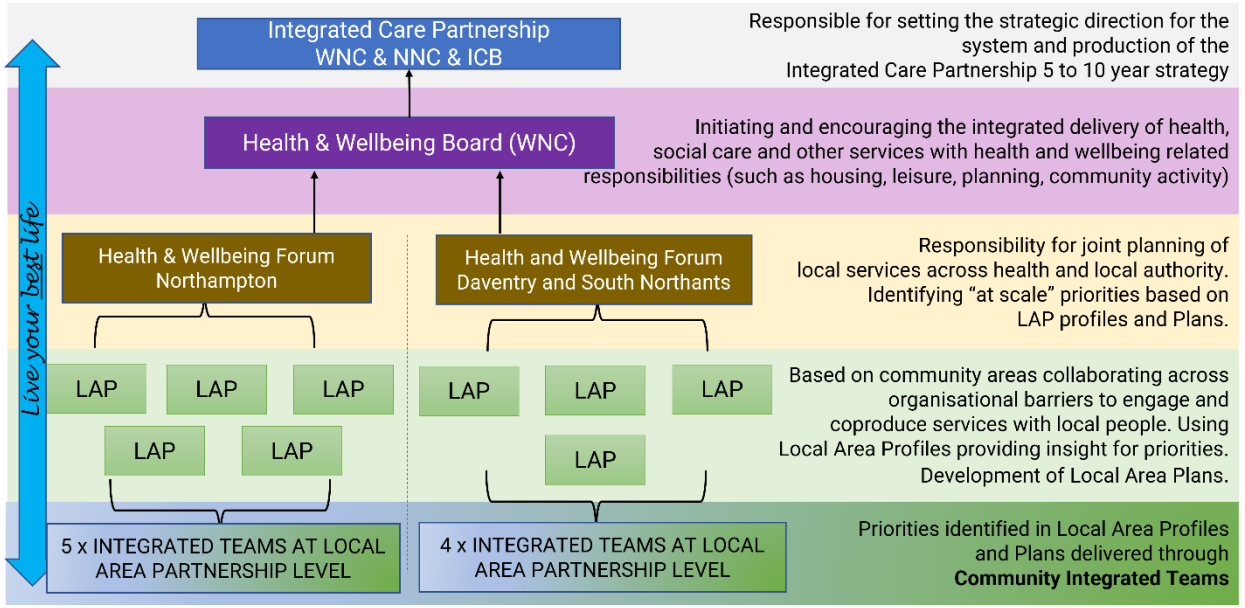
We have agreed 10 domains as part of our overall approach about people "**living their best life**" (LYBL) against which we will measure ourselves and identify and target identified inequalities.

| | |
|---|---|
| Best start in Life | To feel safe in their homes and when out and about |
| Access to the best available education and learning | Connected to their families and friends |
| Opportunity to stay fit, well and independent | The chance for a fresh start, when things go wrong |
| Employment that keeps them and their families out of poverty | Access to health and social care when they need it |
| Housing that is affordable, safe and sustainable in places which are clean and green | To be accepted and valued simply for who they are |

In relation to the ICAN BCF schemes the key inequalities measure is Access to health and social care when they need it. Linked to this we have set out a clear set of outcomes that reflect our plans to reduce hospitalisations, ensure people are discharges in a timely way and where possible to their home. The focus of our schemes is providing the right care in the right place and ensure that all over 65s can live their best life.

As ICAN BCF services are targeting the frail and elderly the main inequality we are seeking to address is the variable outcomes and inconsistent services that over 65s have experienced in the past. In 2022-23 the ICB will be formalising the framework which will then form the basis for contracting and commissioning services that will also deliver to a range of national metrics and service level agreements.

More widely as part of the West Northants ICP development we have agreed that we will adopt an operating model with the **Objective that** Health services, care services and wider determinates of health services are integrated at a local level to focus on the needs of the community. We have also agreed that we will across nine geographical Local Area Partnerships (LAPs).



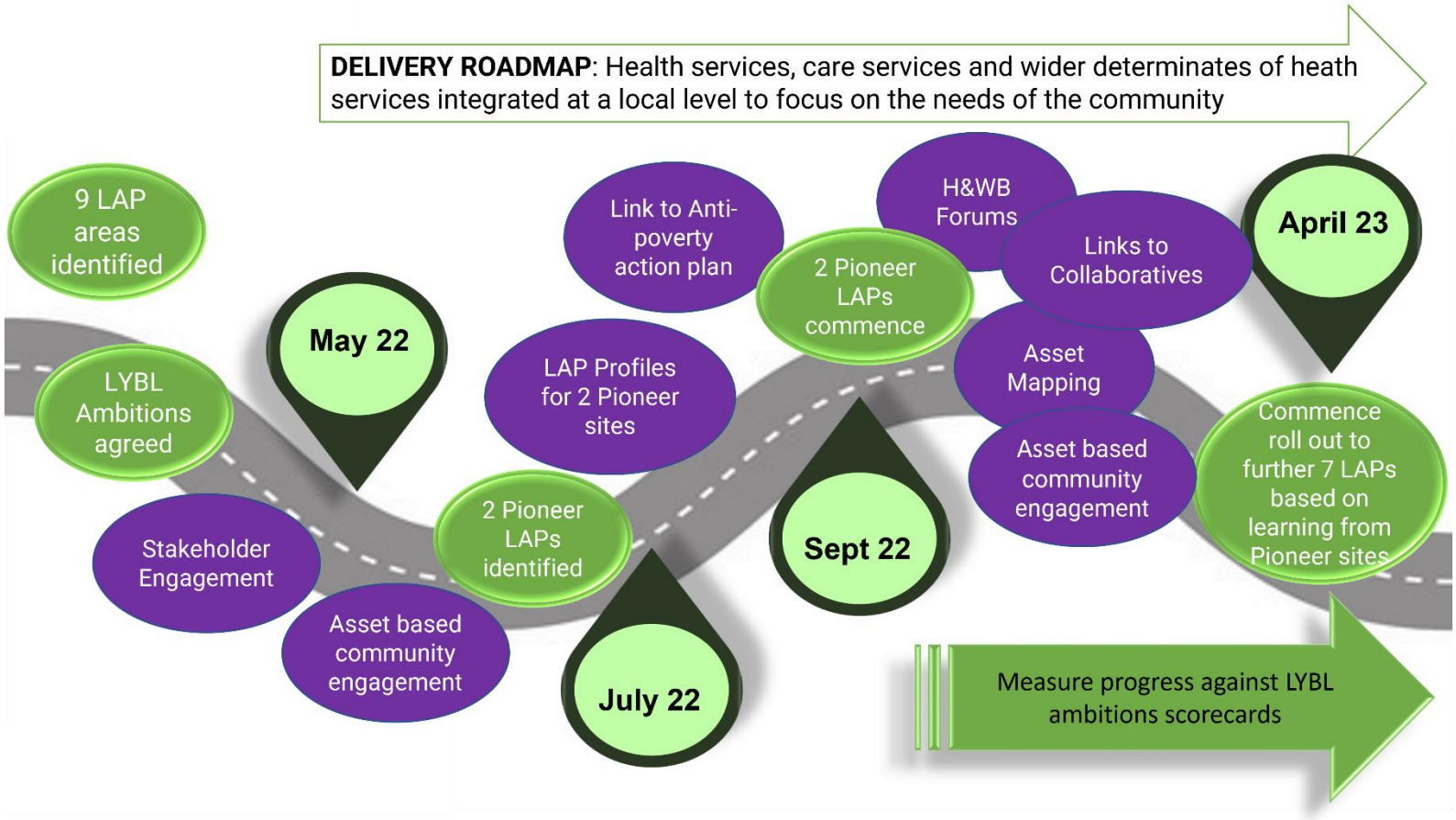

These LAPs will have specific intelligence based local area profiles that set out how the local population measures against the wider determinants of health as well as wider national standards. It will also include the mapping of local assets, community groups and public and voluntary services in the area.

This information will allow us to map and share data insights and local and national data by GPs/PCN and LAP helping us target the specific needs of the community. It will also allow us to see the prevalence of certain conditions, inequities or need and target services, assets and shared resources at improvements. This recognises the unique nature of an area and circumstances of its residents and will ensure we are providing appropriate interventions to improve health outcomes and address inequity of access.

Our plan extends beyond health and care and we have also mapped adults social care services, voluntary sector services, police beats, housing teams, iCAN welfare support teams, buildings, anti-poverty work, anti-social behaviour teams and housing a debt services to each LAP. By doing this we can ensure that services can be aligned, and actions taken to reduce crisis, for example we know that debt and housing issues often underpin mental health issues.

The LAP model and use of local area profiles will commence in September 22 and will start with two "pioneer areas" selected specifically to test the model in very different areas. One is in Northampton with high deprivation, poverty, crime, mental health issues and significant childrens services presence to

meet need. The second is in South Northants and Daventry which is more rural, has an older population and has more issues with isolation, a lack of childrens centres but high falls. Both Pioneer areas have the full engagement of GPs in the areas, and we are building a full data profile on which the Health and Wellbeing board and health and care partners can agree the services that will best address the needs of residents and improve outcomes against the 10 live Your Best Life (LYBL) measures. The roadmap for the rollout of this across all 9 LAPs in the Health and Wellbeing board area is below.



WEST NORTHANTS Health and Wellbeing Board
live your best life

# WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

## 25th May 2023

| | | |
|---|---|---|
| **Report Title** | Joint Local Health and Wellbeing Strategy progress update | |
| **Report Author** | Sally Burns - Director of Public Health | |
| **Contributors/Checkers/Approvers** | | |
| **Other Director/SME** | Sally Burns, Director of Public Health | 17th May 2023 |

**List of Appendices**

**Appendix A & B – Summary feedback from external consultation events**

**1. Purpose of Report**

**1.1** This report updates Members and partners on the progress being made in the development of the Local Joint Health and Wellbeing Strategy (JLHWS). Specifically, it reports on the outcomes of local engagement being used to shape the strategy.

**2. Executive Summary**

**2.1** The Health and Care Act 2022 requires all Health and Wellbeing Boards to develop and deliver a Joint Local Health and Wellbeing Strategy. This strategy will compliment and contribute to, the system wide strategy, 'Integrated Care Northamptonshire' (ICN) which was adopted by the Integrated Care Partnership (ICP) in December 2022.

**2.2** West Northamptonshire now needs to decide and agree the key priority outcomes for the JLHWS to realise its ambition to ensure local people Live Their Best Life. To do this it will take an evidence-based approach to determine where the best progress can be realised. This will be achieved by considering data collected though the Joint Strategic Needs Assessment (JSNA) and listening to residents and local organisations 'lived experiences' on the ground gathered through a range of engagement events over the last 12 months.

**2.3** This report focuses on the local feedback gathered and how it will inform delivery against the 10 Live Your Best Life ambitions. It also outlines the engagement being undertaken now with local leaders and town and parish councils.

**2.4** Finally the report considers future steps and plans and the developmental milestones for the final strategy which will be presented to the HWB meeting on 27th July 2023.

**2.5** To aid the analysis of local engagement feedback a matrix has been produced mapping feedback against each of the 10 ambitions. This matrix is attached as Appendices A&B.

**3. Report Background**

**3.1** The Health and Care Act 2022 changed the leadership architecture around the Health and Care system. An integrated Care Board and Partnership were established in Northamptonshire including membership from West and North Northamptonshire Councils and other key system partners.

**3.2** HWBs will continue to be responsible for assessing the health and wellbeing needs of their population and publishing a joint strategic needs assessment (JSNA) and a joint local health and wellbeing strategy (JLHWS), which sets out the priorities for improving the health and wellbeing of West Northamptonshire and how the identified needs will be addressed, including addressing health inequalities, and which reflects the evidence of the JSNA and feedback from local people.

**3.3** The JLHWS will directly inform the development of joint commissioning arrangements (see section 75 of the National Health Service Act 2006) in West Northamptonshire and the co-ordination of NHS and local authority commissioning, including Better Care Fund plans.

**3.4** As required by the Health and Care Act 2022, the ICB has led on the development of a System-wide Health and Care Strategy which is now agreed and will be in place as a five-year strategy from 2023.

**3.5** This strategy has a framework of 10 challenging ambitions to enable residents to **Live Their Best Life**. The delivery of this ambition will be driven through a series of agreed outcomes, or statements outlining what success will look like in Northamptonshire. A range of metrics and a delivery plan will be used to measure progress and success through the life of the strategy.

**3.6** Whilst many of the outcomes relate to the availability of, and timely access to, primary and acute support and services, many relate directly to the wider determinants of health or the development of healthy communities.

**3.7** To ensure that the board builds on its unique 'place' role to support the delivery of the Integrated Care Northamptonshire Strategy the HWBs is required to agree and deliver a Joint Local Health and Wellbeing Strategy (JLHWS) to ensure that locally agreed ambitions and outcomes can be fully delivered in West Northamptonshire.

**4. What we have done so far**

**4.1** Over the last 12 months partners have undertaken a range of engagement events which address the health and wellbeing of local people. These range from broad surveys to participative events with smaller groups in local communities.

**4.2** Analysis of the feedback from engagement events is rich and detailed however there are key themes emerging which alongside data, provides a strong direction for the JLHWS.

**5. Key themes from engagement insight include:**

- The need for a strong focus on ill health prevention to support stronger, healthy communities and take pressure off primary care and acute services
- Improved access to primary health and care services; in particular for those who suffer from health inequalities/some minority communities
- The desire for outreach support and advice based in local communities particularly in relation to services for families, learning difficulties, mental health, and the frail elderly
- The need for confidence building in local communities to promote self-help, community action, and problem reporting
- More local collaboration across public, private and voluntary organisations within local communities/parish council areas to re-design and commission services.
- Environmental improvements are needed in local areas to reduce blight, improve outdoor spaces, and prevent crime and disorder
- Support for minority groups experiencing health inequalities is required including migrants, travellers, sex workers, carers and the homeless to access services to support health and wellbeing.
- The need for improved and more timely access to mental health services for children and young people
- Increased opportunities for children and young people to access affordable activities out of school to promote well-being and divert them from crime and disorder
- More affordable housing and affordable warmth is critical for health and well-being
- Addressing isolation especially for the elderly, single parents, and recent migrants will support well-being
- Strengthening community transport will improve access to health and care services
- Increase opportunities for vocational training for young people and migrants seeking to convert and build upon skills they have acquired elsewhere will promote employability and local skills shortages
- Improving access to and increasing the availability of green spaces to promote well-being.

A summary matrix of feedback relevant to the 10 Live Your Best Life ambitions is attached at Appendices A&B. This analysis will support service commissioners and providers in the development of key outcomes and delivery plans. Additionally, a report that goes into greater depth for each engagement event is available for consideration.

**6. Engagement Insight Library**

**6.1** This extensive analysis will be incorporated within the Engagement Insight Library which is currently being coordinated by the Integrated Care System. This repository will support any partners who are undertaking engagement or involvement work with the local population. It seeks to collect consistent themes, what the engagement was and who contributed. It also helps partners avoid engagement overload and duplication. Key benefits in supporting this development are: -

- Support for collaboration between organisations around insight. This enables links to be made between individuals/organisations who are working on the same area, or are wanting the answers to the same questions.
- Move away from seeing residents as patients or service users towards seeing them as

members of local communities with valuable experience and insight to share a role in community development
- Support the use of a variety of methods for gathering insight, moving away from an over-reliance on surveys, to methods that nurture and use existing relationships.
- Collect and organise insight being gathered across the system to make it easily accessible and searchable.

**6.2** Some engagement has already taken place with internal leaders to capture key priorities from a delivery perspective. The key themes arising as a priority were:

- The mental health of children and young people
- Supporting those in poverty

**6.3** Consultation with internal teams and local leaders is still in progress including:

- Thematic leads
- Members and Parish Councils
- Community and Voluntary Sector
- System teams

**7. Next Steps**

**7.1** Further analysis of ongoing and planned engagement feedback will add to the rich picture we are forming of the health and wellbeing needs in West Northamptonshire.

**7.2** Using this information, thematic leads will develop and shape the key outcomes against the 10 ambitions including how we will tackle health inequalities and measure progress. This should be completed by the end of May 2023.

**7.3** An engagement plan to sit alongside the draft strategy is also in development to inform and review priorities over the life of the strategy.

**7.4** With the completion of this stage, the strategy can be finalised for presentation to the next Health and Wellbeing Board.

**8. Issues and Choice**

**8.1** Whilst we have an extensive range of feedback from engagement events over the last year Health and Well Board partners may be aware of other engagement events undertaken over the last 12 months that have not been picked up in the development of the strategy.

**8.2** The Board are therefore asked to provide any further insights from engagement events that can be provided prior to the end of May 2023 to inform the development of the JLHWS.

**9. Implications (including financial implications)**

**9.1.1 Resources and Financial**

The additional costs of engagement have been met from existing public health budgets.

**9.1.2 Legal**

There are no legal implications arising from the proposals.

**9.1.3 Risk**

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

**9.1.4 Consultation**

The report sets out the consultation underway as part of the development of the Health and Wellbeing Strategy

**9.1.5 Consideration by Overview and Scrutiny**

This report has not been considered by overview and scrutiny committee

**9.1.6 Climate Impact**

No Implications

**9.1.7 Community Impact**

Engagement is underway with a range of already established community groups and via focused pieces of work. The strategy will also set out the plan for wider consultation going forwards at a place level as part of the Local Area

**10 Background Papers**

No Background papers

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## SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe, and secure in places that are clean and green |
|---|---|---|---|---|---|
| Parker Academy Year 8 | A range of after school activities to support wellbeing | Activities based in a school setting | | | |
| Sex Workers | | | Outreach sexual health mentors and wellbeing support at safe locations | | Need support with housing |
| Southbrook Daventry | | | | | Improve outside social places |
| Eastfield Northampton | | | | | Address fly tipping |
| Kingsheath | Ensure there is somewhere young people can meet | | Provide an outdoor gym and a safe Astro turf space | Provide outreach: Job Club, financial advice service and food bank | Improve outside social places.<br>Address fly tipping and provide more recycling bins |
| St. Davids Kingthorpe | 'Drop in' service for young parents | | Provide an outdoor gym, outreach crisis café for young people | Provide outreach: social enterprise and financial advice, | Set up Neighbourhood Watch |
| Adult weight management survey | | | More weight management groups and other support options | | |

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe, and secure in places that are clean and green |
|---|---|---|---|---|---|
| Boat Dwellers | | | | Get no financial support, no access to GPs as classed as No Fixed Abode | |
| Blackthorn | More activities for young people | Coaching activities to support health and wellbeing.<br>Vocational training opportunities locally e.g. mechanics, brick laying, bike maintenance | Outreach: mental health drop in/support<br>More support services for men | | Increase biodiversity eg no mow areas and pocket parks, community allotments<br>Community 'clean-ups".<br>Improve local outdoor facilities |
| Daventry Young People | Improve advice and support to adults who work with YP.<br>Increased activities which support CYP wellbeing | | | | |
| Big Conversation WNH | Local support services for families and young people.<br>Develop Youth councils locally | | Local support groups for health and wellbeing and those with disabilities | | Protect rural areas and improve parks<br>Address Fly tipping<br>Develop cycle routes and greenways<br>Energy efficient housing affordable housing |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe, and secure in places that are clean and green |
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| PAUSE service for women who have had children removed | | | Bespoke services for improving life chances | | |
| Kings heath coproduction group | | | | Importance of being able to access help and support locally about benefits, employment, etc | A street meet event in each street with residents and public services to discuss improvements.<br>Small scale growing plots. |
| St. Davids Kingsthorpe coproduction group | | Skills and vocational training available locally | Healthy activities at an accessible cost | Community based job Club, financial advice, Food bank | An improved community square to support outdoor social activity |
| Healthwatch: Carer experience during COVID | | Closure of schools during COVID was detrimental to carer and cared for. | Impact of caring detrimental to health and wellbeing. Mental health anxiety and depression had worsened. Many could not take breaks from caring as no one else was available | | |

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| Healthwatch: Young People<br>Impact of COVID | | Some children and YP disliked home/online learning<br>60% felt they had received the right amount of support from their place of education. This was lower in older age groups. | Some struggled with mental health missed the support of school counsellors and other school staff.<br>More than half of all young people said their emotional/mental health worsened | | |
| Healthwatch: Young People<br>Physical, Lifestyle and Emotional Health | 64% said they had 4 or more portions of fruit and veg daily.<br>Highest % of coping strategies used by YP was listening to music. | | 64% had 4 or more days where they got at least 60 minutes of exercise a day.<br>A higher proportion of YP did not participate in a sports team or exercise class then do 64% v 34% | | |
| Healthwatch; Young People Focus Group on specific services | | | YP want more opportunity for outdoor exercise. | | |
| Healthwatch young carers | | Over half of Young carers prefer to access support for emotional wellbeing at school. | 64% said they felt their caring role affected their emotional wellbeing or mental health.<br>65% knew how to access support for this. | | |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

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| Primary Schools Survey 2022 | 36% of pupils said that they feel afraid to go to school due to bullying at least sometimes.<br><br>23% of pupils said that they had been bullied at school in the last 12 months. 22% said they had been bullied online.<br><br>Only 31% of pupils say that their school has a School Nurse. | | 66% boys and (72%) girls reported worrying about at least one problem.<br><br>Issues include:<br><br>**Year 4** Environment 51% (45%) War/Terrorism 51% (46%)<br><br>Crime 43% (46%) Secondary School 46% (62%) Covid 41% SATs/tests (44%)<br><br>**Year 6** War/Terrorism 40% (43%)<br><br>Secondary school 39% (52%) The way you look (47%) Environment 35%, Crime 31%, Friends (41%)<br><br>SATs/tests 30% (39%) | | |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

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| Secondary School Pupil Survey | 21% of pupils reported having nothing to eat or drink for breakfast on the day of the survey. | 42% of boys and 69% of girls worried 'quite a lot' or 'a lot' about exams and tests. | 55% of pupils said that they 'rarely or never' have fish/ fish fingers.<br><br>When asked, what stops them from doing as much exercise as they like, 24% of boys and 37% of girls said they didn't have enough time.<br><br>29% of pupils have at least tried e-cigarettes.<br><br>47% of pupils said that friends were their main source of information about sex and relationships.<br><br>37% of pupils worried about their mental health. | | |

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| Secondary School Survey 2022 Continued Opportunity to be fit well and healthy | | | 51% of pupils said that if they were worried about something, they know an adult they trust who they can talk to about it. 19% said they didn't. When they have a problem that worries them or if they are feeling stressed, 38% would at least 'sometimes' talk to someone about it. 28% said they would think carefully about the problem by themselves. 13% said they would cut/hurt themselves at least sometimes.<br><br>44% of pupils said they were at least 'mostly' happy with their lives now. 18% were either 'not happy' or 'very unhappy'. 39% of pupils said that worry often stops them concentrating on or enjoying other things. | | |

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| Secondary School Survey 2022 Continued Opportunity to be fit well and healthy | | | 20% of pupils said they find it hard to concentrate or enjoy other things because of worry. There are gender differences 'when things go wrong'. If something goes wrong 15% of boys and 52% of girls usually or always get upset and feel bad for ages. | | |

## SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe and secure in places that are clean and green |
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| Hope Charity Poverty Study | | Some African migrants enter the UK with good educational qualifications but are not supported to transfer those skills or undertake short courses to add relevant skills like IT. This results in them being underemployed. | Eastern European migrants do not know how or where to access foodbanks as they do not exist in their countries.<br><br>Some African communities will not accept food support due to pride. Some do not know how to use 'British' food like tinned provisions. Others fear a 'British' diet causes Autism<br><br>Some BAME communities hide health problems due to stigma including, HIV and mental health problems. | There is exploitation of some migrant communities in terms of employment. Often this is by small businesses in their communities e.g., car washes. Long hours, poor pay, and conditions.<br>Some agencies also exploit migrants e.g., in the care sector. | Access to social housing often difficult for migrants in terms of producing key documents etc. Those in social housing and the rental sector also suffer from poor maintenance services. The private rental sector is also a barrier requiring credit score and guarantors. |

## SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 1

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe, and secure in places that are clean and green |
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| LBTQ Forum | | Waste less time and money on legal fights over SEN school places and provide more spaces to those who need them | Seamless transition between child and adult services (currently disconnected)<br><br>Continue to provide talking therapies (this has improved over the past few years) | | Deal with the housing crisis/create more affordable houses and deal with the number of HMOs |
| Parish and Town Councils | NHS needs to have enough pre-natal and neo-natal/post-natal support in place.<br>Better access for residents in rural communities to support groups, information, face-to-face parenting skills groups, quality pre-school groups which they can afford and access | Adequate funding and capacity of education facilities to cope with planned expansion and housing developments.<br>The process of getting financial help to support SEND is inadequate.<br>Often educational psychologists propose recommendations which are not achievable in a village school setting | Provide recreational space on new developments, address YP with nothing to do, youngsters with no access to playing fields.<br>Considering the problems with obesity the lack of anywhere to run, play and conduct informal games will lead to residents who are not as healthy as the could be. | Provision of guidance on how to obtain employment / benefits.<br>Incentives for employers to locate within the area.<br>Promote the National Living Wage.<br>Action against employers who advertise sub-minimum wage work. Increase the personal allowance to keep low paid workers out of tax trap. | Build more affordable housing in town centres, preferably on brownfield sites<br><br>Adopt policies to encourage/facilitate housing provision.<br><br>More affordable rental homes.<br><br>Properties should be well-maintained by landlords |

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| Parish and Town Councils continued | | Financial help for SEND is inadequate, often not even enough for a FT learning support assistant never mind specialised 1:1 teaching.<br>There is no mental health support for SEND children, parents, teaching staff who are left unsupported | Concentrate on development and maintenance of all green spaces in this county.<br>Continue to support the development of cycle paths around towns and linkage to work locations.<br>Stop the rise in parking prices for Pitsford reservoir. Public open spaces need to be more accessible not priced out of the market.<br>Encourage community groups for YP/adults.<br>Return to local playschemes, i.e. gardening, learning new skills etc.<br>. Good health advice in schools. Re-introduce domestic science to the school curriculum.<br>Provide greater access to mental health services.<br>Help with funding the training of community volunteers | Ensure that at the planning stage, enough consideration is given to the type of jobs that are being created and the recognition that warehousing provides largely unskilled work.<br>Many students and lecturers say there is a real shortage of apprenticeships in many skilled areas.<br><br>Ensure the continuation of the rural bus service. | Take great care when compiling Local Planning policy to ensure all future developments are well planned, cause less pollution and employ a local workforce<br><br>Encourage more planting of trees.<br><br>Work with PCs and allow a speed reduction to 20mph zones.<br><br>Invest in areas of deprivation, ensure housing associations /private landlords meet their statutory requirements in the provision of housing and encourage them to invest in their local environment and the people that live in their properties. |

| Engagement Feedback | The Best Start in Life | Access to best available education and learning | Opportunity to be fit, well and independent | Employment and support keep people and families out of poverty | Housing that is affordable, safe and secure in places that are clean and green |
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| Parish and Town Councils Continued | Provide play equipment for children and areas for parents to congregate to enable social interaction<br><br>Support pre and postnatal physical and mental good health<br>Support for parents to raise their children in a safe, secure, loving family<br>Support for parents to aid their child's education.<br>Help parents to communicate well with their children.<br><br>Intergenerational projects between schools with seniors, skill swaps, join learning. | When planning for new housing is being considered the availability in the local school and the capacity of the local doctors should have a much higher priority. | | | |

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# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 2

| Engagement Feedback | Safe in their homes and when out and about | Connected to friends and family | The chance of a fresh start when things go wrong | Access to health and social care when they need it | Accepted and valued for who they are |
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| Sex workers | Need to develop trust with police to report crimes against them | | Need access to Outreach drug treatment | | |
| Big Conversation WNH | | Protect rural transport | | | Cultural events to support community unity |
| Kings Heath | Community CCTV<br>Better Lighting | Check ins on isolated people.<br>Reinstate tea and chat sessions.<br>Localities for people to connect | | | Community buggy walks<br>Build a community 'heart'<br>Community welcome packs /role for new residents |
| St. David's Kingthorpe | Develop Neighbourhood Watch<br>Better lighting and CCTV<br>Tackle drug activity<br>Control scooter misuse | Improve community transport.<br>Regular community fete | | | Community newsletter to share good news and welcomes |
| Voluntary Community Transport providers | More community transport for disabled and vulnerable | | | | |
| Blackthorn | More CCTV, better lights maintenance.<br>Block underpasses, replace with crossings.<br>Safe spaces for cycling.<br>Community safety volunteers to address ASB.<br>Awareness raising for signs of gang activity | Community transport to get elderly people out and about. | | Outreach health and care services and advice | Develop a 'next door' app.<br>Peer support for specific groups |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 2

| Engagement Feedback | Safe in their homes and when out and about | Connected to friends and family | The chance of a fresh start when things go wrong | Access to health and social care when they need it | Accepted and valued for who they are |
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| Kingsheath co-production | Better lighting and CCTV. | Some demand for community transport.<br>A community hub to support people coming together | | | |
| St. David's Kingsthorpe co-production | CCTV | | | | Bring people together at events that are intergenerational |

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| Healthwatch; Young People Transition to adult mental health services | | | YP felt they were not given a safety plan for a mental health crisis. | Transition ofCAHMS to adult MH services rushed/stressful.<br>YP feel they had no choice or say in the process.<br>YP felt that communications between services did not work well.<br>YP expect better handover from CAHMs to Adult MH inc. a transition pack.<br>LAYP would benefit from a better explanation of support after they leave care.<br>YP were not aware of how to get free contraception. | |

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| Healthwatch; Carers COVID experience | | Distress around not being able to visit relatives in care homes<br>40% said they did not have a network of family or friends to support them.<br>Closure of day centres prevented carers having a break with family & friends | | Carers felt isolated. Their health had suffered made worse by the reduced Health and Care services.<br>Caring changed, they had less support from health and care inc. tests and diagnosis.<br>Accessing MH services was the biggest difficulty | |
| Healthwatch; NHS 111 users | | | | Communication difficulties the biggest problem with the service. Auto options, questions etc hard for those with dementia, LD, hearing disorders or language barriers.<br>Several users found the time slot booking worked well. Some. Concern re diagnosis. | |
| Healthwatch; Young People<br>Impact of COVID | 85% YP felt safe at home during COVID. This lower for those who do not identify as male or female | Struggles around not seeing friends or usual support networks. | | Some YP struggled to access mental and physical health services. | |

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| Healthwatch; Young People<br>Physical, Lifestyle and Emotional Health | | | | Services YP accessed most frequently for emotional support: Counselling, GPs, CAHMS. Main difficulties were long waiting times/poor availability outside school hours. | |
| Healthwatch; Young People<br>Focus Group on specific services | | | | YP felt being treated by friendly staff in clean environments was important to them and that the person treating them should show confidence and respect their privacy. Concerns about receiving care online – want face to face. | YP did nor always feel involved in the care they received but when they did it was a positive experience. |
| Healthwatch; Young Carers | | | | Over half YC had experienced long waiting times to access services and around a third felt they had not been given enough support or that the services did not know about their issues. | |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 2

| Engagement Feedback | Safe in their homes and when out and about | Connected to friends and family | The chance of a fresh start when things go wrong | Access to health and social care when they need it | Accepted and valued for who they are |
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| Primary School Survey 2022 | 24% of boys and 28% of girls have seen/received something online that worried or upset them. | | | | |
| Secondary School Survey 2022 | 23% of pupils rated safety when going out after dark as 'poor' or ‘very poor'; 8% said the same of being at school.<br><br>34% of pupils are aware of other people who carry weapons when they go out.<br><br>27% of pupils responded that there has been shouting and arguing between adults at home at least ‘once or twice' in the last month that has frightened them, 5% said it happened every day/almost every day'. | | | | |

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| Secondary School Survey 2022 Continued<br>Safe in their homes and when out and about | 24% of pupils responded that they have experienced at least one of the controlling partner behaviours listed. 32% of pupils said that bullying was dealt with 'quite' or 'very well' or 'not a problem' in school. 53% said bullying was dealt with 'badly' or 'not very well' in their school.<br><br>47% of pupils said they had been told who they could/couldn't see by a partner. 48% of Year 10 pupils said if any of these things happened they would look after themselves without help; 59% said they know where they could get help. 21% of pupils had given personal info to someone online who they don't know | | | | |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 2

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| Hope Charity Poverty Survey | People reported they felt unsafe in Northampton due to knife crime, verbal abuse, poor lighting, and drunkenness<br>Poverty often prevented people accessing public transport placing them in more danger after dark.<br>Poverty makes some communities vulnerable to exploitation by for example drug cartels.<br>Domestic Violence is significant problem in migrant communities dur to cultural differences and if in poverty the inability for people to escape it.<br>There is mistrust of the police amongst eastern European communities because of their past experiences in their home countries | | | Access to primary care in migrant communities hampered by language barriers, inc. vaccines and tests during COVID.<br>There is a misunderstanding that those with no access to public funds cannot register with a GP so many do not. Many do not present until a crisis occurs and they are admitted via A&E<br>African Communities see ill health as a stigma so do not present to services, common re HIV and mental health issues.<br>Some residents with language issues cannot express their selves when accessing services and translation not always available at a primary care level | Many African and other BAME communities felt marginalised from representation and engagement in civil and public life. |

# SUMMARY OF ENGAGEMENT FEEDBACK BY LIVE YOUR BEST LIFE AMBITIONS 2

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| LGBTQ Forum | Lack of safe LGBTQ places in many communities including Northampton<br><br>Community organisations provide LGBTQ safe spaces, but these are not funded | Community and family friendly, openly LGBTQ friendly spaces are important – a rating system/accreditation or charter system to show support would help.<br><br>Support/encourage more LGBTQ venues in the town | | Improve access to GPs and remove barriers to people being able to access/get an appointment<br>Improve access to NHS dentists<br>More support for Transgender and non-binary residents particularly at GP surgeries | Provide/promote LGBTQ and accessibility schemes to help public find suitable spaces they feel comfortable in<br><br>Involve LGBTQ community in shaping services |
| Parish and Town Councils | Encourage communities to be aware of personal and community safety initiatives<br>More access to visible police/PCSO and quicker response times<br>More traffic wardens<br>More education on the topics in schools<br>Ensure Parish has access to local Police Force and know the correct person to go to if needed<br>increase the number of visible police officers. | Provide the accessible open recreational space where people can picnic.<br>Provide buildings and resources to secure indoor accessible space.<br><br>Have venues for local groups to meet with good internet access.<br>Ensure the continuance of rural bus services.<br><br>Support local councils/organisations | In small community's offenders are often known and when sentences are served vigilante behaviour is something we cannot accept. Perhaps more local police presence would reassure.<br><br>Support should be available for ex-offenders and homeless people to get their lives back on track. | Support local GP and community services.<br>Audit how you allocate funding and let Parish councillors know.<br>Need more easily available 'walk – in' general health hubs and/or more doctors at local Health Centres.<br>Primary care is vital for all and it can take up to 5 weeks to get a first appointment to see a GP | Encourage uptake/improve internet facilities to keep people easily in touch with each other.<br>Maintain contact with residents and neighbours in community.<br>Resources need sharing with rural areas, for example all the recent events for Ukrainians guests were towns no funding for rural guests to get to them! |

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| Parish and Town Councils Continued | Introduce safe places for young people to spend their spare time.<br>Joint working on lighting, trees, hedgerows, enabling safe areas to walk.<br>Focus on antisocial behaviour. | to deliver services locally | Important for all to have access to correct support and information.<br>Investment in support services for those released from prison, for both physical and mental issues | Good communication needed with medical professionals<br><br>Access to healthcare huge problem in rural areas with poor transport.<br>Need more investment in Social Services, Healthcare.<br><br>Provide access to public health services for all, including less able/mobile people. Suggest a mobile service that visits periodically<br><br>Have a community hub with visiting health professionals like chiropodists, dentists, etc. that people can access in the community<br>WH PC offered premises for NHS professional led group advice /testing but have had no response. | Children need to be taught respect in all it's forms from not littering to addressing adults respectfully and caring for their community<br><br>Consult with and ensure the opinions of the local community are taken into consideration when making decisions. |

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