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West Northamptonshire Council

West Northamptonshire Health and Wellbeing Board

A meeting of the West Northamptonshire Health and Wellbeing Board will be held at the Council Chamber, The Forum, Moat Lane, Towcester, NN12 6AF on Thursday 27 July 2023 at 1.00 pm

Agenda

1.	**Apologies for Absence and Notification of Substitute Members**
2.	**Notification of Requests to Address the Meeting** The Chairman to advise whether any requests have been received to address the meeting.
3.	**Declarations of Interest** Members are asked to declare any interest and the nature of that interest which they may have in any of the items under consideration at this meeting.
4.	**Chair's Announcements** To receive communications from the Chair.
5.	**Minutes from previous meeting 25th May - Chair** (Pages 5 - 18) To approve minutes from previous meeting 25th May 2023
6.	**Action log - Chair** (Pages 19 - 20) To review outstanding actions
7.	**NHS Northamptonshire Integrated Care Board Joint Capital Resource Plan - Sarah Stansfield** (Pages 21 - 28)

8.	**Joint Health and Wellbeing Strategy - Sally Burns** (Pages 29 - 62)
9.	**Local Area Partnership re-designation - Julie Curtis** (Pages 63 - 68)
10.	**Better Care Fund Governance Structure and Better Care Fund Plan 2023/2025 - Ashley Leduc** (Pages 69 - 186)
11.	**Voluntary Sector Spotlight: Hope Centre**
12.	**Live your best life domains: Housing that is affordable, safe, and secure in places that are clean and green - Jo Barrett & Sally Burns** (Pages 187 - 196) • Disabled Facilities Grant — Report • HMO's • Homelessness Needs Assessment • Rough Sleeping Pathway • Air Quality • Community Fly Tipping Prevention Project (HMO's to Community Fly Tipping Prevention Project — Presentation)
13.	**Any other business - Chair**
14.	**Close public meeting - Chair**
15.	**Reports for information** (Pages 197 - 304) • NHS Northamptonshire 5 Year Forward Plan • Healthwatch Northamptonshire Annual Report

West Northamptonshire Health and Wellbeing Board Members:

Councillor Matt Golby (Chair)

Councillor Fiona Baker
Dr Jonathan Cox
Sally Burns
Colin Foster
Russell Rolph
Colin Smith
Dr Andy Rathbone
Professor Jacqueline Parkes
Nicci Marzec
Dr David Smart
Superintendent Rachel Handford
Heidi Smoult
Robin Porter
Councillor Jonathan Nunn
Anna Earnshaw
Naomi Eisenstadt
Stuart Lackenby
Toby Sanders
Michael Jones
Councillor Wendy Randall
Wendy Patel
Dr Philip Stevens
Dr Santiago Dargallonieto
David Maher
Carella Davies
Miranda Wixon

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

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

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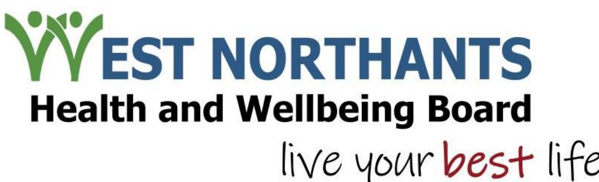
Queries Regarding this Agenda
If you have any queries about this agenda please contact Cheryl Bird, Health and Wellbeing Board Business Manager via the following:

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

Or by writing to:

West Northamptonshire Council
One Angel Square
Angel Street
Northampton
NN1 1ED



WEST NORTHAMPTONSHIRE HEALTH & WELLBEINGBOARD
Minutes of the meeting held on 25th May 2023 at 1.00 pm
Venue: Council Chamber, The Forum, Towcester

Present:

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
Cornelia Andrecut	Director of Children Social Care, Northamptonshire Childrens Trust
Eileen Doyle	Chief Operating Officer, NHS Northamptonshire Integrated Care Board
Carella Davies	Chief Executive, Daventry Volunteer Centre
Sally Burns	Interim Director of Public Health, West Northants Council
Anna Earnshaw	Chief Executive, West Northants Council
Stuart Lackenby	Executive Director for People Services, West Northants Council
Miranda Wixon	Chair, VCSE Assembly
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
Racha Fayad via Teams	Public Health Principal, West Northants Council
Dr Phillip Stevens	GP, Chair Daventry and South Northants GP Locality
Colin Smith	Chief Executive, LMC
David Maher	Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
Russell Rolph	Chief Executive, Voluntary Impact Northamptonshire
Wendy Patel via Teams	Healthwatch Northamptonshire

Also, Present

Ashley LeDuc, Assistant Director Commissioning and Performance, West Northants Council
Cheryl Bird, Health and Wellbeing Board Business Manager
Claire Baxter, Northampton Parent Forum Group
Jodie Low, Managing Director, Free 2 Talk
Julie Curtis, Assistant Director PLACE Development, West Northants Council
Ben Pearson, Assistant Director Education, West Northants Council
Sarah Stansfield, Chief Finance Officer, NHS Northamptonshire Integrated Care Board
Rebecca Wilshire, Deputy Director Childrens Services, West Northants Council

25/23 Apologies

Dr Andy Rathborne, Primary Care Network
Colin Foster, Chief Executive, Northamptonshire Childrens Trust
Heidi Smoult, Chief Operating Officer, Northampton General Hospital
Michael Jones, Divisional Director, EMAS
Naomi Eisenstadt, Chair, NHS Northamptonshire Itnegrated Care Board
Wendy Patel, Healthwatch Northamptonshire
Dr Santiago Dargallonieto, Chair, Northampton GP Locality
Toby Sanders, Chief Executive, NHS Northamptonshire Integrated Care Board

26/23 Notification of requests from members of the public to address the meeting

None received.

27/23 Declaration of members' interests

None received.

29/23 Chairs Announcements

The Chair and Director of People recently visited the Woodford Halse Food Larder which serves 26 villages in the surrounding area. The West Northants Anti-Poverty strategy needs to become more proactive to make tackling poverty and deprivation more sustainable.

The Chair advised the Warm Welcoming Spaces (WWS) project has been helpful in tackling social isolation and will morph into Welcoming Spaces during the warmer months, with the aim to deliver wrap around services from these spaces. There were 52000 attendances to the WWS across West Northamptonshire during January – March 2023.

The Chair welcomed the following new members to the Board:

- David Maher will be the Northamptonshire Healthcare Foundation Trust (NHFT) representative, replacing Jean Knight
- Carella Davies, Chief Executive of Daventry Volunteer Centre and Miranda Wixon, Chair of the VCSE Assembly have recently been elected as Co-Chairs to the Daventry and South Northants Health and Wellbeing Forum and therefore are invited join the Board.

30/23 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.

31/23 Action Log

The Board reviewed the actions from the previous meeting:

- More information is to be circulated to the Board about off rolling. **The Assistant Director for Education will provide an update later in the meeting.**
- Combatting Drugs Partnership action plan and breakdown of grant to come to the next meeting. **This has been circulated to the Board.**

- The Professor in Applied Mental Health will liaise with the Head of Community Safety around the work University of Northampton are completing around the Live Your Best Life ambitions. **This has been completed**.

32/23 Voluntary Sector Spotlight – Free2Talk

The Managing Director, Free2Talk gave an overview of the work completed by the organisation and highlighted the following:

- Free2Talk was created in 2008 to deliver youth work in communities and is funded through the National Lottery, Youth Music and various smaller grants. All the grants received by Free2Talk are on a 12-month basis.
- Free2Talk has an Advisory Board made up of representatives from health, housing , communities, local businesses and youth workers. There are also five Directors four of which are community workers and one from a housing background. Included in the organisation structure is a team leader, youth workers, a counsellor in training, parenting worker, volunteers and students. Some of the youth workers work alongside the WNC Neighbourhood Teams.
- Free2Talk provide strength-based activities for 8-18 years, outside of the home environment, working at a neighbourhood level with communities, providing open access youth groups, with youth workers are trained to understand what young people are telling them. Young people are looking for events to be a part of and organise, to have a voice and be part of social action.
- Part of the outcomes desired is critical thinking for young people to recognise their belonging in the community, coaching them to make good decisions with their peers.
- Free2Talk work with music education and also a broadcasting programme enabling them to develop self-awareness, confidence and self-esteem.
- There is a youth van for work with hard-to-reach communities, which has a music studio, gaming studio and podcasting recording space.
- Free2Talk previously ran a home office project around exploitation, which has enabled them to develop safety mapping techniques. The WNC Community Safety Team commissioned Free2Talk to complete some safety mapping at a secondary school within Northampton. Safety Mapping should be part of an universal offer to schools, to enable young people voices to be heard, as some school environments can be challenging for students and staff.
- A Free2Talk music event at the Roadmender saw approximately 100 young people attend.
- An assessment centre has been created for youth workers and community workers to deliver level 2 and 3 training for skills and education work.
- They also provide a 1:1 mentoring service for young people living in Bellinge, Blackthorn and Northampton Town Centre and run open access groups across Northampton.
- Many of the referrals into Free2Talk are for children and young people without diagnosis, who are unable to attend school due to their needs not being met by universal services and not getting targeted support. Free2Talk are looking at running targeted group work to help these young people develop coping strategies.
- Free2Talk is involved in the N4 Local Area Partnership Education Subgroup, which is looking at how to address the high number of exclusions and suspensions within the area.

The Board discussed the overview and the following was noted:

- The Youth Offer Board has commenced, which includes a representative from Free2Talk. Most organisations on this Board commission or are engaged with some form of early help or youth provision, but the scope of youth early help services is fragmented.

- Northamptonshire Childrens Trust have circulated a questionnaire to agencies asking them to provide information on their early help offer.
- Asset mapping will help identify work being completed in communities by smaller organisations.
- There is a national and local shortage of youth workers. The National Youth Association (NYA) are asking for the number of youth workers that are required in Northamptonshire.
- 50% of adult mental health issues are diagnosed during teenage years, with early intervention initiatives vital for the prevention agenda.
- Contextual safeguarding is working in partnership to create children safe environments and is everyone's business. The Northamptonshire Childrens Safeguarding Partnership has a exploitation subgroup looking at contextual safeguarding and community practice around exploitation.

RESOLVED that:
- **A link to a webinar hosted by Professor Jonathan Campion around children mental health to be circulated to the Board.**
- **The Board noted the update.**

33/23 Northamptonshire 5 Year Forward Plan

The Chief Finance Officer, NHS Northamptonshire ICB provided an update on development of their 5 Year Forward Plan and highlighted the following:
- ICBs have a statutory duty to produce a Joint 5 Year Forward Plan (5YFP) which needs to align with the Integrated Care Northamptonshire Strategy, local Joint Health and Wellbeing Strategies, Operational Plans and NHS Trust strategies.
- The Plan will open with the Integrated Care Northamptonshire vision statement, which will frame the 5YFP.
- The 5YFP is committed to delivering the four aims of an Integrated Care System (ICS) which is framed in a set of local and national priorities and will also include multiple benefit interventions, delivery partnerships and enabling blocks.
- The 3 national priorities for the 5YFP are:
  1. Recover our core services and productivity, these are urgent and emergency care, community health services, primary care, elective care, cancer, diagnostics, maternity and neonatal services, and use of resources.
  2. As we recover, make progress in delivering the key ambitions of the NHS Long Term Plan, which frames a number of ambitions. These are mental health, people with learning disability and autistic people, embedding measures to improve health and reduce inequalities, investing in our workforce, digital and system working
  3. Continue transforming the NHS for the future. As an ICS we will continue to transform our services to meet the needs of our population and deliver a safe, sustainable health and care system through integration – better care, better outcomes = better value.
- There are also 3 local priorities from the Live Your Best Life ambitions:
  - Best start in life
  - Opportunity to be fit well and independent
  - Access to health and social care when needed.
- There are 5 interventions to deliver against the national and local priorities:
  - Digital – joining up information for a patient to tell their story once. Population health management to look at having one version of data.
  - Children and young people – focusing particularly on mental health and wellbeing and health checks for 2-3 years.

  - Recovery of independence – making sure people can live in their own residence, with a particular focus on falls, how beds and capacity is configured across the system for patient pathways.
  - End of life – improvements in delivery of end-of-life pathways for patients and carers.
  - Access to the right services at the right time – enabling access to emergency care and elective pathways. Access and capacity with primary care and community health services. What services are available and what services are most appropriate.
- The interventions will be delivered through several delivery partnerships service based workstreams.
  - Maternity and neonatal
  - Children and young people
  - Primary care
  - Urgent and emergency care
  - Elective care
  - Cancer care
  - Mental health, learning disabilities and autism
- A framework has been created for how we will deliver on our priorities:
  - Integration
  - Health equity
  - Co-production
  - Population health management
  - Quality improvement
  - Clinically led approach
- Once the 5YFP is finalised work will begin on the enabling strategies
  - Supporting our People
  - Enhancing Digital
  - Research and Innovation
  - Improving estates and the environment
  - Aligned communication
  - Community engagement

The Board discussed the update and the following was noted:

- Public Health and Adult Social Care have been engaged and involved in every stage of the development of the 5YFP.
- The challenge is to ensure pathways drill down into a place level and the wider determinants of health are woven through.
- There is an over reliance on beds which can lead to poor outcomes, people need to be supported to regain and retain independence.
- The recruitment challenges in adult social care have started to reduce, which has led to fewer people waiting for care and improved rates of hospital discharge. There are still workforce challenges in place due to the sector being mostly minimum wage and there is a need to consider how to make a career in adult social care more valued by society to enable the service to be more sustainable.
- A recent survey of the social care market including care homes showed in April there were 421 new recruits and 187 resignations.
- Data sharing across the system is a real challenge, due to statutory barriers and information governance. The Northamptonshire Care Record and Northamptonshire Analytical Reporting Platform should help to overcome some of these barriers.

RESOLVED that the Board noted the update.

34/23 Director of Public Health Annual Report

The Director of Public Health gave an overview of the Directors of Public Health Annual Report 2022/2023 and highlighted the following:

- Directors of Public Health have a statutory duty to produce an annual report on the health of their population.
- The 2022/2023 report demonstrates the impact the cost-of-living crisis and poverty has had on the physical and mental health of residents within West Northamptonshire.
- The report covers both rural and urban settings and includes work being completed by the Anti-Poverty Working Group against outcomes included the West Northants Anti Poverty Strategy Action Plan. The report also highlights work being undertaken in communities led by the VCSE and community sector, Household Support Fund and food larders.
- A few minor amendments are needed before the report is ready for publication.

The Board discussed the report and accompanying videos and the following was noted:

- The Director of Public Health address should be at the end of the video to enable viewers to see the content first.
- Voluntary Impact Northamptonshire will start discussions with partners around the Poverty Truth Commission providing an update to the Anti Poverty Oversight Group.
- The Board acknowledged the report highlights co-working with partners and the VCSE sector thanked the Public Health Team for their work and connective working with the VCSE sector.

RESOLVED that the Board endorsed the Directors of Public Health Annual Report 2022/2023 for publication.

35/23 Better Care Fund Annual Report 2022/2023

The Assistant Director Commissioning and Performance presented the Better Care Fund (BCF) Annual Report 2022/2023 to the Board and highlighted the following:

- The Better Care Fund is an agreed plan between health and social care commissioners, and Health and Wellbeing Boards (HWBBs) have a statutory requirement to have oversight of their local BCF arrangements.
- The BCF Plan 2022/2023 was signed off by the HWBB on the 19th September 2022.
- The NHS contribution to adult social care was in line with minimum contribution.
- The BCF policy objectives are to enable people to stay safe, well and independent at home for longer and provide the right care in the right place at the right time. The schemes contained in 2022-2023 plan support these objectives.
- There are national metrics to support the objectives:
  - **Avoidable admissions to hospital**. There was a target of 4160 avoidable admissions with 4136 achieved. Schemes included in the 2023/2025 plan aim to improve performance against this metric.
  - **% of people discharged from hospital to their normal place of residence.** The target was 94.7% returning to their normal place of residence with 93.5% achieved. This is a reduction in achievement from 2021/2022, where delays with pathway 0 meant patient discharges were supported using pathways 1 and 2 and not returned to their normal place of residence. The additional winter pressures funding has helped to improve reducing the delays for pathway 0.

- ➢ **Rate of admissions to residential care per 100000 population achieved**. 479 achieved against a target of 549.
- ➢ **Proportion of older people still at home 91 days after discharge from hospital or rehabilitation services**. 80.7% was achieved against a target of 79.2%, which is an improvement on 2021/2022 figures. Pathway 1 services have increased and it is expected for improvement to continue during 2023/2024.
- The first draft of the 2023/2025 plan for West Northamptonshire will be presented at the next Health and Wellbeing Board meeting for sign off. Future commissioning for schemes within the BCF are moving to separate place based, West and North Northamptonshire. Where services can be aligned with North Northamptonshire these opportunities will be undertaken, but they are likely to be outside of BCF planning arrangements.

RESOLVED that the Board:

- **Approved the final return template for the Better Care Fund schemes (2022/23).**
- **Noted the proposed timelines for the Better Care Fund plan for 2022/23**

36/23 Joint Health and Wellbeing Strategy

The Director of Public Health gave an update on development of the Joint Health and Wellbeing Strategy (JHWBS) and highlighted the following:

- Health and Wellbeing Boards have a statutory duty to produce a JHWBS detailing how to collectively improve the health and wellbeing of the local population.
- Development of the JHWBS is ongoing and the draft strategy will be brought to the next meeting for feedback.
- Engagement with communities and partners is a golden thread running through the Strategy, with previous engagement completed by partners across the system was used and built upon. Digital engagement is underway with elected members and parish/town councils. The key themes from the engagement will be woven into the strategy:
  - ➢ Children and young people
  - ➢ Children and young people mental health
  - ➢ Loneliness
  - ➢ Social isolation
  - ➢ People feeling safe in their communities
- Specific needs assessments are also being completed as part of the JSNA work which will feed into the JHWBS.
- Feedback from discussion within the Local Area Partnerships have also been woven into the JHWBS.
- Engagement feedback has been aligned to the Live Your Best Life ambitions.
- A workshop will take place in June to engage with more diverse communities.

RESOLVED that the Board noted the development of the Joint Health and Wellbeing Strategy and endorsed the direction of travel.

37/23 Emerging priorities from Local Area Partnerships

The Assistant Director PLACE Development gave an update on the emerging priorities from the Local Area Partnerships (LAPs) and highlighted the following:

- All nine LAPs are now operational and each have held several individual meetings.
- The LAP has a core leadership team who have local community knowledge comprising of:

- Elected members;
- Local GPs;
- VCSE;
- Public Health;
- WNC Director;
- Police,
- Northamptonshire Childrens Trust
- WNC Community Development Workers
- WNC Adult Social Care

- The LAP leadership team were asked to review the Local Area Profile and discuss insights intelligence from their local communities to identify what are the emerging issues a LAP should start to focus on.
- All the emerging priorities from the LAPs will be mapped to the Live Your Best Life priorities.
- N3 has the highest proportion of children under 16 (25%) with the second highest pupil exclusion and suspensions. This LAP will have an education subgroup created to try and address this. There are also high level of crime spots within the LAP area and the worst level of connectivity with communities.
- In N4 there is a high level of exclusions and suspensions from school. An Education Subgroup has been created to work on how best to address this issue.
- DSN1 has the highest level of rurality across West Northamptonshire with larger urban areas such as Moulton and Brixworth. The LAP has a high proportion of elderly population and also has poor community connectivity. The emerging priorities are frailty, isolation and transport.
- DSN2 identified that Woodford Halse is one of the most deprived rural areas in West Northamptonshire and a Task and Finish Group will be created to see how to improve the deprivation and poverty being faced by some residents.
- The collective emerging themes from the 5 Northampton LAPs are;
  - Crime
  - Lack of connectivity with communities
  - COPD
- The collective emerging themes from the 4 Daventry and South Northants LAPs are:
  - Social isolation
  - Rurality
  - Access to services.
- The collective themes emerging from across all 9 LAPs are:
  - Drugs and anti-social behaviour
  - Children and Young people mental health
  - Young families
- Some of the activities taking place within the LAPs are:
  - One Stop Shop pilot in St Lukes Medical Centre, there is potential to One Stop Shop roadshows across West Northamptonshire.
  - Access to community space for youth provision – working with Free2Talk on developing this activity.
  - New community forum in Castle ward
  - Mental Health Workers for children in general practice; training for Social prescribers around children
  - FLARE APP promoted
  - Police Environmental Visual Audit of St James and Spring Boroughs
  - Development of Welcome Pack for new residents.
  - Identification of lone males for targeted social isolation interventions
  - Family hubs in Towcester, Daventry, Northampton
  - Teen Clinic pilot in Daventry
  - School Ambassadors and Youth Forum

- ➢ Mental Health services in schools
- ➢ Asset mapping and youth offer mapping
- ➢ Access to digital training for those suffering from digital isolation

The Board discussed the update and the following was noted:

- NHS Northamptonshire Integrated Care Board representatives sit on the West Executive PLACE Board (WEPB) where the emerging priorities from the LAPs are shared.
- The WEPB will drive the collaborative delivery across the live your best life ambitions.
- Police data, birth and death data and Census data will all be valuable as an evidence base behind the emerging priorities.
- Where good practice has been identified this can be replicated across other LAPs.
- There is a need to consider how we can align the enabling strategies within the 5YFP to the LAP action plans.

RESOLVED that the Board noted the update.

38/23 Children and Young People Needs Assessment

The Public Health Principal provided an update on development of the Children and Young People (CYP) Needs Assessment and highlighted the following:

- This needs assessment forms part of the of Joint Strategic Needs Assessment (JSNA) refresh being completed by the Public Health Team and provides an overview of the priorities for West Northamptonshire.
- The JSNA refresh will drill down into the 10 Live Your Best Life ambitions and the CYP Needs Assessment aligns with the Best Start in Life and Access to Best Available Education and Learning ambitions.
- The CYP needs assessment will be presented in 6 chapters and filter into the re-commissioning of the 0-19 years' service:
  - ➢ **Demographic chapter** will describe the ethnicity and diversity of the 0-19 population in West Northamptonshire. In 2011 Census data 0-19 population was 24.8% of the overall population in West Northants, in 2021 census 0-19 population this is 24.7% of the population. The proportion of white British has fallen to 75% from 83.9% in the 2011 census.
  - ➢ **Maternal and infant health chapter**.
    - ❖ There were 4,647 live births in West Northamptonshire in 2021,significantly higher than East Midlands and England. Between 2019-21 there were 58 stillbirths in West Northamptonshire, rate of 4.2 per 1,000 similar to the East Midlands rate of 3.8 and the England rate of 3.9.
    - ❖ 11.3% (479) of women who gave birth in West Northamptonshire were smokers at the time of delivery in 2021/22, down from 12.3% in 2020/2021. This was similar to the East Midlands average of 11.8%.
    - ❖ It is estimated between 466 and 932 mothers in West Northamptonshire experienced perinatal mental health problems in 2021.
    - ❖ Nearly 6 out of 10 babies (58.8%) were totally or partially breastfed at 6-8 weeks in West Northamptonshire in 2021/22, which was 2,551 babies. A total of 41.2% were not breastfed – 1,784 babies. The proportion of babies breastfed at 6-8 weeks was significantly higher than the averages for North Northamptonshire (46.6%), East Midlands (49.6%) and England (49.2%).
  - ➢ **Early years chapter 0-5 years**.
    - ❖ 97.5% of babies in West Northamptonshire received a face-to-face new birth visit from a Health Visitor within 14 days of birth in 2021/22, which was significantly higher than the averages for the East Midlands (92.4%) and England (82.7%).

- ❖ In 2021/22, 98.5% of babies received a 6-8 week review, significantly higher than the East Midlands (91.1%) and England (81.6%);
- ❖ at 12 months, 77.4% of babies received a 12 month review in West Northamptonshire, significantly higher than the East Midlands average of 70.1% but significantly lower than England (82.0%).
- ❖ 49.6% of 2 to 2½ year olds received a health visitor review in 2021/22, significantly lower than the East Midlands and England.
- ❖ 96.4% of 2 to 2½ year olds received an Age Stage Questionaire-3 in 2021/22, significantly higher than the East Midlands and England.
- ❖ 78.3% of 2 to 2½ year olds met the expected levels of development across all five domains of the ASQ-3 in 2021/22.
- ❖ 22.1% of five year olds suffered from tooth decay in 2021/22, similar to the East Midlands and England.
- ❖ 65.8% of children achieved a good level of development by the end of Reception in 2021/22, similar to the East Midlands and England.

- ➢ Work is still being completed on the **Primary School Age chapter.**
- ➢ **Secondary Age Children.**
  - ❖ 31,879 young people aged 10-15 years in West Northamptonshire.
  - ❖ Based on a Schu Survey completed by 8 secondary in West Northamptonshire 2.6 % of secondary school pupils suffer with social, emotional, and mental health needs in 2021/22 (England value was 3.2%).
  - ❖ The secondary school exclusion rate (0.04%) was lower than the East Midlands region (0.046%) and England (0.052%) rates for Autumn term 2021/22.
  - ❖ NHFT received around 500 CAMHS referrals per month in 2018, but recently referrals are above 1,000 per month with 1,165 referrals made in January 2023.
  - ❖ Self harm rates for ages 10-14 were significantly better than England. Girls rates by 10-15 years were highest of all East Midlands regions and 28th highest of the all England table.
- ➢ **Transition into adulthood.**
  - ❖ There were 75 hospital admissions for alcohol-related conditions among under 18s in 2018/19 – 20/21 similar to the East Midlands and England.
  - ❖ 165 hospital admissions due to substance misuse among 15-24 year olds in 2018/19 – 20/21 was significantly higher than the East Midlands and England.
  - ❖ 225 admissions to hospital among 15-19 year olds due to self-harm in 2021/22 significantly higher than the East Midlands and England.
  - ❖ 2020 estimates for 18-24 year olds show there were 813 adults with a learning disability.
  - ❖ 2.3% of 16-17 year olds were not in education, employment or training (NEET) in 2021, significantly lower than the East Midlands and England.

- There were 1207 Children in Care by May 2023.
- The CYP assessment is due to be completed by end of July.
- Public engagement is currently taking place for the CYP and Sexual Health needs assessment which started on the 20th May and will be completed by 24th June.
- Free2Talk in partnership with HomeStart Daventry and NHFT engagement team have been commissioned to complete engagement with young people. There are a series of workshops/focus groups planned in person and virtually between now and the end of June.
- Fact sheets will be completed for each chapter to give a snapshot of what the data tells us at a LAP level.
- More analysis will be completed on the engagement and surveys, the final report will have highlight the strategic implications for each chapter describing what are the needs and what is needed to address gaps.

The Board noted the update and the following was noted:

- NHFT are seeing a high prevalence of eating disorders was not reflected in the assessment, especially with girls.
- Could contextual safeguarding issues be driving the high prevalence of self harm and drug misuse.
- The performance of the 2½ year health check is flagged as an indicator in the 5YFP. The improved performance of this indicator would need involve partners across the system rather than just NHFT .

RESOLVED that the Board noted the update

39/23 Peer challenge Review

The Director of People gave an update on the recent West Northants Youth Service provision peer review undertaken by LGA and National Youth Association and highlighted the following:

- West Northants Council (WNC) was one of three local authorities in the country chosen to take part in this peer review.
- WNC recognised the current youth offer is inadequate to meet the needs of young people in West Northamptonshire.
- There is a need to consider how to use the messages in the peer review letter to enable the Youth Offer Board to develop and take forward a programme of work.
- A cross partnership bid was submitted to the National Youth Endowment fund for £500k to support a voluntary sector collaborative to recognise and take forward youth interventions. This will be structured in the first instance around N4 and DSN2, with the aim for this approach to be replicated in other LAPs. An update will be brought back to the Board once the result of the submission is known.

RESOLVED that:

- **The peer review letter to be circulated to the Board.**
- **An update to be brought to the Board once the result of the submission to the Youth Endowment fund is known.**

40/23 Off Rolling

The Assistant Director Education advised off rolling is when schools encourage parents to move their child to another school which is illegal. This tends to be prevalent with children who have additional needs and vulnerabilities, misbehaving at school, or not likely to achieve the outcomes the school would like the child to achieve. When schools become academies WNC may not always know a child is being off-rolled, but if WNC are informed the Assistant Director for Education speaks to the school directly to raise concerns. Where there is a pattern of off-rolling concerns this will be raised during with regular meetings with OFSTED and the Department for Education. The governing body of every school should be provided with information about students who have started and left the school midway through, and the governors should be asking why children are leaving part way through their education.

RESOLVED that the Board noted the update.

41/23 N4 Education Sub Group

The Assistant Director for Education advised the N4 LAP Education Subgroup looked at the risks to young people and permanent exclusion or temporary suspensions. Education data

has been overlayed with police data, fire service to target families and children to prevent them from being excluded. The rate of exclusion in N4 was twice as high as other LAP areas in West Northamptonshire, and last year children excluded or suspended missed a total of 12.5 years of education. There are six education providers within the N4 area willing to look how services support for families can help to reduce the rate of exclusions.

RESOLVED that the Board noted the update.

42/23 SEND Strategy

The Assistant Director Education gave an update on the SEND Strategy and highlighted the following:

- There is a new Area SEND Inspection Framework and Handbook published by Ofsted and the Care Quality Commissioned on the 1st January 2023
- West Northants will be inspected as a local partnership areas, with the areas of focus being all services for children and young people with SEND aged 0-25 years.
- Evidence will need to be provided to show we know the outcomes children and young people with SEND are achieving in education, health, care, leisure, employment, transport, housing, voluntary activities and what we are doing to support young people to become successful adults. There is a specific focus on alternative provision and children out of school
- In March the Department for Education (DfE) launched a SEND Alternate Provision Improvement Plan, with the expectation local partnerships will support children with additional needs. Within 2 years there will be national standards everyone should be working towards, developed by the DfE in collaboration with local areas, with no new funding attached. The areas of focus is around early identification, how children move through the education system, how we develop our workforce and what alternative provision looks like.
- In West Northamptonshire and nationally the demand and level of complexity Is increasing, with 19% increase of children with Education Health Care Plans (EHCP) in Northamptonshire during 2022. This is significantly higher than the national average.
- The COVID pandemic has had a negative impact on the level of anxiety some children are feeling about returning to school.
- There is lack of capacity to undertake assessments for children, which causes significant delays for children not being able to have their needs met.
- WNC have recruited a new team of SEND Improvement professionals and there is a West Northamptonshire SEND Improvement Board to develop a new approach and investment to drive early years work.
- SEND Ranges is a descriptive tool for teachers to identify additional needs in the classroom.
- There ae 5 key priorities:
  - Accessibility where children and young welcomed and included
  - Resources – how best to use existing resources
  - Identification and assessment – this must be completed at a earlier stage
  - Training – wide range of training and development for everyone
  - Working together
- There are 3 golden threads throughout the SEND strategy
  - Co-production
  - Thrive
  - To be more inclusive
- The aim is for SEND children to be better educated and more accepted in society

The Northamptonshire Parents Forum (NPF)representative gave an overview of the Co-Production Charter and highlighted the following:

- Co-production is a legal requirement within the Children and Families Act 2014 – all agencies must demonstrate how they co-produce SEND strategy especially with children and parents.
- The Co-production Charter will embed co-production as a standard way of working together for families and across agencies that support families (settings, school and services). All schools will be asked to sign up to this charter.
- The NPF has been working with WNC to launch a new Co-Production Charter for September 2023.
- A series of engagement events across West Northamptonshire have taken place, to ask parents, carers and professionals for their thoughts on co-production and what this should look like. There will also be specific children and young people events to ensure their views are heard in terms of co-production and outcomes. It has been recognised that more engagement needs to take place with children form underrepresented groups.
- Communication transparency and respect have all come out as the most prominent feedback during the engagement events.
- The Co-Production Charter will go to WNC Cabinet 11th July for approval.

The Board discussed the update and the following was noted:

- There will be a detailed action plan sitting underneath the strategy monitored by the SEND improvement Board and the Board will hold all partners to account.
- The VCSE Disability thematic group are engaged in developing opportunities for children with disabilities, their families and carers at main streams schools.
- There is a need to ensure health are engaged in the SEND progress and engagement.
- There is a need to ensure the targeting of health inequalities is included in all strategies

RESOLVED that the Board noted the update.

43/23 Corporate Parenting Board

The Deputy Director for Childrens Services gave an update on the West Northamptonshire Corporate Parenting Board and highlighted the following:

- The Children and Social Work Act 2017 says that when a child or young person come into the care of the local authority or is under 25 and was looked after by the authority for at ***least 13 weeks after their 14th Birthday***, the authority becomes the 'Corporate Parent'.
- Corporate parenting relates to how everyone has a responsibility for children in care and care leavers to ensure children in care and care leavers needs are met.
- There are 7 legal principles which serve to define the corporate parenting role:
  - To act in the best interests, and promote the physical and mental health and wellbeing, of those children and young people
  - To encourage those children and young people to express their views, wishes and feelings
  - To take into account the views, wishes and feelings of those children and young people
  - To help those children and young people gain access to, and make the best use of, services provided by the local authority and its relevant partners.
  - To promote high aspirations, and seek to secure the best outcomes, for those children and young people
  - For those children and young people to be safe, and for stability in their home lives, relationships and education or work; and
  - To prepare those children and young people for adulthood and independent living.

- West Northamptonshire Corporate Parenting Board had its inaugural meeting on the 24th May, prior to this there had been a countywide Corporate Parenting Board. This will allow better understanding of local needs, ensuring local provision and support is available to children who need it most and how this can align with the PLACE Operational model.
- OFSTED will also be completing separate West and North NORTHAMPTONSHIRE inspections.
- Children experiences in care vary, their health and safety and can be managed better on a more local footprint.

RESOLVED that the Board noted the update.

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

West Northamptonshire Health and Wellbeing Board Action Log

Action No	Action Point	Allocated to	Progress	Status of Action
240523/02	The peer review letter to be circulated to the Board.			

Actions completed since the 25th May 2023

Action No	Action Point	Allocated to	Progress	Status of Action
240523/01	A link to a webinar hosted by Professor Jonathan Campion around childrens mental health to be circulated to the Board.	Cheryl Bird	Circulated 11th June	completed

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

27th July 2023

Report Title	NHS Northamptonshire ICS Joint Capital Resource Use Plan 2023-24
Report Author	Sarah Stansfield – Chief Finance Officer, NHS Northamptonshire Integrated Care Board

List of Appendices

Appendix A – NHS Northamptonshire Joint Capital Resource Use Plan 2023-24

1. Purpose of Report

To present the NHS Northamptonshire ICS Joint Capital Resource Use Plan 2023-24 to the West Northants Health and Wellbeing Board.

2. Executive Summary

The NHS Northamptonshire ICS Joint Capital Resource Use Plan sets out the capital plans across the NHS health system in the county including sources of funding and risks.

This Capital plan reflects the joint capital ambition of NHS Northamptonshire ICB and its partner NHS Trust and Foundation Trusts for 2023/24. It sets out how the system will balance long term affordability, maximising value for money and optimal capital financing.

The System is working in a number of areas over the course of the year:

- Routine and backlog maintenance of estates to ensure patients are kept safe and the replacement of ageing equipment.
- Medical equipment maintenance and refresh
- Continued digital improvements including clinical systems and work on Electronic Patient Record.

The total system Capital Departmental Expenditure Limit (CDEL) is £69.7m which includes £1.3m for Primary Care held by NHSE.

3. Recommendations

It is recommended that the board note the planned expenditure and funding set out in the report

4. Report Background

The Health and Care Act 2022 (the amended 2006 Act) established Integrated Care Boards (ICBs) with effect from 1 July 2022 to empower local health and care leaders to join up planning and provision of services, both within the NHS and with local authorities. This formalised the system capital planning approach and ICBs have a financial duty to ensure that the system's allocated NHS capital budget is not overspent.

Under the Act, ICBs and their partner NHS trusts are required to produce and publish annual NHS joint capital resource use plans on direction from the Secretary of State. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to ICBs is being prioritised and spent to achieve the ICB's strategic aims.

This plan sets out the ICB and its partner NHS trusts' plan for 2023/24 in line with our commitment to provide our stakeholders with this transparency and going forward. However, it should be noted that additional funding can often become available in year so this may change the original published plan.

5. Issues and Choices

The Northamptonshire ICS capital plan aims to support the corporate objectives:

Improve health for all
Reduce health inequalities
Make the best use of public funding
Support our county's economic and social development

6. Implications (including financial implications)

6.1 Resources, Financial, Legal and Risk

Consideration of the resourcing, financial, and legal risks have been undertaken by each individual organisation and been through their own governance procedures.

6.2 Consultation

Consultation has been undertaken across the system, including trust boards, governors, and stakeholders.

REGION	Midlands
ICB / SYSTEM	NHS Northamptonshire ICS

Introduction

The Northamptonshire ICS capital plan aims to support the corporate objectives:

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- Reduce health inequalities
- Make the best use of public funding
- Support our county's economic and social development

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- Medical equipment maintenance and refresh
- Continued digital improvements including clinical systems and work on Electronic Patient Record.

The total system Capital Departmental Expenditure Limit (CDEL) is £69.7m which includes £1.3m for Primary Care held by NHSEI.

Assumed Sources of Funding for 2023/24

The total CDEL plan for the system in 2023/24 is £69.7m. The two main sources for this capital funding are:

- Internally generated funds from within Provider Trusts and Foundation Trusts, mostly from depreciation.
- National NHS programme funding

Overview of Ongoing Scheme Progression

Guidance:

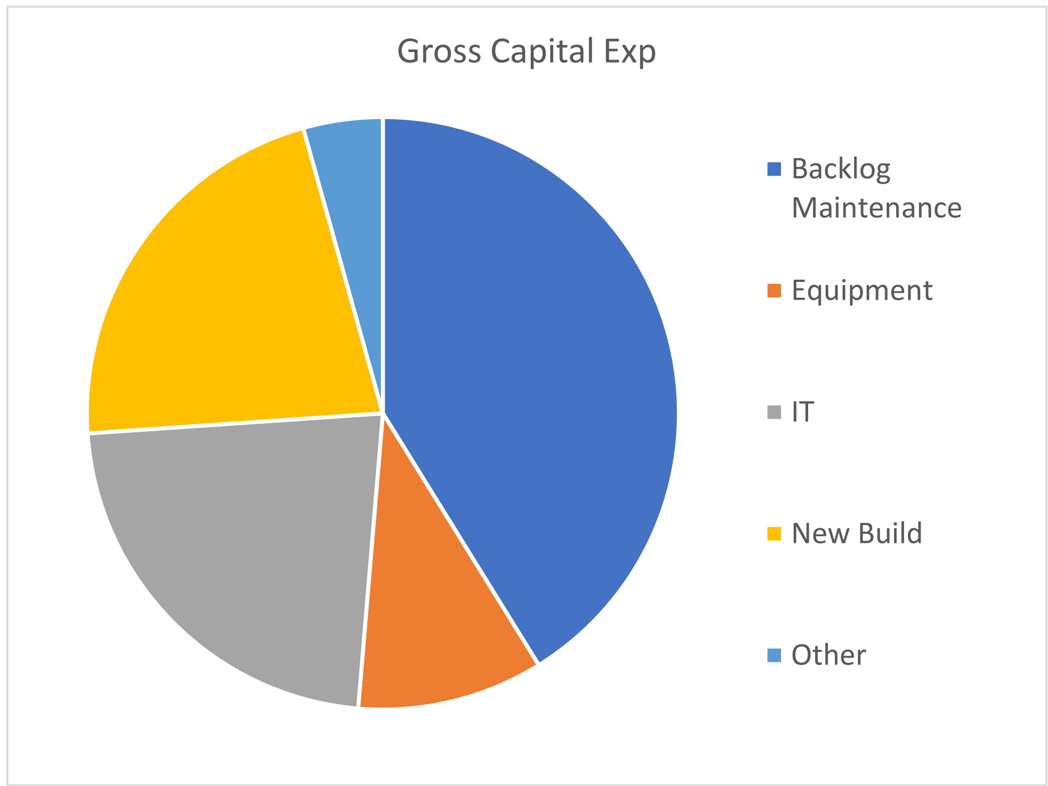
Please provide an overview of scheme progression. Probably should only be schemes above a certain level

Estates maintenance (backlog maintenance) is the largest investment in the capital programme (42% of gross capital expenditure). This is split between moderate/low risk and significant/high risk. Assessment and prioritisation of capital schemes is done by Trust based capital committees directed by lead clinical, estates, digital and finance roles.

The most significant scheme outside of the backlog maintenance and equipment replenishment relates to the clinical diagnostic centres in the North & South of the county. The £13m and £3.3m plan being predominantly construction and project management related, with c. £1m invested into new equipment.

IT investment is key to modernising services, improving efficiency, planning and outcomes for patients. The investments include improvements in clinical systems, cybersecurity, infrastructure, networking and software across all trusts. The most significant digital investment is the NGH Electronic Patient record advancement £6.4m in 23/24, supported by Front Line Digitisation funding.

New build includes the New Hospital Programme early stages of energy centre and high voltage work.



Detailed monitoring and development of schemes will be a feature of individual Providers reporting. The Annual report for the Integrated Care Board will look to provide an overview of the delivery against plan for 2023/24.

Risks and Contingencies

The programme contains a small contingency to support the management of risk. Other risks which will be managed in year:

- The impact of inflation on deliverability of plans
- Availability of equipment
- Procurement timelines
- Approval timelines for national programme funds
- Project delays – slippage

These risks are detailed within monthly reporting, with mitigations planned to minimise impact.

Business Cases in 2023/24

Guidance:
Please insert detail of some of the key business cases in the ICB that are likely to be submitted in 2023/24.

KGH is preparing the case for a reconfiguration of the Rockingham wing, Family Health Division, adapted to support planned service developments and future levels of demand, improve clinical adjacencies. Includes Midwifery led unit to comply with NICE requirements, improve choice to patients and development opportunities for midwives. Ensure that any reconfiguration or remodelling of building layout supports future strategic service objectives and does not compromise future service plans.

NGH is preparing the case for a second phase of Clinical Diagnostic Centre located in Northampton with the site and services provided by an independent sector provider (ISP) but overseen and managed by Northampton General Hospital as part of the overall Northamptonshire CDC programme of work. The CDC will provide all the diagnostic tests set out in the planning guidance, as well as some additional physiological and endoscopy examinations.

Cross System Working
The ICB will support management of the System-wide capital programme across the course of the year. It will monitor risks and report on progress to the Integrated Planning and Resources Committee and by exception to the ICB Board. NHS Trusts and Foundation Trusts will also provide assurance via internal committees and Boards for their own sections of the plan. There is currently none of the 2023/24 capital plan which is reliant on inter-System support or coordination.

Capital Planning & Prioritisation
The system is working on development of a robust estates strategy as part of it's 5-year planning. This is expected to form part of the underlying work for capital planning for the Integrated Care Board, partners, and the wider ICS.

Annex A – Northamptonshire ICS 2023/24 CAPITAL PLAN

	CDEL	ICB	Provider			Total Full Year Plan £'000	Narrative on the main categories of expenditure
			KGH	NGH	NHFT		
Provider	Operational Capital		12,834	14,997	5,018	32,849	Equipment, estates maintenance, IT
ICB	Operational Capital	1,323				1,323	
	Total Op Cap	**1,323**	**12,834**	**14,997**	**5,018**	**34,172**	
Provider	Impact of IFRS 16		2,864	500		3,364	Lease additions
ICB	Impact of IFRS 16					-	
Provider	Upgrades & NHP Programmes		5,304			5,304	New Hospital Programme @ KGH
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)		14,396	11,881	-	26,277	£16m community diagnostics, £7m front line digitisation, £3m UEC
Provider	Other (technical accounting)				576	576	PFI capital charges
	Total system CDEL	**1,323**	**35,398**	**27,378**	**5,594**	**69,693**	

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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

27 July 2023

Report Title	Draft Joint Local Health and Wellbeing Strategy
Report Author	Sally Burns - Director of Public Health Chloe Gay- Public Health Specialist Practitioner

List of Appendices

Appendix A – Draft Joint Local Health and Wellbeing Strategy

1. Purpose of Report

1.1 This report presents the draft Joint Local Health and Wellbeing Strategy to Members for consultation

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 Board (ICB) 1 December 2022.

2.2 Reports to this Board on 23 March and 25 May 2023 focused on local engagement gathered to inform the strategy and priorities against the 10 Live Your Best Life ambitions. The Board now needs to agree a draft strategy including the key priority outcomes to jointly deliver and focus its ambition to ensure local people Live Their Best Life.

2.3 The draft strategy has adopted an evidence-based approach to determining priorities. This has been achieved by considering data collected through 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.

3. Recommendations

3.1 The board are asked to agree the draft Joint Local Health and Wellbeing Strategy for wider consultation with partners, stakeholders, communities and residents.

4. Report Background

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

4.2 Health and Wellbeing Boards will continue to be responsible for assessing the health and wellbeing needs of their population and publishing a JSNA and a Joint Local Health and Wellbeing Strategy, 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 need and feedback from local people.

4.3 The Strategy 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.

4.4 To ensure that local authorities build on their unique 'place' role to support the delivery of the ICB Health and Care Strategy, the Board is required to agree and deliver a Joint Local Health and Wellbeing Strategy to ensure that locally agreed ambitions and outcomes can be fully delivered in West Northamptonshire.

4.5 Work on the development of the draft strategy started in January working closely with system wide colleagues and extensive engagement with stakeholders and local people. A draft strategy is now prepared for approval for wider consultation and is attached at Appendix A

5. Next Steps

5.1 If the Board is minded to approve the draft Strategy it will be circulated to key stakeholders for further consultation, and wider public consultation before being presented for final approval at the next Board meeting on 28 September.

5.2 Wider engagement with residents, local community leaders and organisations will be undertaken during the summer to refine the delivery plan associated with the strategy.

5.3 An engagement plan is being developed to facilitate community feedback to sit alongside updated evidence from the JSNA during the life-course of the strategy enabling it to be reviewed and updated as necessary.

5.4 Work is also underway to ensure regular progress reporting is scheduled for key thematic groups and committees and ultimately this Board.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 There are no immediate financial implications as a result of this report but the strategy sets out the priorities for the Health and Wellbeing board and therefore it is anticipated that all organisations support, align and focus their resources towards these priorities.

6.2 Legal

6.2.1 Health and Wellbeing Boards have a statutory responsibility for assessing the health and wellbeing needs of their population and publishing a JSNA and a Joint Local Health and Wellbeing Strategy. The draft strategy sets out the priorities for improving the health and wellbeing of West Northamptonshire

6.3 Risk

6.3.1 Work is underway to produce delivery plans behind each of the ambitions in the Health and Wellbeing Strategy, this includes risk identification and risk management

7. Consultation

7.1 Extensive consultation has taken place so far with partners, stakeholders and with communities. Further wider consultation is planned and the delivery approach is based on consultation and co-production

8. Consideration by Overview and Scrutiny

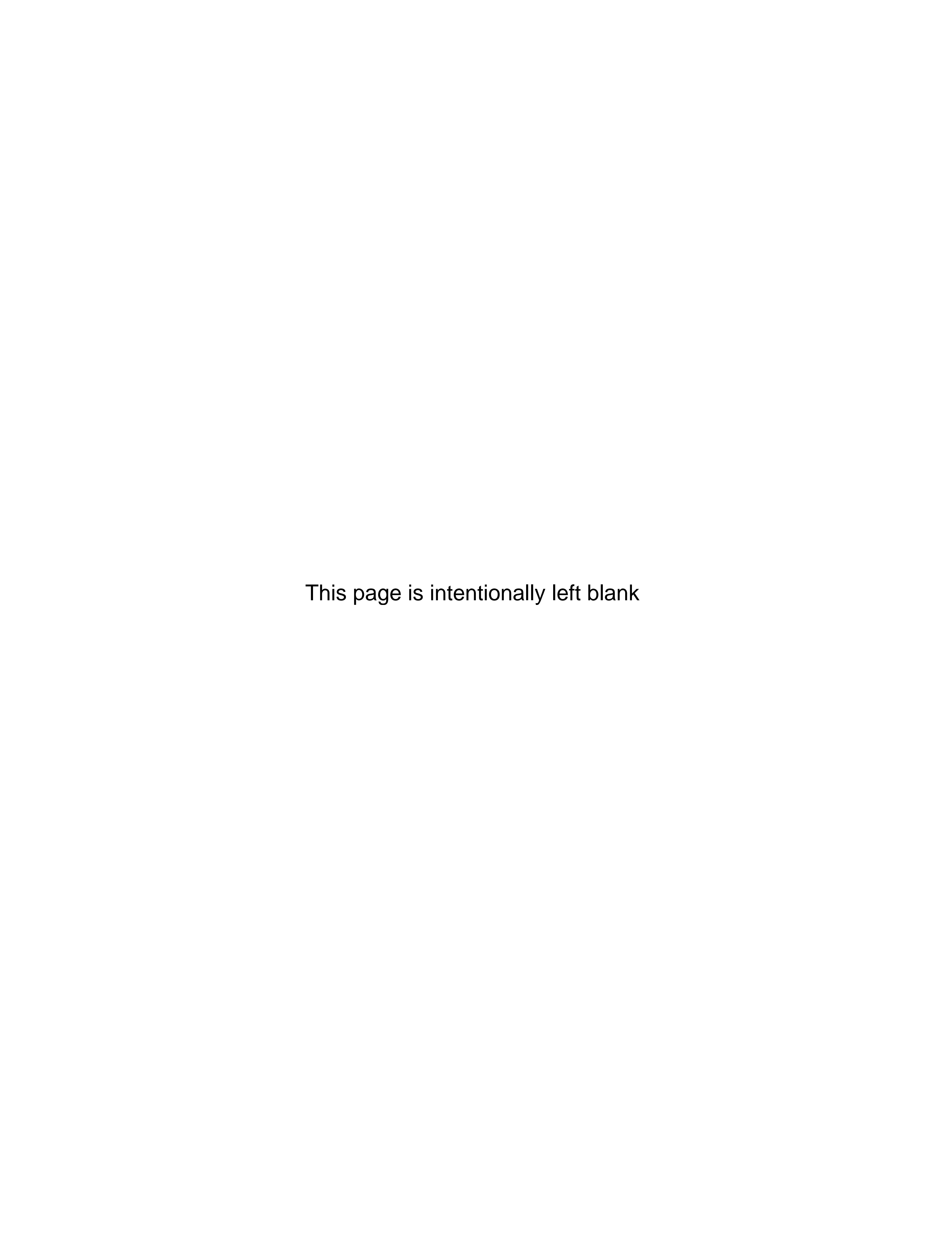
8.1 The strategy has not been considered by overview and scrutiny however there have been two member workshops so far as part of the progression of this work. A further workshop is planned in September

9. Community Impact

9.1 The place delivery model which underpins the draft Joint Health and Wellbeing Strategy will help focus on reducing health inequalities across both geographical communities and communities of interest.

10. Background Papers

- West Northamptonshire Health and Wellbeing Strategy Engagement overview (presented to the last board meeting)
- Northamptonshire Joint Strategic Needs Assessment Refresh
- Integrated Care Northamptonshire Strategy
- Five Year Forward View Strategy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WEST NORTHANTS
Health and Wellbeing Board
live your best life

Joint Local Health and Wellbeing Strategy

2023-2028

Please note, this is a draft version subject to consultation feedback, final proofing and accessibility checks

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Our approach

Our ambitions for residents in West Northamptonshire - Live Your Best Life

Our governance

Our performance framework

Our partners

Summary of our strategy

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Our shared vision

We want to work better together to create a place where people are active, confident and enjoy good health and wellbeing. A West Northamptonshire where people can see and feel a bright future for quality support and services when they need help.

Across the life course we are committed to Starting Well Living Well Ageing Well

Ambition	Key outcomes	Available system priority metrics
Best start in life	Women are healthy and well during and after pregnancy. Children are healthy from birth. All children grow and develop well so they are ready and equipped to start school. Children in care are healthy, well and ready for adulthood.	% achieving good level of development at age 2-3
Access to best education and learning	Children and young people perform well at all key stages. SEND education meets the needs of children locally. Schools serve all children and young people well and nobody misses out on learning. Adults have access to learning opportunities which supports employment and life skills.	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	Adults are healthy and active, and enjoy good mental health. People experience less ill-health and disability due to lung and heart diseases.	9% of adults currently smoke' (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps them and their families out of poverty	More adults are employed and receive a 'living wage'. Adults and families take up benefits they are entitled to.	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Good access to affordable, safe, quality, accommodation and security of tenure. The local environment is clean and green with lower carbon emissions.	Number of households owed a prevention duty under Homelessness Reduction Act
People feeling safe in their own homes and when out and about	People are safe in their homes, on public transport and in public places. Children and young people are safe and protected from harm.	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to their families and friends	People feel well connected to family, friends and their community. Connections are helped by public transport and technology. Improving outcomes for those who are socially excluded.	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Homeless people and ex-offenders are helped back into society. People have good access to support for addictive behaviour and take it up.	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	Timely access to all health and social care services when they need across life course from conception to end of life. People are supported to live at places of their residence and only spend time in hospital to meet medical needs. Services to prevent illness (all health screening and vaccinations) are easy to access with quality service provision. People are treated with dignity and respect in all care provisions including end of life.	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible looked after children and adults with Learning disability/Severe mental illness receive annual health check
To be accepted and valued simply for who they are	Diversity is respected and celebrated. People feel they are a valued part of their community and are not isolated or lonely. People are treated with dignity and respect.	Metrics to be developed

Our approach

1. Prevention as a priority
2. Tackling health and wellbeing inequalities
3. The importance of 'Place' and delivery through our Local Area Partnerships and Local Area Forums
4. An evidence-based and community insight led approach
5. Co-production

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Foreword

I am delighted to introduce the West Northamptonshire Joint Local Health and Wellbeing Strategy for 2023 to 2028. This challenging new plan sets out how, in West Northamptonshire, we will work together as a partnership and with residents to improve health outcomes for local people.

We do this at a time of significant pressures on public services post pandemic, and on people nationally due to unprecedented cost of living challenges, exacerbated by the conflict in Ukraine and the impact of climate change.

In 2022 changes to the health system architecture and leadership led to the development of 'Integrated Care Northamptonshire' a system wide strategy for the county and a fundamental shift in health and care organisation.

An Integrated Care Board (ICB) replaced the former Clinical Commissioning Group and both West and North Northamptonshire Councils are key partners on this board alongside local healthcare leaders. 'Integrated Care Northamptonshire' has been developed around 10 ambitions, to enable people living and working in the area to Live Their Best Life.

The Health and Wellbeing Board will play a significant role in the delivery of 'Integrated Care Northamptonshire' over the next 5 years. These ambitions are the starting point for us as we shape our own Joint Local Health and Wellbeing Strategy (JLHWS).

This document explains how the Health and Wellbeing Board intends to play its part to improve the wider determinants of health in West Northamptonshire; and how we will do this by engaging and enabling our local communities through a 'place' based approach.

This is our health and wellbeing commitment to the people of West Northamptonshire for the next five years. We will regularly review and report back on our progress and develop an open two-way dialogue with our local communities to ensure we deliver what is important to residents. It is intentionally ambitious to ensure we can turn the tide of growing demand on health and care services enabling them to have the space to improve.

Our starting point is prevention, through education and by empowering local people to take responsibility for their own good health and wellbeing. To achieve this, we are committed to tackling health inequalities in some of our communities.

Our mission is to ensure the people of West Northamptonshire are supported and able to live their best life. I hope you agree that this exciting strategy will help us get there.

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

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Introduction

West Northamptonshire is a great place to live but it is also a place that has challenges and like all areas, faces some uncertainty. Despite this we have the opportunity and potential to create a bright future, and we will use our strengths to improve the lives of people who live and work in the area helping them to 'Live their Best Life'.

Together, we can shape our own journey and destination by working closely with our NHS, primary care, emergency services, local businesses and institutions, voluntary sector and our community partners.

The pandemic put an enormous pressure upon services and local businesses and has left a challenging personal legacy for our residents. The 'cost of living' crisis adds to this challenge nationally and locally; influencing the level of public funds available and the pressures faced by local people in their daily lives. Some of the challenges we face require changes in behaviour or in the way we work together, some will require considerable national and local investment.

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Our shared vision

Together, with our partners, we share a vision for health and wellbeing:

We want to work better together to create a place where people are active, confident and enjoy good health and wellbeing. A West Northamptonshire where people can see and feel a bright future for themselves and their families, take personal responsibility for their own health, but can reach out to quality support and services when they need help.

Through Integrated Care Northamptonshire we have agreed 10 challenging ambitions to enable local people to Live Their Best Life. Our West Northamptonshire Joint Health and Wellbeing Strategy brings vision this to life at a place level.

Many of these ambitions require us to address the wider determinants of health and this is where all partner organisations in West Northamptonshire can add the greatest value.

Our 10 ambitions reflect what local people need to have or be to help them Live their Best Life. These are:

- The best start in life
- Access to the best available education and learning
- Opportunity to be fit, well and independent
- Employ that keeps them and their families out of poverty
- Good housing in places which are clean and green
  – so need to use this throughout
- Safe in their homes and when out and about
- Connected to their 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

Our understanding of what makes us healthy and happy

Impacts of the wider determinants of health - Robert Wood Johnson model

Health and wellbeing is a complex interaction between individual characteristics, behaviours, the social and economic environment, as shown below. A holistic approach to health and wellbeing which takes 'everything' into account and encourages people to take charge of their health and wellbeing.

Socioeconomic Factors

Education
Job Status
Family Support
Income

Physical Environment

Housing

Health Behaviors

Tobacco Use
Diet and Exercise
Alcohol Use
Sexual Activity

Health Care

Access and quality of care

A focus solely on healthcare provision will not solve all health problems

This requires a system, not an organisational approach

We need a greater focus on important wider determinants because health starts - long before illness - in our homes, schools and jobs

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Drivers of inequalities

The overlapping dimensions of health inequalities

Health inequalities are determined by social circumstances largely beyond an individual's control. The dimensions of inequality show the different groups that are most vulnerable to health inequalities and how these overlap, as shown in the diagram.

Socioeconomic groups and deprivation
e.g. unemployed, low income, deprived areas

Inclusion health and vulnerable groups
e.g. homeless people, Gypsy, Roma and Travellers, sex workers, vunerable migrants, people who leave prison

Protected characteristics in the Equality Duty
e.g. age, sex, religion, sexual orientation, disability, pregnancy and maternity

Geography
e.g. urban, rural

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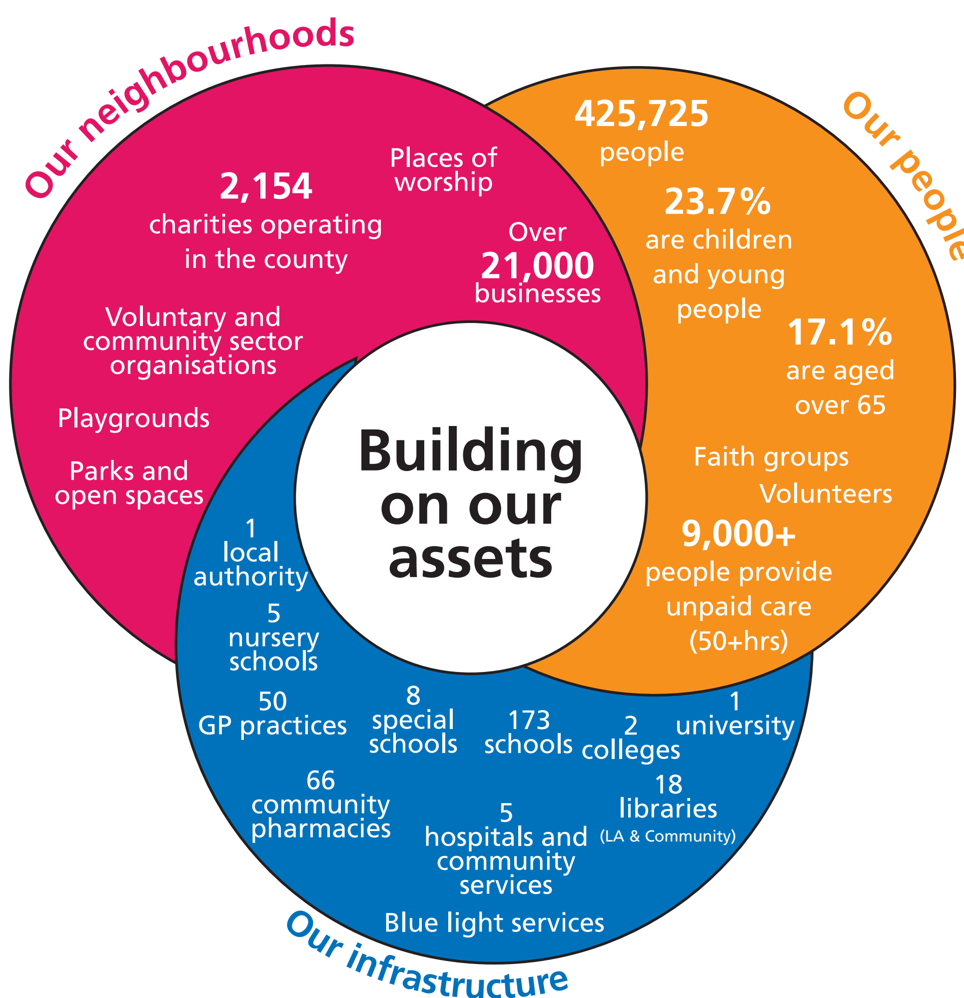
Key factors for health and happiness

Marmot (ref) identifies eight principles for health and happiness which are reflected in our 10 ambitions for West Northamptonshire. The eight principles are:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention
7. Tackle racism
8. Environmental sustainability



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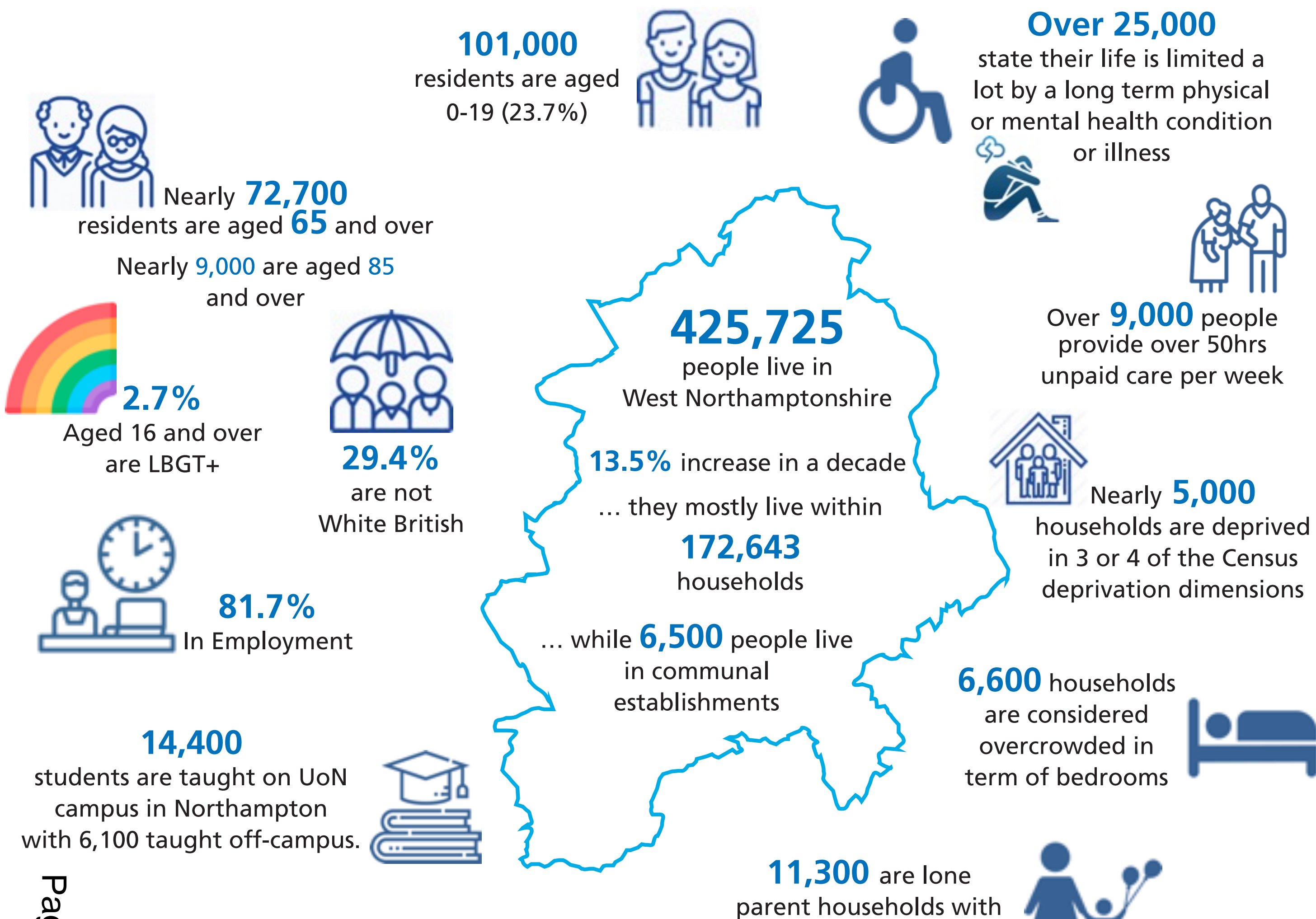
Our current position in West Northamptonshire

The diagram below explains the population in West Northamptonshire



Key health challenges that we face

- Our key health challenges are informed by our joint strategic needs assessment (JSNA) and supporting themed fact sheets. (Link to JSNA summary and fact sheet)
- Social determinants and poverty set a pattern of poor lifestyle behaviours that compound poor health
- We must take a preventative approach to poor health and tackle the social determinants whilst supporting people to have positive behaviours.

Health and Wellbeing in West Northamptonshire

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Life course challenges in West Northamptonshire

This page sets out the challenges we face through the life course and also the difference in inequalities within our communities in West Northamptonshire.

Start Well

- 4,647 babies were born in 2021.
- 12.3% of mothers smoked at the time of birth in 2020/21. This is worse than the England average.
- The population of West Northamptonshire was 425,700 in 2021.
- 72% of children achieved a good level of development at the end of reception class in 2019.
- 14% of children aged under 16 lived-in low-income families in 2020/21. This is better than the England average.
- 21% of children in reception class were overweight or obese in 2019/20. This is better than the England average.*
- 30% of children in Year 6 were overweight or obese in 2019/20. This is better than the England average.*
- 73% of young people gained a standard pass (4) in English and Maths GCSEs in 2021.
- The Chlamydia detection rate was 1,417 per 100,000 in 15- to 24-year-olds in 2020 This is below the national target range.
- There were 10 pregnancies in females aged under 18 per 1,000 girls aged 15 to 17, in 2020. This is lower than the England average.

* Please note that figures on childhood excess weight should be interpreted with caution due to low 2019/20 NCMP participation.

Live Well

- A 2018 based projection estimated there were 170,103 households in West Northamptonshire in 2021.
- The average salary (persons) in 2020 was £32,467. This was an increase of 2% compared to 2019.
- 78% of adults were employed in 2020/21. This is similar to the England average.
- 9% of households experienced fuel poverty in 2018.
- There were 374 new sexually transmitted infections per 100,000 population in 2020. This is lower than the England average.
- 63% of adults were physically active in 2020/21. This is worse than the England average.
- 52% of the population aged 16+ ate their "5-a-day" in 2019/20. This is worse than the England average.
- 69% of adults were overweight or obese in 2020/21. This is worse than the England average.
- There were 467 alcohol related hospital admissions per 100,000 population in 2020/21. This is similar to the England average.
- 15% of adults smoked in 2019. This is similar to the England average.
- There were 8 suicides per 100,000 population in 2018-2020. This is lower than the England average.
- There were 297 hospital admissions for self-harm per 100,000 population in 2020/21. This is worse than the England average.
- There were 3 deaths from drug misuse per 100,000 population in 2018-2020. This is lower than the England average.
- 42 people were killed or seriously injured on roads per 100,000 population in the 2016-2018. This is similar to the England average.
- There were 26 deaths from preventable cardiovascular diseases per 100,000 population in 2017-2019. This is similar to the England average.
- There were 20 deaths in under 75s from preventable respiratory diseases per 100,000 population in 2017-2019. This is similar to the England average.
- There were 54 deaths from preventable cancers per 100,000 population in 2017-2019. This is similar to the England average.

Age Well

- There were 2,727 hospital admissions due to falls in people aged 65+ per 100,000 65+ population in 2020/21. This is worse than the England average.
- The average male life expectancy was 79.8 in 2018-2020. This is better than the England average.
- The average female life expectancy was 82.8 in 2018-2020. This is worse than the England average.

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Health inequalities in West Northamptonshire

This diagram will be redrawn pending updated information.

West Northamptonshire

20% least deprived

8%	18%	28%	507	8.0	2.4	0.6%	£20 3%	£4 0.6%	87	2,148
14%	25%	39%	1,214	7.6	2.8	3.0%	£14 3%	£7 1.4%	203	2,587

20% most deprived

Life expectancy 82 / 84

Life expectancy 75 / 79

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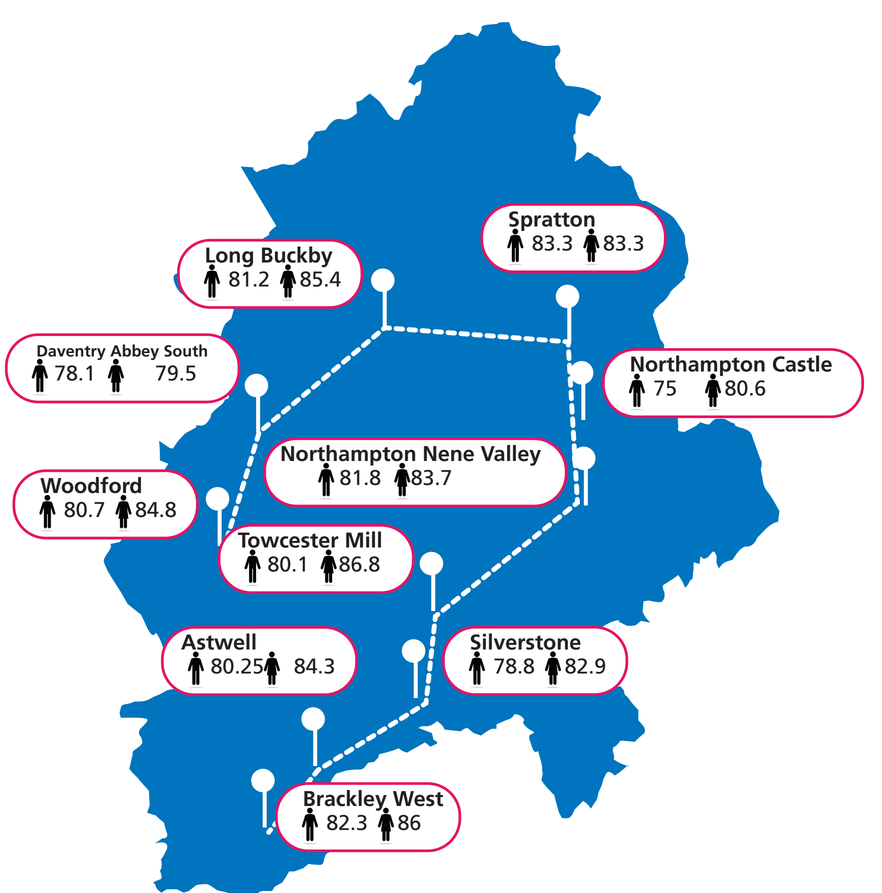
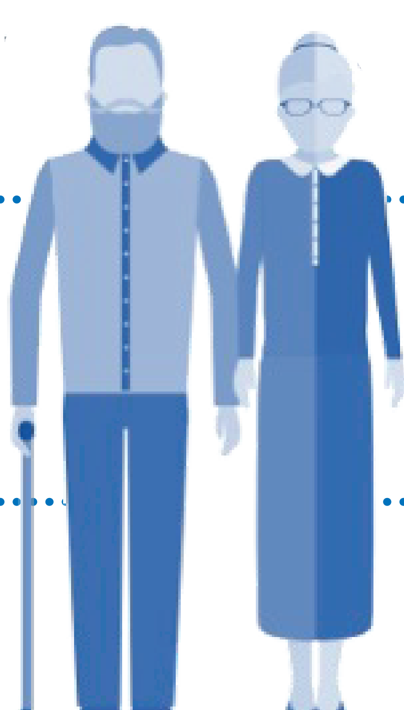
Life expectancy in West Northamptonshire



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

Average life expectancy at birth for men is 79.8

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



Average life expectancy at birth for women is 82.8

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

Healthy life expectancy (the average number of years a person would expect to live in good health) for men and women in Northamptonshire ranges between 63 and 65 years of age meaning that most people will start their retirement with some degree of poor health

Source Data : Fingertips 2018-2020

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Our approach

Through our services and policies, we can make the greatest impact within the partnership by focussing our efforts on improving outcomes within the wider determinants of health including; housing, air quality, community cohesion and social improvements in places and communities which we live and work for example and critically social improvements in the places and communities in which we live and work.

Five key approaches will shape our strategic health and wellbeing ambitions.

1 - Prevention as a priority

National and local resources to support health and wellbeing are critically stretched because of high demand often due to lifestyle and environmental pressures on people of all ages. Preventing poor health and wellbeing is more important than ever.

Local data suggests that there is more we can do on prevention in West Northamptonshire – supporting people to make good lifestyle choices, picking problems up earlier and creating local environmental conditions that support good health; thereby taking pressure off primary and acute services.

Generally, people want to be in control of their lives and not rely on services to put things right. We will support them by providing help in preventing health problems and enabling people to manage their lives in a way that can lead to a happy, healthier future. We are also committed to ensuring local communities are great places to live with a culture of wellbeing.

The Health and Wellbeing Board is well placed to support preventative interventions through; housing and environment, children's and adults, leisure and cultural services, highways and footways and community safety.

2 -Tackling health and wellbeing inequalities

We recognise that there are people in our communities who experience greater health and care challenges or are not always visible to the services that can support them.

Health inequalities are preventable, unfair, and unjust differences in health between groups, populations, or individuals. These arise from unequal social, economic, and environmental conditions which in turn, can determine the risk of people getting ill, their ability to prevent sickness, or their chance to get treatment when health or care needs occur.

In short, inequalities mean that some people do not have the same chances to be healthy. The disproportionate impact of COVID further highlighted long-standing health inequalities.

We know from data and feedback where these inequalities occur locally and through this strategy, we will target those most in need or seldom heard.

DRAFT

Our approach

3-The importance of 'place' and local assets

We need to take very local action to address specific problems in some communities that prevent good health and wellbeing. To do this we need to work side by side with local people and community leaders. Our place model for West Northamptonshire includes the development of nine Local Area Partnerships (LAPs) supported by two Health and Wellbeing Forums.

The model is reliant on all partners working together to identify local priorities, improve outcomes and reduce inequalities for residents and their communities.

The initial functions of the Local Area Partnerships are to:

- represent local areas and give a voice to residents, translating strategy into local action
- empower residents to co-produce new services and solutions locally with partners
- contribute to system-wide priorities by utilising evidence-based information and local insight from frontline services and communities
- empower local leaders to take accountability for local action.

The Health and Wellbeing Board will oversee the development and roll out of the Health and Wellbeing Forums and the nine Local Area Partnerships which support huge potential to tackle health and wellbeing priorities at a local level.

The Health and Wellbeing Forums have a shared responsibility to:

- support the development of LAPs
- identify "at scale" priorities based on profiles and priorities
- agree a local, multi-partner action plan for their locality.

Each Local Area Partnership has a core membership that brings together leaders who work closely within their community and understand the local landscape.

For more information about the Place delivery structures including our Health and Wellbeing Forums and the LAPs please see the LINK here.

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Our approach

4 - An evidence-based and community insight led approach

The Joint Strategic Needs Assessment (JSNA) is a summary of data related to health and wellbeing across Northamptonshire that provides a view of local health and wellbeing information alongside national data. This data informs our priorities and performance focus. We have used this valuable resource to shape our priorities, identify where we need to improve and allocate our resources.

Enriching that knowledge, we have also taken on board insights from our local communities. These may be geographic communities a defined local area, for example a Local Area Partnership or Parish, or communities of interest. It can also be a cross cutting community, for example young people across West Northamptonshire. Insight from across our area has already been built into the development of this strategy and we will continue to work in this way to support its further development. We are particularly keen to build on our Well Northants asset-based model of community engagement.

The West Northamptonshire Health and Wellbeing Board values this insight from local people and has listened to a wide range of local voices including our community forums in developing this strategy. There were many common themes which have helped us to focus on what matters most locally. We will continue to listen to local voices as we roll out delivery plans and fine tune our priorities.

5- Co-production

Passion for the place, experience, assets, and skills are abundant in our local communities. This is often an untapped resource when designing and commissioning services locally. Our fantastic community and voluntary sector are a critical part of our co -production and are our secret weapon locally. Co-production is a way of working were service providers and service users work together to reach a shared outcome. This approach is value driven and built on the principle that those who are affected by a service are best placed to help design it. It contributes to a sense of shared identity and purpose locally. The 'Place' approach outlined above creates the right environment for this to work well; and local insight sets the context for the creative development of services designed together.

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Ambition 1 - The best start in life

Our ambitions for resident in West Northampton to support them to 'Live Your Best Life'

Introduction

In West Northamptonshire we are committed to give children the best start in life to grow happy and healthy, flourish and succeed in life. With the current cost of living crisis long lasting impacts of the COVID-19 pandemic, children and families are facing huge challenges to receive the support they need when they need it, leading us to pick up issues at crisis point. We want to ensure we develop an integrated support offer for families and children to meet their needs at the earliest point of identification, and enable them to access local, timely and welcoming services to prevent problems from escalating. We want to ensure we give children the best start for life to flourish and live a healthy adulthood.

Where we are now

- Risks of birth complications and poor health in new-born children is higher than it ought to be due to high levels of smoking and obesity in pregnancy.
- Children in care in Northamptonshire have poorer access to regular health and dental checks than other areas.
- Not enough children are starting school with the skills they need to succeed.
- There is a lack of youth provision for young people.
- Too many young people have poor mental wellbeing and this is increasing.
- The severity of poor mental health in adolescence is also increasing resulting in high rates of admission to hospital for self-harm and eating disorders.

What you have told us

- The community want locally based support services for families and young people.
- The community would like a 'drop in' service with tailored support for young parents.
- We want more support for children with special needs and their parents.

What is the inequalities focus

We need to focus on children and families in the 20% most deprived areas, children in care, young parents, children with special needs and children with long term conditions.

What we want to achieve

- Women are healthy and well during and after pregnancy.
- Children are healthy from birth.
- All children grow and develop well so they are ready and equipped to start school.
- Children in care are healthy, well and ready for adulthood.

What system measures are being used for the HWB to monitor progress?

- Reduce the % of women smoking at time of delivery.
- Increase the % of children with good level of development at age 2-3.

How we will achieve our ambition

We will develop a supportive, integrated and consistent offer to support women from pre-pregnancy stage to postnatal stage by working with the Local Maternity System prevention group and wider partners across the system.

We will work to increase the uptake of free early education entitlement for all three and four years old. We will work with the 0-19 service to increase the integrated aged 2-2.5 reviews and expand the universal and targeted support for parents to ensure that all children are ready to start school and able to flourish and live a healthy adulthood.

We will develop an early help universal offer to support families in need at the earliest point of identification and to prevent issues from reaching crisis point.

We will develop the family hubs programme building on existing services and community assets and strengthen integrated services across local authority, Northamptonshire Integrated Care Board, Children Trust, and the voluntary community sector to improve outcomes for children and young people across West Northants.

We will increase access to specialist care and support services for at risk children and their parents.

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Ambition 2 - Access to the best available education and learning

Introduction

In West Northamptonshire we are committed to giving all children access to the best education and learning. We want all children to attend safe, inclusive and aspirational schools, settings and providers. We want to all educational establishments to be at least 'Good' in all areas and to deliver an innovative, carefully planned curriculum that promotes personal development and provides a high quality, inclusive and diverse education.

We will work together to provide a robust multi-agency approach to support all children and young people to have access to the best educational provision, which meets their needs and enables them to thrive and fulfil their potential. Our aim is to ensure that we provide an appropriate, high quality, sustainable Education service. In doing so, we will improve life chances of all children and young people and enable them to flourish into adulthood as valued citizens.

Where we are now

- 91% of primary schools are good and outstanding
- 82% of our secondary schools are good and outstanding
- Our school attendance across is 92.5%
- 5,569 incidents of suspension linked or related to 2005 pupils, and 93 permanent exclusions in 22/23
- 63% of eligible 2 year olds access free education and childcare for 2-year-olds
- 60% of 3 and 4 year olds access the free universal funded early education entitlement
- 53% of eligible 3 and 4 year olds currently accessing the universal entitlement,
- We know there is limited access to activities for young people outside of school

What you have told us

- Schools and other settings need to be more inclusive.
- Children and young people need 'safe spaces' outside of school.
- More support for children with special needs and their parents is needed.

What is the inequalities focus

We need to focus on children and families in the 20% most deprived areas, children in care, children with special needs and children who are vulnerable or those who are disadvantaged.

What we want to achieve

- Children and young people perform well at all key stages.
- SEND education meets the needs of children locally.
- Schools serve all children and young people well and nobody misses out on learning.
- Adults have access to learning opportunities which supports employment and life skills.

What system measures are being used for the HWB to monitor progress?

- Increase average attainment 8 score of all pupils.
- Reduce percentage of SEND children electively home educated.
- Reduce rate of permanent exclusions (per 100 pupils).

How we will achieve our ambition

We will ensure all families have access to the best education and can access educational settings to meet their children's needs.

We will ensure that all children, including those with SEND or vulnerabilities are able to develop resilience and independence.

We will work to Increase the uptake of free early education entitlement for all two, three and four years old.

We will work with all education partners to identify children at risk of exclusion, and develop packages of support to enable children to remain in appropriate education settings.

We will ork with all education partners to provide sufficient education places to meet need of all children, including those with SEND.

We will develop a West Northants youth offer to provide children with safe spaces out of school.

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Ambition 3 - Opportunities to be fit well and independent

Introduction

The ability of our residents to live well, be fit and independent is hugely shaped by the circumstances in which they live their lives. To enable residents to live healthy lives, prevent ill health and promote wellbeing, people need the right information, services and support, with targeted interventions for those who need it most.

By working together as a system, and taking a life course approach, we can make sure that local people in West Northamptonshire have the opportunities to be fit, well and independent.

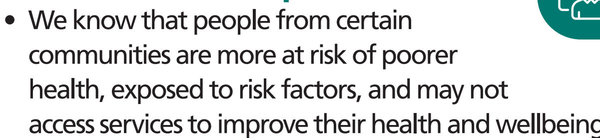
Where we are now

- Over one in four adults in West Northants are classified as physically inactive, and almost two thirds are classified as overweight or obese.
- Smoking is the single greatest risk factor for death and disability in West Northants with 11.5% of adults being current smokers.
- West Northants has growing older population and with people living in poor health.
- There are high rates of respiratory, diabetes and cardiovascular disease conditions with higher rates of mortality.
- Admissions for self-harm is higher than the England average.

What you have told us

- Bring people together by offering local activities and events to support healthier lifestyles that are affordable.
- The opportunity to receive care in our own homes to support independence is something that is important to us.
- We would like to see better communication, so we can stay informed and up to date on what is going on, as well as having a clear understanding of where to go for support.

What is the inequalities focus



- We know that people from certain communities are more at risk of poorer health, exposed to risk factors, and may not access services to improve their health and wellbeing.
- We need to make sure all of our services take into account needs of different communities and target them to ensure good uptake, experiences and outcomes. In particular, we will focus on supporting people living in areas of deprivation and marginalised groups.

What we want to achieve

- Adults are healthy and active, and enjoy good mental health.
- People experience less ill-health and disability due to lung and heart diseases.

What system measures are being used for the HWB to monitor progress?

- Reduce % adults who are current smokers.
- Reduce % adults classified as overweight or obese.
- Reduce the standardised rate of emergency admissions due to COPD.

How we will achieve our ambition

We are developing a more joined up approach to the way we deliver services to support people to live healthy lives and improve their physical and mental health – working through the Well Northants programme to better understand what communities need and to develop targeted offers to meet those needs within local communities.

We are developing early intervention / wellbeing teams to support people to improve their physical and mental health – with a particular focus on addressing health inequalities.

We will support people to stay well for longer through provision of advice, education, guidance on falls prevention, staying active and healthy, as well as living with and management long-term conditions.

Through the Mental Health and Learning Disability Collaborative, and the Mental Health Prevention Action Plan, we are working together across the system to promote emotional wellbeing and mental health.

We will ensure that we focus on tobacco control, promoting healthy weight and physical activity to address the risk factors for poor health and we wil we embed making every contact count at all opportunities.

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Ambition 4 - Employment that keeps them and their families out of poverty

Introduction

The causes and consequences of poverty are often complex. There is no single cause, but a range of factors contribute to people's risk of experiencing poverty. Over half of those living in poverty live in working households, where work does not provide enough income to meet basic needs or people fall into poverty due to circumstances beyond their control. Low pay and low wage growth is a key cause of poverty, and we have seen a significant rise in part-time contracts. There is still a strong association between unemployment and poverty. It is clear that our young people are particularly impacted

Where we are now

- We have relatively high rates of employment across the area as a whole but there are significant disparities at a more local level.
- There are large gaps in employment for vulnerable communities such as those with serious and enduring mental illness and those with learning disabilities.
- Cost of living crisis and resulting poverty having particular impact on health and wellbeing of residents. There are particular concerns regarding fuel and food costs.
- Many people and families are not claiming financial support they are eligible for.

What you have told us

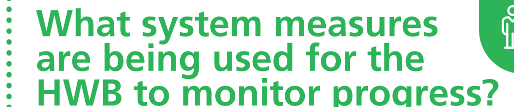
- The community would like local outreach employment support services including skills training, financial and benefits advice, support for business start-ups and social enterprises.
- Increase the number of apprenticeships for residents of all ages.
- Improved rural transport is needed to support local working people to access jobs.

What we want to achieve

- More adults are employed and receive a 'living wage'.
- Adults and families take up benefits they are entitled to.

What is the inequalities focus

We need to address gaps in employment for vulnerable communities such as those with serious and enduring mental illness and learning disabilities, care leavers and those living in areas of deprivation.



What system measures are being used for the HWB to monitor progress?

Reduce the gap between overall employment rate and the employment rate for those in touch with secondary mental health services.

How we will achieve our ambition

We will continue to deliver the Anti-poverty Strategy and work on the sustainability of cost-of-living support.

We will support the West Northants Sustainable Food Network to address food poverty.

We will develop our financial information and advice offer, especially in considering the needs of under-served communities.

We will work with education settings, employers and recruiters to ensure there are meaningful and sustainable employment opportunities with targeted hyper-local support for vulnerable groups and those in groups who are under-employed to access jobs and remain in employment.

The Northamptonshire Anchor Institutions Network will support provision of inclusive employment opportunities, particularly with under-served groups such as care leavers.

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Ambition 5 - Good housing in places which are clean and green

Introduction

A stable and secure home is one of the foundations of a good life. The condition and nature of homes, including factors such as stability, space, tenure and cost, can have a big impact on people's lives, influencing their wellbeing and health. A secure, comfortable home enriches our lives and supports our mental and physical health. But high costs and a shortage of affordable homes means many people have to live in poor, overcrowded conditions, fall into debt because costs are too high, move frequently, or may face repossessions or evictions. This all creates further instability and stress, with a significant impact on people's health and wellbeing.

As well as housing, the places we live can also impact physical and mental health. Having access to clean and green spaces is important for wellbeing and promoting a healthy life, as well as can enable people to build social connections.

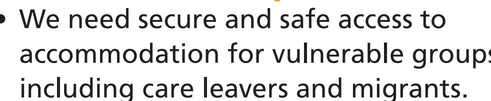
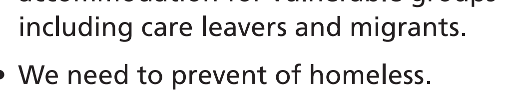
Where we are now

- The population of West Northamptonshire has grown by over 13.5% in the last decade which represents among the highest growth in the country.
- 1,972 households were threatened with homelessness within 56 days over 2021/22.
- While the area is largely green and rural, with much of land usage agricultural, access to green spaces for people who live in our urban centres requires improvement.
- Air quality in some areas of Northampton requires improvement.

What you have told us

- More affordable rental accommodation is needed that is well maintained by landlords.
- It's very important that the environment around housing is clean, green safe and well maintained.
- We need to tackle shortage of housing and enable all people to access good housing, and considering the need for car parking spaces, open spaces and recreational land.

What is the inequalities focus

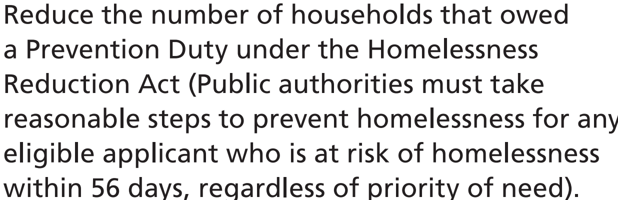



- We need secure and safe access to accommodation for vulnerable groups including care leavers and migrants.
- We need to prevent of homeless.
- People living in areas of deprivation are particularly affected by a lack of access to quality green spaces and air pollution.

What we want to achieve

- Good access to affordable, safe, quality, accommodation and security of tenure.
- The local environment is clean and green with lower carbon emissions.

What system measures are being used for the HWB to monitor progress?



Reduce the number of households that owed a Prevention Duty under the Homelessness Reduction Act (Public authorities must take reasonable steps to prevent homelessness for any eligible applicant who is at risk of homelessness within 56 days, regardless of priority of need).

How we will achieve our ambition

We will support the priorities of the Housing Partnership Board and contribute to the action plans of the board's subgroups.

Through our Parks Strategy, we will ensure our green spaces are equally accessible for all and provide the opportunity to participate in activities. Local Area Partnerships will enable us to develop community led approaches to improving our local environment.

We will support the work detailed in the air quality action plan through a collaborative working group.

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Ambition 6 - People feeling safe in their own homes and when out and about

Introduction

Feeling safe, whether at home, in the street or at work has an effect on quality of life and enabling people to pursue and obtain the fullest benefits from domestic, social and economic lives without fear or hindrance from crime and disorder. The factors that affect community safety include higher levels of deprivation, estate design which favours criminality and youth involvement in anti-social behaviour, drug criminality and violence. Involvement in drug criminality has been linked to missing persons, and children are often exploited, increasing the risk of serious or sexual violence against vulnerable persons. Women and girls do not feel safe on our streets as a result of sexual harassment, and misogyny has become more prevalent online, with websites and chatrooms encouraging sexual violence against women.

Where we are now

- The age of youths engaging in drug related violence/weapons and violence against women and girls (VAWG) criminality is decreasing and commonly commences from pre/ early teenager years.
- Those dependent on drugs are often closely associated to neighbourhood crime to fund their addictions. The Home Office estimates 50% of all neighbourhood crime is committed by drug users, mainly heroin and crack users.
- Drug criminality analysis indicated that around 30% of Northamptonshire acquisitive crime was committed by individuals associated with drugs.

What you have told us

The majority of worries and concerns are about; youth violence and drug dealing, anti-social behaviour and knife crime, road safety, home safety, burglary and theft, which means we are scared to go out at night or use certain areas.

What is the inequalities focus

- There is a clear link between deprivation and crime, with focus needed on high need areas.
- Particular groups disproportionally affected by crime, including women and girls and sex workers.
- We particularly want to focus on supporting young people who are more vulnerable to exploitation.

What we want to achieve

- People are safe in their homes, on public transport and in public places.
- Children and young people are safe and protected from harm.

What system measures are being used for the HWB to monitor progress?

Reduce the number of referrals to Multi Agency Risk Assessment Conference for children experiencing domestic violence.

How we will achieve our ambition

Through West Northamptonshire Community Safety Partnership we will :

Increased partnership outreach, promoting wellbeing and safety in our communities focused on contextual safeguarding, working with schools and those who are most vulnerable.

Development of collaborative programmes and pathways for support, training and education.

Working through the Local Area Partnerships to develop place-based community approaches to priority neighbourhoods and vulnerable locations to ensure people are safe.

Development of environmental improvements at neighbourhood level that design out crime will be delivered through the safer streets programme.

Promotion of Fire and Rescue service home safety checks, and use of online home hazard checklist to help prevent falls and other accidents.

Increased early intervention and youth provision offer to ensure young people are safe and protected from harm – establishing and working with the youth collaborative.

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Ambition 7 - Connected to their families and friends

Introduction

The assets within communities, such as the skills and knowledge, social networks and community organisations, are building blocks for good health. Community life, social connections and having a voice in local decisions all underpin good health, however too many people experience the effects of exclusion or lack social support.

The internet and digital technology is at the heart now of how public, economic and social life functions. It has transformed how we work, communicate, consume, learn, entertain and access information and public services. However, the spread of access and use is uneven, and many people remain digitally excluded. Those who are excluded can be limited or unable to participate fully in society.

Where we are now

- Many of our neighbourhoods score poorly compared with the national average in measures of connectivity to key services, digital infrastructure and isolation.
- While lots of learning and positive action has been taken from the COVID-19 pandemic, social isolation remains an issue including for younger people in deprived urban centres.

What you have told us

- You would like to see better communication, so you stay informed and up to date on what is going on.
- Bring people together by offering local activities and events to support healthier lifestyles and to connect with others.
- People in rural communities can feel isolated and lack of community transport affects our ability to get out and about.

What we want to achieve

- People feel well connected to family, friends and their community.
- Connections are helped by public transport and technology.
- Improving outcomes for those who are socially excluded.

What is the inequalities focus

- Some groups experience social exclusion, such as those mental health conditions, Gypsy Roma Traveller community, people who are homeless, migrants, sex workers.
- Older people and people with disabilities.
- There is huge variation in digital exclusion across the county with high rates of exclusion both in our most deprived communities as well as less deprived rural communities.

What system measures are being used for the HWB to monitor progress?

Increase % adult social care users who have as much social contact as they would like.

How we will achieve our ambition

We will work through our place approach to ensure the right services are in the right place and joined up to enable people to feel well connected to their communities.

We will communicate in a variety of ways to ensure communities are aware of what is happening in their local communities and how to access support.

We will build on our Welcoming Spaces Scheme and development of One Stop Shops in communities.

We will work with the Local Transport Board to develop the Highways Strategy and Transport Plan.

The Integrated Care Northamptonshire Digital Transformation Strategy will enable us to join up health and social care services and provide more digital access, through the creation of the Northants Care Record and single digital front door. Alongside this we will develop projects to improve access to digital technology and the skills to use it.

DRAFT

Ambition 8 - The chance for a fresh start when things go wrong

Introduction

As well as ensuring that, as far as is possible, we prevent "deep social exclusion" which includes combinations of homelessness, substance misuse, history of offending and 'street culture' activities (such as begging and street drinking). We also want to ensure that people who have these experiences have a "fresh start in life".

Our West Northamptonshire housing strategy commits to tackling homelessness and rough sleeping in a way that delivers positive long-term outcomes for each individual.

In addition to this, our county-wide Combating Drugs Partnership Strategic Plan recognises the strong connections between addressing aspects of social exclusion in order to improve chances of recovery. This means ensuring access to housing and employment opportunities for those trying to make a fresh start.

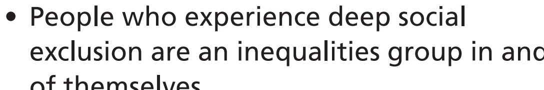
Where we are now

- Too many people in the county have experiences associated with 'deep social exclusion' – namely, homelessness, substance misuse, history of offending and 'street culture' activities (such as begging and street drinking).
- Too many preventable and early deaths happen due to drug and alcohol use or in people experiencing rough sleeping.

What you have told us

- Drugs dealers target young people in our area and it is worrying.
- Targeted support should be available for ex-offenders and homeless people to get their lives back on track.
- More investment in support services for those released from prison, for both physical and mental issues.
- Concern re increasing number of rough sleepers who are asylum seekers with no recourse to public funds.

What is the inequalities focus



- People who experience deep social exclusion are an inequalities group in and of themselves.
- Inequity of access to current services still requires further exploration but we believe affects those in rural communities, BAME communities and vulnerable women.

What we want to achieve

- Homeless people and ex-offenders are helped back into society.
- People have good access to support for addictive behaviour and take it up.

What system measures are being used for the HWB to monitor progress?

Reduce the number of emergency hospital admissions for those of no fixed abode.

How we will achieve our ambition

We will deliver a new homelessness and rough sleeping strategy by April 2024.

We will increase numbers of people in drug and alcohol treatment services by improving service promotion, address gaps in geographical access, as well as access for under-served groups.

We will Improve successful completion of treatment by improving treatment for co-existing mental ill health and substance use.

Increasing the capacity and capability to respond to increasing complexity and Improving quality of care, including particularly for young adults, and transition to adult services, and older people.

We will Reduce harm due to drug and alcohol use by Strengthening the harm reduction offer and further improve harm reduction and quality of treatment by reviewing and learning from deaths.

DRAFT

Ambition 9 - Access to health and social care

Introduction

In West Northamptonshire we want to ensure our residents are able to access the most appropriate health and social care services to meet their needs. We know we need to work with our partners and communities to provide easy and timely access to all health services including primary, secondary and specialist care. As well as access to social care support in places of residence including care homes, nursing homes, specialist centres, or homes. We want our services to be of be good quality, to ensure all people have positive experiences and get the same outcomes, regardless of who they are.

Where we are now

- There is delay in access to health services for medical, surgical or mental health interventions.
- Demand of service provision is exceeding current capacity including primary care, accident and emergency, acute services and social care and people are not accessing the right services at the right time.
- Delays in access to health screening and vaccinations is creating delays in early detection and diagnosis of diseases and protecting less people from vaccine preventable illnesses.
- Access to primary care services such as GP, dentists, opticians, podiatry and pharmacy is a challenge, especially for those with learning disabilities due to changing consultation methods.
- There is an inadequate social care bed capacity for patients with changing mental health status.
- There is a delay in timely processing of discharge plans due to medically unfit people not being able to return to a suitable place of residence.

What you have told us

- Health care hubs needed in our local communities with walk-in access for a range of services all on one site.
- People with language or communication difficulties find accessing primary care services a challenge.
- Migrants with no access to public funds find it hard to register with a GP, so have to present in crisis to A&E
- More investment is needed in social care services
- The transition from Children and Adolescent Mental Health Services to adult mental health services is not good enough and causes delay in treatment and stress to the family.

What is the inequalities focus

- Reaching out to residents not accessing health and social care services through community outreach services.
- Improving accessibility to health and wider services for the vulnerable groups i.e., homeless and rough sleeper, people with substance misuse, unregistered migrant workers, people with learning disabilities or mental health, carers and asylum seekers/ refugees, vulnerable women.

What we want to achieve

- Timely access to all health and social care services when they need across life course from conception to end of life.
- People are supported to live at places of their residence and only spend time in hospital to meet medical needs.
- Services to prevent illness (all health screening and vaccinations) easy to access with a quality service provision.
- People are treated with dignity and respect in all care provisions including end of life.

What system measures are being used for the HWB to monitor progress?

- Increase % cancer diagnosed at stage 1 and 2
- Increase % people discharged from hospital to usual place of residence
- Reduce rate of Emergency Department attendances for falls in those aged 65+
- Increase % eligible adults with Learning disabilities/ severe mental illness who receive annual health check

How we will achieve our ambition

We will use health equity assessments to understand inequality and inequities in access, experience and outcomes and develop targeted programmes to address the gaps.

We will take a collaborative approach to develop consistent outreach provision of health services.

We will redesign existing care pathways by including additional provisions with the help of alternate providers to help deliver the services for people who need it closer to home with appropriate use of the better care fund plan.

We will work collaboratively to support people to have timely access to services and triage people through appropriate pathways to overcome delays in health and social care support.

Work to be carried out for a collective system approach to resolve bed capacity issues for people with changing mental health status.

DRAFT

Ambition 10 - To be accepted and valued simply for who they are

Introduction

It is well known that people get a sense of belonging if they are part of a vibrant, welcoming community which can also provide support during difficult times. In West Northamptonshire we want to promote this sense of wellbeing in both rural and urban areas and across all ages and communities. We want everybody who lives in West Northamptonshire to feel valued, to celebrate diversity and the good things this brings to life in our area.

We will continue to work together and with our local communities to ensure living here is a great experience regardless of who you are and how you choose to live, what you believe or how you appear.

Promotion of understanding, tolerance and celebrating what we share, and our differences will support a happy, healthier Northamptonshire which in turn can set a great example to other parts of the country.

Where we are now

- The 2021 census showed an increase in the population in West Northamptonshire by 13.5% to 425,700 people - across all ages with growth greater than the England average 30.3% (20.1% in England).
- We are an increasingly diverse population with 24.9% identifying as non-White British an increase from 8.8% in 2001.

What you have told us

- We want more cultural events to support community cohesion.
- Welcome packs and newsletters at a community level would support community unity.
- We need more intergenerational activities locally to promote inclusivity.
- African migrants and some other BAME communities feel marginalised from representation in civil and public life.
- LGBTQ accessibility schemes should be promoted and LGBTQ community involved in shaping services.
- Ensure investment and resources are available in rural communities.
- Involve local communities in decision-making and service design.

What is the inequalities

- Seldom heard and ethnically diverse communities.
- Marginalised communities e.g. sex workers, Gypsy, Roma Travellers, homeless.
- People living in the most deprived areas.

What we want to achieve

- Diversity is respected and celebrated.
- People feel they are a valued part of their community and are not isolated or lonely.
- People are treated with dignity and respect.

What system measures are being used for the HWB to monitor progress?

We will work with communtieis to develop appropriate measures for this ambition.

How we will achieve our ambition

We will take a community based approach to shape the ambition and actions in partnership with identified groups and communities using the Well Northants model.

We will implement equality standards and strategies across system organisations.

We will ensure our extensive community engagement framework established is built on and maintained, and that it is reflective of our communities.

We will increase access to activities and community events to develop inclusion and participation and celebrate diversity.

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Our governance - making things happen

Leadership

Our Health and Wellbeing Board plays a key statutory role in facilitating joint working across the system and setting the strategic direction to improve local health and wellbeing in West Northamptonshire.

It provides a forum where political, clinical, professional and community leaders from across the system come together to improve the health and wellbeing of their local population and reduce health inequalities.

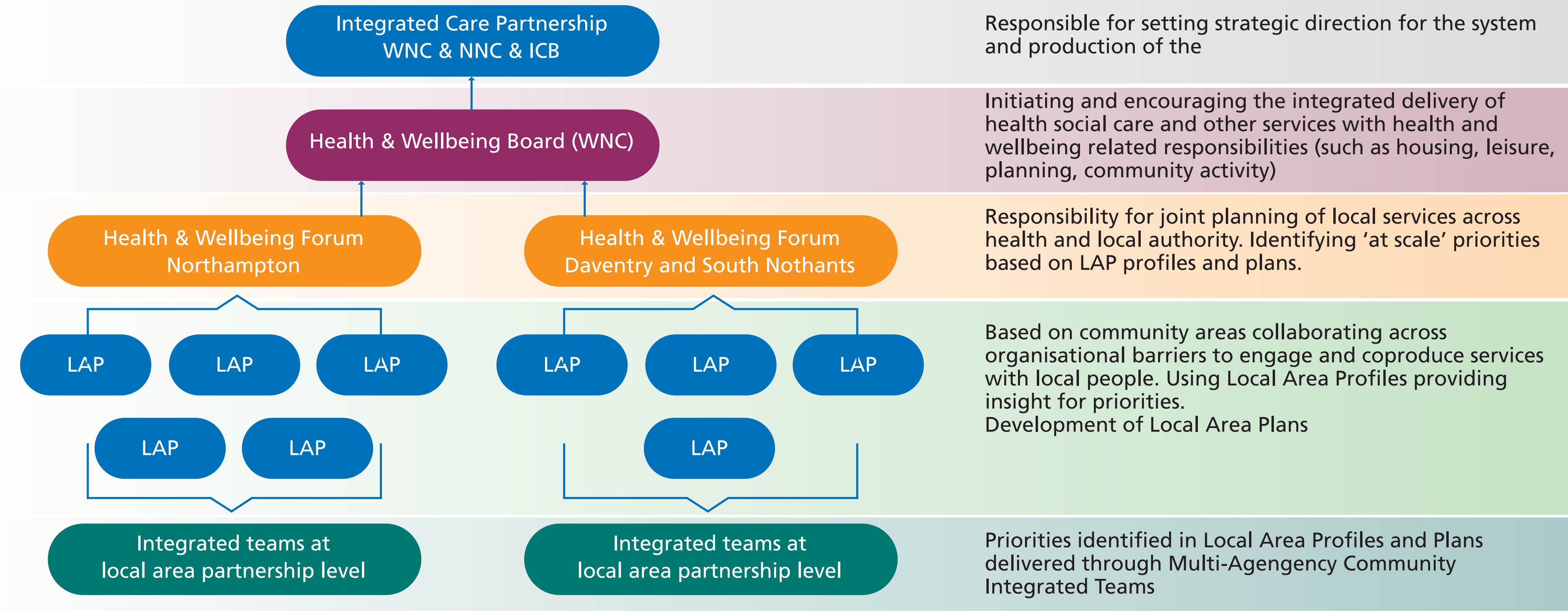
The strategy is strongly linked with many wider strategies and strategic delivery boards for example the Community Safety Partnership, Combatting Drugs Partnership and Housing Delivery Board to name a few.

Governance

A strong model of accountability is in place to ensure this strategy is driven forward and that performance against key outcomes is measured, monitored, and reported.

Reporting progress

It is the intention of the Health and Wellbeing Board to regularly review progress against the key outcomes in this strategy aligned to our 10 Live Your Best Life ambitions. We intend to share this progress with our communities in West Northamptonshire on a regular basis and if necessary, adjust our trajectory and resourcing.



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Our performance framework

Ambition	Available system priority metrics
Best start in life	% achieving good level of development at age 2-3
Access to best education and learning	Average attainment 8 score of all pupils % of SEND children electively home educated Rate of permanent exclusions (per 100 pupils)
Opportunities to be fit, well and independent	9% of adults currently smoke' (APS) % Adults classified as overweight or obese Adolescent self-reported wellbeing (SHEU) Standardised rate of emergency admissions due to COPD
Employment that keeps them and their families out of poverty	Gap in employment for those in touch with secondary mental health services
Good housing in places which are clean and green	Number of households owed a prevention duty under Homelessness Reduction Act
People feeling safe in their own homes and when out and about	Number of re-referrals to MARAC for children experiencing domestic abuse
Connected to their families and friends	% adult social care users with as much social contact as they like
The chance for a fresh start when things go wrong	Number of emergency hospital admissions for those with no fixed abode
Access to health and social care	% Cancer diagnosed at stage1/2 % of people discharged from hospital to their usual place of residence Rate of emergency department attendances for falls in those aged 65+ % eligible looked after children and adults with Learning disability/Severe mental illness receive annual health check
To be accepted and valued simply for who they are	Metrics to be developed

Having a set of metrics which we can use to monitor our progress is really important in ensuring that we are moving forward and delivering the ten 'Live Your Best Life' ambitions.

The metrics outlined in this performance framework have been agreed by the Integrated Care Northamptonshire Partnership as metrics we as a county will be working together to improve.

There will be many other detailed performance metrics that we will be monitoring as part of the delivery of this strategy but the performance frameworks outlines those metrics that are key priorities for us as a partnership and these will be reported to the HWB.

DRAFT

Members of the West Northamptonshire Health and Wellbeing Board

WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

27th July 2023

Report Title	**Redesignation of West Northants Local Area Partnerships**
Report Author	**Julie Curtis, Assistant Director for Place Development, West Northants Council**

Contributors/Checkers/Approvers		
	Members of 9 Local Area Partnerships	June 2023 Meetings
	WNC Executive Leadership Team (ELT)	10th July 2023
	WNC Executive Partnership Board (EPB)	10th July 2023
	West Northants Executive Place Delivery Board	11th July 2023
	Stuart Lackenby, WNC Executive Director of People	11th July 2023
	Sally Burns, DPH	11th July 2023

<u>List of Appendices</u>
None

1. Purpose of Report

1.1. The purpose of the report is to seek approval from the West Northants Heath & Wellbeing Board on the adoption of the proposed redesignation of the Local Area Partnerships (LAPs) from 1st August 2023. This is based on the recommendations from the nine LAPs, WNC ELT, WNC EPB and the West Northants Executive Place Delivery Board.

2. Executive Summary

2.1 This report sets out the background to the original designation of the 9 LAPs by West Northants Council and the proposal for the adoption of new designations from 1st August 2023. It was agreed that the original letters and numbers identified as names for the LAPs in October 2021 required review.

2.2 Following discussions in all the June 2023 LAP meetings the approach and rationale for redesignation was agreed by the Partnerships. It was agreed to adopt a simple and generic approach to the redesignation of the LAPs. This has the aim of moving the LAP names from the original letter and numbers to a more directional approach.

2.3 The outcome of the discussions is the recommendation to change the Northampton LAP letters and numbers to Northampton East, West, North, South and Central and Daventry & South Northants LAP letters and numbers to Rural East, West, North and South as detailed in sections 5.2.1 and 5.2.2 of this report.

2.4 It is proposed that the new designation will include the West Northants Heath & Wellbeing Board Logo and the communities/wards covered by each LAP included under the name for reference and listed in alphabetical order.

3. Recommendations

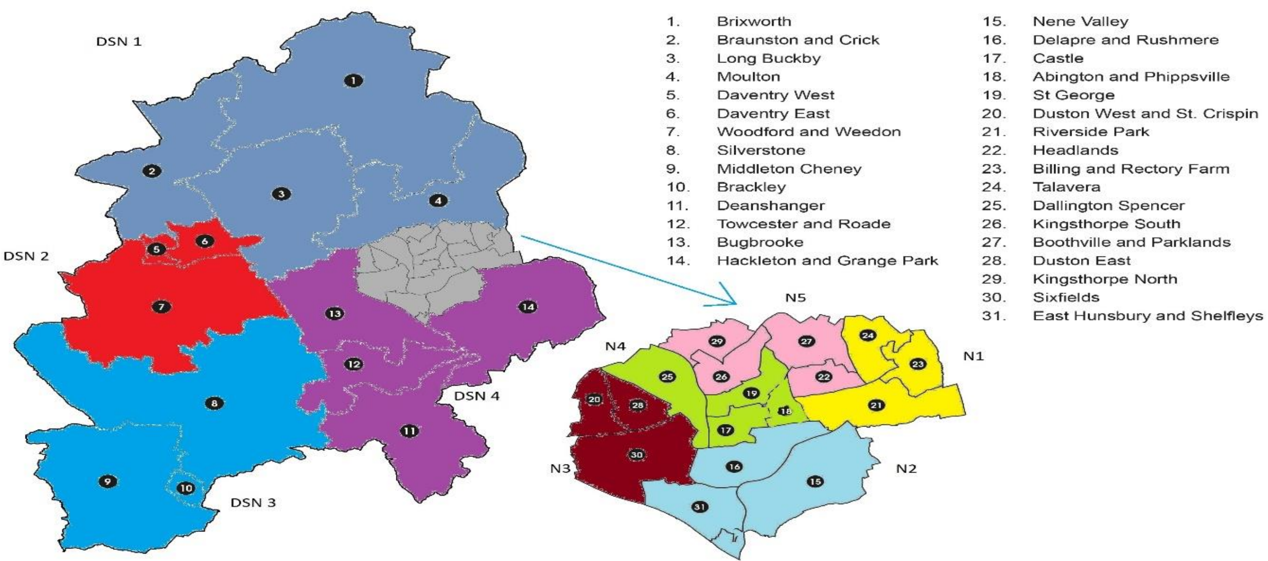
The recommendations from the LAPs, WNC ELT, WNC EPB and West Northants Executive Place Delivery Board to the West Northants Health & Wellbeing Board are to:

3.1 Adopt the new LAP designations as set out in section 5 of this report
3.2 Introduce the new designations from 1st August 2023

4. Report Background

4.1 The Health and Care Act 2022 received Royal Assent on 28th April 2022. It set out the new legislative framework to facilitate greater collaboration within the NHS and between the NHS, local government and other partners in the form of Integrated Care Systems. In preparation for the requirements under the new legislation, West Northants Council initiated the foundations of their new local Place Operating Model. In October 2021 it was agreed to create nine Local Area Partnerships (LAPs) across the West Northants unitary area as the fundamental building blocks for the new model.

4.2 In accordance with the legislation the LAPs were identified based on circa 30,000 to 50,000 populations. The boundaries of the LAPs were established based on the electoral wards across West Northants and grouped on this basis. The diagram below provides the details of each LAP boundary and their corresponding Electoral Wards.



4.3 At that point in time the LAPs were given a generic letter and number:

- Northampton LAPs: N1,2,3,4,5
- Daventry and South Northants LAPs: DSN1,2,3,4

4.4 These designations for the LAPs have been used to date and it was agreed by the West Northants Health & Wellbeing Board that the LAPs would discuss alternative designations with the view to recommending new titles.

5. Issues and Choices

5.1 **Approach and rationale**

During June 2023 each LAP meeting agenda included an item to discuss naming of the LAP. It was agreed that it could not continue to use a series of letters and numbers as designation for each one.

It was agreed that it could not use the following as the title:

- Titled as a list of Electoral Wards in the LAP: too long and too difficult for people to remember
- Titled as one / two largest communities: doesn't reflect all communities covered by the LAP
- Titled with a landmark: may not resonate with people if they don't know the landmark and / or doesn't reflect all communities covered by the LAP

It was agreed to adopt a simple and generic approach to the redesignation of the LAPs. This has the aim of moving the LAP names from the original letter and numbers to a more directional approach. On average circa 150 people attended the nine LAP meetings in June including elected members, GPs, police, VCSE and WNC Executive Directors all contributing to the discussions and agreeing to this recommendation.

5.2 **New LAP designations**

Please see below the recommended new LAP designations. Please note Electoral Ward names continue to be included for reference and listed in alphabetical order.

5.2.1 **Northampton LAPs:**

Former designation	Associated Wards	New designation
N1	Billing & Rectory Farm, Riverside Park and Talavera	**NORTHAMPON EAST**
N2	Delapre & Rushmere, East Hunsbury, Nene Valley and Shelfleys	**NORTHAMPTON SOUTH**
N3	Duston East, Duston West & St Crispin and Sixfields	**NORTHAMPTON WEST**
N4	Abington & Phippsville, Castle, Dallington Spencer and St George	**NORTHAMPTON CENTRAL**
N5	Boothville & Parklands, Headlands, Kingsthorpe North and Kingsthorpe South	**NORTHAMPTON NORTH**

5.2.2 **Daventry and South Northants LAPs**

Former designation	Associated Wards	New designation
DSN1	Braunston & Crick, Brixworth, Long Buckby and Moulton	**RURAL NORTH**
DSN2	Daventry East, Daventry West and Woodford & Weedon	**RURAL WEST**
DSN3	Brackley, Middleton Cheney and Silverstone	**RURAL SOUTH**
DSN4	Bugbrooke, Deanshanger, Hackleton & Grange Park and Towcester & Roade	**RURAL EAST**

5.2.3 Examples of possible LAP logos could be depicted as follows:

Northampton East Local Area Partnership
Serving the communities of Billing & Rectory Farm, Riverside Park and Talavera

Rural West Local Area Partnership
Serving the communities of Daventry East, Daventry West, Woodford & Weedon

live your best life

Please note: Further development and discussion are ongoing in relation to branding and supported by the digital design team aligned to the LAP website build. Progress will be shared with the West Executive Place Delivery Board in August and October with the aim to make final proposals.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 There are no resources or financial implications arising from this proposal.

6.2 **Legal**

6.2.1 There are no legal implications arising from the proposals.

6.3 **Risk**

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

6.4 **Consultation**

6.4.1 No consultation undertaken.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Scrutiny have not been involved in discussions around the LAP Redesignation to date.

6.6 **Climate Impact**

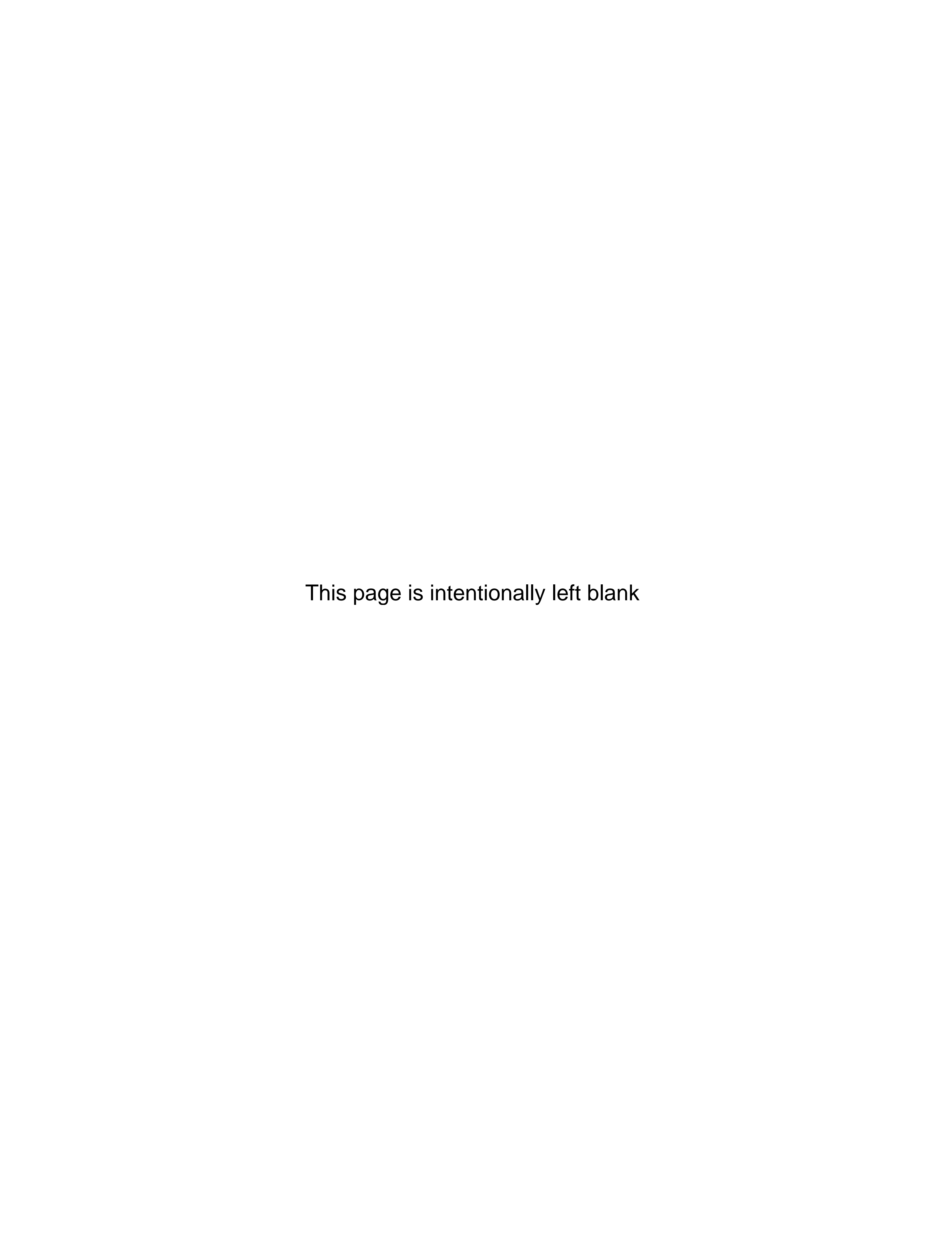
6.6.1 There is no climate/environmental impact.

6.7 **Community Impact**

6.7.1 Engagement with communities regarding the impact of the new Place Operating Model including the roll out of the LAPs requires further development. It is planned that all LAPs will agree and produce their individual Engagement Plan and their Communications Plan with the local communities. This will ensure that all plans are bespoke and tailored to the way each community wishes to be engaged and communicated with.

7. Background Papers

7.1 None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WEST NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD
27th July 2023

Report Title	**Better Care Fund Plan 2023-25**
Report Author	**Ashley Leduc – Assistant Director Commissioning and Performance**

Contributors/Checkers/Approvers		
Executive Director of People Services	Stuart Lackenby	Approval Obtained by Acting DASS in the absence of the DASS.

List of Appendices

Appendix A – West Northamptonshire Planning Template
Appendix B – West Northamptonshire Narrative Plan
Appendix C – BCF Executive Board Terms of Reference
Appendix D – BCF Schemes, Actions and Risks
Appendix E – BCF Project Plan Template

1. Purpose of Report

1.1. To obtain formal sign off to the West Northamptonshire Better Care Fund Plan for 2023-25 from the Health and Wellbeing Board

1.2. To note the contents of the Report and Appendixes.

1.3. To agree the new Governance Arrangements relating to the West Northamptonshire Better Care Fund. Health and Wellbeing Board will still retain overall responsibility.

2. Executive Summary

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

2.2 The policy framework, for 2023-25, was published on 4th April 2023. The policy Framework outlines the national conditions that must be met by the use of Better Care Fund pooled budgets

2.3 The BCF Plan and schemes for 2023-25 have been submitted to comply with the National Deadline of 28th June 2023.

2.4 The Better Care Fund is no longer hosted by North Northamptonshire Council as per previous years. West Northamptonshire Council now act as the leads for the West Northamptonshire BCF Plan and schemes.

3. Recommendations

3.1 It is recommended that the Health and Wellbeing Board:

a) That delegated authority to submit the plan before board approval was provided by the Chair of the Health and Wellbeing Board in an email dated 9th June 2023.
b) Note that detailed plans have been submitted to NHS England for moderation.
c) Note that West Northamptonshire Council have undertaken a review of the schemes to align the BCF to the Aging Well programme, and this has been agreed by the Northamptonshire ICB.
d) Note that additional funding to support hospital discharge has been included within the planning template. Details of the schemes are also included.
e) Agree the new BCF governance

4. Report Background

4.1 For West Northamptonshire, the total funding for 2023/24 is £54,518,690. Please see appendix A for a full breakdown. The planning template and BCF Narrative Plan confirm that the funding is being spent in line with the BCF Conditions.

4.2 Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:

Objective 1: to enable people to stay well, safe and independent at home for longer
The priorities for health and social care are to improve quality of life and reduce pressure on UEC, acute and social care services. This will be achieved through various mechanisms, including:

- collaborative working with the voluntary, housing and independent provider sectors
- investment in a range of preventative, community health and housing services
- supporting unpaid carers

Objective 2: to provide people with the right care, at the right place, at the right time.
The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.
This will be achieved by embedding strong joint working between the NHS, local government, and the voluntary, housing and independent provider sectors.

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

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

4.3 National Condition 1

A jointly agreed plan and narrative has been approved by Health and Social Care Commissioners and submitted to NHS England.

4.4 National Condition 2

Pag 18 of the Narrative Plan details how the commissioned services will meet the requirements of this National Condition.

4.5 National Condition 3

Page 19-24 of the Narrative plan details how the commissioned services will meet this requirement.

4.6 National Condition 4

NHS contribution to adult social care has been maintained in line with the uplift to ICB minimum contribution.

4.7 In addition, there is a requirement to include Discharge Funding within the wider BCF Plan which has specific conditions to adhere to, namely that any funding must support additional discharges from hospital settings. This has been agreed in collaboration between Health and Social Care and details of the schemes are contained within Annex A.

4.8 Beyond this, areas have flexibility in how the fund is spent over Health, Social Care and housing schemes or services, but need to agree outcomes and ambitions which build upon the output from 2022/23 performance. This is achieved via metrics and expected outcomes per scheme. The metrics are confirmed below:

- Avoidable Admissions – this metric indicates the number of hospital admissions we aim to avoid with preventative actions.
- Falls – this metric shows the ambition to reduce the number of hospital admissions due to a fall for over 65 year olds.
- Discharge to usual pace of residence – this metric shows the ambition for volume of discharges returning to their own homes.

- Residential Admissions – this metric shows the ambition to reduce the amount of people who are discharged from acute settings into a care home.
- Reablement – this metric shows the ambition to keep people at home following a hospital discharge with reablement support.

In addition, the planning template also includes expected outputs form each BCF scheme. Further details are shown in Annex A.

5. Issues and Choices

5.1 To improve on the governance of the BCF administration, a Service Manager for the Better Care Fund has been appointed.

5.2 A BCF Executive Board has been established and have agreed a set of terms of reference for the board and the boards that sit underneath it. They are a BCF Delivery Board and a BCF Data and Finance Board.

5.3 The Executive Board consists of senior staff from WNC and the ICB as decision makers and Northamptonshire Healthcare NHS Foundation Trust and Northampton General Hospital NHS Trust in an advisory capacity. The Executive Board will meet monthly.

5.4 Each of the BCF schemes will have a scheme manager appointed that will have the responsibility of completing a review form for their scheme and maintaining a risk log. The risk logs will be monitored by the Delivery Board and escalated to the Executive Board as required.

5.5 New schemes being proposed will submit a proposal form and if given approval to proceed, the appointed scheme manager will develop the scheme project plan.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 BCF finances are already agreed for 23-25 and are included in the BCF Plan. The finances will be monitored by the Executive Board and any risks associated with finance, such as increased demand, will be entered into the risk register and escalated to the HWB where required.

6.1.2 Both ICB and WNC finance colleagues contribute to finance monitoring reports.

6.2 Legal

6.2.1 The Health and Wellbeing Board has overall responsibility for ensuring the integration of health and care functions within their localities and it is a requirement of the BCF that local plans are agreed by HWB's. They have statutory ownership of the BCF and have overall accountability for the delivery of the BCF plan and for agreeing high level commissioning intentions. They have a statutory duty to encourage integrated working between commissioners and oversee the strategic direction of the BCF and the delivery of better integrated care. They are responsible for gaining system-wide buy-in to the Better Care Plan, which sets out the broad commissioning intentions for the use of the BCF.

6.3 Risk

6.3.1 The Executive Board will maintain the overall BCF risk register and escalate risks to the HWB as required. Each scheme will have its own risk log.

6.4 **Consultation**

6.4.1 The BCF plans included consultation with the ICB, Northamptonshire Healthcare NHS Foundation Trust and Northampton General Hospital NHS Trust

6.5 **Consideration by Overview and Scrutiny**

6.5.1 tbc

6.6 **Climate Impact**

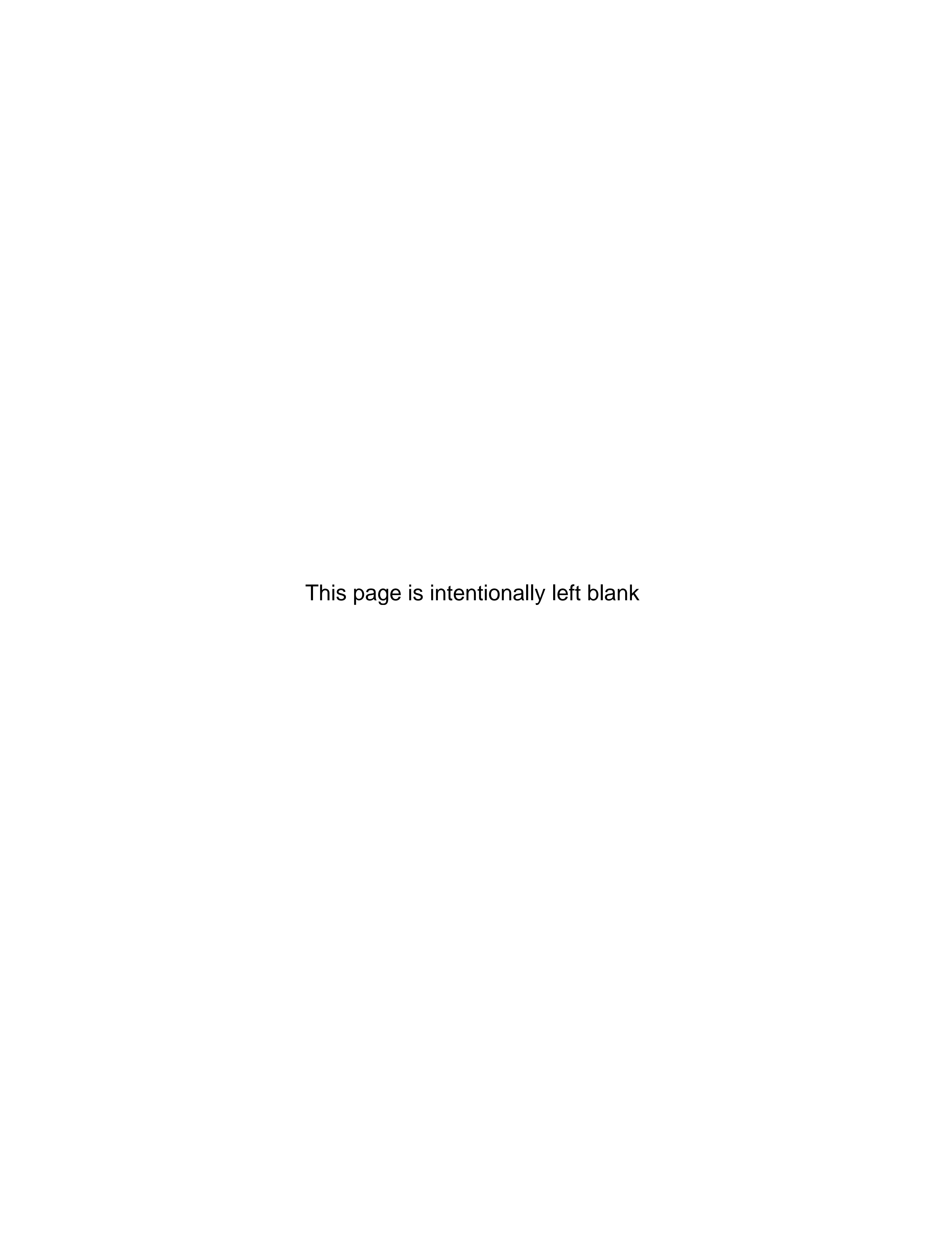
6.6.1 No climate impact.

6.7 **Community Impact**

6.7.1 The aims of the BCF are to support people to remain independent for longer and reduce the risk of hospital and care home admission. Where people do need a hospital admission, the services funded and monitored by the BCF, are there to reduce length of stay and support people to get back and remain at home for as long as possible.

7. Background Papers

7.1 West Northamptonshire BCF Planning Template
7.2 West Northamptonshire BCF Narrative Plan
7.3 BCF Executive Board Terms of Reference
7.4 BCF schemes, actions and risk log
7.5 BCF Project Plan Template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BCF Planning Template 2023-25

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

2. Cover

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).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, 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'.
5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

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 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. 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.

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

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, 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 Condition 4 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 6b.
- 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. Expected outputs

- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. 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 eligible expenditure on social care under National Condition 4.
- 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.

7. 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 on NHS commissioned out of hospital services under National Condition 4. 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.

8. 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.

9. 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.

10. Expenditure (£) 2023-24 & 2024-25:

- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme

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

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

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 2023-25. 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 2023-24.

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 2023-24. 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 (2021)
- Actual performance for each quarter of 2022-23 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.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- 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. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. 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 2022-23, 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 2023-24 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 2022-23 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.

4. Residential Admissions:
- 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 2022-23. 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.

5. Reablement:
- 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 2022-23. 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.

8. Planning Requirements

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 Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 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 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	West Northamptonshire
Completed by:	Ashley Leduc
E-mail:	ashley.leduc@westnorthants.gov.uk
Contact number:	7912891860
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No
If no please indicate when the HWB is expected to sign off the plan:	Thu 27/07/2023 << Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	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@westnorthants.gov.uk
	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		Ashley	Leduc	ashley.leduc@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. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: West Northamptonshire

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,558,938	£2,558,938	£2,558,938	£2,558,938	£0
Minimum NHS Contribution	£31,007,039	£32,762,038	£31,007,039	£32,762,038	£0
iBCF	£10,069,033	£10,069,033	£10,069,033	£10,069,033	£0
Additional LA Contribution	£2,176,411	£1,529,673	£2,176,411	£1,529,673	£0
Additional ICB Contribution	£5,095,136	£3,095,136	£5,095,136	£3,095,136	£0
Local Authority Discharge Funding	£1,411,663	£2,352,772	£1,411,663	£2,352,772	£0
ICB Discharge Funding	£2,200,470	£3,667,450	£2,200,470	£3,667,450	£0
Total	**£54,518,689**	**£56,035,039**	**£54,518,690**	**£56,035,040**	**-£1**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£8,811,487	£9,310,217
Planned spend	£20,082,171	£21,266,369

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£7,685,163	£8,120,143
Planned spend	£9,452,318	£9,939,773

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	220.0	220.0	220.0	220.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,972.6	1,739.7
	Count	1502	1427
	Population	76142	77713

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	95.0%	95.0%	95.0%	95.0%

Residential Admissions

		2021-22 Actual	2023-24 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	442	470

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.8%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	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 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: | West Northamptonshire

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Assumptions were calculated on previous activity data and modelling to manage the demand. Initiatives to reduce length of stay and improve discharge are as follows: • Creation of Assessment and Enablement Workers that meet and greet patients on the wards to ensure that they are medically fit and explain the reablement model to people before their discharge. This has reduced the number of failed discharges • Increased use of therapy support across pathway 1 • Working in partnership with specialist moving and handling team to recognise people for single-handed

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Social support (including VCS) (pathway 0)	1530	1620	1635	1632	1667	1617	1646	1625	1607	1654	1567	1615
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Reablement at home (pathway 1)	155	157	151	152	152	151	156	167	176	176	174	176
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Rehabilitation at home (pathway 1)	106	116	114	109	118	111	112	114	111	116	108	111
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Short term domiciliary care (pathway 1)												
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Reablement in a bedded setting (pathway 2)	36	38	36	38	38	36	44	43	44	44	41	44
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Rehabilitation in a bedded setting (pathway 2)	30	31	26	27	27	26	27	26	27	27	25	27
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement	48	51	52	52	53	51	53	52	50	53	50	51
Totals	Total:	1905	2013	2014	2010	2055	1992	2038	2027	2015	2070	1965	2024

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	25	25	25	25	25	25	25	25	25	25	25	25
Urgent Community Response	496	520	503	536	536	526	544	534	552	560	506	560
Reablement at home	15	15	15	15	15	15	15	15	15	15	15	15
Rehabilitation at home	0	0	0	0	0	0	0	0	0	0	0	0
Reablement in a bedded setting												
Rehabilitation in a bedded setting	3	3	3	3	3	3	3	3	3	3	3	3
Other short-term social care												

3.3 Capacity - Hospital Discharge

Service Area	Capacity - Hospital Discharge Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly) ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	1530	1620	1635	1632	1667	1617	1646	1625	1607	1654	1567	1615	100%		
Reablement at Home	Monthly capacity. Number of new clients.	155	157	151	152	152	151	156	167	176	176	174	176		100%	
Rehabilitation at home	Monthly capacity. Number of new clients.	106	116	114	109	118	111	112	114	111	116	108	111	100%		
Short term domiciliary care	Monthly capacity. Number of new clients.														100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.	36	38	36	38	38	36	44	43	44	44	41	44		100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	30	31	26	27	27	26	27	26	27	27	25	27	100%		
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	48	51	52	52	53	51	53	52	50	53	50	51			100%

3.4 Capacity - Community

Service Area	Capacity - Community Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly) ICB	LA	Joint
Social support (including VCS)	Monthly capacity. Number of new clients.	25	25	25	25	25	25	25	25	25	25	25	25	100%		
Urgent Community Response	Monthly capacity. Number of new clients.	496	520	503	536	536	526	544	534	552	560	506	560		100%	
Reablement at Home	Monthly capacity. Number of new clients.	15	15	15	15	15	15	15	15	15	15	15	15	100%		
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0		100%	
Reablement in a bedded setting	Monthly capacity. Number of new clients.														100%	
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	3	3	100%		
Other short-term social care	Monthly capacity. Number of new clients.															100%

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: West Northamptonshire

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
West Northamptonshire	£2,558,938	£2,558,938
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,558,938**	**£2,558,938**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
West Northamptonshire	£1,411,663	£2,352,772

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Northamptonshire ICB	£2,200,470	£3,667,450
Total ICB Discharge Fund Contribution	£2,200,470	£3,667,450

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
West Northamptonshire	£10,069,033	£10,069,033
Total iBCF Contribution	**£10,069,033**	**£10,069,033**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
West Northamptonshire	£1,447,731	£1,529,673	Community Equipment
West Northamptonshire	£580,680	£0	Carried forward Discharge funding from 22-23 agreed
West Northamptonshire	£148,000	£0	Public Health contribution for ageing well
Total Additional Local Authority Contribution	**£2,176,411**	**£1,529,673**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Northamptonshire ICB	£31,007,039	£32,762,038
Total NHS Minimum Contribution	**£31,007,039**	**£32,762,038**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Northamptonshire ICB	£2,000,000		UEC funding for RIBU
NHS Northamptonshire ICB	£3,095,136	£3,095,136	Contribution to Ageing well Programme
Total Additional NHS Contribution	**£5,095,136**	**£3,095,136**	
Total NHS Contribution	**£36,102,175**	**£35,857,174**	

	2023-24	2024-25
Total BCF Pooled Budget	**£54,518,689**	**£56,035,039**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: West Northamptonshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,558,938	£2,558,938	£0	£2,558,938	£2,558,938	£0
Minimum NHS Contribution	£31,007,039	£31,007,039	£0	£32,762,038	£32,762,038	£0
iBCF	£10,069,033	£10,069,033	£0	£10,069,033	£10,069,033	£0
Additional LA Contribution	£2,176,411	£2,176,411	£0	£1,529,673	£1,529,673	£0
Additional NHS Contribution	£5,095,136	£5,095,136	£0	£3,095,136	£3,095,136	£0
Local Authority Discharge Funding	£1,411,663	£1,411,663	£0	£2,352,772	£2,352,772	£0
ICB Discharge Funding	£2,200,470	£2,200,470		£3,667,450	£3,667,450	£0
Total	**£54,518,689**	**£54,518,690**	**-£1**	**£56,035,039**	**£56,035,040**	**-£1**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£8,811,487	£20,082,171	£0	£9,310,217	£21,266,369	£0
Adult Social Care services spend from the minimum ICB allocations	£7,685,163	£9,452,318	£0	£8,120,143	£9,939,773	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Planned Expenditure: Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
12	Home Based	Provide additional capacity to support people to remain at home / return home to	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)		39	39	Packages	Social Care		LA	0.0%		Private Sector	Local Authority Discharge
11	Bed Based	Provide additional capacity to support people to be discharged from hospital who	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		58	58	Number of Placements	Community Health		LA			NHS Community Provider	Local Authority Discharge
18	Workforce	Additional Assessor, Brokerage capacity to support flow	Workforce recruitment and retention						Social Care		LA			Local Authority	Local Authority Discharge

12	Home Based	Provide additional capacity to support people to remain at home / return home to	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)		498	498	Packages	Social Care		LA			Private Sector	ICB Discharge Funding
18	Workforce	Additional Assessor, Brokerage capacity to support flow	Workforce recruitment and retention						Social Care		LA			Local Authority	ICB Discharge Funding
17	Residential Placements	Provide DTA capacity to support complex needs (Pathway 3)	Residential Placements	Care home		145	0	Number of beds/Placements	Social Care		LA			Local Authority	Additional LA Contribution
18	Workforce	Recruitment campaign	Workforce recruitment and retention						Social Care		LA			Local Authority	Additional LA Contribution
1	Telecare and Assistive technology	Assistive technology and call lifelines designed to help keep people safe in their home	Assistive Technologies and Equipment	Assistive technologies including telecare		3000	3000	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
17	Demographic and care cost pressures	Ongoing underlying care cost pressures (volume, complexity and cost increases	Residential Placements	Care home		113	113	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
8	Domiciliary Care	Additional Market Capacity to meet the ongoing additional pressure and demand for	Home Care or Domiciliary Care	Domiciliary care packages		219,000	219000	Hours of care	Social Care		LA			Local Authority	iBCF
7	Integrated Discharge Teams	Social Care teams supporting Integrated Discharge hub DTA processes, hospital Flow and	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	IBCF
5	Disabled Facilities Grants	The DFG provides funding through local councils to make adaptations to a	DFG Related Schemes	Adaptations, including statutory DFG grants		352	352	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
3	Carers Support Services (CCG Contract)	This Service provides Carers health support ensuring that they can continue to	Carers Services	Respite services		65000	65000	Beneficiaries	Other	Carers health support	NHS			Private Sector	Minimum NHS Contribution
4	Continuing Healthcare	LD Health care at home/CHC/domiciliary care	Community Based Schemes	Other	Residential and Nursing				Continuing Care		NHS			Private Sector	Minimum NHS Contribution
4	LD Service Delivery	LD service delivery- community based health support	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
4	Intermediate Care Teams (ICT)	Community health reablement team supporting discharge with clinical support	Home-based intermediate care services	Rehabilitation at home (to support discharge)		1472	1472	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
1	Community Equipment (Health)	Jointing commissioned and funded Health and social care provision of universally	Assistive Technologies and Equipment	Community based equipment		9020	9200	Number of beneficiaries	Community Health		LA			Private Sector	Minimum NHS Contribution
19	Contingency	Unallocated	Other						Other	Contingency	NHS			NHS	Minimum NHS Contribution
19	Residential Short Breaks	Residential Short Breaks - This is a contribution towards a county/system wide contract	Residential Placements	Short term residential care (without rehabilitation or reablement input)		75	75	Number of beds/Placements	Other	Childrens Residential Short breaks	NHS			NHS	Minimum NHS Contribution
3	Carers Support Services WNC Contract	Council Contracted Service hosted by North Northants on behalf of both Councils -	Carers Services	Carer advice and support related to Care Act duties		570	570	Beneficiaries	Other	carers social care support	LA			Private Sector	Minimum NHS Contribution
7	Integrated Discharge Teams	Social Care teams supporting Integrated Discharge hub DTA processes, hospital Flow and	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Minimum NHS Contribution
11	Specialist Care Centres (SCC) Step and Step Down	Specialist Care Centres (SCCs) with a mix of Nursing rehabilitation and general	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		328	328	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
12	Community Reablement Team	Team providing reablement support post discharge home or from community referrals	Home-based intermediate care services	Rehabilitation at home (to support discharge)		1512	1512	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
6	Joint Brokerage	Joint Brokerage Team	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution

12	Community Occupational Therapy	Community Occupational Therapy Teams - The occupational therapy team	Home-based intermediate care services	Reablement at home (to support discharge)		2250	2250	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
2	Safeguarding (Assurance) Teams	quality and safeguarding team responsible for monitoring the quality of Care home	Care Act Implementation Related Duties	Safeguarding					Social Care		LA			Local Authority	Minimum NHS Contribution
6	Commissioning & Intelligence Capacity	Provision of commissioning capacity and expertise to support accelerated market	Enablers for Integration	Other	Provision of commissioning capacity and				Social Care		LA			Local Authority	Minimum NHS Contribution
1	Community Equipment (Social Care)	Jointly commissioned and funded Health and social care provision of universally	Assistive Technologies and Equipment	Community based equipment		8940	9119	Number of beneficiaries	Social Care		LA			Private Sector	Additional LA Contribution
16	Ageing well Programme	A range of schemes to enable people to live at home longer and more independent in	Prevention / Early Intervention	Other	Ageing well schemes				Community Health		NHS			NHS	Additional NHS Contribution
16	Ageing well Programme	Befriending service as part of ageing well Programme	Prevention / Early Intervention	Social Prescribing					Other	Public Health	LA			Local Authority	Additional LA Contribution
11	Bed Based	Provide additional capacity to support people to be discharged from hospital who	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		106	106	Number of Placements	Community Health		LA			Local Authority	Additional NHS Contribution

Further guidance for completing Expenditure sheet

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'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. 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. Independent Mental Health Advocacy 2. Safeguarding 3. 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 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. 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 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 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) 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 2. Discretionary use of DFG 3. Handyperson services 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. 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 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. 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. 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 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 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 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. 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 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 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. 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. 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 (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. 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.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 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.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 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.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 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	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	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.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: West Northamptonshire

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	227.1	192.2	242.8	1,020.0	The value within the ambition is an average of the actual performance in 2022/2023. Urgent Care funding which includes our ageing well programme has been reduced and therefore we are not able to operate an expanded programme in 2023/2024. Maintaining success of previous year within standstill resource	We have made significant progress in reducing the number of attends and admits of persons, particularly in our 65+ population, where the admission could have been avoided through earlier support and intervention. We are continuing to expand the range of local support available to persons at risk of escalation including
	Number of Admissions	995	842	1,064	-		
	Population	426,462	426,462	426,462	426,462		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	220	220	220	220		

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

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,598.1	1,972.6	1,739.7	Population from 8.4 used for 22/23 and 23/24. PH- Trend information visible in the local Falls Dashboard (SUS based data) has been used to inform future projections for this indicator. 2022-23 shows a 19% reduction in admissions of people 65+ for West Northants compared to 2021-22. Applied to the 2021-22 PHOF figure we get an	Through our transformation programmes we will continue to improve outcomes. We are increasing the number of targeted strength and balance classes provided each week for people with frailty, delivering falls awareness education in all of our long term condition peer support groups, increasing the number of persons receiving extended GP reviews including medicines review
	Count	1,855	1502	1427		
	Population	73,287	76,142	77,713		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	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	Quarter (%)	94.3%	93.9%	93.7%	94.7%	Average for 22/23 as the denominator with the outcome 95% for each of the quarters.	Assessment and Enablement workers working in ED to return people home at the first opportunity. The are linked to Reablement West and can arrange short term packages of care if that is the result of their assessment.
	Numerator	7,046	6,947	7,169	6,002		
	Denominator	7,470	7,398	7,653	6,340		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		

(SUS data - available on the Better Care Exchange)	Quarter (%)	95.0%	95.0%	95.0%	95.0%		Trusted assessors work with people admitted from a care home as their usual place of residential and they liaise with
	Numerator	7,130	7,130	7,130	7,130		
	Denominator	7,507	7,507	7,507	7,507		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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	442.1	549.0	479.4	469.7	22/23 estimated as per SALT (refined)- 502.22 (365/72677) Amended to reflect BCF population within the planning document- 479.37 (365/76142) 21/22 region = 562.0	Within our Discharge Fund Allocation we are increasing the volume of pathway 1 and pathway 2 capacity to maxminise reablement potential and avoid care home admissions and continue the good progress made from last year.
	Numerator	321	418	365	365		
	Denominator	72,609	76,142	76,142	77,713		

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

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 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 (%)	83.8%	79.2%	80.7%	81.8%	22/23 As per SALT (refined) (92/114*100 = 80.7%) These figures are provisional. 21/22 region average = 82.0 21/22 England average = 81.8 (Used as 23/24 plan)	Due to resource challenges in 2022/23, our reablement capacity was unable to deliver services to all who could utilise the service. This mean that some people went home with a traditional home care package and as a result, fewer people remained at
	Numerator	119	240	92	248		
	Denominator	142	303	114	303		

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

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11*	Expenditure plan
			Has the HWB approved the plan/delegated approval? *Paragraph 11*	Expenditure plan
			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? *Paragraph 11*	Narrative plan
			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?	Validation of submitted plans
			Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • 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 - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* 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. *Paragraph 15*	Narrative plan
	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? *Paragraph 33*	Expenditure plan
			• Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33*	Narrative plan
			• In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan

NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**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 to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**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? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**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 based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

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West Northants BCF 2023-25

Narrative Plan

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1. Cover (1)

Board: West Northamptonshire Health & Wellbeing Board

Bodies involved in preparing the plan:

- West Northants Council - Adults Services and Public Health
- Northamptonshire ICB
- Northamptonshire Health Foundation Trust (NHFT)
- Northamptonshire Universities Group Hospital
- Patient Advisory Group (carers and patients with lived experience)
- Voluntary sector and patient Group (including Healthwatch)
- West Northants Community and Opportunities (Housing services & DFG services)

1. Cover (2)

Integrated Care Northamptonshire

How have you gone about involving these stakeholders?

Our BCF plan 2023-24, ambitions for 2024-25 and our Discharge schemes 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 conversations across all the stakeholders listed on the previous slide as part our ICS' ongoing work for Integrated Care Northamptonshire. The plan is a continuation of the improvement journey started in 2020 and sits within a wider context of our **Integrated Care Northamptonshire 10-year 'Live Your Best Life' Strategy** (ICP Strategy Integrated Care Partnership | Integrated Care Northamptonshire (icnorthamptonshire.org.uk)) underpinned by the ICB Five Year Forward Plan recently agreed by partners across the system to ensure cohesion across stakeholders and activities in the system.

Our ICB "Integrated Care Northamptonshire" is overseeing system wide transformation and our BCF schemes, discharge plans, investments and out of hospital services are all focused on trying to improve our performance in relation to BCF metrics and national conditions. Over overall ICN vision is

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

Within the BCF activities we are bringing together services across our community partners, primary care leads, hospital front and back door activity, intermediate care and community 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 people get the right care in the right place**, aims aligned to the BCF national objectives.

The content described within our plans has been designed and produced entirely through coproduction. Working directly with those using services and those supporting people who use services to continuously test, learn and adapt what we do to achieve the best outcomes with the resources we can deploy. Steering groups with leads from stakeholders are responsible for shaping delivery, monitoring progress, identifying opportunities within pathways and tackling challenges. Overall transformation programmes benefit from the scrutiny and advice provided through our Patient Advisory Bodies and from our Health and Wellbeing Forums and Local Area Partnership (LAP) Groups. Stakeholders inform the content of the BCF through contributions to formal evaluations supported by the University of Northampton and by the Regional Academic Health Science Network.

Forecast activity plans reflect those set within the Northamptonshire ICB submitted Operating Plan for 2023/2024 with single version of demand and capacity modelling in place and held by our Chief Operating Officer Group. The Plan will be formally signed off by the West Northants Health and Wellbeing Board on 27th July, but delegated authority to submit a draft and final plan was granted by the board in its meeting of 25th May 2023.

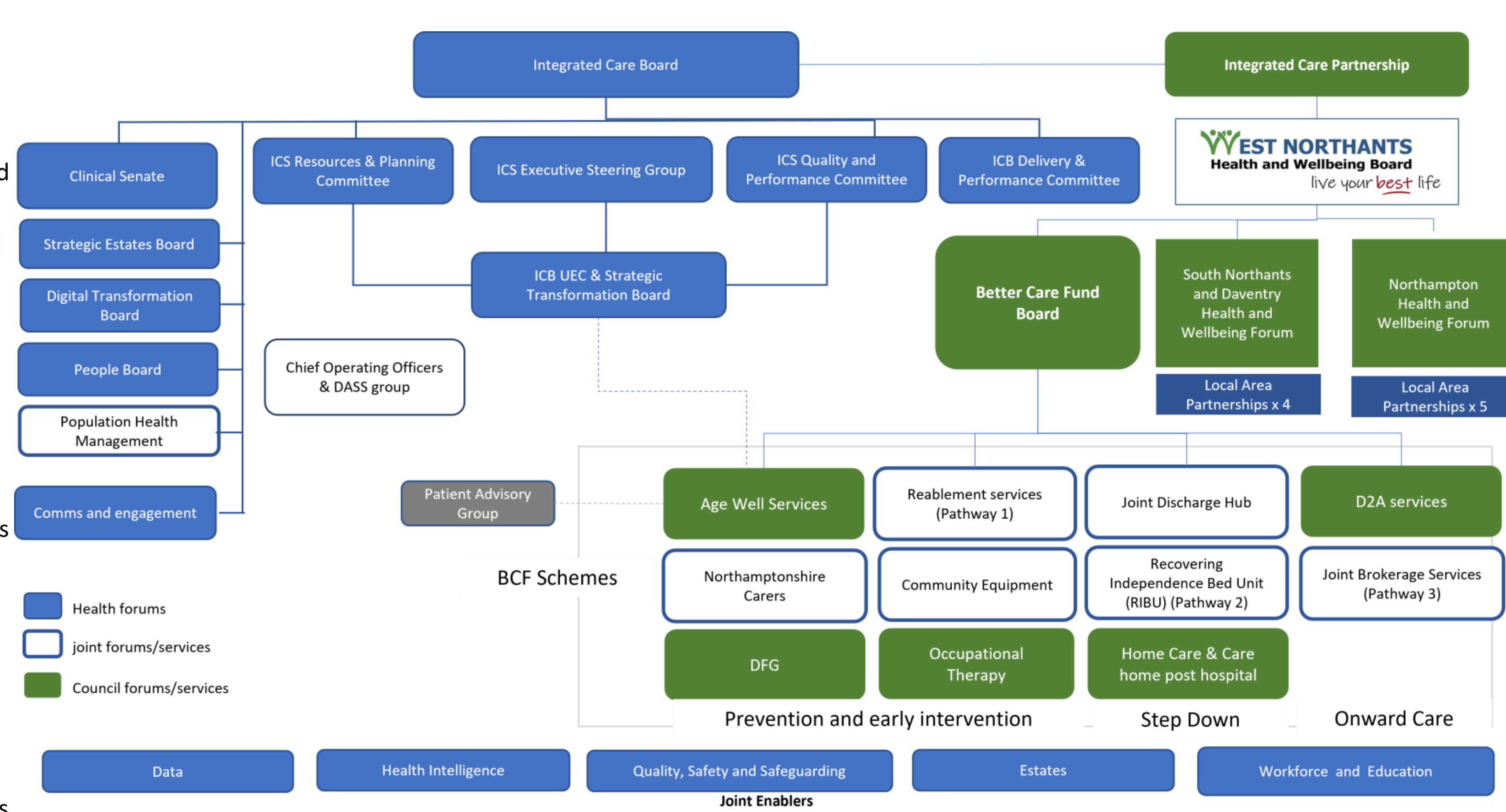
2. Governance

West Northamptonshire is undergoing a change in its governance arrangements relating to oversight and management of the BCF plan including budgets and transformation programmes.

In 2023-24 onwards this will include a monthly BCF Board where partners from West Northamptonshire Council, Northamptonshire ICB, NHFT and provider representation will discuss progress against BCF objectives and metrics, ensuring that schemes are frequently monitored and delivering desired outcomes.

This board will report into the multi- agency Health and Wellbeing Board, which will retain overall oversight of the BCF Plan but will also be assured by the ICB resources and Planning committee to provide additional assurance within the ICN. West Northants Council has now also employed a dedicated BCF manager to oversee the BCF, performance of the schemes and maintain oversight of the discharge fund, spend and performance.

Below all our plans are a number of enabler workstreams designed to bring system partners together to enable improved planning, data gathering and reporting for discussion.



3. Executive Summary

Frailty and the care for the over 65s has been a core focus of our BCF system priorities, not least because we have a challenging demographic. Based on the 2021 Census our over 65 population has risen at twice the national average (13% vs 6%) but our over 75 population has grown even faster (57% growth). As a result, frailty, more than any other condition, has been driving significant system wide cost, capacity issues and potentially poor outcomes and therefore performance issues in terms of delayed discharges etc.

Over 65 care was the key priority in our 2022-23 BCF Plan and there was a commitment as a system to transforming and improving care for our frail and elderly population through our ICAN (Integrated Care Across Northamptonshire) programme. The programme had three core elements (shown below.). ICAN recognised that we needed to improve hospital discharge like every area and our **flow and grip** work in 22-23 has made a difference with shortened length of stay, earlier discharge discussions, better systems and the opening of new intermediate care facilities. We were also the only system in the region not to see an increased length of stay in the Winter 22 pressures.

But our ICAN programme also had a big long-term focus on community, prevention and the supporting people to stay well and **Age Well** at home and stay independent for longer. This included significant focus on local support solutions and admission avoidance working with community health, primary care. The voluntary sector and at our hospital front door. In 2023-24 the ICAN programme moves into "business as usual" BCF services and away from a programme approach.

The ICAN changes we made in our hospitals is now embedded with integrated working, shared information and forms and a greater focus on outcomes and our intermediate care centre (RIBU "recovering independence Bed Unit") is showing positive results

Our Age Well approach and services continue in the BCF are now part of every PCN in our area and MDTs (multi-disciplinary teams) with GPs, community nurses, social workers, therapists and the voluntary sector are working well to support people with long term health conditions and develop personalised care plans with patients & carers. Our Ethos is about helping people stay well and age well at home..

We will continue to provide transformation focus to build on the platform created to date as we enter year three of our five-year roadmap.

3. Executive Summary (2)

Our BCF schemes 2023-25 fall under 3 core areas that support the BCF national conditions 1, 2 and 3 and the national metrics of the BCF/Discharge. These are: Prevention and Wellbeing, Discharge and Step-Down Services and the schemes and where they fit are shown below.

This shows how Age Well services have boosted our prevention and admission avoidance focus but across the BCF we have also focused on maintaining flow with smooth joined up discharge and more step-down services that assist with timely discharges and reduced lengths of stay. In this BCF plan we are providing more joint services and integrated provision than we have previously and making our pooled staff and resources go further in the face of continued financial and demand pressure.

PREVENTION & WELLBEING Live Well & Admission Avoidance	DISCHARGE In Hospital Flow activity	STEP DOWN Follow on & Longer term care – Stay Well
Community Equipment	Integrated Discharge Hub (Team)	Bed-based intermediate care & rehabilitation (Pathway 2)
Telecare and Assistive technology	Joint Brokerage Team – Health & Care Discharge Placements	Home-based intermediate care – Reablement (Pathway 1)
Carers Support Services	Discharge to Assess Beds - complex needs (Pathway 3)	Domiciliary Care – Social Care Community Support
Disabled Facilities Grants		LD Continuing Healthcare Placements
Age Well - Prevention & Wellbeing *		LD service delivery- community based health support
Age Well – Virtual Wards & Telehealth *		Demographic Pressure – Long Term Care (Pathway 3)
Age Well – 2 hour Urgent Community Response *		
Age Well – joint Monitoring Hub *		
Residential Short Breaks – Childrens Respite *		

CROSS CUTTING SYSTEM SCHEMES	
Commissioning & Intelligence Capacity	Safeguarding (Assurance) Teams
Workforce capacity Brokerage	Workforce Recruitment

All the above schemes are part of the BCF pooled funds with those indicated by the * being additional system or partner contributions brought into the BCF pooled arrangement by agreement between the partners to ensure that we can maintain our momentum and successes in 2022-23 and ensure that services are monitored and developed under the BCF governance arrangements.

3. Executive Summary (3)

Will our BCF and Age well services focused on the over 65s as the area of biggest pressure increasingly our work will be more generally focused on frailty and people suffering long term conditions and how we take a more preventative approach in these areas. The Age Well “community resilience” services are helping us move care away from crisis and acute intervention, where hospital admission really isn’t needed, and do more to support people at home. Working as joined up partners in an integrated way we are preventing more escalations and helping to resolve any crisis that would lead to admissions. This work has involved our GPs, PCNs, health, social care and voluntary sector and the need to think and work very differently. Feedback from patients, carers and staff is also hugely positive as they are having to tell their story once and say they no longer need to navigate across separate agencies and processes.

We intend to grow Age Well reach in 2023-24 and we plan to look at how we can merge the Age Well and with our Public Health Supporting Independence programme (SIP) to create a joined-up falls' prevention and support service. This will then combine risk stratification and targeted intervention to prevent falls, with our urgent community response service and follow up recovery classes and help us reduce the currently high levels of falls that lead to a hospital admission in our County.

We are providing proactive community care in line with the Fuller Report – while we can't anticipate what care our elderly will need or when they might have a crisis, through our joined up approach and earlier engagement we are having a positive impact - We have seen A&E attendances reduce and we are engaging more patient and carers in long term health condition management and we are working with the VCS to offer preventative sessions for common long term conditions that effect the frail and elderly. This is described in more detail later. Our Age well programme will also continue its 2-hour Urgent Community Response “Rapid Response” service to target home visits to crisis calls, including non-injurious and minor injury falls passed to them by EMAS (our regional ambulance service). We already attend 80% of the priority calls in less than 2 hours and are avoiding 800 people a month being admitted because of the community team attending people at home (see table opposite).

Admission Avoidance Referral Urgency	22/23 Total
Amber - Same day response	5545
Green - Over 24 hour response	892
Red - 2 hr response	4180
Total	10617

Daily Summary		22/23 Total
Average per day Red		11.5
Average per day Amber		15.2
Average per day Green		2.4
Total		29.1

Performance		20/23 Total
Red Referrals		4146
2hr response met		3459
As %		83.4

RR Success of all Referrals		9267
as %		87.3

Our admissions avoidance work in 2022-23 meant unplanned hospital admissions for our 65+ population decreased in real terms between 2019 and 2022 equal to 40 Acute Beds. In addition, no growth in demand was seen despite significant increase in older person population size described earlier offsetting further 57 Acute Beds. Combined Total = 97 Acute Beds. We saw big reductions in patients who were admitted more than 5 times in a year. The number of conveyances from “frequent conveyer” Care Homes has also reduced with the installation of our virtual health monitoring equipment, which is also set to expand in 23-24.

As well as maintaining this positive direction in prevention in our 2023-24 BCF we will continue to focus on admission avoidance and Length of Stay reductions across all our beds (recognising the NHS national operating plan target of 92% occupancy in hospitals and BCF national targets), and have a continued focus on timely discharges and Home First strategies .

3. Executive Summary (4)

This all requires ongoing investment in services via the Discharge funding, the further development and growth of our intermediate care pathways, a more targeted use of Discharge to Assess beds, expanding our reablement capacity through new commissioning arrangements and doing more with technology across our Virtual health, joint remote monitoring service and equipment stores. We also recognise that we must smooth out our discharges adopting trusted processes that mean 7 days discharges becomes the norm.

In terms of other changes to the 2022-23 plans, during 2023-24 we will be moving towards joint commissioning of bed placement brokering, joint dashboards for all our pathways out of hospital and working together on the future design of our community bed model to see how as a system we can best utilise the assets we have to meet future needed for bedded rehabilitation and recovery. Having these system approaches will mean that we are working to a single set of processes, avoiding duplication and competition for beds and we are able to see where we have delays or escalating issues and can act faster to address this. Our longer-term vision will be to have released community bed capacity to enable greater number of short-term step-up to local units where admission to acute hospital can be diverted.

Lastly in 2023-24 we have added some focus on children, with the inclusion for the first time of funding for residential and non-residential short breaks. This forms part of our carers and children respite services and supplements the shared Carers services that we already commission through Northamptonshire Carers and that supports older and young carers with assessments, advice, support and services. The Short breaks service is undergoing transformation and this year we engaged in a wide-ranging consultation on its future design and delivery model as a jointly commissioned service.

In conclusion, we expect 2023-24 to be a year in which we build on the successes we have had in ICAN and Age Well in 22-23 and we work together across the BCF existing and new schemes and discharge fund initiatives to improve our performance against the national conditions and metrics for the benefit of residents.

Our vision is to support more people to choose well, stay well and age well at home resulting in reduced unnecessary admissions to hospitals and better outcomes for people.

More of this……

Left shift to community based care & prevention

Less of this….

Neighbourhood MDTs working with GPs, VCS and outreach consultants to provide proactive care in the community and help people manage long term conditions.

Care navigation and social prescribing
Rapid response/2 hour response
Falls service & Supporting Independence
Step up & step down intermediate care
Access to wider Council services like housing advice

Emergency admission (if acute intervention needed) with plan to discharge as soon as safe to normal place of residence and focus on returning to independence if possible

4. National Condition 1 – Overall BCF plan & Approach to Integration

Joint priorities for 2023-24 & Approaches to joint/collaborative commissioning. How BCF funded services are supporting your approach to continued integration of Health and social care and how commissioned services from 2023-25 will support improvement of outcomes for people with care and support needs?

The creation of West Northants and North Northants as new councils (In April 2021) and the Integrated Care System (in July 2022) was a new start for the County.
Our contribution to the geography of the relatively small size of our ICS means we are uniquely placed to get the economies of scale associated with a countywide footprint alongside a strong place-based model where that makes sense. Our ICS partnership is called Integrated Care Northamptonshire and brings together health, social care, the voluntary sector and wellbeing organisations to deliver and commission services in partnership, ensuring that our communities are at the heart of everything we do.

Through the relationships that **integrated Care Northamptonshire** embodies, where partners work together to tackle variations in the wider detriments of health inequalities and we are using our collective local assets to support us in the delivery of our statutory preventions duties and to make the most of the strengths of our residents and communities, enabling them to live their best life. This is underpinned by the ICN strategies 10 ambitions shown on the next slide and adopted across the whole system.

Joint & collaborative commissioning is a core component of the way we work and increasingly we have commissioned services together rather than as organisations with separate governance and budgets. Joint BCF commissions to support improved outcomes include:

- **RIBU (Recovering Independance Unit Beds)** - the jointly staffed and delivered health and Care Intermediate Beds for rehab and reablement
- **Age Well Health and Care Monitoring Hub** – jointly staffed - providing call alarm services, virtual ward monitoring and telehealth services for care homes and people at home
- **Age Well prevention and Wellbeing services** – jointly health and Care funded and staffed (alongside the VCS) providing long term condition support and asset groups
- **The Care Brokerage** – single new jointly staffed placements team for both CHC and social care increasing coordination and quality and avoiding competition for places
- **Community equipment** – pooled budget and shared contract for all community equipment for discharge and in the community
- **P2 Community Bed Review** – Work has started on a review for all community beds with a view to creating one county model for integrated blended care services across both heath and care staff and buildings – with services to be commissioned for 2023-24 following consultation

As an ICS a single ICN strategy has been adopted and embedded as the delivery model for how we deliver the best outcomes for children, young people and adults.

This means from a practical sense that the council is supported through the ICS partnership to deliver its statutory duties for adult care and support needs.

This includes system led quality interventions, workforce development and outside of traditional Adults Social Care a significant relationship with interventions that focus on the wider determinants of health, such as our community safety partnership, combatting drugs partnership and development of our Local Area Partnerships.

Our ICN strategy 10 system ambitions are shown opposite

Ambition	Outcome
The best start in life	Women are healthy and well during and after pregnancy. All children grow and develop well so they are ready and equipped to start school.
Access to the best available education and learning	Education settings are good and inclusive and children and young people, including those with special needs, perform well. Adults have access to learning opportunities which support them with work and life skills.
Opportunity to be fit, well and independent	Children and adults are healthy and active and enjoy good mental health. People experience less ill-health and disability due to lung and heart diseases.
Employment that keeps them and their families out of poverty	More adults are employed and receive a 'living wage'. Adults and families take up benefits they are entitled to.
Good housing in places which are clean and green	Good access to affordable, safe, quality accommodation and security of tenure. The local environment is clean and green with lower carbon emissions.
To feel safe in their homes and when out and about	People are safe in their homes, on public transport and in public places. Children and young people are safe and protected from harm.
Connected to their families and friends	People feel well connected to family, friends and their community. Connections are helped by public transport and technology.
The chance for a fresh start, when things go wrong	Ex-offenders and homeless people are helped back into society. People have good access to support for addictive behaviour and take it up.
Access to health and social care when they need it	People can access NHS services and personal and social care when they need to. People are supported to live at home for as long as possible and only spend time in hospital to meet medical needs. Services to prevent illness (e.g. health checks, screening and vaccines) are good, easy to access and well used.
To be accepted and valued simply for who they are	People are treated with dignity and respect, especially at times of greatest need like at the end of their lives. Diversity is celebrated. People feel they are a valued part of their community and are not isolated or lonely.

4. National Condition 1 – Overall BCF plan & Approach to Integration

An example of this partnership and how it is serving our population while meeting national priorities, is our 3-year locality-based prevention strategy. This brings together our 3 conversations model in Adult Social Care (a strengths-based approach to care and support), with social prescribing and GP/PCN (Primary Care Network) based wellbeing interventions that are commissioned by Public Health. This approach will provide significantly increased reach to enable proactive preventative interventions that reduce crisis and reliance on long term care services.

To enable us to achieve our collective goals and ambitions, we are committed to working together through our new locality delivery approach. The diagram below shows the current operating model for Integrated Care Northamptonshire which outlines how we work together. This model recognises that some services will always be commissioned at a county or system level, but we can still deliver targeted interventions at a community level to address local needs and provide personalised services.

Northamptonshire
Integrated Care System

Improve the health and well-being of the population

Reduce inequalities in health and wellbeing outcomes

Contribute to the economic and social wellbeing of Northamptonshire

Ensure value for money

Integrated Care Board
Integrated Care Partnership
iCAN Collaborative
Mental Health & LDA Collaborative
Health & Care Collaborations
Children & Young People Collaborative
Elective Collaborative
Voluntary Community Social Enterprise
Wider public sector services
Place
West Northants Health & Wellbeing Board
North Northants Health & Wellbeing Board
Locality/Community
Local Area Partnerships
Health and Wellbeing Forums
Northampton Health and Wellbeing Forum
South Northants and Daventry Health and Wellbeing Forum
Community Wellbeing Forums
Kettering Area Community Wellbeing Forum
Corby Area Community Wellbeing Forum
WellingboroughArea Community Wellbeing Forum
East Northants Area Community Wellbeing Forum
Local Area Partnership

Access to health & social care when needed
Opportunity to be fit & well
Best start in life
Access to the best available education & learning
Employment that keeps them & their family out of poverty

Good housing in places which are clean and green
To feel safe in their homes & when out and about
Connected to their families
To be accepted & valued simply for who they are
Access to health & social care when needed

National Condition 1 – Overall BCF plan & Approach to Integration

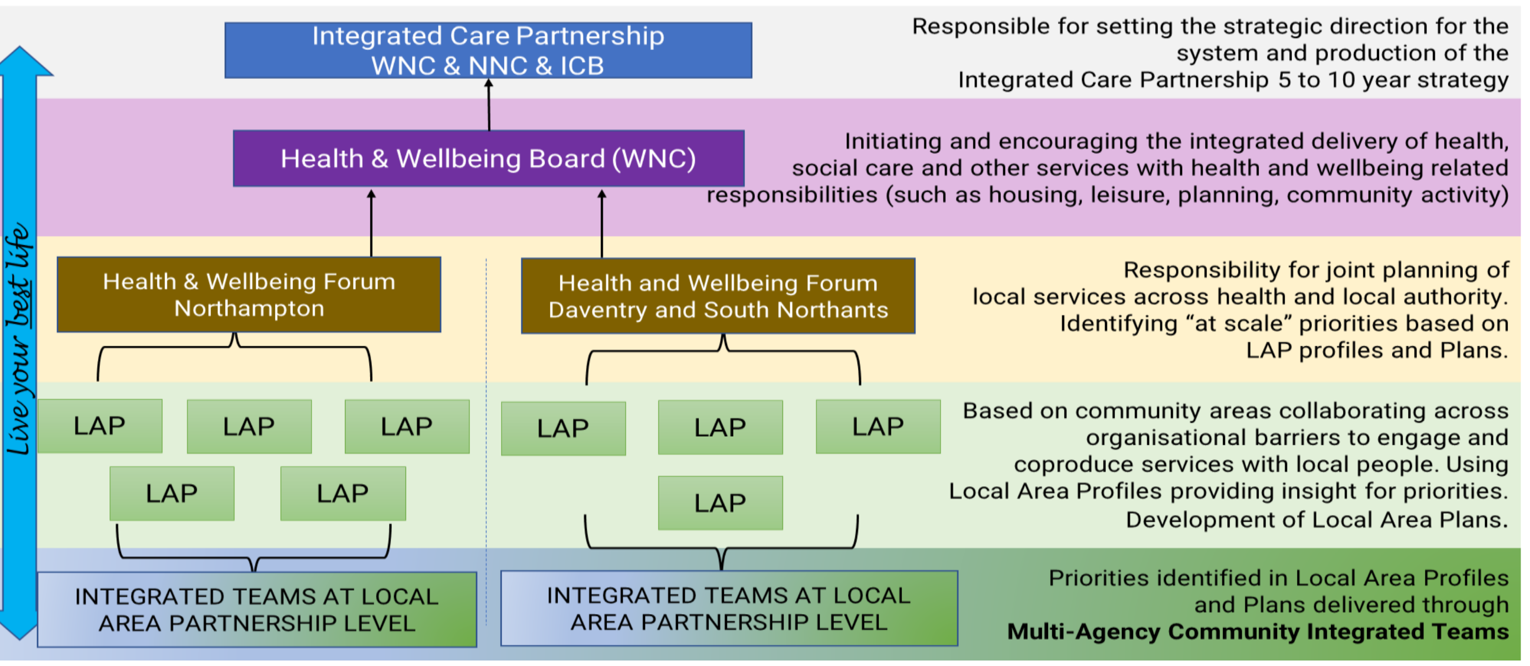
West Northants Place Development

In our 2022/23 BCF Plan we referenced the development of our Place (or locality) Operating approach through the creation of 9 Local Area Partnerships (LAPs) across West Northants. Our Place model has now been further refined after pilots and is now been rolled out across West Northants. The model below details the formal governance flows. The purpose of this is to positively impact on the health and wellbeing of local communities as their needs are not all the same. For example, while Northampton is young area with high deprivation and with more mental health issues, South Northants has relative wealth and many more elderly isolated people who suffer falls or long-term conditions.

Our 2 Localities and 9 LAPs are the focus of how local communities can design activities and where we agree local interventions with stakeholders designed to improve outcomes, reduce health inequalities and contribute to the 10 "Live Your Best Life" (LYBL) ambitions. These are designed to make sure more people stay well, independent and thrive supported by the services they need across Health, the Local Authority and the Voluntary Sector to address any health and wellbeing challenges they face.

The activities and services that we chose to provide at a local level are selected to improve outcomes, reduce health inequalities and contribute to the 10 LYBL ambitions. They adopt an intelligence and data led approach using the combined data of health, public health and the police plus ONS data to identify inequalities that would benefit from redesign and integration of service provision. They also review evidence on local health needs, social and economic determinants of health and collectively determine two to three priorities that need addressing.

The LAPs are based on populations of between 30,000 – 50,000 and are small enough to provide personal care through integrated multi-agency teams, but big enough to make sure residents can use the range of services they need.



National Condition 1 – Overall BCF plan & Approach to Integration

Our BCF schemes provide a range of integrated and joined up out of hospital services that link into this locality working and help us all keep more people well and (where possible) out of hospital. For Example:

- We have housing and DFG care and repair team members working in our hospital discharge teams to facilitate timely discharge
- Our dual registered and jointly staffed Recovering Independance Bed Unit (RIBU) has had significant success in reducing its Length of Stay and we are now looking at a business case to bring together all our community beds as County assets with a shared workforce and focus on rehabilitation and reablement and reducing the use of long-term beds.
- Our discharge to assess services and contracts are supported by locality teams who follow up placements and discharges to ensure that people don't get readmitted or stay in a bedded setting for too long.
- We have equipment stores at our community hospitals and in the community to make sure care homes, reablement staff , Rapid Response staff and community teams can access equipment to avoid delayed discharges and raiser chairs to help get people up from falls rather than default to ambulances.
- Our Carers contract (covering adults and young carers) and Childrens Residential and non-Short Breaks services are jointly funded by health and Care and jointly staffed.
- Our new Home care contract is being recommissioned to align to our LAPs and there is an opportunity to weave into local integrated Multi-Disciplinary Teams (MDT) delivering Age Well services so that they are part of the integrated care plan approach for example with same direct access to 2hr Urgent Community Response team or to extended GP reviews rather than only being the commissioned care provider.
- We have expanded our Assistive Technology services and Call Care alarm service with more virtual health and clinical remote monitoring services that are jointly staff by health and social care, and we now share a joint monitoring hub where nurses support Council call care staff and can link into the Urgent community response team if needed.
- In 2023 we will run a single jointly commissioned brokerage team to do all care home placement for health and care including all CHC placements. This will prevent the challenges in duplication of effort, competing for beds driving costs up and ensure that where we do make placements, we are jointly monitoring the quality and capacity is suitable as a system.

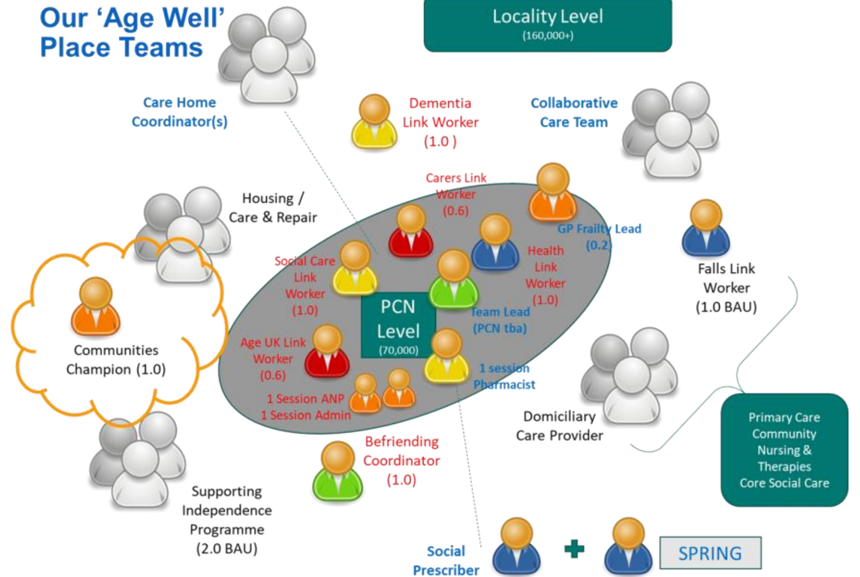
5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer

The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, steps to personalise care and deliver asset-based approaches, implementing joined-up approaches to population health management, neighbourhood teams and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches

Northamptonshire has been at the forefront of development of Personalisation / Anticipatory Care, supporting Regional and National in sharing of best practice. Using geography which makes sense for our population we have structured our capacity around our Local Area Partnership, Primary Care Network footprints to ensure that support and service are available locally and that our universal offer can also be tailored to needs of specific populations. Our SPRING programme has, through partnership with the BRIDGES Foundation expanded the Social Prescribing capacity across Northamptonshire aligning additional Voluntary Sector commissioned staff with PCN staff. Our Social Prescribers are able to focus predominantly on the needs of persons under the age of 65 as we have established local multi-disciplinary Age Well teams who focus on those with mild to moderate frailty (mainly those over 65 years). Our Public Health Supporting Independence Team seek to engage with those with emerging frailty needs ensuring we are reaching in across all levels of our communities.

Our investment has created dedicated Frailty GPs one day per week in each PCN, allowing time for extended GP led patient reviews (with patient present and usually in patient's own home) and for medical leadership to the integrated MDT of staff. We have also funded a project lead for each PCN to manage and develop the local resource and processes. Each Age Well Team has support worker from, Age UK Northamptonshire, Northamptonshire Carers, Northamptonshire Healthcare NHS FT and an AEW worker from West Northamptonshire Council. Working across clusters of PCNs we also have dedicated support workers from Alzheimer's Society, a Befriending Coordinator and part time support from Black Communities Together. It is our ambition to increase our BCT capacity to 2 WTE for West Northants.

All Age Well staff work in a non-time restricted way with the person and their support to develop a meaningful holistic care plan. Each team member has core set of skills, including ability to prescribe low level equipment, undertake basic observations, prepare attendance allowance and benefit check documentation and update the patient record (all staff are set up with NHS laptops, emails etc), in addition to the core skills they bring as part of their home organisation.

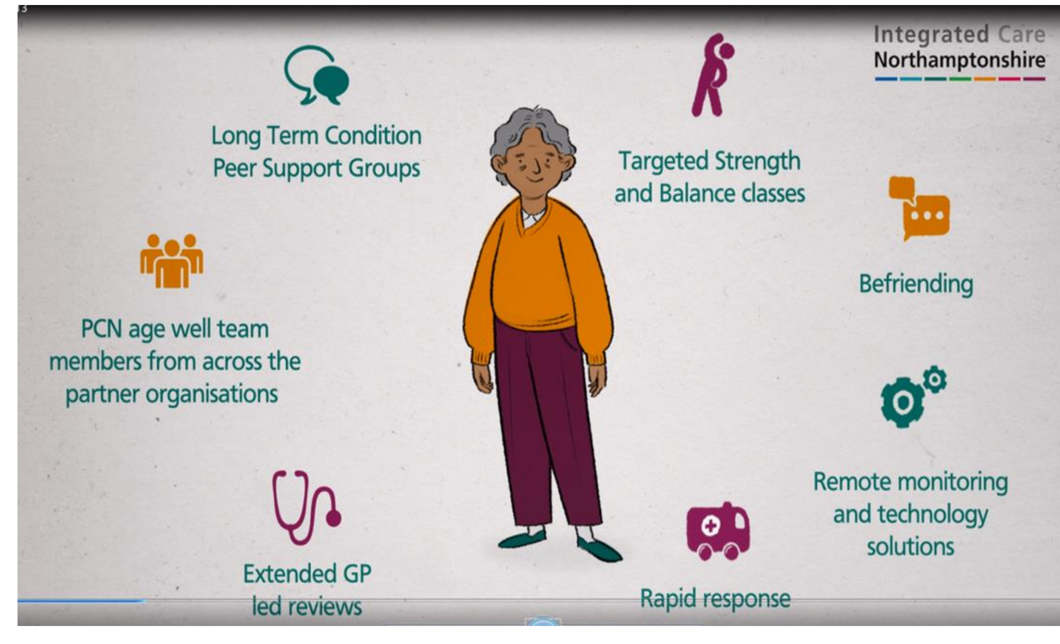


5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer

Taking a holistic approach focused on "what matters to me rather than what is the matter with me" is central to our new ways of working. Through listening to our population, we identified that we needed solutions which empowered the person to better manage their long-term condition(s), tackled isolation, improved wellbeing and linked people to people to create resilient local communities and in turn ensure they stay well at home for longer.

Age Well has also built up a programme of strength based or “asset” classes that are supporting people with a range of different needs and hard to reach groups in our communities . These include helping people at risk of falls (a key wider determinant of health in which we need to improve) but also provide befriending services, a dementia Hub, get up and go classes for people already at Frailty Level 5 and various other services that are helping us prevent escalation and crisis and keep people well.

Taking learning from our successful Breathing Space Asset based support groups for persons with COPD and their carers we have established asset-based groups for persons living with Heart Failure, with Diabetes and with Dementia. Our 23/24 programme sees further phased expansion from 14 sessions per month to 28 sessions per month (countywide) ensuring that there is a group for each condition within ten miles of the person



We have brought together several existing befriending services and supplemented with countywide leadership and additional local capacity to recruit additional volunteers and increase the numbers of persons able to be matched with a befriendee with over 2,000 hours of befriending now being provided per month. In 2023/2024 We are investing to increase our group befriending (virtual and in person) capacity and to utilise additional resources for meaningful conversations including the Life Stories App.

We had identified that our existing universal strength and balance class offer was excluding those already with levels of Frailty. Working with Northamptonshire Sport we have created a new programme for those who already Frail which include longer time in classes to support social inclusion and to provide wider education and advice sessions over refreshments to be provided. In 2023/24 we will be increasing our weekly classes from five to eight countywide.

To achieve this, we have reallocated existing resource and invested new funding to develop a range of support solutions, summarised in this visual.

5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer

Creating time to be heard and addressing the things that matter to the person are essential to their success in achieving the goals they have identified. Empowering the person to retain or regain control and level of independence requires the ability of the team member supporting to have access to a range of potential solutions. These include :

- Setting person up with technology to support independence and equipment which can remotely monitor and track health measurements and changes / trends within these.
- Peer support groups which are co-delivered by Voluntary Sector and Health Specialists, providing social inclusive and activity based sessions with health education, advice, tips and techniques woven through
- Befriending and linking people to existing community support groups and networks
- Targeted strength and balance classes
- Early identification of care hour support avoiding waiting for unplanned hospital admission to trigger care needs assessment process

We have established an integrated approach to assistive technology and remote monitoring with joint project leads from ASC and Health. We now have a nurse led remote monitoring hub working 7 days per week, 7am to 11pm, working alongside our existing 24hr Customer Call Centre for persons with lifeline or assistive tech equipment. In 2022/23 we have increased to have seven care homes and over 100 persons in their own homes identified at being at risk of escalation set up with remote monitoring. The equipment installation, training etc is undertaken by our West Northants Council technicians.

5. National Condition 2 (cont) - Enabling people to stay well, safe & independent at home for longer

The rationale for our estimates of the demand and capacity is based upon the demand of last year with a 0.78% population growth. We recognise that the Winter estimates may be less than predicated because there was a high flu admission rate last year, however, we will continue to monitor this during our monthly returns. Any issues or concerns will lead us to review our capacity and consider additional capacity if required.

Pathway 1 (P1) reablement and Pathway 2 (P2) Bedded rehabilitation – during 2022-23, we held several Multi Agency Discharge Events (MADE) and during these events, it was identified that the system was considering care home placements for those with more complex presenting needs over an enhanced pathway 1 support service. The learning from this has enabled us to reconsider our pathway 1 offer, to be able to move towards the right capacity to support those who may present higher acuity needs to go home.

For pathway 3 we had a recent MADE support by ECIST which identified delays in Care Act Assessments affecting flow and increasing lengths of stays. Therefore, a pathway 3 DTA project pilot has been designed this year using discharge fund allocations and the findings of this pilot pathway will determine our future approach.

During 2022-23, we set out our pathway 1 reablement offer to be delivered in house by WNC. During the year, it was identified that we had sufficient capacity to accept 50% of all referrals from the acute hospitals. This meant that approx. 50% of referrals were going home via a short-term home care package without the robust reablement wrap around. As a result, we introduced support from the independent care sector via an informal arrangement to pick up additional pathway one referrals. This resulted in an additional 25% of referrals receiving reablement support, with the remaining going home via a short-term home care offer. As a result, we have built in an additional BCF scheme for 2023-24 to formalise a blended approach to reablement.

During the year we reviewed the transfer of care hub at Northampton General Hospital and identified that there was insufficient resource in the hub and therefore we added an additional discharge and recovery role into the hub which has helped to reduce the number of false starts into pathway one.

From a workforce perspective, we have a gap in capacity for case management and reablement support workers and we are continuing to recruit. Both the Adult Social Care Teams and Reablement West maintain staffing shortages and we are addressing this via workforce incentives.

We recognise that we still have a gap in having real time data and the ability to expand to community capacity and demand and we will look to address this in 2023-24.

5. National Condition 2 (cont) - Enabling people to stay well, safe & independent at home for longer

Describe how BCF funded activity will support delivery of this objective. With reference to changes or new schemes for 2023-25, and how these services will impact on unplanned admissions to hospital for chronic ambulatory care sensitive conditions and Emergency hospital admissions following a fall for people over the age of 65

We have created a platform through our personalised approach models which has yielded demonstrable improvements in outcomes for the Northamptonshire system. Financial pressures have reduced the scale of our initial ambition for 2023/2024 with maintenance of the existing budget creating a stand still position. However, there are some elements within our model which were part year effect in 2022/2023 where the full year effect will continue to impact positively on the system. These include the additional peer support groups, strength and balance classes and befriending capacity referred to previously as well as the further expansion to the assistive technology / remote monitoring provision. By the end of 2023/20204 we expect the nurse led hub to have increased to ten care homes being supported in West Northants and to 250 persons in their own homes.

Our Virtual Ward Community Frailty provision will enable a further three persons each day average to be supported through additional admission avoidance capacity. A series of presenting conditions which otherwise would have been directed to Acute Hospital have been agreed as clinically safe for electronic transfer to the 2hr UCR / Community Virtual Ward Service.

We are continuing to expand the number of persons trained in the use of community lifting equipment and are creating a database of community champions who can respond to be with persons during escalation in between structured visits by health and care professionals

We have introduced and will expand further evening and weekend dementia specialist advice and response route for persons living with dementia and their carers recognising the peak demand times for carer breakdown. In partnership with Dementia UK we are increasing the number of Admiral Nurses in Northamptonshire from 2 WTE to 7 WTE including one specifically focusing on early onset dementia. We have identified poor outcomes for persons with dementia at end of life and the opportunity to provide better experience for persons and their families whilst also reducing unplanned hospital admissions. Taking the learning from Derbyshire we will be looking to implement a joint dementia / palliative care pathway by the end of 23/24.

The benefits of these have been modelled into our system demand and capacity plan to bring benefit of 21 Acute Beds for West Northamptonshire.

Describe how BCF funded activity will support delivery of the objective to reduce the number of people aged 65 and over and whose long term support needs were met by an admission to residential and nursing care homes per 100k of population

As an area that has seen a higher-than-average growth in the number of over 65s in the last census (13% vs 6%) and even bigger rise in over 75s (57% growth) we achieved consistently good results in the metric relates to the number of over 65s whose needs are met through admission to residential and nursing care homes. While the post pandemic period saw a rise in their use for Discharge to Assess short stays the 2022-23 return shows that we admitted 479 per 100k of population against a plan of 549 with both lower than national averages.

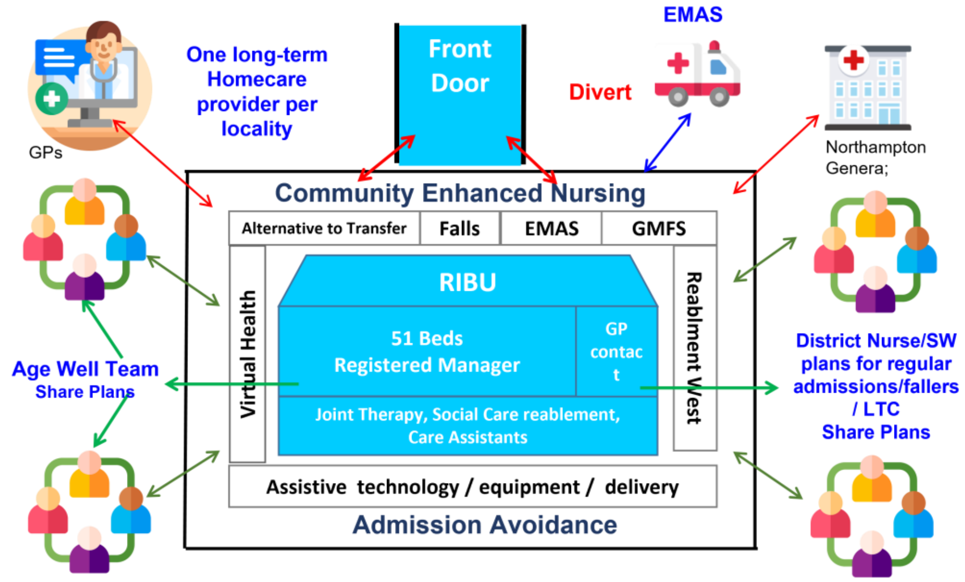
6. National Condition 3 - Provide the right care in the right place at the right time

Please describe the approach to your area to integrating care to support people to receive the right care in the right place at the right time including, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge and community support guidance

As an ICS we have remained significantly challenges on both the occupancy levels of our Acute Hospitals and length of stay and this has caused ongoing difficulty with delayed discharges exacerbated by challenges in securing home care and staffing up reablement services. But we have made significant strides in reducing the length of stay with a 5% reduction since pre-pandemic levels.

We are meeting national guidance that 95% of people should go home with no further input (pathway 0) and we have been working together to reduce the historical over reliance on bedded solutions. While recruiting to our Pathway 1 (reablement service) has been hard we have commissioned external support to ensure complex discharge or double handed care requirements are now being met and we are taking out more referrals through this route with minimal delays on referral acceptance. We are looking at further joint pathway 1 redesign to ensure the best use of resources between health and care.

We have expanded pathway 2 services with the dual registered and jointly staffed Recovering Independence Bed Unit (RIBU) at Turn Furlong that we opened in 2022 now fully operational with 51 beds receiving referrals for step down rehabilitation and reablement care to help get people home. We have significantly reduced length of stay here (from 70 days to under 40) and are aiming to further improve flow by getting this to below 30 days as an average. The RIBU is one of the key services that we are funding through our Discharge funding and its success and duplication in the North of the County reflects its status as a system priority.

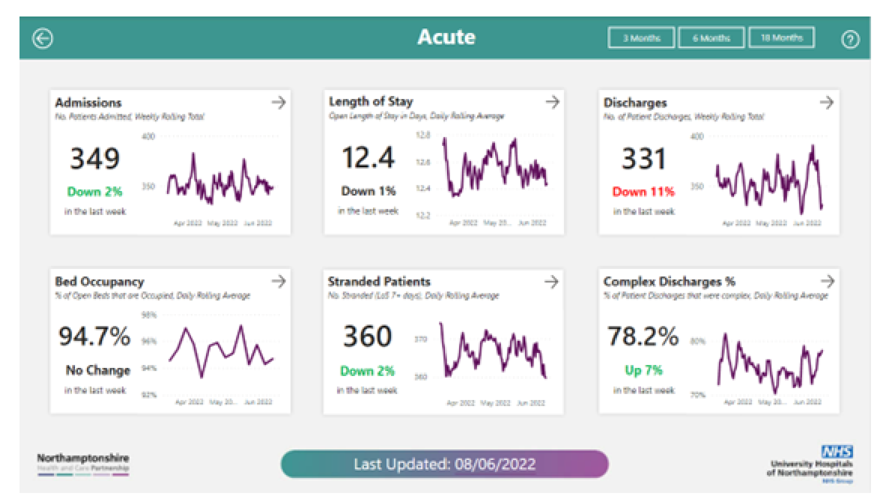


The success of the RIBU and consideration about long lengths of stay at our community hospital beds (which then contributes to delayed acute discharges and occupancy challenges) and the condition of some of the community hospital estate has now prompted a wider review of how we will use the County's community bed stock across health and care more effectively and cohort patients for specific treatments or conditions. A Business case for a redesign is now being progressed in 2023 and initial indications are that this could be a cost effective, joined up offer than gives patients better care and experiences and will better equip us to meet future demand of outside our Acute Hospitals.

6. National Condition 3 - Provide the right care in the right place at the right time

We have been subject to NHSEI National Discharge team discussions which has highlighted the improvements we have made in length of stay and the improvements we have made in the time between the Discharge Hub referral to social care and the actual placement/discharge of a patient needing some ongoing care. But we still have issues to address in relation the time a patient is deemed to be medically fit and creating the referral (which our hospital teams are working to improve) and the quality of data on the Transfer of Care Forms which can lead to a discharge referral being returned. This has been a system challenge for some time and the introduction of electronic patient records has been a challenge for some clinical staff and in terms of access to GP records or with GPs being able to see discharge records from the hospital, but getting accurate digital and shared care records is a system priority for the ICB 5 year Forward plan and us as a system and will be driven by the new Director of Digital in the ICB.

Our first choice will always be to help get someone home where appropriate and in 2023-24 we will continue to do this but now with an extended capacity to support that with Virtual Ward monitoring, telehealth services, voluntary sector discharge follow up services (all in Age Well) and reablement services where some short-term support is appropriate. We continue to use targeted discharge to assess beds as part of our discharge funding and where we see pressure on delayed discharge. But using the discharge funding we now have expanded the follow up services that ensures assessments take place and where possible people move on before they decondition.



Lastly, we have continued work on our command centre and dashboards. Key to flow and timely discharges is having an accurate picture of patients, the queues by pathways and as a system being able to target work, interventions and escalation at the right places. Our Dashboard is now helping us see this more clearly, drill down on patients and delays and be able to make informed decisions based on evidence not anecdote. This helped us get through Winter 2022 and recover more quickly from winter pressures than ever before.

6. National Condition 3 - Provide the right care in the right place at the right time

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas of improvement identified and planned work to address these.

Last year we made improvements across our discharge processes implementing good practice that ensures all patients will receive a letter on admission about their expected discharge expectations. In addition, we implemented a best practice model of 'What Matters to Me' when discussing expectations with patients. This created more focus on a strength based, home first focus for 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 were also improved to reduce 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. Our work in 2022-23 saw us make some significant improvements across our acutes

- A Complex discharge hub was established as we knew that the most complicated patients often faced the biggest delays and needed multi disciplinary teams to work together to resolve things.
- 90% of referrals are now accepted by Hub (up from 70%) because of better and more reliable patient information
- There were improvements to SBAR ((situation, background, assessment, recommendation) processes and onward flow management – the time to submit and accept TOC (Transfer of Care) at NGH reduced from 4.9 days to 3 days.
- Time to discharge complex patients has reduced to 3 weeks to under 2 from medically optimised for discharge. This is amazing progress but there is still improvement to be made, 2.9 and 3 days respectively should be reduced to 1.5 over the next year as a target
- IV antibiotics review process and monitoring system – reducing length of course by 4 days on trial wards

We are now also replicating the success of these models and the dashboards we are using in our Community Hospitals where we know we have stubbornly high length of stay.

- There is still an over-reliance on bedded pathways as a system, and especially in times of surge or system pressure. As far as possible we try to avoid moving people to other Discharge to Assess bedded settings purely while they wait for the appropriate pathway to be available. Reducing the need for this is one of the reasons we have redesigned pathway 1 (reablement) and pathway 2 (bedded reablement and rehabilitation) services as set out above to ensure that there is a greater likelihood of people returning home and/or to independence. We can confirm that our approach addresses all the key criteria set out in the High Impact Change Model as shown in the slides that follow

6. National Condition 3 - Provide the right care in the right place at the right time

High Impact Change Model continued

High Impact Change	What we do well	What we want to improve	Maturity Level	Improvement timescale
Early discharge planning	• Expectations for discharge set on admission and letters issued • Common SBAR communication tool (situation, background, assessment, recommendation) adopted across all wards and short form update before medically fit to allow care planning to commence • we are now recording all patient information electronically using systemOne	• Not all GPs can see SystemOne or share their data into it, which limits joint planning and delays follow ups • We need to get the Shared Care Record (SCR) live with all patient information shared	Established	GPs information and End Q2 2023 Shared Care Record Live Sept 2023
Monitoring and responding to system demand and capacity	• Shrewd Systems in place to track all beds, demand and partner status and community/step-down beds • System Dashboards are live with all pathways and queue information shared so we are working with common information and views to make decisions about interventions as partners or act when surges occur – this stood us in good stead in Winter 22 major incident response when we were the only system to reduce length of stay in the region	• The Dashboards are moving to a sustainable footing with real time (rather than twice a day) updated information and systems are standardized and trusted • the Graphnet NARP (Northants Analytics Repository Platform) solution for a data sharing and intelligence hub are in place and sharing protocols, agreed - need to sustain the data flows and move consolidate more data and systems so have a single version of the truth and can use information to target interventions for cohorts	Established Dashboards Planned - live NARP	Q3 2023 sustained and shared Dashboards Shared Data Warehouse First phase live Q3 2023
Multi-disciplinary working	• Multi-disciplinary hub in place in both hospitals • Coordinated discharge using single SBAR assessment processes and protocols • VCS, housing and equipment services in place to help discharge • We have MDTs in place in all PCNs to follow up on those at risk and follow ups following discharges		Mature	

6. National Condition 3 - Provide the right care in the right place at the right time

Integrated Care Northamptonshire

High Impact Change Model continued

High Impact Change	What we do well	What we want to improve	Maturity Level	Improvement Timescale
Home first	• We avoid 750 over 65 admissions a month through community interventions and SDEC (Same Day Emergency Care) unit & frailty teams at hospital front doors and supported to go home without admissions. • 2-hour Rapid Community Response service • 25% reduction of elderly people who are admitted 5 times over a year – 1600 less unplanned admissions • Established D2A services and joint brokerage management for placements • Transformation of pathway 1 and 2 services to provide additional capacity to supplement high workload for P1 • RIBU "recovering independence beds" provides 51 beds for all pathway 2 discharges with Rehab and reablement focus and therapy embedded approach	• We still have challenges in home care capacity that causes blocks in Pathway 1 discharges dur to recruitment challenges in the Council reablement teams – but we commission external reablement packages for the double handed Reablement packages freeing time for us to clear a greater volume of cases and avoid blocked exits • We are reviewing all community beds to form a single integrated set of services across the health and care bed based and staff with key service specialisms and offers in specialist sites and greater flexibility across the system to help flow, discharge and length of stay reductions - likely to see 3 RIBU centers across county	Mature D2A Mature Admission avoidance Established Step down beds but plans to grow	Q4 2023 – Q1 2024
Flexible working patterns	• Council P1 services operate 7 days and brokerage services work weekends in all surges	• Our transformation of P1 services in the council includes change in terms to 7-day working but it's not yet implemented • there is still a challenge about low numbers of discharges at weekends but over the major incidents 22 we saw how concerted joint efforts could change this and we are working to get to steady all week referral/discharge numbers	Planned	Q4 2023
Trusted assessment	• Discharge coordinators and hub lead on discharge • Trusted assessors in place on behalf of external providers		Established	
Engagement and choice	• new board round and discharge processes rolled out across 18 wards with "what matters to me " focus		Established	

6. National Condition 3 - Provide the right care in the right place at the right time

Please describe how you have used the BCF funding, including the IBCF and ASC discharge Fund to ensure that Duties under the Care Act are being delivered?

Our Care Act Duties are supported through all the funding streams into the BCF and across a range of services, these include

- **BCF Funding to support unpaid Carers** - As a system Health and Care invest over £1m of our BCF joint funding annually in Northamptonshire carers as the main provider of unpaid carers support across all ages groups. Northamptonshire Carers provides support for 16,925 registered Carers with an average of 5,000 Carers currently accessing services across a year at any one time. We are also funding the short Breaks service for children providing carers and child respite for disabled children and their families
- **BCF - Safeguarding** – we also use the funds to support the quality work of our safeguarding teams ensuring that we have a robust, good quality market and that we take action where providers fall short of the required standards of care
- **BCF funding reablement, Intermediate Care Teams (ICT) and Specialist Care Centre/RIBU** - services are helping meet our duty to try and prevent an escalation into long term care by helping people recover their independence
- **BCF & Additional funding community equipment** – as a system we fund a jointly commissioned contract for community equipment and minor adaptations and have added further investment is Raizer chairs and stockrooms that allow quick access and support community and care homes faced with falls or discharged patients that require equipment to prevent an escalation or readmission and aid recovery.
- BCF and Discharge funding - we continue to invest in integrated discharge teams to manage the flow and pathways of patients using common forms, process and MDT decision making. We have enhanced the in hospital and community discharge teams to ensure that timely assessments are made post discharge and that people move on to the optimum future setting in a timely way from a D2A or Pathway 2 placement
- **IBCF funding Home Care and Demographic Pressure** – we continue to top up the additional local authority funding for additional home care and care home capacity required to meet the demands coming out of our hospitals and ensure that people are provided with care to meet their assessed needs
- **Discharge Funds** – we have included a range of schemes designed to avoid delayed discharges utilising intermediate care step down facilities, Reablement teams and Voluntary sector support for discharge follow up services. We have also included commissioned services for discharge to Assess spot beds and external Reablement services to pick up complex discharges and avoid delays
- **Age well funding** – additional investment in age well is ensuring we are meeting our Care Act duty to prevent or delay an escalation to hospital or long-term care and avoid unnecessary admissions

7. Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In West Northamptonshire, we recognise, value and support unpaid carers as individuals provide information, advice and support to enable them to have better health and wellbeing. One in ten people in West Northamptonshire is a carer. Using our BCF pooled funds we commission a range of carers specific health and Social Care services from the Northamptonshire Carers to ensure that carers assessments are completed, and concerns and opportunities are discussed with us to maximise support offered. This includes carers breaks, support groups, carers café's, sit in services and emergency overnight support. Our offer through the Alzheimer's society and Dementia UK provides information, advice and support to those unpaid carers who are caring for a loved one with cognitive concerns and formal diagnosed health needs.

Northamptonshire Carers undertake our carers assessments on our behalf and in 2022-23, they completed over 600 carers assessments. The Carer Trust actively seeks out those with caring responsibility who may not see themselves as a carer, to offer support, guidance and an assessment if required so that a preventative approach is taken to avoiding carer breakdown.

In addition, West Northamptonshire has a developing money advice service which supports all members of the community, including carers, to apply for benefits and to manage financial concerns which are causing a short-term crisis. This is usually identified via our three conversations model, which as part of conversation one, will support a carer through a crisis and ensure that sign posting to the right advice is provided. Our workers would support the carer until the crisis is resolved.

The PAG (Patient Advisory Group) is led by Northamptonshire 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

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

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 in 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 2022-23 as a legacy impact from the Covid-19 pandemic, we have cleared this and we are now utilising all of our budgets including legacy underspend. In 2022-23 this saw the Council invest c£3.2m in major adaptations for owner-occupiers, private rented sector tenants, and residents of registered providers. This compares with the BCF DFG grant of £2.55m. We have also introduced some new elements of service including:

- Increasing capacity in the service, particularly with design and project supervision to ensure that adaptions can be completed quickly
- Maintained the fast-track, light touch approach to low-cost adaptations such as stair lifts
- Introduced a fast-track, light touch approach to ensuring residents can be discharged from acute care quickly, and for those residents facing end-of-life care there are provided with a safe home environment during their end-of-life support

We continue to work with health to develop our supported housing offer, inclusive of adaptations and care delivery, to develop the housing offer to mean that people stay in the community for longer and avoid hospital and care home admissions. Some of the work we are doing includes:

- A review of Extra Care provision has identified surplus supply vs demand and analysis is being undertaken to understand the challenges in fully utilising available extra care provision. Consideration is currently being given to whether this extra provision can be repurposed to support step down hospital discharge while we look for opportunities to maximise occupancy.
- As well as our specialist supported living schemes (Oak Tree Rise and Moray Lodge), we are currently assessing the need for additional supported living schemes to compliment these facilities. Analysis has shown that around 17% of all supported living provision is in single occupancy accommodation where people are at risk of social isolation. We are therefore of the intent to work with our Market in 2023-24 to develop new schemes that maximise community living opportunities and independence.

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

have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a proportion of your DFG funding for discretionary services?

The Council has not allocated a specific proportion of the overall BCF DFG grant to the discretionary policy alongside the mandatory DFG and continues to respond to its applications under both the mandatory and discretionary regimes.

The unitary council adopted its first Housing Strategy in September 2022, the West Northants Housing Strategy 2022-2025 has four themes these are:

- Theme 1: Deliver homes people need and can afford
- Theme 2: Improve the quality, standard and safety of homes and housing services
- Theme 3: Support residents to live healthy, safe, independent and active lives
- Theme 4: Support thriving and sustainable communities

Theme 3 is where our strategic approach to housing activity to prevent hospital admissions, support getting people out of hospital quickly and reducing admissions into residential care settings and supporting people in their home is set out. Theme 3 also outlines our ambition for much closer working across housing, ASC and health. Key commitments and deliverables to support people staying in their homes rather than entering residential care or being admitted to hospital include:

- bringing together teams from different disciplines including housing, health, adult social care and others to work out of the same locations to support more joined-up working especially preventative and early intervention work.
- Mapping the different needs data previously collected separately in district/borough councils, the county council and health providers in one place using the relationships and increased joint working resulting from the new unitary council arrangements and the integrated care system to facilitate a more joined-up understanding of needs for specialist and supported housing
- Bringing commissioners together to use the joined-up dataset to plan joined up service provision for the future
- Development of a Supported Housing Strategy

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

Some of the commitments and deliverables relate to homelessness and the impact this has on local primary health care, acute health provision and adult social care. Completing a review of Homelessness and developing a new West Northants Homelessness and Rough Sleeping Strategy. This work and the strategy will identify opportunities for preventing homelessness & rough sleeping in order to reduce costs to the 'system' in the round.

Jointly commissioning a health, housing and support needs assessment of those who are or are at risk of rough sleeping to inform the design of a new rough sleeper pathway of accommodation, support and health services potentially including some jointly commissioned services

Alongside the Housing Strategy commitments, the services include roles that contribute to supporting people to remain at home. The Housing Solutions Team has a Hospital Outreach Worker who is based at the local acute hospital focused on creating rapid housing pathways out of hospital to reduce bed-blocking and enable timely hospital discharge. We also have a Hospital Transitions Officer in the Council's Housing Solutions Team who works collaboratively and proactively with local hospitals, social care professionals, social landlords, private landlords and advice and support providers to facilitate the safe and timely discharge of patients from hospital.

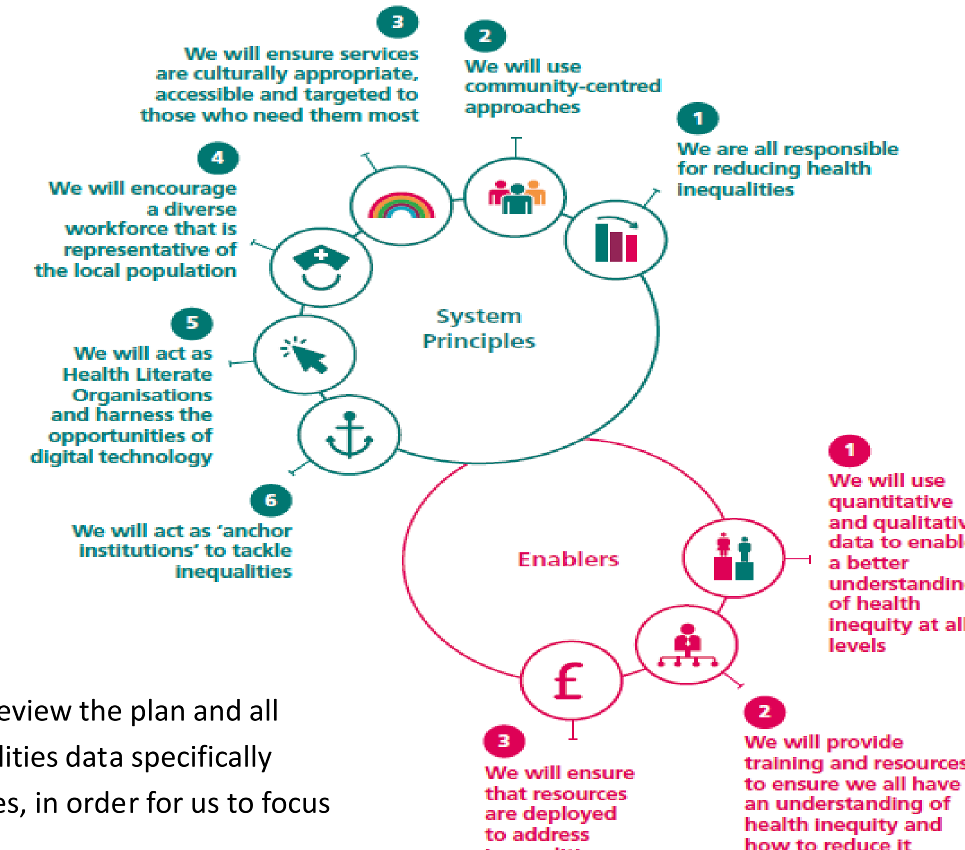
9. Equalities and Health Inequalities

Integrated Care Northamptonshire

How will the plan contribute to reducing health inequalities and disparities in the local population taking account of people with protected characteristics?.

ICN's Health Inequalities Plan 2022-25 sets out the vision to work with communities to ensure that people living in Northamptonshire have the opportunity to thrive, to access quality services providing excellent experiences and optimal outcomes for all. The plan also identifies the priority groups the system needs to reach to address health inequalities, this aligns to the Core20PLUS5 approach, and includes:

- People with protected characteristics under the Equality Act 2010
- Socioeconomic groups and deprivation
- Inclusion health and vulnerable groups
- People living in urban and rural areas.



The Plan sets out the system principles that the ICS will adopt alongside the enablers required to ensure that we achieve the ambition to reduce health inequalities and the BCF programme will use these to ensure that health inequalities are considered throughout.

To ensure that the BCF plan considers the impacts of inequalities a Health Equity Assessment Tool will be used to review the plan and all schemes within it and develop actions to address any inequities. There is still work to do to understand our inequalities data specifically related to BCF schemes that will enable us to identify where there are inequities in access, experiences or outcomes, in order for us to focus on a particular group.

Our approach will be to establish a data project group which reviews what information is collected, and ensure that the right data is being collected, in order to annual equity audits on all schemes. Any inequities that are identified will be addressed through gathering further insight to understand the causes of these and to work with service users and stakeholders to codesign and coproduce solutions that ensure that services are meeting the needs of our communities, delivered in culturally appropriate and accessible ways.

9. Equalities and Health Inequalities (1)

Our current work recognises that people's needs differ based on their environment and opportunities and often differ by area with some health inequalities more prevalent in some areas than others. Over time we expect to coalesce more services in locality to reflect the issues we regularly see and based on evidence about what health inequalities or poor wider determinants are flagged for residents based on our combined data.

We have several targeted services and initiatives that recognise this. They include:

- Countywide befriending model created with a pipeline of befrienders and befrienders – allowing us to tackle loneliness in areas of high rurality and isolation. February had 235 active volunteers providing over 1,350 hours of befriending.
- Targeted Get up and go classes for people with Frailty held in Corby, Wellingborough and Northampton. Now rolling out to have free weekly classes in eight venues across the county.
- Joint work with Black Communities Together to provide support groups to Older Asian communities in Northampton ahead of further expansion.
- Oakley Vale Memory Hub, co-produced with patients supporting over 50 people and their carers each week. Roll out model in place for every locality to have Memory Hub and the system to be supporting 200 persons living with dementia each week.
- Dementia Asset groups running in Rushden, Northampton and Wellingborough.
- Pumped Up Asset Group for Heart Conditions live in Daventry and launching in May in Northampton
- Diabetes Asset Group started in Kettering.
- We have Mental Health Crisis Cafes and Houses in Northampton and Corby in the County.

Better Care Fund: Executive Board Terms of Reference

1 Background

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:

- Minimum allocation from integrated care systems (ICSs)
- Disabled facilities grant – local authority grant
- Social care funding (improved BCF) – local authority grant
- Winter pressures grant funding – local authority grant.

Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:

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

The BCF achieves this by requiring integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB), governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people. 94% of local areas agreed that joint working had improved as a result of the BCF in 2021 to 2022.

2.0 BCF objectives and priorities for 2023 to 2025

Objective 1: to enable people to stay well, safe and independent at home for longer

The priorities for health and social care are to improve quality of life and reduce pressure on UEC, acute and social care services.

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This will be achieved through various mechanisms, including:

- Collaborative working with the voluntary, housing and independent provider sectors
- Investment in a range of preventative, community health and housing services
- Supporting unpaid carers

Objective 2: to provide people with the right care, at the right place, at the right time.
The priorities for health and social care are to tackle immediate pressures in delayed discharges and demand for hospital attendances and admissions, bringing about sustained improvements in outcomes for people discharged from hospital, and wider system flow.

This will be achieved by embedding strong joint working between the NHS, local government and the voluntary, housing and independent provider sectors.

The national conditions for the BCF in 2023 to 2025 are:
1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB
2. Implementing BCF policy objective 1: enabling people to stay well, safe and independent at home for longer
3. Implementing BCF policy objective 2: providing the right care, at the right place, at the right time
4. Maintaining the NHS's contribution to adult social care (in line with the uplift to the NHS minimum contribution to the BCF), and investment in NHS commissioned out of hospital services.

3.0 Funding

Details for the minimum contributions to the BCF for 2023 to 2025 are set out below. This includes the additional £1.6 billion funding for supporting hospital discharge.

Minimum contributions to the BCF in 2023 to 2024 and 2024 to 2025		
BCF funding contributions	**2023 to 2024 (£m)**	**2024 to 2025 (£m)**
Minimum NHS contribution	4,759	5,029
Improved Better Care Fund (iBCF)	2,140	2,140 (TBC)
Disabled Facilities Grant (DFG)	573	573
Discharge funding	600	1,000
Grand total	8,072 (+4.6%)	8,741 (+8.3%)

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3.1 The flexibility of local areas to pool more funding than the mandatory amounts will remain.

3.2 Minimum NHS contribution from the integrated care board

RNF 2023/24 (£'000)	RNF 2024/25 (£'000)	Total ICB contribution 2023/24 (£'000)	Total ICB contribution 2024/25 (£'000)
17133	18103	57664	60928

3.3 West Northamptonshire

RNF 2022/23 (£'000)	RNF 2023/24 (£'000)	RNF 2024/25 (£'000)	Total ICB contribution by LA 2022/23 (£'000)	Total ICB contribution by LA 2023/24 (£'000)	Total ICB contribution by LA 2024/25 (£'000)
8719	9213	9734	29346	31007	32762

4.0 Health and Wellbeing Board

The Health and Wellbeing Board has overall responsibility for ensuring the integration of health and care functions within their localities and it is a requirement of the BCF that local plans are agreed by HWB's. They have statutory ownership of the BCF and have overall accountability for the delivery of the BCF plan and for agreeing high level commissioning intentions. They have a statutory duty to encourage integrated working between commissioners and oversee the strategic direction of the BCF and the delivery of better integrated care. They are responsible for gaining system-wide buy-in to the Better Care Plan, which sets out the broad commissioning intentions for the use of the BCF. The HWB is a committee of WNC and include lead members and chief officers from WNC and health and social care system, HWB's are accountable to elected members and ultimately to the electorate.

5.0 Purpose and Duties

The purpose of the BCF Executive Board is to ensure appropriate and effective governance arrangements are in place to support the BCF and to make recommendations to the Health and Wellbeing Board. The Board will act as the single health and wellbeing commissioning body for West Northamptonshire and will:

- Oversee the use of the BCF in West Northamptonshire
- Sign off their organisation's contribution to the BCF s75 Agreement
- Sign off or challenge reporting from the BCF Delivery Group (including risks to the national conditions being met)
- Engage with other governance boards to ensure consistency of decision making
- Reconcile differences in opinion and approach, and resolve disputes arising from them

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- Make decisions relating to decommissioning or commissioning of services in relation to the BCF
- Determine scheme priorities and reallocate financial resources as required
- Determine the use of unallocated financial resources
- Agree any financial risk sharing agreements
- Address any issue that has major implications for the fund
- Monitor the progress of the BCF plan
- Direct any recovery plans that may be needed
- Ensure that commissioning decisions are the result of consultation and engagement with the key people involved in all aspects of the function of delivering joined up health and social care
- Promote positive risk taking
- Promote the joint commissioning of services
- Promote Co-production of BCF schemes:
  I. Co-design, including planning of services
  II. Co-decision making in the allocation of resources
  III. Co-delivery of services, including volunteers
  IV. Co-evaluation of the service

6.0 Core Members

- Director of Adult Social Care: West Northamptonshire Council – Chair
- Assistant Director of Commissioning and Performance: West Northamptonshire Council
- Assistant Director Discharge to Assess Services: West Northamptonshire Council
- Strategic Finance Business Partner: West Northamptonshire Council
- Chief Finance Officer: NHS Northamptonshire Integrated Care Board
- Director of Commissioning: NHS Northamptonshire Integrated Care Board
- Primary Care representative
  Director: Northamptonshire Healthcare NHS Foundation Trust
- Chief Operating Officer: Northampton General Hospital NHS Trust

7.0 Accountability

As legal recipients of the funding, ICBs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. Only the ICB and WNC directors are decision makers. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the funding in accordance with the approved plan and their general duties. Provider representatives will attend in an advisory role.

8.0 Frequency of meetings

Monthly for 23-24.

9.0 Quorate

One director from WNC and one director from the ICB.

10.0 BCF Delivery Board

The BCF Executive Board is underpinned by the BCF Delivery Board. The BCF Delivery Board are responsible for the following:

- To agree and put forward new schemes to the BCF Executive Board focused on achieving the national BCF objectives
- To make recommendations to the BCF Executive Board relating to commissioning and decommissioning of services in relation to the BCF
- Review the effectiveness of existing schemes and adherence to achieving the national objectives
- Sign off BCF returns
- Monitor and review scheme risk registers
- Agree and rate risks for the BCF as a whole and forward to the Executive Board for approval
- Monitor progress and escalate issues to the BCF Executive Board as appropriate
- Nominate a representative when not able to attend
- The Board is responsible for overseeing financial and performance monitoring to ensure compliance with national conditions
- Support the development of the BCF annual plan

10.1 Frequency of BCF Delivery Board meetings

Monthly

10.2 BCF Delivery Board Members

- BCF Service Manager – chair
- WNC finance
- WNC performance/data
- WNC commissioner/manager or provider side
- ICB reps
- Provider reps
- Health Watch
- Carer's groups representatives
- Scheme Managers for reporting and presenting new scheme proposals

11 Scheme Managers

Each programme that sits under the BCF should be allocated a scheme manager. This includes new schemes being proposed. Scheme Managers will have the following responsibilities:

- Complete new scheme proposal forms
- Complete and update scheme project plan
- Report to the BCF delivery group
- Take responsibility for ensuring the schemes are working to their full potential in achieving the national objectives
- Support accurate data collection

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- Maintain a scheme risk register and update it for each delivery group meeting
- Nominate representative when not able to attend
- Provide information and data for the scheme review
- 360^{0} review from partner services (what are they like to work with)

12 BCF Data Quality and Finance Group

Supporting the BCF Operational Group and Executive Board are the BCF Data Quality and Finance group. The group will have the following responsibilities:

- Agree where data will come from for BCF returns
- Agree and develop a data quality improvement plan (DQIP)
- Involved in all new schemes to agree how data will be collected, reported on and when, as part of the new scheme proposal form
- Named individual leads for data responsibility – accountable person
- Timescales for data reporting
- Escalation routes where data is not provided in a timely way
- Report into the BCF delivery group
- All members to ensure they have access to ‘The Better Care Exchange’, understand fully what is required of them, to actively work at improving their own processes/knowledge of BCF and sign themselves up to the BCF discussion forum.
- Each member to have a support system in place from their own organisation.
- Each member to ensure there is adequate cover for them in the event of annual leave or sickness for reporting purposes.
- A clear process to be agreed for new additions to the template (e.g. new metrics, templates, data requirements).
- Monthly dataset from all parties that covers the required data in a simple format that requires minimal manual intervention.
- Monitor the BCF finance, support the BCF returns and escalate concerns to the BCF Delivery Board and BCF Executive Board
- Support the developments around finance for new scheme proposals.

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12.1 Frequency of BCF data Quality and Finance Group meetings

tbc

12.2 BCF Data Quality and Finance Group membership

tbc

Better Care Fund New Scheme Project Plan

West Northamptonshire Council

NHS Northamptonshire Integrated Care Board

Name of Scheme:

Scheme Manger:

Scheme Approved:

Brief Description of Scheme:

BCF Objectives scheme will meet:

• Enable people to stay well, safe and independent at home for longer • Provide people with the right care, at the right place, at the right time		*Click yes or no then describe how below*

Provider:

Cost: £

Funding from:

Project Milestones

Overall Progress:

West Northamptonshire Council

NHS Northamptonshire Integrated Care Board

Significant slippage (red)
Minor slippage (amber)
Element is complete (green)

Consider co-production, finance, governence, comms, data collection & reporting, quality, legal, procurement and brokerage

Use a column below for each week starting from a Monday, from the start of the project to map progress and slippage until each element is complete. Use the colour scheme (left) to fill the boxes with the appropriate colour.

No	Task	Owner	Planned time (days)	Planned start date	Planned finish date	Actual start date	Actual finish date	Percent complete	RAG	Comments & update notes																										

BCF Risk Log							
Reference	**Date**	**Risk Category**	**Risk Description**	**Inherent Risk**	**Actions**	**Residual Risk**	**Escalated to**
			Describe the nature of the risk	before any action has been taken to manage it	Identify the additional control measures to reduce the risk	remaining risk once the control measures have been put into place	If the residual risk is greater than the risk appetite then the risk must be escalated *
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

Risk Matrix	Consequence				
Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

What is the likelihood of the risk and then the consequence

Department	Staff Name	Hours required	For how long in months or weeks	Support with what?	Agreement needed with manager	Agreed?	Date
Finance Governence Procurement Communications Brokerage Performance/data Legal Quality Team							

Please enter changes for milestones or risks and save the document with a new version number on the cover page

Date	Risk or Milestone number* & version	Changes Made	Reason for change	Name of person making the change

* enter N/A for form c

Number	Author	Learning	Action Required yes/no?	By Whom	By When
1					
2					
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Date	Author	Notes

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West Northamptonshire Health and Wellbeing Board
27th July 2023

Report Title	Disabled Facilities Grant End of Year Report 2022/2023	
Report Author	Chris Stopford, Head of Private Sector Housing, West Northamptonshire Council (chris.stopford@westnorthants.gov.uk)	
Contributors/Checkers/Approvers		
Other Director/SME	Joanne Barrett	Assistant Director Housing and Communities, West Northamptonshire Council

List of Appendices

Appendix 1 – DFG Data 2022/2023

1. Purpose of Report

1.1. To update the Board on Disabled Facilities Grant (DFG) allocation and spend across West Northamptonshire for 2022 – 2023

2. Executive Summary

2.1 DFGs are an allocation provided by central government in order to enable people with a disability to remain in, or return to, and live independently in their own homes, thereby avoiding them having to be looked after in a care home or in hospital. This report provides an overview of how the DFG 2022/2023 allocation was spent and the issues that occurred during this period.

3. Recommendations

3.1 The Board are asked to note the DFG spend for 2022/2023

3.2 It is a statutory requirement of Health and Wellbeing Boards to oversee local DFG arrangements.

4. Report Background

4.1 DFGs are provided in order to enable people with a disability to remain in, or return to, and live independently in their own homes, thereby avoiding them having to be looked after in a care home or in hospital. The adaptations funded by DFGs range from level-access showers, stairlifts and ramping to major property extensions and are granted in consultation with the Council's Community Occupational Therapist (COT) Service. Costs vary from around £5,000 for the former to £30,000+ for the latter. Mandatory DFG funding is limited to £30,000 per application.

4.2 The Council's Home Adaptations Policy, enabled through the Regulatory Reform (England and Wales) Order 2002, provides for a range of additional funding on a discretionary basis. This includes schemes providing a £15,000 top up to the mandatory grant, and schemes focused on supporting resettlement, hospital discharge, palliative care, dementia friendly and other long-term cognitive impairments

4.2 The timescale to process a DFG application can vary hugely and is dependent on the requirement and availability of various professional partners; requirements for a COT assessment and/or architects' drawings, permissions granted from landlords and planning departments and building control approval. Inevitably, this means that some of the grant funding committed as at 31st March in any given year will not be paid until the following financial year, and the committed but unspent amounts can vary significantly from one year to the next.

5. Issues

5.1 The total national funding for DFG in 2022/2023 remained the same amount as the previous year (£505 million) therefore the allocation and breakdown for Northamptonshire stayed unchanged.

5.2 Funding locally, within the West Northamptonshire being £2,558,938 for the 2022/23 financial year

5.3 High demand for the service continues across West Northamptonshire. As reported to the Health and Wellbeing Board previously the impact of the Covid19 pandemic resulted in a reduction in service demand during 2020/21. This demand has been recognised in the increased demand for service during 2021/2022, and 2022/2023 with clients, previously shielding, now approaching the Council for assistance.

5.4 The impact of the national economy has had a significant impact on the costs of adaptations works. We have seen significant increases particularly in the costs of construction materials. This has resulted in high expenditure across all grant types.

5.5 The new Private Sector Housing Assistance Policy for West Northamptonshire, adopted in April 2021, has continued to be promoted within our community, and our sector contacts particularly the health and VCSE sectors. This has seen the range of options for discretionary home adaptation assistance being offered by the service, see data in Appendix 1. The aim of the discretionary element is to assist those meeting certain criteria and whose

application would cost in excess of the maximum mandatory award of £30,000 and who otherwise would have to make a financial contribution themselves.

5.5 This transformational work, supported by the Directorates Transformation resources, will see the recognition of existing best practice, benchmarking with our services, engagement with service users, and the development of a new operating model that seeks to reinforce the Council's vision for a 'great place to live, work and thrive' being at the heart of the team's delivery culture.

5.6 The Home Adaptations Team across the whole of West Northamptonshire Council, whilst not seeking affirmation of the impact of their work, regularly receive comments and compliments from customers, some examples of these are reproduced below:

Before my driveway had been built, I was having to walk down a steep slope and over the road to my car. Due to my mobility problems, this was very difficult and in bad weather dangerous.

The Council officer was very understanding and supportive from the start to the finish. She was friendly and approachable if I needed anything.

The contractors were friendly and helpful through the time they were here and were empathetic to my situation.

Having the driveway done has made such a difference to my life . I am now able to get into my car right outside the house, meaning less pain and discomfort as well as reducing my risk of falling

I am writing to provide some feedback on the recent adaptation to our home, namely the creation of a downstairs shower / wet room for my mother who is elderly, disabled and has Alzheimer’s disease.

Before we had the shower put in we were really struggling. Trying to wash mums hair in the sink and then do a strip wash was extremely difficult because of her poor mobility. It put a lot of strain on both of us both physically and mentally and was very stressful. Obviously we couldn’t do this every day .

When I made an enquiry to the council about the possibility of a downstairs shower room being built in an existing shed adjacent to the toilet I wasn’t sure if it would even be possible.

I was sent some paperwork to be filled out and was then assigned a caseworker.

The caseworker came out to visit us at home to measure up the area and see if the build would be possible. She spent a long time talking to me and my mum and assessing the property. She was very personable and understanding. She listened to all our needs and concerns and was very empathetic. She talked us through all the stages of the development if it were to go ahead and we were given her contact details should we need her at any time .

Everything went through as Kim had explained and the process was very straightforward. Everything happened in a timely fashion from surveyors and quotes from builders and completing paperwork for the grant. It was pretty much stress free.

The builders came to do a prestart meeting with us. They came across as very competent and experienced in this type of build. They discussed how the job would go, fixtures and fittings and time frames. They were very mindful about the time frame as my mum had to stay at my sister’s home whilst the building took place as the downstairs toilet would obviously be out of action.

Every day when they arrived they said what they were going to do on that day and had a clear plan.

Some days we were at work and we gave them a key to our home so they could come and go. They were completely trustworthy and got on with the job in hand.

Their workmanship was of a very high standard and we were absolutely delighted with the overall finish.

Nothing was too much trouble for them and they wanted everything to be just right for mum.

When the job was finished they gave us their contact details in case of any problems.

We have not had any problems and our case worker Kim came out to inspect the work.

It's impossible to say how much having the new shower has improved our lives.

To just be able to shower mum at anytime is great. It is so much of an improvement on what we were doing before providing so much more privacy and dignity for mum. It has removed much of the stress for both of us and I only wish we had done it sooner.

In summary, the whole process for us has been excellent from start to finish. Using the Care and Repair facility took any stress away from us and having an assigned Case worker meant we had nothing to worry about and we were kept fully informed throughout.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 There are no resources or financial implications arising from the report**.**

6.1.2 Funding for the disabled facilities grant regime is confirmed annually from the Department of Health and Social Care, and forms part of the Better Care Fund. This money is ring fenced for the delivery of the grant scheme. The Council has received confirmation that funding will remain at the same level for 2023/2024.

6.2 Legal

6.2.1 The Council has a statutory duty under the Housing Grants, Construction and Regeneration Act 1996 to ensure the effective delivery of a mandatory disabled facilities grants. The delivery of additional discretionary grants is activity encouraged, but not statutory, by the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002. In 2020, the MHCLG advised that 85% of local authorities had a discretionary policy.

6.3 Risk

6.3.1 Applications for significant grants, particularly where substantial alterations to someone's home are required, can take several months to process, and the DFG grant may not be fully spent in the year to which it relates.

6.4 Consultation

6.4.1 Not applicable.

6.5 Consideration by 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 Housing Grants, Construction and Regeneration Act 1996
Regulatory Reform (Housing Assistance) (England and Wales) order 2002.

West Northamptonshire Health and Wellbeing Board

Meeting Date : 27th July 2023

Report Title : Disabled Facilities Grant End of Year Report 2022-2023

Appendix A – DFG Data 2022/2023

Financial BCF Grant Data

Carried forward from previous year	£	2,922,143
BCF Grant allocation for 2022/23	£	2,558,938
Actual Spend during 2022/23	**£**	**3,317,485**
Carried forward for 2022/23	£	2,163,596

* This is financial data from the Council's financial management system. It includes all payments made between 1st April 2022 and 31st March 2023, including full and part payments towards awarded mandatory disabled facilities grants, and discretionary home assistance grants. The data does not include the additional financial value of grants that have been approved, but against which no expenditure as occurred.

Performance Data

Grant Type	No of Grants	Value of Payments
Mandatory Disabled Facilities Grant	397	£ 3,115,098.69
Discretionary Top Up	11	£ 106,468.73
Discretionary Resettlement	2	£ 9,243.67
Discretionary Hospital Discharge	8	£ 56,892.75
Discretionary Palliative Care	30	£ 166,459.00
Discretionary Dementia Friendly & Cognitive Impairment	5	£ 24,838.10
Discretionary Special Purpose Grant	5	£ 26,601.65
Total Spend	**458**	**£ 3,505,602.58**

** Cognitive impairment, includes the Council's support under the Dementia Friends (Alzheimer's Society), Act to Adapt (Motor Neurone Disease Association), and Change Attitudes (Parkinson's UK) initiatives

* There will be some discrepancy between the financial data and the performance data, in terms of the financial value of grants. The data is held in two separate independent IT systems.

Analysis by Integrated Care System (ICN) Local Area Partnership

LAP Area	No of Grants	Value of Payments
N1	54	£ 390,064.21
N2	26	£ 208,151.31
N3	50	£ 392,428.38
N4	35	£ 222,530.71
N5	66	£ 464,154.39
DSN1	75	£ 446,310.84
DSN2	109	£ 963,317.18
DSN3	11	£ 97,989.58
DSN4	32	£ 320,655.98
Total Spend	**458**	**£ 3,505,602.58**

Analysis by West Northamptonshire Council Electoral Ward

Ward	No of Grants	Value of Payments
Abington and Phippsville Ward	9	£ 38,528.86
Billing and Rectory Farm Ward	19	£ 154,218.00
Boothville and Parklands Ward	20	£ 101,338.03
Brackley Ward	7	£ 54,172.60
Braunston and Crick Ward	29	£ 138,920.04
Brixworth Ward	11	£ 67,409.05
Bugbrooke Ward	10	£ 93,879.15
Castle Ward	13	£ 94,943.50
Dallington Spencer Ward	6	£ 53,082.25
Daventry East Ward	34	£ 237,081.48
Daventry West Ward	41	£ 482,319.54
Deanshanger Ward	5	£ 51,819.56
Delapre and Rushmere Ward	11	£ 132,606.69
Duston East Ward	16	£ 100,824.78
Duston West and St. Crispin Ward	12	£ 122,322.59
East Hunsbury and Shelfleys Ward	8	£ 39,322.27
Hackleton and Grange Park Ward	6	£ 55,174.45
Headlands Ward	30	£ 257,683.71
Kingsthorpe North Ward	6	£ 31,729.50
Kingsthorpe South Ward	10	£ 73,403.15
Long Buckby Ward	22	£ 182,988.50
Middleton Cheney Ward	4	£ 43,816.98
Moulton Ward	1	£ 6,687.75
Moulton Ward	11	£ 50,305.50
Nene Valley Ward	7	£ 36,222.35
Riverside Park Ward	18	£ 125,966.47
Sixfields Ward	22	£ 169,281.01
St. George Ward	7	£ 35,976.10
Talavera Ward	17	£ 109,879.74
Towcester and Roade Ward	11	£ 119,782.83
Woodford and Weedon Ward	35	£ 243,916.16
Total Spend	**458**	**£ 3,505,602.58**

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NHS Northamptonshire Integrated Care Board Five-Year Joint Forward Plan

2023-2028

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Foreword

We are pleased to introduce the NHS Northamptonshire Integrated Care Board Five-Year Joint Forward Plan, which is directly linked to the 'Live Your Best Life' Strategy, published earlier in 2023 by Northamptonshire Integrated Care Partnership (ICP).

This plan articulates how we will help deliver many of the ambitions outlined in the ICP Live Your Best Life Strategy, while also rising to the challenges the NHS faces across the country.

As an integrated care system, we have a shared vision to work better together to make Northamptonshire a place where people are active, confident and empowered to take responsibility for good health and wellbeing, with quality integrated support and services available for them when they need help.

As part of this, as an integrated care board we are striving to achieve four aims:

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

Like many areas across the country, we are seeking to do this against a difficult backdrop. The economic and financial context is challenging, and we need to take that into account as we work to make the NHS more sustainable.

Operating costs are high and increasing, utility costs are going up and people are feeling the impact of the rising cost of living. This financial context is one of several considerable challenges that continue to place pressure on our county's health and care services.

We face significant demand for all our services. We know that through shared working and community involvement, we have the best opportunity to respond to these challenges.

This plan is just the start of a process of working together as health, care and public sector organisations, and with the communities we serve, to achieve our shared vision.

This is the first iteration of a five-year plan which we will review, engage upon and develop on an annual basis throughout that period. In doing this it is critical that we listen to our county's communities and ensure their voices are heard as we continue to develop the activity set out in this plan.

We do hope that by taking the time to read this plan you are able to see more of what we are seeking to achieve and how we intend to do so and are therefore better placed to take part in this ongoing conversation.

Naomi Eisenstadt
Chair
NHS Northamptonshire
Integrated Care Board

Toby Sanders
Chief Executive
NHS Northamptonshire
Integrated Care Board

1. Introduction

1. Introduction

1.1 Purpose of this document

The purpose of this Five-Year Joint Forward Plan is to set out how NHS Northamptonshire Integrated Care Board (ICB) intends to work with partner NHS trusts and local authorities to deliver its statutory duty to provide health services in an integrated way to our population over the next five years (2023/24 to 2027/28).

This will be accompanied by a delivery plan outlining the work required to take place, and throughout the development of our delivery plans we will have a continuous process of engagement and involvement with our communities and providers.

In February 2021 the government white paper 'Integration and innovation: working together to improve health and social care for all' set out legislative proposals for a new Health and Care Bill. The Health and Care Act 2022 provides the formal establishment of our integrated care system, including the transition from NHS Northamptonshire Clinical Commissioning Group to NHS Northamptonshire ICB. This was completed in July 2022.

The Act provides the legislative framework that supports collaboration and partnership working to integrate services for our population. The Act requires the ICB and partner trusts to develop this plan before the start of each financial year. Our initial plan will be developed for 2023/24 and thereafter it will be updated on an annual basis. We will review the plan regularly and use it as the basis for monitoring delivery of our integrated care system.

Working with our councils and wider partners we have developed our Northamptonshire Integrated Care Partnership 10-year 'Live Your Best Life' Strategy (ICP Strategy). This sets out our ambitions to support the people of Northamptonshire to 'live their best life' and focuses on improving a set of outcomes for the health, care and wellbeing of local people which will realise these ambitions.

We have a strong record of partnership working across our local health and care sector and our wider communities. This sets the foundation for providing integrated health and care services to the people of Northamptonshire. Our ICB Five-Year Joint Forward Plan will form part of our shared delivery plan for our ICP Strategy, together with the strategies and delivery plans being developed by our Health and Wellbeing Boards for North Northamptonshire and West Northamptonshire. In this way our plan will be fully aligned with our wider system partnership ambitions.

Across the health and care system we are facing a number of sustainability and financial challenges that place pressure on our local health and care services. There is significant demand on our services from a growing population, increased pressures on the workforce due to staff shortages in some areas and increased operating costs. We will ensure that everything we do is developed and delivered in a way which supports our population by working together to respond to these challenges and improve health and care outcomes for our local population.

1.2 Who we are

Northamptonshire is a predominantly rural county but nearly 70% of its 785,200 residents – and 813,203 patients registered with our GP practices – live in towns and urban areas.

Northampton is our county town and largest urban area and is in the West Northamptonshire Council area alongside Daventry, Towcester and Brackley. Corby, Wellingborough, Kettering and Rushden are the main towns in the North Northamptonshire Council area.

In the last 10 years the population of Northamptonshire has grown by over 92,000, an increase of 13.5%. This is higher than the overall increase for England (6.6%) and among the highest rate of growth in the Midlands.

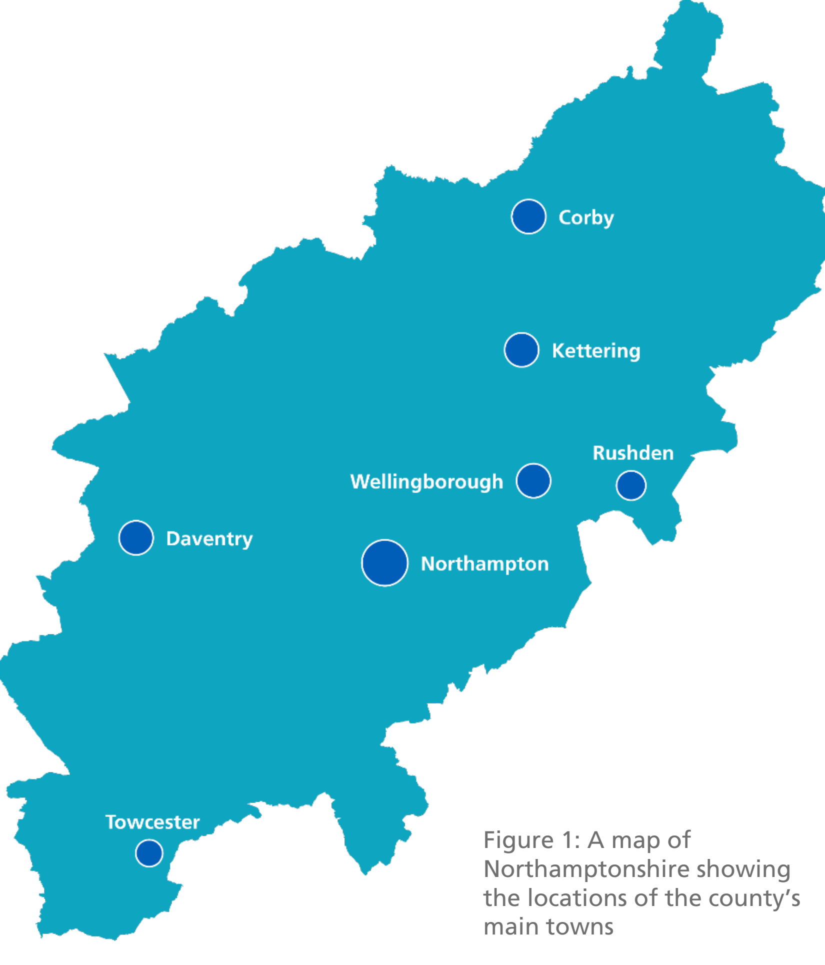


Figure 1: A map of Northamptonshire showing the locations of the county's main towns

About NHS Northamptonshire ICB

NHS Northamptonshire Integrated Care Board (ICB) is a statutory body responsible for local NHS services, functions, performance, and budgets.

We do not directly provide services but work with our partners to support the delivery of care.

The ICB is responsible for joining up care services to improve patient experience and outcomes in Northamptonshire.

The core functions of the ICB are to:

- Identify and plan services to meet the needs of our population
- Allocate resources, and ensure that services are in place to deliver against national and local priorities
- Support the implementation of service transformation
- Co-ordinate and improve the development of our people and culture
- Oversee delivery of improved outcomes for our population

About Integrated Care Northamptonshire (ICN)

Our integrated care system, Integrated Care Northamptonshire (ICN), is overseen by Northamptonshire Integrated Care Partnership (ICP) and NHS Northamptonshire ICB. The ICP includes NHS and council representatives as well as representatives from various voluntary, community and social enterprise (VCSE) sector organisations. The ICB is a smaller body, including NHS provider organisations and senior representatives from both local councils. NHS organisations and local government partners on the Northamptonshire ICB include:

- Northamptonshire Healthcare NHS Foundation Trust, which provides community and mental health services
- North Northamptonshire Council
- Primary care providers, including general practice, dentists, pharmacy and ophthalmology (eye health)
- University Hospitals of Northamptonshire NHS Group, which includes Northampton General Hospital NHS Trust and Kettering General Hospital NHS Foundation Trust
- West Northamptonshire Council

Our system operates at different levels

To enable us to achieve our collective priorities and outcomes, we are committed to working together through our new delivery approach, summarised in the image below.

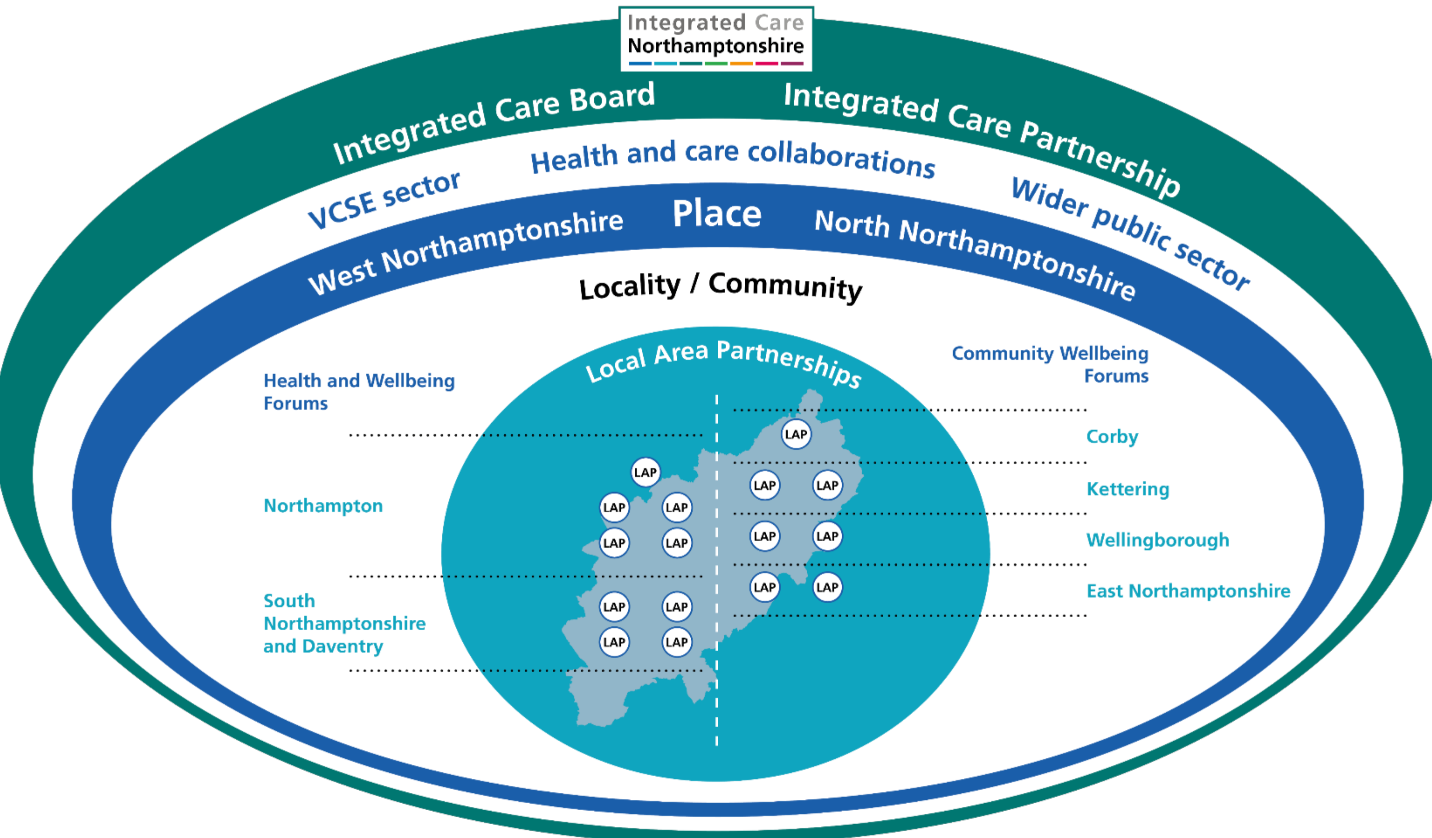


Figure 2: A summary of the Integrated Care Northamptonshire delivery approach

System-wide

As a system we will analyse the needs of our population, set priorities and outcomes, allocate funding and develop our systemwide collaboration programmes and collaboratives. These include mental health, learning disability and autism; elective care; and children and young people.

Place

There are two 'Places' in Northamptonshire which mirror the population footprints and boundaries of our two unitary councils (West and North Northamptonshire).

Our Places:

- Initiate and encourage the integrated delivery of health, social care and other services with health and wellbeing related responsibilities such as housing, policing, education, skills, employment, leisure, planning and community activities
- Understand and work with communities by joining up and coordinating services such as frail elderly services, urgent care, mental health and community services around the needs of people

Local Area Partnerships (LAPs)

There are 16 Local Area Partnerships across Northamptonshire: nine in West Northamptonshire and seven in North Northamptonshire. Local Area Partnerships:

- Represent local areas and give a voice to residents, translating strategy into local action
- Empower residents to co-produce new services and solutions for their local area
- Contribute to system-wide priorities by utilising strong evidence-based information and deep local insight from frontline services and communities
- Empower local leaders to take accountability for local action

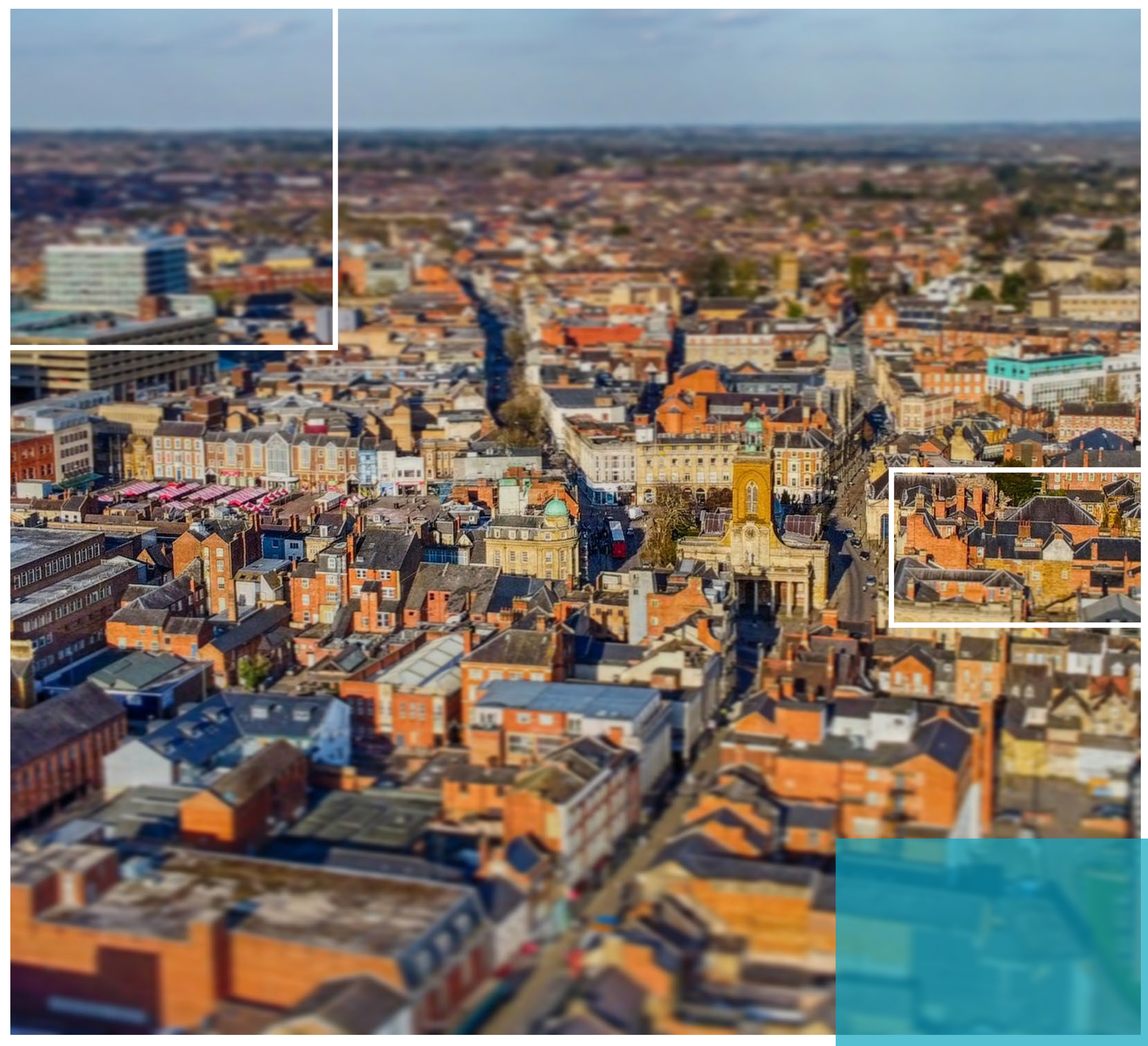
1.3 Our summary plan on a page

We have ensured that this Five-Year Joint Forward Plan aligns with our Northamptonshire Integrated Care Partnership 'Live Your Best Life' Strategy and our Health and Wellbeing Board strategies at Place level.

This plan presents a cohesive narrative for how we intend to work together across the system with all our partners to transform our services and ways of working together to improve outcomes for our local population.

This is a shared delivery plan which will be underpinned by defined work programmes and agreed outcome measures. We have engaged our local system partners in defining the priorities for this plan and we will undertake a continuous process of wider engagement with our communities and partners as we develop the plan and implementation programmes.

The approach to delivering our plan is set out in detail in this document and is also summarised in the graphic on the following page.



Integrated Care Northamptonshire

Our shared 10-year vision

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

Our ICS aims

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

Our delivery focus areas

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

Multiple-impact interventions

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

Our approach to creating the conditions for success

Integration	Health inequalities	Data	Quality improvement	Prevention

Our delivery partnerships

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

Our enabling programmes

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

1.4 Statement from our Health and Wellbeing Boards

The North and West Northamptonshire Health and Wellbeing Boards have been involved in the development of the NHS Northamptonshire ICB Five-Year Joint Forward Plan.

Together with our Health and Wellbeing Strategies for North and West Northamptonshire, the Five-Year Joint Forward Plan will contribute to delivery of our Northamptonshire ICP Live Your Best Life Strategy.

We support the ICB Five-Year Joint Forward Plan and working in collaboration across Northamptonshire to deliver our plans for improving the health and wellbeing of our population, addressing the needs of our populations in North and West Northamptonshire identified in our Joint Strategic Needs Assessments, focusing on prevention and reducing health inequalities.

Cllr Helen Harrison
Chair
North Northamptonshire
Health and Wellbeing Board

Cllr Matthew Golby
Chair
West Northamptonshire
Health and Wellbeing Board

2. Understanding our biggest challenges

2. Understanding our biggest challenges

2.1 Our population

A Joint Strategic Needs Assessment (JSNA) is an analysis of the current and future needs of a local population to inform the planning of health, wellbeing and care services.

The JSNAs for our county (North Northamptonshire JSNA and West Northamptonshire JSNA) identify, alongside some of the great strengths of Northamptonshire, some of the significant challenges we face as a system in improving health and wellbeing.

There remain significant inequalities in life expectancy due to socioeconomic deprivation, as well as inequalities for certain communities of interest. While we have relatively good data on, for example, the gap in life expectancy for adults with learning disabilities (up to 20-year life expectancy gap between adults with learning disabilities and the average life expectancy), there is a lack of data and evidence on experiences and outcomes for some of our other communities. The cost of living and impact of COVID-19 are exacerbating health conditions and inequalities.

Northamptonshire's population is growing faster than the England average but follows the national trend of an ageing population. Northamptonshire benefits from high employment levels and a beautiful rural setting but many in our communities face the same challenges affecting people nationally around poverty (including food poverty and fuel poverty), a lack of affordable housing, crime and safety in our neighbourhoods and issues such as a lack of access to green space. These challenges have a significant impact on the health of our children, young people and adults alike and affect people's ability to be able to engage in healthy behaviours like eating well, moving more, sleeping well, drinking less alcohol and stopping smoking.

The conditions that cause the greatest burden of ill-health and early deaths in Northamptonshire are cancers, heart disease, chronic lung disease, musculoskeletal disease and poor mental health. While the rate of death and disability linked to these conditions may be similar in scale to the national average, the volume of hospital care required is significantly higher, suggesting that the county is much better at treating these conditions than preventing them.

In the 2021 Census 22.5% of people in Northamptonshire described their ethnicity as something other than 'White UK'. This includes around 10% of the population whose ethnicity was in other White groups, around 4.5% who described their ethnicity as Asian and 4% who described their ethnicity as Black.

Diversity of our communities varies significantly from very diverse wards in Northampton and Wellingborough to more rural areas where the vast majority of the population identify as White British.

Across the life course the needs of our population vary. Highlights at each stage are:

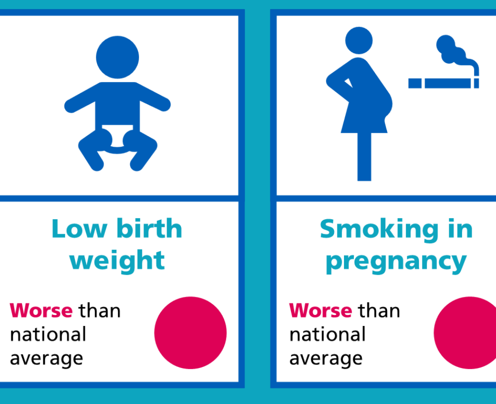
Pregnancy and birth

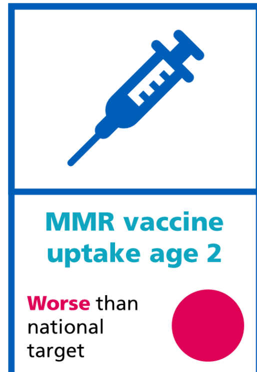
Maternal health and wellbeing before, during and after pregnancy are all critical indicators of child health outcomes

6.6% of the 8,000+ babies born each year in Northamptonshire have low birth weight.

12% of mothers smoked at the time of birth.

Both rates are higher than the England average.





Early years

While our rates of breastfeeding (52.5% at six to eight weeks) are better than the England average (47.6%), by the time children reach the age of five, a quarter have evidence of tooth decay and 22.4% are classified as overweight or obese. In 2020/21 only 92.4% of two-year-olds had at least one dose of MMR vaccine, which is lower than previous years and under the target of 95%. A&E attendances in under-fours are rising and are higher in North Northants (2019/20). The number of those children who then require admissions to hospital for children is higher in West Northants (2020/21).

Children in need

In 2022 there were 1,185 looked-after children in Northamptonshire. Although this is similar as a proportion of overall population to the England average, we know that this group experience significantly worse health and wellbeing outcomes than their peers. In 2021 the percentage of looked-after children who had up-to-date health checks was only 54% in Northamptonshire compared with 91% in England and 81% in the county in the previous year. Children's social care services are in Secretary of State intervention, which required a trust to be set up and work with partners to improve practice, outcomes and safeguarding for the county's children.

Developing well

Future in Mind, the Children and Young People's Mental Health and Wellbeing Taskforce's report, estimates that half of mental health conditions in adult life start by the age of 14. An NHS Digital survey found that one in six children in England had a probable mental disorder in 2021, an increase from one in nine in 2017.

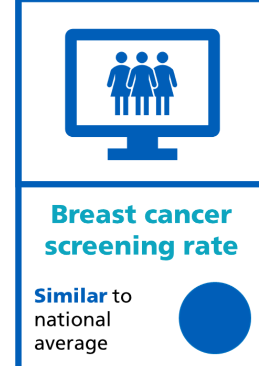
There were 50,000 contacts with community and outpatient mental health services among under-18s in Northamptonshire in 2019/20, a rate that is higher than the England average. The rate of inpatient mental health stays for under-18s was also higher in the county than for England.

Living well

One in four of our adults is classified as physically inactive and around two-thirds are overweight or obese.

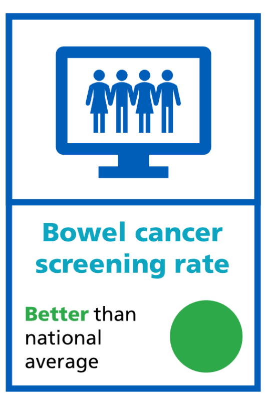
Smoking is the single greatest risk factor for death and disability in the county and an estimated 95,000 people (16.4% of the population) currently smoke.

Smoking is closely related to both coronary heart disease and chronic obstructive pulmonary disease (COPD) and Northamptonshire has significantly more emergency admissions for these conditions than our peers. Smoking is also related to cancer.



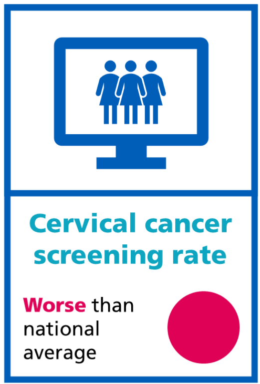
Breast cancer screening rate

Similar to national average



Bowel cancer screening rate

Better than national average



Cervical cancer screening rate

Worse than national average

Cancer detection and treatment continues to improve so that the number of people living with cancer continues to increase. Good cancer outcomes rely on early diagnosis (often through screening). In Northamptonshire coverage of breast screening is 69.2% compared to the national target of 70%, bowel cancer screening is 65.1% compared to the national target of 60% and cervical cancer screening (under 50s) is 69.6% compared to the national target of 80%.

Poor mental health is second only to musculoskeletal conditions in Northamptonshire in terms of causes of years spent living with ill health.

Ageing well

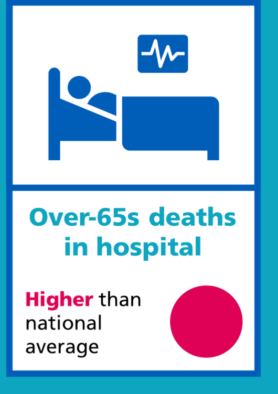
In 2019/20 Northamptonshire's rates of hospital admission for dementia were significantly higher than the England average.

Our residents aged over 65 are more likely to die in hospital and less likely to die at home than the England average.

They are also more likely to be admitted to hospital three or more times in their last three months of life.

Dementia hospital admissions

Higher than national average



Over-65s deaths in hospital

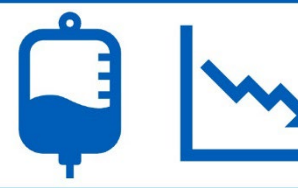
Higher than national average

2.2 Our performance

Urgent and emergency care

Increased
pressure on urgent and emergency care

Our urgent and emergency care system has remained under pressure since the end of the COVID-19 pandemic. The winter of 2022 was extremely challenging due to industrial action and high numbers of influenza, COVID, other respiratory infections and concerns with Strep A, which were highly publicised by the media. Ambulance response times throughout the year continue to cause concern and are being hindered by busy A&E departments, full wards, internal hospital processes and delays in the discharge of patients needing support in the community. Northamptonshire as a system responds to this pressure extremely well in very difficult circumstances; however, there is more that we can do to improve the way we work.



Reduced
over-75 admissions from targeted action

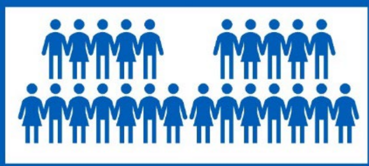
Our transformation programme that commenced in 2022/23 has made good progress. Initiatives such as virtual wards, recovering independence beds, the community rapid response team working with East Midlands Ambulance Service, and the launch of system discharge dashboards have all contributed to improvements in the way the system works together. We are one of a small number of integrated care systems that can evidence a reduction in over-75 hospital admissions, which has been achieved through the provision of enhanced community support – our 'Ageing Well' programme. Moving forward, we have set out a programme of work to further build on our successes. Key to our success so far has been the close working relationship between health trusts, local authority services and the voluntary sector. No one partner can resolve the challenges we face and where we have seen improvements is where we have worked together to resolve issues and deliver new services.

Increased
patient contacts and appointments

Primary care

Within primary care the emphasis is on improving access for patients as demand on general practice services continues to increase. Since COVID-19, primary care is offering 20 to 40% more patient contacts and 12% more clinical appointments compared with pre-pandemic figures. This is exacerbated by a reduction in the number of experienced GPs. Our ability to provide more services within the current primary care estate is challenging, as many have various constraints in infrastructure. We recognise all of these have contributed to a general reduction in patient satisfaction and experience.

Elective (planned) care



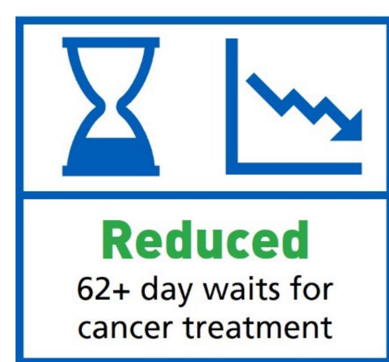
1,900
patients waited 52+ weeks for treatment

Better
than England average for 52+ week, median, and -18 week wait times

The COVID-19 pandemic has had a significant impact on the delivery of elective care. Our patients are now waiting longer for treatment than before the pandemic began; however, as a system, we have made significant improvements in the length of time our patients are waiting for treatment and our current performance compares favourably with other systems. We still have a long way to go to deliver the services that our patients deserve while waiting for an elective procedure.

Patients are still waiting too long, with nearly 1,900 patients having waited more than 52 weeks for treatment as of March 2023. This represents 2.4% of our patients waiting for treatment, less than half of the England average. Our median wait (13.7 weeks) is also lower than the England average (15.9 weeks) and 61.7% of our patients wait less than 18 weeks, compared with just 55.2% regionally. There are opportunities to work together across the system to focus on reducing waiting times and transforming our pathways with a focus on prevention and patient self-management.

Cancer



We have successfully reduced the number of patients waiting over 62 days for cancer treatment and have met the interim target set in March 2023, 62% of patients referred by their GP with suspected cancer had this confirmed, and started treatment, within 62 days.

Again, this is better than the England average; however, we work to continually improve our performance across all cancer measures.

Our hospitals also routinely meet the Faster Diagnosis Standard for patients with suspected cancer being diagnosed within 28 days of referral, achieving this for 95% of patients in March 2023.

We have further to go to ensure that patients at every part of their treatment, from primary care through to discharge, experience a service without delays. Providing increased diagnostic services is critical to this improvement.

We will improve in all aspects of the cancer care pathway from two-week waits for initial referrals and 62-day waits for first definitive treatments, through to ongoing support for those living with cancer.

Mental Health, learning disability and autism

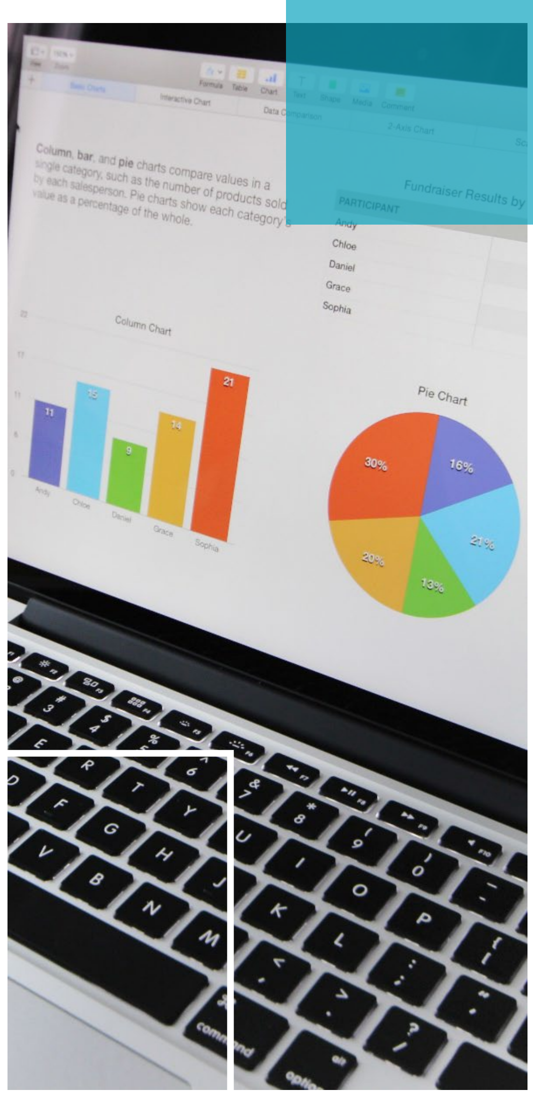
The focus across mental health services is on providing timely access to compassionate, trauma-informed crisis care as early as possible. This will enable us to prevent avoidable admissions to mental health hospitals, which will decrease the pressure on these services.

We continue to expand and develop community mental health teams around neighbourhoods, allowing them to tailor their support to the needs and opportunities of the local area. We also continue to expand access to early intervention and preventative mental health support, including support with housing, employment, debt, substance / alcohol misuse, and social isolation.

Service users are supported along pathways that straddle organisations. No organisation, working in isolation or only via a loose partnership, can transform our pathways. Since 2016 we have had a well-defined set of shared challenges that cannot be solved by individual organisations. We developed a new approach to working collaboratively across whole pathways and populations. Delivering transformational change requires the gaps between multiple organisations to be removed and this requires one infrastructure of equal partners to make the best use of available resources. Our collaborative enables clinical leadership, the voice of the service user and equality among system partners. These partners hold the accountability for the work we do together and all partners have equal access to information for the decision-making process to enable transformation across all organisations.

2.3 Our financial sustainability

The national economic context, combined with a series of pressures on the NHS nationally and locally, have created a challenging financial backdrop in which to deliver care.



Our integrated care system in Northamptonshire is experiencing rising demand for services and increases in the complexity of people's needs, while at the same time needing to increase activity and productivity to recover services after the pandemic.

The 2023/24 financial plan for the health system is one of breaking even across all NHS partners. This is challenging and will require a material level of efficiency and productivity improvement. We will work over the coming months to develop a medium-term financial plan which looks to put the system and services on a sustainable financial footing for the future.

As an integrated care board we will need to reduce our overall spending on management costs. By 2025/26 ICB running costs need to be reduced by 30% with a reduction of at least 20% delivered in 2024/25. We will do this in partnership with others to ensure that the ICB continues to deliver for our population and our patients.

This is the context within which all our key programmes of work and enablers are working, and so the outcomes we seek to achieve must be closely aligned to clearly identified and prioritised needs, as well as considered in terms of their affordability, sustainability and value for money.

2.4 Our workforce

Our sustainability as an integrated care system is driven not only by our financial position and performance.

To operate as a sustainable system, we also need to have a resilient workforce with the right number of staff working in the right ways.

Our health and care landscape has changed significantly following the COVID-19 pandemic. Two years on, our NHS providers and their workforces are still navigating new ways of working, as well as needing to adapt to changing circumstances in their personal lives. We recognise that our staff feel the pressures of working in health and social care and our ambition is to improve satisfaction, ways of working and opportunities to refocus on what being a flexible workforce means, including changing expectations of shift patterns, portfolio careers and job satisfaction.

Recruitment and retention challenges are being felt in many areas, including nursing and midwifery. Pressures are also being felt in many other areas across the health and care system, particularly in primary care and the ambulance service. In addition, a proportion of our current workforce either returned to practice or delayed retirement to support our response to the pandemic. There is a risk that many of these will now choose to leave our health and care system and, with the increased pressure on our entire workforce, there is a risk of further loss.

The health and care system in Northamptonshire is undergoing a fundamental transformation in how we serve our population.

The emphasis is moving from a traditional approach of treating conditions that are already established towards a proactive approach of working to prevent avoidable conditions wherever possible.

With continuing pressures on our services, increasingly complex issues to manage and the ongoing impact of COVID-19, we know that significant focus and sustained work will be required.

3. Defining our priorities

3. Defining our priorities

3.1 Our priorities will deliver our vision and aims

Our vision

Across Integrated Care Northamptonshire we have agreed a shared vision:

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

Our aims

We are striving to achieve four key aims:

1 Improve outcomes in population health and healthcare
Delivering better health and wellbeing outcomes for the population of Northamptonshire, by providing the right services to support the needs of our communities and supporting people to prevent ill-health.

2 Tackle inequalities in outcomes, experience and access
Working to tackle unfair and avoidable differences in people's health, their access to health services, and their ability to prevent illness – as well as the factors which cause these differences.

3 Enhance productivity and value for money
Ensuring that local health and care services are effective and sustainable for the future through coordinated decision-making, planning, delivery and monitoring.

4 Help the NHS support broader social and economic development
Close partnership working between the NHS, local authorities and other partners to address the social and economic factors affecting people's health and wellbeing – including through our roles as major local employers and stewards of public land and buildings.

3.2 National priorities

The national ask is to focus on the following three key broad priorities:

1 Recover our core services and productivity

Recovery of our core services will be the focus of our 2023/24 Operational Plan. These core services are urgent and emergency care, community health services, primary care, elective care, cancer, diagnostics, maternity and neonatal services, and use of resources.

2 Progress delivery of the key ambitions of the NHS Long Term Plan

Other areas of focus are the key ambitions set out in the NHS Long Term Plan. These are mental health, people with learning disability and autistic people, embedding measures to improve health and reduce inequalities, investing in our workforce, and digital and system working.

3 Continue transforming the NHS for the future

As an ICS we will continue to transform our services to meet the needs of our population.

3.3 Our local priorities

Northamptonshire Integrated Care Partnership has worked collaboratively and engaged with local communities to develop a series of ambitions and outcome priorities for Northamptonshire, as set out in the ICP 'Live Your Best Life' Strategy 2023-2033.

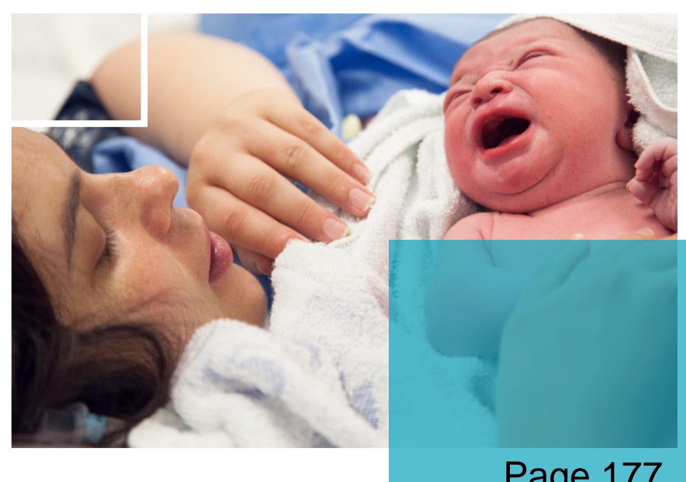
We have 10 ambitions to support the people of Northamptonshire to live their best life. The ICP Live Your Best Life Strategy focuses on improving a set of outcomes for the health, care and wellbeing of local people which will meet these ambitions. These were identified because it is these outcomes that:

- Really matter to people
- We are collectively responsible for
- We can only change by aligning our ambitions
- We can only change by aligning our resources and how we do this together.

The ICB is working to support the delivery of all 10 'Live Your Best Life' ambitions; however, based on health inequalities data, the ICB has also prioritised driving improvement in three of the 10 ambitions, highlighted in the tables below. Within these three ambitions, the ICB Board has agreed nine priority outcome performance metrics on which to focus.

Ambition: Best start in life

Outcomes	ICB outcome metrics
All children grow and develop well so they are ready and equipped to start school	• Percentage of children with a good level of development at age 2-3



Ambition: Opportunity to be fit, well and independent

Outcomes	ICB outcome metrics
Children and adults are healthy and active and enjoy good mental health	• Reducing prevalence of adult overweight and obesity
People experience less ill-health and disability due to lung and heart diseases	• Reducing prevalence of adult smoking • Reducing rate of emergency chronic obstructive pulmonary disease (COPD) admissions
Young people and adults have good mental health	• Improving self-reported wellbeing score

Ambition: Access to health and social care when needed

Outcomes	ICB outcome metrics
Services to prevent illness (e.g., health checks, screening, and vaccines) are good, easy to access and well used	• Increasing proportion cancer diagnosed stage 1 / 2 • Increasing health checks for looked-after children and adults with learning disabilities and severe mental illness
People are supported to live at home for as long as possible and only spend time in hospital to meet medical needs	• Reducing rate of ED attendance for falls in those aged 65+ • People that return to their normal place of residence after discharge from hospital

3.4 Our multiple-impact interventions

In chapter 5 we describe our delivery programmes setting out how we will work collaboratively to shape our services to deliver our aims and enable us to achieve the agreed improved outcomes for our local population.

We have decided across our system that we would highlight five priority 'multiple-impact interventions' that would have the greatest impact on our national and local priorities in the first two years of our strategy. We recognise these multiple-impact interventions will not answer everything, but they will create the conditions for us to focus on delivering improvements for our local population, develop our partnership working and prioritise and align our delivery programmes. Below is a summary of our five priority multiple-impact interventions. Further work is now needed with system partners to scope, evaluate and quantify the benefits of each of these interventions. As we develop our plans, we will identify specific outcomes to be achieved for each intervention. We will have our delivery plans completed by the end of July 2023.

3.4.1 Digital

Why is this a multiple-impact intervention?

We have identified this as one of our priority multiple impact interventions as access to high-quality timely data, and digital technology and innovation will have the greatest impact across all our partnership programmes and priorities to improve outcomes and reduce inequalities.

Although we have already started to develop and evolve our digital and data solutions based on the needs of our local organisations and the patients and citizens we care for, we recognise there remains inconsistency across our county. There is also a clear need to use shared data, tools and platforms to enable a unified understanding of our patients and pathways. This allows us to better target change and improvement and ensure we take the right actions and make the right interventions based on evidence.

We will empower our population and workforce with access to digital and data solutions that are inclusive, integrated and high quality to transform health, well-being and care.

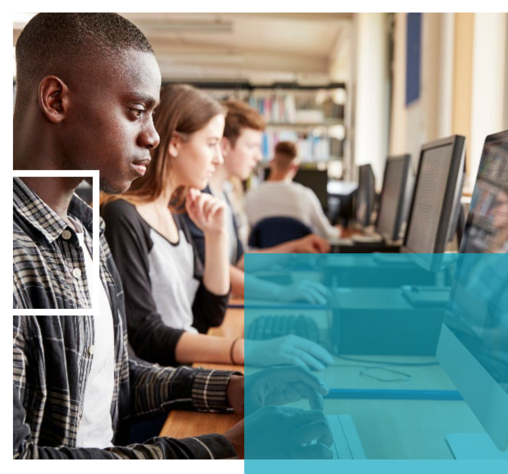
The digital programme is central to fulfilling our aims of improving health and healthcare outcomes, tackling inequalities, enhancing productivity and value for money and supporting broader social and economic development. Access to high-quality, joined-up data will support evidence-based decision-making, identification of priorities and enable us to monitor delivery against our plans. We will upskill our workforce to help them to use the tools provided to drive efficiencies and improve patient care.

What will we prioritise?

During the first two years of our plan, we will prioritise delivery of:

- The Northamptonshire Care Record
- The Northamptonshire Analytic Reporting Platform
- A single digital front door via the NHS App
- A digital skills academy and accreditation programme for our workforce

We have an ambitious digital transformation strategy that will enable us to increase our digital maturity and meet our ambitions to continue to join-up health and care services through integrated digital systems, provide more digital access to health and care services and leverage the power of data and analytics to redesign health and care pathways.



3.4.2 Recovery of independence

Why is this a multiple-impact intervention?

Length of stay in health and care settings has a significant impact on patient experience and has been an issue for our system for some time. It drives additional cost and challenges capacity across the system, but most of all it impacts both patient experience and their long-term outcomes as it often results in greater dependency going forward. We also know that our patients do not want to stay in bedded care but instead want to be helped to return to their own homes and regain their independence wherever possible.

Longer lengths of stay negatively impact our financial sustainability and ability to invest in the right care in the right place for our local population. We have therefore prioritised reducing length of stay across all areas of care as one of our high-impact interventions.

This forms part of our wider urgent and emergency care programme and will impact on several interventions to enable us to ensure patients have access to the right bed at the right time for the right care.

This work is critical in enabling us to deliver our aims of improving health and healthcare outcomes, tackling inequalities and enhancing productivity and value for money. We will review our bedded capacity across the system and invest in services that are aimed at giving patients the care they need outside of hospital settings wherever possible, only admitting them to hospital when it is absolutely necessary, and ensuring they only remain in hospital for as long as is needed to provide their care.

What will we prioritise?

We will continue our work to avoid unnecessary hospital admissions, always taking into account the most appropriate setting of care for the person's circumstances, but where they are admitted to hospital we will focus on processes and pathways to ensure timely discharge home, or where needed, to a setting that best suits their needs. No matter which pathway a patient follows, returning people to independence and their own home where possible will always be our first choice. Our plans include:

- Enhancing our admission avoidance schemes to focus on all of our citizens
- Optimising and integrating community / intermediate care, hospital at home, improved discharge co-ordination and optimising community-based pathways
- Maximising processes and capacity for the discharge of patients requiring different levels of care across our system
- Improving our digital and information services to share information in real time and maximise utilisation of our bed capacity and improve timely discharges
- Focusing on services for patients with dementia and delirium as well as those at risk of deterioration to reduce the need for acute hospital admission

The interventions prioritised here will not only impact recovery of independence but will also contribute to the 'Access to services' priority below (section 3.4.3).

3.4.3 Access to services

Why is this a multiple-impact intervention?

We know that accessing care and, in particular, same-day care is challenging in Northamptonshire. Many patients present to emergency departments if they cannot access same-day urgent care.

We have already developed some services in the community and integrated ways of working to help patients access the most appropriate services, such as our mental health crisis cafes. However, we know that our patients and clinicians cannot always access the care they require at the right time..

We will develop our primary care strategy to deliver an integrated prevention-focused care system and community offer. The NHS England Fuller Stocktake report describes this as a foundation for achieving our core aims of improving health and healthcare outcomes, tackling inequalities and enhancing productivity and value for money.

We will work collaboratively to support people to have timely access to services and enable people to be better supported in their communities to live healthier lives.

While we develop our partnerships to transform urgent and emergency care and services in the community, including an integrated primary care offer, as described in chapter 5, we have agreed to specifically prioritise access to services in the first two years.

Building on the progress and success from our iCAN collaborative, this multiple-impact intervention will have the greatest impact towards our aim of improving health and healthcare outcomes, tackling inequalities and enhancing productivity and value for money.

What will we prioritise?

Our priority focus in the 'Recovery of independence' intervention above (section 3.4.2) will ensure patients return home or move quickly into a care environment that best suits their needs – and this will also impact on our 'Access to services' intervention.

Ensuring we have the right capacity in the right place will enable us to invest our resources in services within the community to improve access to health and care.

We will develop a model of care to shift from acute to community service provision to include balancing same-day access pressures.

We will develop plans to focus on:

- Reviewing progress to date in developing our community focused model of care
- Developing our strategy for primary care
- Empowering patients by rolling out tools they can use to manage their own health
- Implementing 'Modern General Practice Access'
- Building capacity in primary and community care

3.4.4 Children and young people

Why is this a multiple-impact intervention?

Children and young people is an enduring priority for our health and care system. It was defined as one of our four priority collaboratives in 2019 as we developed our sustainability and transformation partnership. While we recognise there has been progress in our collaborative working across children's and young people's services, it remains a key priority and ambition in our Northamptonshire Integrated Care Partnership 'Live Your Best Life' Strategy, with system partners committed to delivering a series of defined outcomes for our children, young people and their families.

While children and young people remains one of our key delivery partnerships, as described in chapter 5, we recognise that more detailed work is required to determine interventions that have the greatest multiple impact on improving outcomes for children and young people. The two things that have been identified to have the greatest impact on delivering our aims of improving health and healthcare outcomes, tackling inequalities, enhancing productivity and value for money and supporting broader social and economic development, are:

- Children's two-to-three-year health checks
- Children's and young people's mental health and wellbeing

We believe having the best start in life will prevent ill-health and help us to identify the needs of our population earlier. Data demonstrates children's development and mental health are affected by various factors, including the environments they are raised in, the relationships they build and the experiences they have.

We recognise we need to be more joined up in our approach. By working in collaboration we can develop and embed effective mechanisms to share knowledge, information and resources to provide our children and young people with the services which meet their needs.

Data shows children and young people with mental health problems often have other areas of difficulty, such as poor school attendance, adverse childhood experiences, attachment and trauma. Some specific cohorts of children, such as children in care or those with a neurodivergence, may be more susceptible to developing mental ill health due to their life experiences. Failure to effectively support a child's mental health may have a negative impact over the life course. In Northamptonshire, the proportion of children and young people attending acute hospital settings following an episode of self-harm is higher than in other areas.

Health checks offered to children at two to three years provide an opportunity to identify developmental concerns which can have a lifelong impact on children and their families, carers, future educational settings and wider support networks. Children with a long-term condition or a neurodivergence can be at risk of developing mental health problems or reduced school attendance. It is therefore imperative that the system works together to provide early identification, assessment and holistic support options.

What will we prioritise?

- Mental health and wellbeing for children and young people
- Achieving improved rates of two-to-three-year health checks and access to the appropriate services and support
- Ensuring our pathways provide a structured approach to addressing the common issues identified by professionals associated with the transition of a family and child from health visiting to school nursing services. The pathway will build on good practice and provide a systematic, solution-focused approach on which to base future local practice.

3.4.5 End of life

Why is this a multiple-impact intervention?

In Northamptonshire there are areas of end-of-life care that are exceptional; however, the existing system and communication platforms do not always enable the delivery of a seamless, well-planned and coordinated service.

Further evidence from discussions with system partners and the public identifies challenges with accessibility for patients across the county. This may be due to some services not being available county-wide or to the distance some patients and families need to travel to access services being too great. It is recognised, however, that what may be delivered at one end of Northamptonshire may not be the same at the other end.

Our aim is to rectify our current gaps and challenges and ensure that all individuals have the best possible experience towards and at the end of their life.

Increased demand for services in the last months of a person's life is well documented. Last year, 2,872 of our patients died in hospital (statistically higher than national rates) and significantly fewer of our patients die at home. While in some cases this may reflect patient choice, in many more it is likely to not be the best care for the patient and their carers. We know that, on average, last year 8% of our hospital beds (102) were occupied by people who would go on to die in hospital. Only 10% of those patients were admitted for cancer, with respiratory disease (27%), circulatory disease (18%) and infections (14%) linked to a greater number of deaths in hospital.

The length of time these patients spent in hospital prior to their death varies greatly. While for many (7%) this occurred on the day of admission or within one (10%) or two (7%) days of admission, many were admitted for a lot longer. 55% of the patients dying in hospital (1,589) were in hospital for more than a week before death and 359 (13%) were in hospital for more than a month. This does not take into account the previous admissions many of these patients would have had in the year before their death. It does, however, demonstrate how improvements in palliative and end-of-life care can have impacts across the system simply by looking at one area of care.

The vision and priorities of our Northamptonshire Palliative and End of Life Care Strategy describes how we will endeavour to improve the quality of life of all-aged individuals, their families and carers who are living and dealing with a life-limiting illness, ensuring everyone receives person-centred, dignified and compassionate care and individual choices are respected.

Additionally, it is our intention for all individuals who need care in the last year of life can access palliative and end-of-life care services and support in a time frame appropriate to the urgency of their need and, where possible, in their preferred place of care.

What will we prioritise?

The Northamptonshire Palliative and End of Life Care Strategy will begin addressing the gaps in service provision, proceed to introduce more efficient and coordinated ways of working and then build the capacity of our integrated care system to ensure higher quality and greater equality of provision of palliative and end-of-life support across Northamptonshire. During the first two years of our plan, four areas of development work have been identified. These include:

- Development of a countywide 24/7 palliative and end-of-life care information hub that patients, families, carers and professionals can access for advice and connection to local health and care services
- Replacing the county Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form with Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to aid communication and appropriate planning

- Commissioning and embedding of an Electronic Palliative and Care Coordination System (EPaCCS) that meets national requirements and, locally, provides access to all system partners to enable them to update patient records contemporaneously which can be seen by relevant health and care professionals.
- Ensuring equitable bereavement services exist for all by reviewing bereavement services to understand the demand, current provision and any gaps that need to be addressed. Once scoping is completed, co-ordinating and developing a countywide equitable bereavement service

The benefits of our palliative and end-of-life care development work will include:

- A better experience for individuals who require palliative and end-of-life care, their families and carers
- Timely and effective symptom control
- Easier access to information, advice, and support
- Hospital admission avoidance
- Palliative and end-of-life care plans in place for every individual
- Where possible, individuals will be supported to be cared for and die in their preferred place of care
- Improved communications within the system
- Improved partnership working with all organisations
- Improved co-ordination of service delivery
- Increased local health and care professional knowledge, skills and confidence to deliver high-quality palliative care
- Improved wellbeing of all care professionals across the system

3.4.6 Our multiple-impact interventions summarised

Each multiple impact intervention has been mapped against our aims, national and local priorities to demonstrate where they will have the greatest impact. The table below demonstrates how these will deliver multiple impacts across a number of our priorities and our agreed target outcomes.

Our ICS aims	Digital	Recovery of independence	Access to services	Children and young people	End of life
Improve outcomes in population health and healthcare	X	X	X	X	X
Tackle inequalities in outcomes, experience and access	X	X	X	X	X
Enhance productivity and value for money	X	X	X	X	X
Help the NHS support broader social and economic development	X			X	

National priorities	Digital	Recovery of independence	Access to services	Children and young people	End of life
Recover core services and productivity	X	X	X		X
Deliver the key ambitions of the NHS Long Term Plan	X	X	X	X	X
Continue transforming the NHS for the future	X	X	X		X

Local 'Live Your Best Life' ambitions	Digital	Recovery of independence	Access to services	Children and young people	End of life
Best start in life	X		X	X	
Opportunity to be fit, well and independent	X	X	X	X	
Access to health and social care when needed	X	X	X	X	X

4. Our approach to creating the conditions for success

4. Our approach to creating the conditions for success

In order to address the needs of our population and deliver the locally agreed priorities we will need to collectively agree how we will work together across system partners to deliver the outcomes we want to see.

The following section describes how we will work collaboratively and embed our approach to addressing health inequalities, promoting prevention and driving quality improvements across all our work programmes and service provision.

4.1 Our approach to integration

We are committed to working collaboratively to use all available resources to deliver improved quality and remove unwarranted variation and improve outcomes for our local population. We will do this by:

- Making a **cultural shift** to collaboration and new ways of working. We need to continue to move away from siloed organisational working towards a system and partnership focus, where we all are collectively responsible for improving health and wellbeing and outcomes for our local population. We will develop a culture of working collaboratively to develop our culture and organisational development programmes across the system to enable this. We will hold each other and organisations to account for delivering success measures in collaborative working.
- Our delivery approach. We will work through our new delivery approach at **Place and Local Area Partnership levels** to develop our health and care services to meet the needs of our communities, based on health inequalities evidence and wellbeing issues identified for the local population. Our challenge will be how we manage the relationship between system-wide planning and delivery of services with designing and delivery at a local level building on local insights and needs of our communities.
- Creating the **environment for collaborative working**. Developing our partnerships and using new legislation and innovation, for example, the NHS England Collaborative Innovator pilot, to enable new ways of working to deliver improved outcomes. There will be different models across our collaborative partnerships with each at different stages of maturity and taking different planned approaches to delivery. However, their visions and plans clearly demonstrate how, by working in collaboration across identified populations, they align and contribute to the delivery of our Five-Year Joint Forward Plan. The collaboratives are each critical components of pursuing the delivery of our aims to improve health and healthcare outcomes, tackle inequalities and enhance productivity and value for money.
- Creating **conditions for greater integration** to improve outcomes. One way we will achieve this is through the Better Care Fund. The Better Care Fund is one of the government's national vehicles for driving health and social care integration in a way that supports person-centred care and better outcomes. We will review our Better Care Funding to support improvement in outcomes for people and best value for money by developing community-based services and reducing reliance on urgent and emergency care services. We will explore other options with our system partners, such as pooled funding and joint commissioning.

4.2 Our approach to health inequalities

As an integrated care system we are working to drive forward work programmes that reduce inequalities, prevent poor health and improve people's opportunities for better health.

The structural inequalities in our society include low income, unemployment, overcrowded housing and a lack of green space, to name just a few examples.

While we have little control over some of the causes of inequality, we can mitigate their effects by improved targeting on populations most affected by inequality and by supporting our local government colleagues in addressing the wider determinants of poor health, including housing, employment and education.

Further information is set out in Northamptonshire's Population Health Management Strategy.

The actions will involve working together to ensure we take effective steps to address the following key areas:

- Determinants of health: education, employment, housing and poverty-reduction programmes
- Health and wellbeing services: smoking, alcohol, nutrition, physical activity, recreational drug use, promoting parity between mental and physical health
- Ill-health prevention programmes: vaccinations, screening
- Health care services (mental and physical health): diagnostic, treatment and rehabilitation programmes
- Social care programmes: care in the community including hospital at home, domiciliary support and residential care support
- End-of-life support: services that support a dignified and pain-free death

Our work to address health inequalities is informed by the national Core20PLUS5 approach.

The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20 refers to the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD) (14.2% of the Northamptonshire population).

PLUS population groups are identified at local level and include, among others, ethnic minority communities; groups experiencing social exclusion, known as inclusion health groups (people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups); and people with a learning disability and autistic people.

The '**5**' refers to areas of clinical focus which drive inequalities. For adults these are maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension.

4.3 Our approach to using data, including population health management

We have developed the Northamptonshire Analytic Reporting Platform (NARP) to be our integrated care system's central population health management tool.

The NARP draws data from the Northamptonshire Care Record to ensure it is timely and accurate. It links this with a range of other data sets to undertake population health management analysis.

This is an integrated data set which currently includes data from acute hospitals, community and mental healthcare services and general practice, and in the coming year will also include data from social care, Northamptonshire Children's Trust and end-of-life services, as well as a range of additional data sets.

The NARP allows the collation of data and insight around individuals, which then allows that understanding of people's needs and service-use to be built up into population, pathway and system insight and understanding.

We have a developed an information governance framework across the integrated care system. This ensures patients' data is safe and protected while allowing us to make the best use of it. These controls mean that clinicians in contact with patients can see their personal details, but those planning services or interventions cannot see identifying patient details. It also allows us to generate anonymised data which can be used for research and reporting, where patient details are completely protected.

The main analytic priorities for population health management and the NARP are set out below.

Population segmentation

A core principle of population health management is that different populations have different needs. The NARP allows us to consistently and reliably segment the Northamptonshire population into different sub-populations. This will include:

- **Whole-population segmentation** using mutually exclusive groups to understand system performance and compare need between different geographies, such as Local Area Partnerships
- **Sub-population segmentation** to understand needs at pathway, diagnosis or "population of interest" level (such as Core20PLUS groups). Sub-populations are not exclusive: for instance, one individual may be on both the diabetes and the coronary heart disease pathways. Sub-populations take into account these factors and are the lenses through which we look at need in detail

Risk stratification

Within populations, different individuals have different levels of needs. Risk stratification allows us to take this into account.

For instance, if two people both have chronic obstructive pulmonary disease (COPD) but one also has a range of other health conditions, that person has greater risk than the first. Quantifying that risk of emergency hospital admission, complex pharmacy requirements or frailty can help us to compare areas more accurately, understand the impact of care pathways, and identify need and design services to better meet those needs.

Outcomes

The Northamptonshire Integrated Care Partnership 'Live Your Best Life' Strategy sets out our ambitions for improving the health of our population, capturing the metrics which will demonstrate that improvement and developing the approaches and sub-metrics which will allow us to help our population make that journey. These are key tasks for the NARP and population health management.

The ICP Strategy is just part of our wider outcomes work in Northamptonshire and we will develop an outcomes strategy that:

- Defines a system-level health framework to guide our population health work and ensure that we are mindful of inequalities and prevention as well as treatment outcomes
- Helps us understand the impact and effectiveness of care pathways
- Develops and uses Patient Reported Outcomes Measures (PROMs) more consistently as we know what matters most can differ from person to person and experiences can vary

Needs assessment

Our new council landscape of two unitary local authorities has meant we have had to change our approach to needs assessment, including Joint Strategic Needs Assessment (JSNA).

Working with colleagues in public health and across the ICP we will undertake a rolling programme of JSNAs targeted at areas of priority and need as well as undertaking system-wide JSNAs. Transparency is key and we will work to 'democratise' data, offering direct access to this information using portals and other online tools.

Population health management strategy

Population health management is data-driven and analytic insight is key to its work. Achieving the 'management' element requires action and intervention.

While Northamptonshire has many individual and applied examples of population health management, including the work developed by Primary Care Networks through the NHS England Population Health Management Development programme, these are not systematic or coordinated.

As the NARP and related infrastructure become more mature, we will develop these coordinated approaches. The roadmap to do this will be set out in a revised population health management strategy. This will be informed by the JSNAs and our understanding of need. It will also be local, building from Local Area Partnership level and from work to map and harness community assets to understand and improve health.

4.4 Our approach to quality improvement

The Northamptonshire ICB quality team is developing a programme for system-wide quality oversight. This is a key element of fulfilling our aim of improving health and healthcare outcomes.

This will focus on:

- Delivery through a culture of quality improvement and collaboration
- Successfully achieving system delivery of clinical priorities and improving outcomes and equality for our patients
- Taking responsibility for continued 'business as usual' quality assurance and improvement of our local NHS services

A key change in quality processes is the reporting and escalation of risks and concerns to the system rather than just within individual organisations. The quality team will bring together statutory committees to include a broad range of system partners inclusive of local government, community, collaboratives, the VCSE sector and health. This will be in line with National Quality Board guidance on risk and quality improvement.

As part of system-wide quality oversight, a standardised approach to risk management has been identified to promote engagement and the sharing of intelligence, and to support triangulation of risks throughout the system and shared learning.

Safeguarding

In August 2022, the 'Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework' (SAAF) (NHS England) was updated. This reflects the context for safeguarding as it continues to change and expand in response to the findings of large-scale enquiries, incidents in a rapidly evolving and increasingly digitalised world (such as modern slavery, human trafficking, radicalisation, exploitation) and new legislation aimed at strengthening protection of those at risk.

The ICB safeguarding team and the health system generally have adopted a 'Think Family' approach to safeguarding and acknowledge that many priorities have a wider focus than just adults and children.

However, to ensure that the ICB statutory duties are captured, safeguarding adults and safeguarding children have been separated.

Safeguarding adults

Northamptonshire statistics up to 31 March 2022 highlight that:

- Within the reporting period 5,118 concerns were raised, with 3,750 remaining safeguarding alerts and 1,368 becoming section 42 enquiries
- Age bands for section 42 enquiries were 42% for 18-64; 13% for 75-84; 21% for 86-94 and 5% for 95 and above
- The most common type of risk in section 42 enquiries was neglect, which accounted for 54% of risks; 13% physical; 11% psychological and 9% financial
- Following investigation, 93% of those identified with risk had their risk removed or reduced

Northamptonshire Safeguarding Adults Board (NSAB), of which the ICB is part, is the overall local safeguarding governance arrangement for safeguarding adults.

NSAB's three key priorities, in line with other adult safeguarding boards in the East Midlands region, are prevention, quality and making safeguarding personal, which include the themes of:

- Domestic abuse
- Street homelessness
- Serious organised crime
- Adults that do not meet the need for statutory services (adult risk management process)

Safeguarding children

Child deaths in Northamptonshire have shown a slow increase over the past three years after falling significantly in 2019/20. However, with the exception of 2020/21, when an increase was seen, unexpected deaths have remained steady over the past five years. In 2021/22 there were 40 deaths (30 expected and 10 unexpected deaths). 70% of all child deaths occurred in the first year of life, with unexpected death occurring more commonly in this age group than any other. This is in line with national figures reported by the National Child Mortality Database.

Northamptonshire statistics (Northamptonshire Safeguarding Children Partnership (NSCP) Annual Report 2021/22) up to 31 March 2022 highlight that:

- There were 43,393 initial contacts received in children's social care, which was 2,020 more than 2020/21
- 12,959 of the contacts were progressed to referrals, which was 1,602 more than 2020/21
- 9,110 section 17 assessments were completed with 98% completed within 45 days
- There were 2,670 child protection enquiries (section 47) compared to 2,436 in the previous reporting period
- 82% of child protection conferences were completed within 15 days
- 28% of children were on a second or subsequent plan compared to 23% in 2020/21
- 47% of children in care had initial health assessments within 28 days of entering care
- 12.7% had three or more placements over the year compared to 8.8% in 2020/21
- 63% of care leavers were in education, employment or training compared to 59% the previous year

NSCP's three priorities are:

- Taking positive action early enough to protect children, focusing on early help, neglect, safe sleeping
- To support children, young people, and families at risk of exploitation, focusing on child sexual exploitation, vulnerable adolescent panel, community initiative to reduce violence (CIRV) and children and young people missing
- To work effectively as a partnership and support our staff focusing on training and learning from CSPRs

Domestic abuse and serious violence duty

It is estimated that domestic abuse costs the health care system £1.7 billion a year, with one in three women experiencing domestic abuse in their lifetime. One in five women and one in 20 men experience sexual violence as adults and one in 20 people suffer sexual abuse as children. The impact of domestic abuse and sexual violence is across the health care system, from emergency departments and ambulance callouts to maternity wards.

The Domestic Abuse Act (2021) has widened the legal definition beyond physical violence to include emotional, coercive, and controlling behaviour and economic abuse. The ICB recognises domestic abuse as high risk and a safeguarding priority, alongside the detrimental impact on health and wellbeing for all ages. As such, there is senior representation on the two Local Authority Domestic Abuse Partnership Boards, supporting work at both strategic and operational levels.

Generally, across the Northamptonshire system, health safeguarding teams recognise domestic abuse and sexual violence as a high priority and therefore representation and engagement are in place at Multi Agency Risk Assessment Conferences (MARAC) and Multi Agency Public Protection Arrangements (MAPPA). The ICB has secured funding for several years for Hospital Independent Domestic Violence Advisors (HIDVAs) to be in place in acute hospitals to offer advice and support to both patients and staff.

In Northamptonshire a Serious Violence Board has been formed, hosted by the Police, Fire and Crime Commissioner in the absence of a violence reduction unit (VRU). The ICB will focus on training, data collection and analysis and consideration of preventative action that can be undertaken in health settings for both victims and perpetrators.

The ICB will continue to be an active participant in Domestic Homicide Reviews (DHRs) across the county to ensure that recommendations and learning are formally shared and monitored across the health system.

Continuing Healthcare and Personal Health Budgets

Continuing Healthcare (CHC), which includes personal health budgets (PHB) for eligible adults, provides personalised care and support for some individuals with long-term complex health needs funded entirely by the NHS following a nationally prescribed eligibility assessment.

CHC in Northamptonshire is provided through a Commissioning Support Unit (CSU) Arden & GEM, which provides a service fully compliant with CHC national guidance and legislation and working within best practice. This is governed by an assurance document and a contract between NHS bodies.

National position performance for the CHC service is measured by several NHS England indicators. These are known as Quality Premium Indicators and are reported quarterly to NHS Digital. The indicators measure performance against a 28-day standard for referral to outcome of assessment and the percentage of assessments which are carried out in an acute setting. Northamptonshire is fully compliant in both areas.

Non-reportable performance (known as benchmarking) is submitted quarterly by the CHC service, including financial reporting and conversion rates. Northamptonshire is not an outlier in any area.

4.5 Our approach to prevention

Prevention is established as a key priority of ICN and is embedded within our Live Your Best Life ambitions.

This covers the tiers of prevention from primary prevention, with outcomes on childhood development, smoking and obesity; to secondary prevention through early cancer diagnosis; to tertiary prevention, with a focus on minimising falls and increasing independence in those discharged from hospital.

Our work within prevention supports the achievement of our aims of improving health and health outcomes, tackling health inequalities, enhancing productivity and value for money, and supporting broader social and economic development.

Work is guided through our Population Health Board and a dedicated Prevention subgroup. This has been responsible for reviewing our current performance and mapping prevention services across the county to champion and spread best practice, as well as to identify gaps and opportunities. This work will be collated into a Prevention Strategy supported by a detailed implementation plan this year.

This will build on examples of excellence such as Northamptonshire Sport, one of 43 Active Partnerships nationally, whose work ranges from providing active childhoods through holiday activity, food programmes, the Xplorer challenge; to Jog Northants and Ping! seeking to increase the number of adults exercising regularly; to Get Up and Go and exercise on referral, which aim to maximise and maintain independence and activity in the elderly and those with additional needs. Linked to our inequalities plan, this work is targeted at areas and groups of greatest need and reflects our targeted, lifespan approach in action.

Another example is personalised care, which aims to benefit all individuals living in Northamptonshire by enhancing their choice and control over the way their care is planned and delivered. Its focus is on 'what matters to me' and the individual strengths, needs and support that individuals have or require. We have exceeded the end-of-year targets for personalised care and support planning and social prescribing referrals and are on target for social prescribing link worker employment.

While we have plans in place for the delivery of the separate priorities of the prevention agenda and the NHS Long Term Plan priorities, we lack a comprehensive and collective Prevention Plan.

Work on the development of this has begun with the stocktake being undertaken by our Prevention subgroup and this will develop into our Prevention Strategy.

This will be closely aligned with our Inequalities Strategy, and both will focus on ensuring that they are embedded within business as usual across all areas of the ICS agenda as well as providing the specific insight, intelligence and interventions required by National priorities and our local ambition that everyone in Northamptonshire is enabled to 'Live Your Best Life'.

Much of our current work reflects this approach with examples including:

- A partnership with Northamptonshire Black Communities Together, an umbrella group of voluntary sector organisations, to undertake opportunistic screening for atrial fibrillation and hypertension within hard-to-reach groups reflecting the Core20Plus5 priority on undiagnosed cardiovascular disease and our local needs assessment
- Working with our local authorities who are building Local Area Partnerships (LAPs) across the county following a community assets approach to bring together statutory and voluntary sector services with the communities they serve to improve health and minimise equalities. LAPs are developing but have already identified their initial priorities including redesigning pulmonary rehabilitation within the community, developing 'Healthy Heart Hubs' and establishing a network of holistic support within the voluntary sector
- Using data and insight to target and improve services. This has included using GP data to create registers of people with serious mental illness which has been used to improve our performance on health checks with this group and develop greater understanding of their needs and the opportunities for secondary prevention of health conditions
- Enabling people with lived experience to play a key part of many of our face-to-face and virtual groups. We are identifying our first cohort for training 'Peer Leaders' as part of the Healthy Hearts Community Hub development in one of our most deprived LAPs. We will expand and cascade the personalised care leadership training and peer leader (people with lived experience) opportunities. This will expand access to 4S training, Action for Happiness and 'tiny habits' champion training, the latter two of which will introduce patients to the benefits of living healthier lives and changing behaviours

- Following the Making Every Contact Count (MECC) approach and enhancing this with a data driven population health management approach. We know from our analysis the health checks are not taken up as readily by those from Core20PLUS groups and from our clinicians that there is more than can be done in the checks themselves. We are therefore using outreach and community groups to target people for checks, technology such as portable ECGs to identify atrial fibrillation and protocols such as blood pressure diaries to create a threefold enhancement

We will continue to develop these new and enhanced ways of working and using our strategy to cement the benefits in practice, ensure we know we are achieving our objectives and outcomes, and to continue this cycle of innovation and improvement.

Personalised Care

A personalised care approach aims to benefit all individuals living in Northamptonshire by enhancing their choice and control over the way their care is planned and delivered. Its focus is on 'what matters to me' and the individual strengths, needs and support that individuals have or require.

In Northamptonshire we have exceeded the end-of-year targets for personalised care and support planning and social prescribing referrals and are on target for social prescribing link worker employment. We are significantly short of the personal health budgets target.

Our performance contributes to the Midlands region in terms of national benchmarking. The Midlands is viewed as a good performing area for personalised care and at the end of Q2 required less than 25% growth to meet end-of-year targets for personalised care and support planning and social prescribing referrals. It required greater growth in the areas of personal health budgets and social prescribing link worker employment.

5. Our delivery partnerships

5. Our delivery partnerships

In this section of the plan, we describe the delivery partnerships which are in place across our system to deliver services to our population.

There is more work to be done in this first year of our plan to develop many of the detailed deliverables and action plans. We will develop delivery plans with measurable outcomes and metrics, and these will be working documents which will continue to evolve and be reviewed on a regular basis.

Each of these will be central in enabling us to achieve our aims of improving health and access to health and care services for all, reducing health inequalities, making best of public funding and supporting our county's social and economic development.

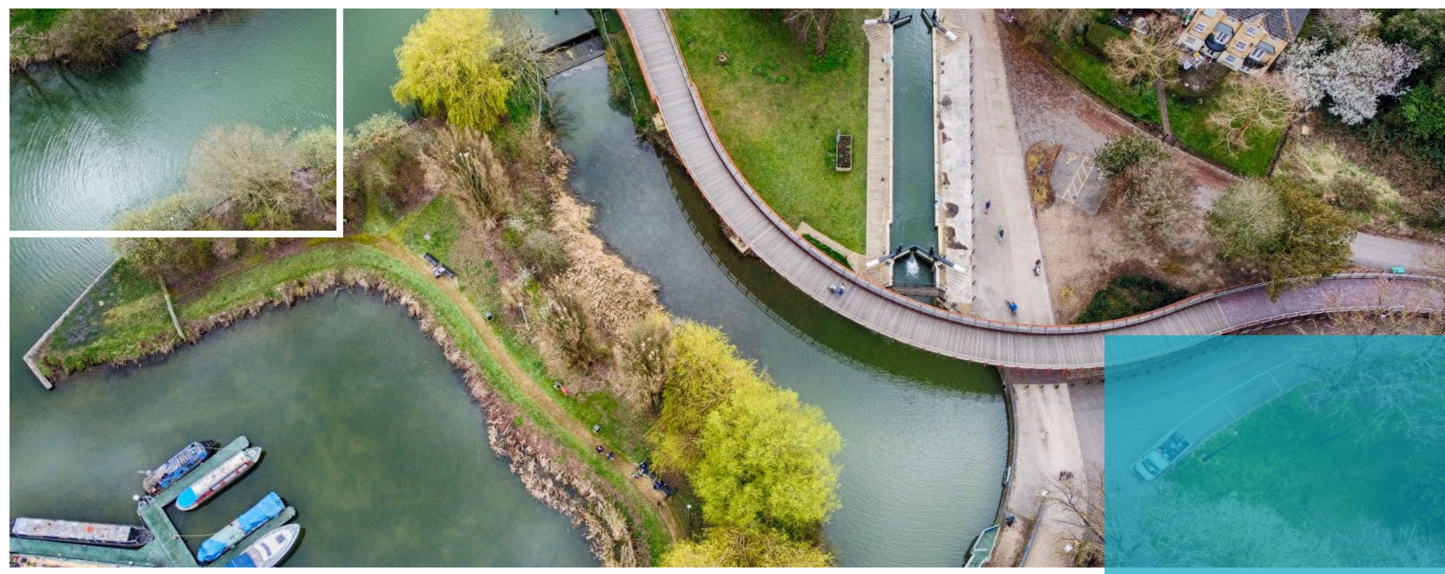
Our delivery partnerships vary in their maturity. We have examples of a range of partnerships from our mental health, learning disability and autism collaborative, through to transformation programmes. We will continue to work towards developing maturing partnerships that include multi-agency partnerships including representatives from voluntary and community groups working together to focus on delivering our core aims, tackling inequalities and improving health outcomes for our local population. We recognise we need to work collectively with our local communities and care organisations to plan and deliver more joined-up care to improve outcomes for their populations.

Bringing together all stakeholders as equals, including those with lived experience and their supporters, to co-produce solutions which meet the holistic needs of our population is the bedrock of our partnership approach. We will build on the success to date when, as exemplified through our Ageing Well approach, solutions are locally owned and enable and empower the person to achieve their goals. We will provide the architecture, support and governance which encourage innovation and creativity; creating new contracting arrangements which give flexibility to our partnerships to achieve the outcomes identified.

You will see in this section we describe our key delivery partnerships like this:

Where are we now? The current situation in the county

Where are we heading? What we are looking to achieve



5.1 Maternity and neonatal services

Where are we now?

Integrated Care Northamptonshire has set out strategic objectives for maternity and neonatal services.

These are for services across Northamptonshire to become safer, more personalised, kinder, professional and more family friendly; where birthing women have access to information to enable them to make decisions about their care; and where they and their babies can access support that is centred on their individual needs and circumstances.

The government's national maternity safety strategy sets out an ambition, by 2025, to halve rates of stillbirths, neonatal and maternal deaths and brain injuries during or soon after birth, and to reduce the rate of preterm births from 8% to 6%. To achieve the 'halve it' ambition, it is important to improve outcomes for those groups most at risk. It is recognised that different populations have different risk and protective factors and therefore different approaches are needed for different populations. In order to improve equity and equality in maternity and neonatal care, it is first imperative that interventions are targeted at groups of women and families within the community who are more likely to experience poorer outcomes.

Northamptonshire Local Maternity and Neonatal System (LMNS) comprises our two unitary councils (North and West Northamptonshire), the ICB, two acute hospital trusts and our community and mental health trust, which commission or provide maternity services to the families of Northamptonshire.

The ambitions and priority areas for maternity services are co-produced by those within the LMNS and will help guide our work and refresh our approach to help achieve equity and equality for all mothers and babies in Northamptonshire.

Where are we heading?

Integrated Care Northamptonshire's year one and two delivery plan for maternity and neonatal services is informed by the NHS England three-year delivery plan for maternity and neonatal services (March 2023). Our plan sets out the following key deliverables across four priority areas, which link with the four high level themes in the NHS England three-year plan.

Priority 1

Provision of responsive, high-quality maternity and neonatal services (NHS England Delivery Plan – Themes 1 and 2)

- Restore maternity and neonatal NHS service inclusivity
- Ensure clinicians have a lower threshold to review, admit and consider multi-disciplinary escalation in women from ethnic minority groups
- Reach out to and reassure pregnant ethnic minority women with tailored communication
- Ensure hospitals discuss vitamins, supplements and nutrition in pregnancy with all women
- Ensure all providers record the ethnicity of every woman as well as their risk factors such as living in a deprived area, co-morbidities, body mass index (BMI) and aged over 35 years to identify those most of risk of poor outcomes – target completion
- All women will be offered personalised care and support plans
- Ensure safe staffing in maternity services
- Develop a strategy to support a succession-planning programme for the maternity workforce
- Ensure all midwives responsible for co-ordinating a labour ward attend a fully funded and nationally recognised labour ward co-ordinator education module
- Locally agree minimum staffing levels with the local maternity and neonatal system (LMNS), which must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training
- Implement and monitor mandatory training in line with the Core Competency Framework. LMNS to validate training at least three times a year

Priority 2

Harness digital technology to make it much easier for health professionals to collect and share data with each other and with their patients (NHS England Delivery Plan – Themes 1 and 2)

- Continue to improve the collection and recording of maternity and neonatal datasets
- Ensure maternity electronic health records enable paper-free records and allow health care professionals to minimise data entry
- Develop a system-wide business case to procure a new maternity clinical IT system –
- Mitigate against digital exclusion
- Use data to identify and inform birthing people and staff when planning care pathways and discussing personalised care and support plans

Priority 3

Accelerate preventative programmes that engage those at greater risk of poor outcomes (NHS England Delivery Plan – Themes 1, 3 and 4)

- Understand the local population's maternity and perinatal health needs
- Ensure women have access to perinatal pelvic health services
- Monitor and review outcomes in relation to the implementation of the Saving Babies Care Bundle v3
- Fully implement the elements of the Saving Babies Lives Care Bundle v3
- Implement maternal mental health services with a focus on ethnicity and deprivation
- Ensure staff and teams continuously measure the quality of their service, learning from any serious incidents and mistakes in order to constantly improve the quality and outcomes being delivered

Priority 4

Ensure maternity and neonatal staff are supported to provide safe care (NHS England Delivery Plan – Theme 3)

- Develop strong working relationships between staff and the Maternity Voices Partnership
- Understand what is required to raise the standards of workplace health, safety and wellbeing
- Develop a plan to promote a safer working environment and promote best practice
- Support cultural competency training across Northamptonshire
- Understand staff experience using Workforce Race Equality Scheme data
- Effectively implement the NHS-wide Patient Safety Incident Response Framework approach to support learning and a compassionate response to families following any incidents

5.2 Children and young people

Where are we now?

A Northamptonshire Children and Young People Risk Summit in January 2023 enabled an open discussion on developing ambitions and mitigating risks.

This helped us identify the following ambitions for children's and young people's services:

- All children and young people access help in a timely manner and partners across our system have sufficient capacity to deliver statutory responsibilities (including equalities duties) effectively
- Our workforce recruitment and retention strategies are effective in creating and sustaining an inclusive and diverse workforce that reflects our communities at all levels.
- We have an outstanding offer of early help and intervention services that meets the diverse needs of children, young people and their families across the system, including the voluntary sector
- Reduced acuity and inequality among children, young people and families presenting with various needs
- Improved outcomes on substance abuse, self-harm and suicide, and a reduction in levels of disproportionality of groups of young people experiencing these issues
- Pathways are aligned, integrated and inclusive, and partners have sufficient capacity to collaborate effectively which is seen as business as usual

Where are we heading?

Our ambitions will be shared system-wide and with our children and young people's engagement groups and forums.

This will tell us if these ambitions are right for our population and will provide a mechanism for children, young people and families to tell us how they may want to work differently, with services to be supported effectively.

It will also help to identify how organisations can work differently to achieve these ambitions.

Children and young people is one of the ICB's multiple-impact intervention areas, which shows the importance of ensuring children and young people receive the right care at the right time, which meets their needs, to support towards positive health outcomes over their life course.

Outputs from the Risk Summit have provided the Children and Young People Transformation Team at Northamptonshire ICB with the opportunity to focus on the risks that lie within our workstreams and to commence planning on how to address them.

Children’s and young people’s mental health

Research shows that one in six children aged between seven and 16 have a probable mental disorder. This rises to one in four for 17- to 19-year-olds. The ICB will focus on working collaboratively across our system in this crucial area of health to deliver improvement and growth and ensure there is a range of high-quality mental health and emotional wellbeing services for our children and young people to access across Northamptonshire when they need it. Particular areas of focus will be:

Promote early intervention and self-management of emotional wellbeing

- Pilot Children and Young People’s Mental Health Practitioners in three Primary Care Networks
- Invest in digital tools and options for mental health support, resources and participation
- Expand Wellbeing Cafés and LGBTQ+ groups, delivered by our VCSE partners, into rural areas
- Support the continued expansion of Mental Health Support Teams (in schools) programme

Ensure our children with the highest needs receive access to specialist services as soon as possible

- Ensure the Child and Adolescent Mental Health Service (CAMHS) crisis team is compliant with the four service elements required to meet the national model
- Expand the capacity of the CAMHS crisis team to enable more integrated care pathways with NHS111
- Facilitate development of a formalised pathway between community and acute hospitals where a child presents at A&E with a mental health issue or an eating disorder
- Reduce CAMHS waiting lists by enabling flexibility of service modelling to ensure skill mix in teams to meet the current and projected future need
- Use non-recurrent funding to pilot new approaches to care and offer alternative options

Ensure eating disorder services for children are best placed to support increases in demand and complexity

- A deep-dive exercise has been undertaken and actions will be agreed and monitored
- Upskill workforce in awareness of eating disorders to promote early identification and management
- Develop a robust early intervention pathway, including universal and VCSE services
- Invest in additional staffing and skill-mix opportunities using allocated 2023/24 funding
- Facilitate development of a formalised pathway between community and acute hospitals where a child presents at A&E with a mental health issue or an eating disorder
- Develop and implement workforce recruitment and retention challenges impacting service capacity
- Review pathway for higher levels of acuity post-COVID requiring more intensive professional intervention
- Maintain constitutional standards for eating disorders

Across all areas of children’s and young people’s mental health and emotional wellbeing, the ICB is committed to ensuring the voice of the child and their health outcomes are kept at the centre of service design, and we will work with our partners to support participation and co-production practices which enable this.

Children’s and young people’s physical health

Our focus will be on working collaboratively across the system to implement and deliver plans to address the following identified priority areas:

Meet statutory requirements for two-to-three-year health checks

- Improve the percentage of children with good levels of development aged two to three years
- Ensure appropriate pathways into specialist services are in place and review these pathways if they are not meeting expectations. We know some services within our specialised services are pressured, for example community paediatrics, ADHD, diagnostic pathways and speech and language therapy services. We will work collaboratively across the system to address these challenges
- More detailed work is required to develop the work programme and priority interventions and we will explore examples of innovative practice to address inequalities and improve school readiness
- Meet statutory requirements for health assessments for children in care including two-to-three-year health checks

Meet statutory requirements for health assessments for children in care

- All children are individually risk-assessed and prioritised accordingly
- Explore opportunities to increase medical resource to provide initial health assessments
- Ensure timely notification from Northamptonshire Children's Trust when a child comes into care
- System Delivery Group in place to oversee improvement in performance
- Regular reporting into ICB Quality Committee and Corporate Parenting Board supporting system approach to ensure improvements are achieved

Meet national requirements for core and specialist palliative and end-of-life care

- Continue to develop specialist services working with East Midlands Children's and Young People's Palliative Care Network (EMCYPPCN) Operational Delivery Network (ODN), including a 24/7 helpline provision, to meet requirements of the national service specification
- Review business case and secure funding to deliver the recommendations of Project Cygnet and improve the core offer across Northamptonshire to meet requirements of the national service specification
- Meet national requirements for core and specialist palliative and end-of-life care

Special educational needs and disabilities (SEND)

Our focus will be on working with system partners to implement and deliver recovery action plans to address the following identified priority areas:

Deliver improvements to waiting times and access to Speech and Language Therapy (SALT)

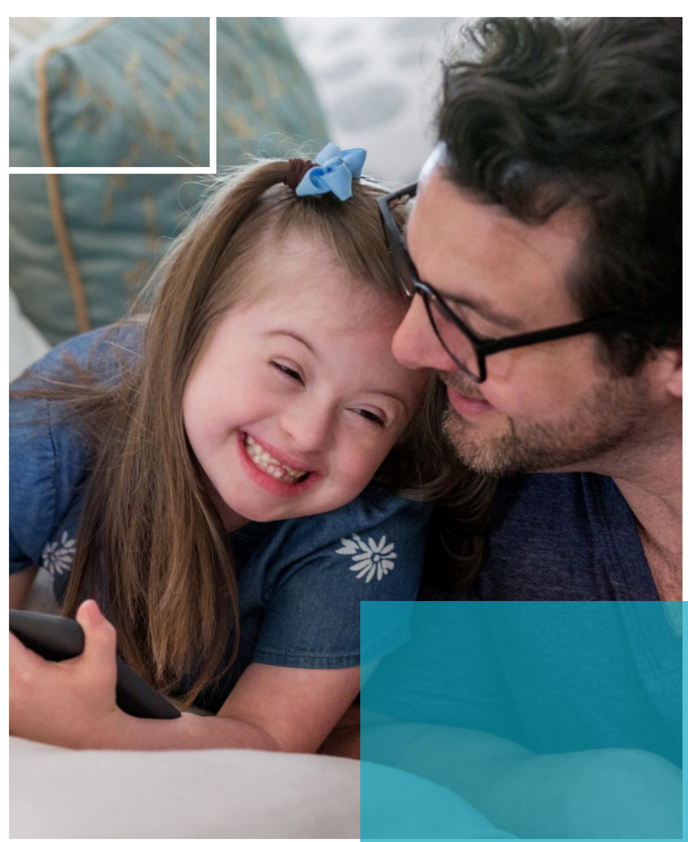
- Recovery action plan in place
- Deliver improvements to waiting times and access (SALT)
- Team reviewing operational practice and workflow
- Additional staff being recruited to target backlog
- Balanced System commissioned to undertake gap analysis of speech, language and communication needs and resource to meet these needs and make recommendations for system transformation work

Develop and embed SEND system joint commissioning arrangements

- Children and young people joint commissioning group set up with partners from education, health and social care – strategy being developed
- Develop and embed SEND system joint commissioning arrangements for children and young people aged 0-25
- A key area for early work will be speech and language therapy provision for Part F of education, health and care plans

Increase the timeliness of health advice requested for Education Health and Care (EHC) needs assessments in line with statutory timescales

- Recovery action plan in place
- Reporting to understand demand and performance at individual service level
- Meetings with service leads to agree arrangements to meet statutory responsibilities in relation to six-week timescale for the provision of health advice for EHC needs assessments when requested by the local authority
- Increase the timeliness of health advice requested for education health and care needs assessments in line with statutory timescales
- Monitoring and oversight will be via the SEND Assurance Group and ICB Quality Committee



5.3 Primary and community care

Where are we now?

We fully support the national vision of integrated primary care to improve access, experience and outcomes for our communities.

This vision is centred around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention

Access

Our patients are telling us that they have difficulty accessing appointments. The national 2023/24 Core Planning Objectives state it is a priority to make it easier for people to contact a GP practice. This includes supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day, according to clinical need.

NHS England published the Delivery Plan for Recovering Access to Primary Care in May 2023. This sets out the arrangements, and support for, improvement / recovery in access in order to deliver 14-day and same-day targets. In Northamptonshire, 84% of patients are seen within 14 days. This is slightly above both the national and regional averages (both around 82%) and provides a strong basis to work from. Similarly, 45% of patients are seen the same day.

Working within networks, our primary care partners have been able to increase staffing numbers by 323 whole-time equivalent over the last four years. This has included roles such as pharmacists, physiotherapists, social prescribers, care coordinators and mental health workers with the intention to enable more people to see the right person, first time.

Our Primary Care Networks (PCNs), supported by Federations and our Super Practice, have been able to deliver same-day access services across a larger population footprint, such as extended access services and winter acute respiratory infection (ARI) hubs

New digital tools have provided patients with the choice of having a virtual consultation and have improved the way in which staff are able to communicate with patients.

Proactive and personalised care

General practice colleagues are telling us that they are struggling with an increased and more complex workload, which is being further compounded by GP recruitment and retention challenges. Developing a sustainable, supported and vibrant primary and community care sector is a key priority for Northamptonshire. We have invested into local capacity to provide extended patient reviews, undertaken by multi-disciplinary teams including GP, pharmacy, nursing, adult social care and VCSE sector staff.

People identified at risk of escalation, including those in care homes, are set up with technology overseen by our new nurse-led remote monitoring hub – increasing patient and family confidence and enabling changes in presentation and trends to be identified and reviewed by hub staff working in partnership with PCN multi-disciplinary teams.

We have expanded the number of peer support groups for a range of long-term conditions, including heart failure, diabetes and dementia, building on the success of our chronic obstructive pulmonary disease (COPD) solution (Breathing Space). These all act as the first step towards the priorities set out in the Fuller Report and are intended to create a strong foundation for general practice to support the wider integration of primary care.

Staying well for longer

Advice, education and guidance on living with and managing long-term conditions, falls prevention, keeping active and maximising wellbeing is a core provision of our integrated primary care delivery. Our Supporting Independence programme and SPRING social prescribing project have provided capacity for people with emerging needs. We have introduced specific classes targeted for strength and balance and designed to support people with moderate frailty to maintain function and confidence.

Where are we heading?

The new approaches implemented in Northamptonshire have been achieved through co-production with all stakeholders and have created a platform from which further integration of services can be achieved.

Local design and ownership are essential for future success. We will align our PCNs to the Local Area Partnerships, established through our Health and Wellbeing Boards, and continue to work with our Patient Participation, Advisory and Representative Groups to set the clear vision of what good will feel like for our population. Utilising the learning from our transformation to date, we will continue to test and innovate new ways of working. The energy of primary care as driver for change will be critical to this.

The Northamptonshire Primary Care Alliance (NPCA) is developing a strategy – to be published in autumn 2023 – describing the part that general practice can play in supporting the delivery of ICN visions and priorities and a move towards a more collaborative approach. Informed by stakeholders familiar with today's issues in general practice, it will incorporate national primary care policy such as the Fuller Report, relevant strategic direction from ICN and give a clear vision for general practice in the future.

As an ICB we will support PCNs through the delivery of their Capacity and Access Plans (CAP) to set out how they will deliver against the recovery plan to empower patients and to modernise general practice access, improving the experience for patients. This will include identifying opportunities to develop new community pathways, reduce secondary care bureaucracy and maximise digitisation opportunities.

We will focus on integrating all pillars of primary care to include the recently delegated community pharmacy, dental and ophthalmology services. We will work collaboratively with the East Midlands ICBs while driving locally led improvements. Key specific areas of focus will be the new Pharmacy First services, oral contraception and blood pressure services. We will also continue to drive the GP Community Pharmacist Consultation Service (GP-CPCS), which links general practice to community pharmacy. We want to improve uptake of this to transfer lower-acuity care away from both general practice and NHS 111.

Further improvement will need to be driven through PCN working, for example, using the Enhanced Access service. There is a mixture of models throughout the county providing the additional 2,600 hours of GP appointments above core hours per month. The ICB needs to develop this further by encouraging development of the models over time into an approach that supports an ICB model for urgent care and same-day access continuing to support the urgent and emergency care recovery plan.

Several acute respiratory infection (ARI) hubs have been operating over winter 2022/23. The ICB will continue to review these models in 2023/24 to assess their effectiveness and suitability as part of a wider urgent and emergency care and winter plan and further areas for development such as remote monitoring.

We will continue to drive PCN recruitment through the Additional Roles Reimbursement Scheme (ARRS), supporting the national target of 26,000 new recruits through the scheme by the end of March 2024.

Keeping a focus on continued development of the PCNs through the Enhancing Opportunities Programme (EOP) is a priority for the next 18 months. This aims to facilitate the alignment of PCN and ICB ambitions and work collaboratively to direct ICB resources as efficiently as possible. The EOP will support the development of PCNs and enable practices to seek out opportunities to innovate and find solutions and improvements to everyday challenges. The programme should also empower PCNs and practices so they can describe what they need and be successful when bidding for funding. This will be driven by the clinical strategy linked with wider community needs to seek premises to provide collective solutions for health and the community.

Working in Place-based models, clinical leadership will work closely with local authority leads in both North and West Northamptonshire and with other partners such as police, education, and the VCSE sector to develop community solutions (including health) targeted at the needs of the population.

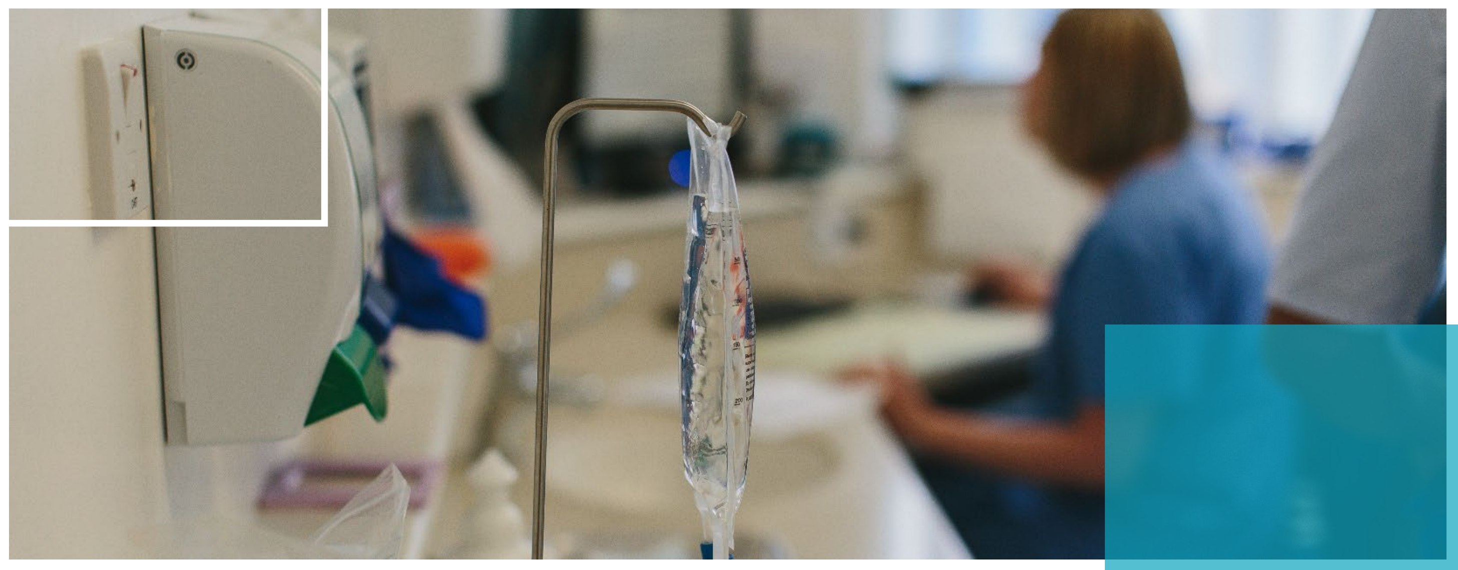
We will continue the development of the Assurance Framework (Medical Services) to drive improvement and address inequalities and necessary improvements to access across general practice. Further development will be required to incorporate pharmacy, optometry and dental functions (in line with ICB host).

There will also need to be further consideration at the conclusion of the 2023/24 contract negotiations (for 24/25 contract changes) which will further support general practice in delivering the visions of the Fuller Report.

Summary

In summary, we will focus on:

- Finalising and implementing the assurance framework to improve quality
- Implementing actions within the Recovery Plan
- Primary Care Networks completing clinical strategies
- Continuing delivery of the Enhancing Opportunities Programme
- Developing and agreeing PCN Capacity and Access Plans
- Assessing progress against PCN Capacity and Access Plans
- Publishing ICB Access Recovery Plan for Primary Care (presented to Public Board in October or November 2023)
- Completing Primary Care Clinical Strategy



5.4 Elective care

Where are we now?

The vision for elective care is to improve health outcomes, address inequalities and improve quality of life through all partners working together in a patient-centred approach, across the whole elective pathway.

We will deliver this by transforming delivery of services to enable patients to be supported to keep well, and, where required, to ensure equitable access to timely treatment for patients across the county. Integrated care is about:

- Giving people the support they need, joined up across the NHS, local councils, voluntary and community organisations, and other partners
- Removing any barriers or gaps between different parts of health and care – for example, between hospitals and GP practices, between physical and mental health, and between the NHS and council services

Our elective care programme includes cancer care and the restoration of services that meet NHS Constitution standards. The Northamptonshire system starts in a comparatively better place than other systems by having no patients waiting longer than 78 weeks for treatment as of 31 March 2023, except where the patient has chosen to wait longer.

Elective care in Northamptonshire has for some time had very positive operational performance on waiting times when compared with other ICS footprints regionally and nationally. For example:

- We have the lowest number of long elective care waiters in the Midlands region
- We are one of the strongest performing systems in the Midlands for faster diagnosis cancer and other cancer targets (for example, 62-day treatment target)
- We have the joint-best performance in the Midlands for advice and guidance improvement, supporting system working between primary and acute care
- Utilisation per room for diagnostics is generally higher than average for the Midlands region, and work is progressing to improve MRI utilisation at both acute hospital sites and endoscopy utilisation
- We have adopted many of the opportunities set out within the Med Tech Funding Mandate programme

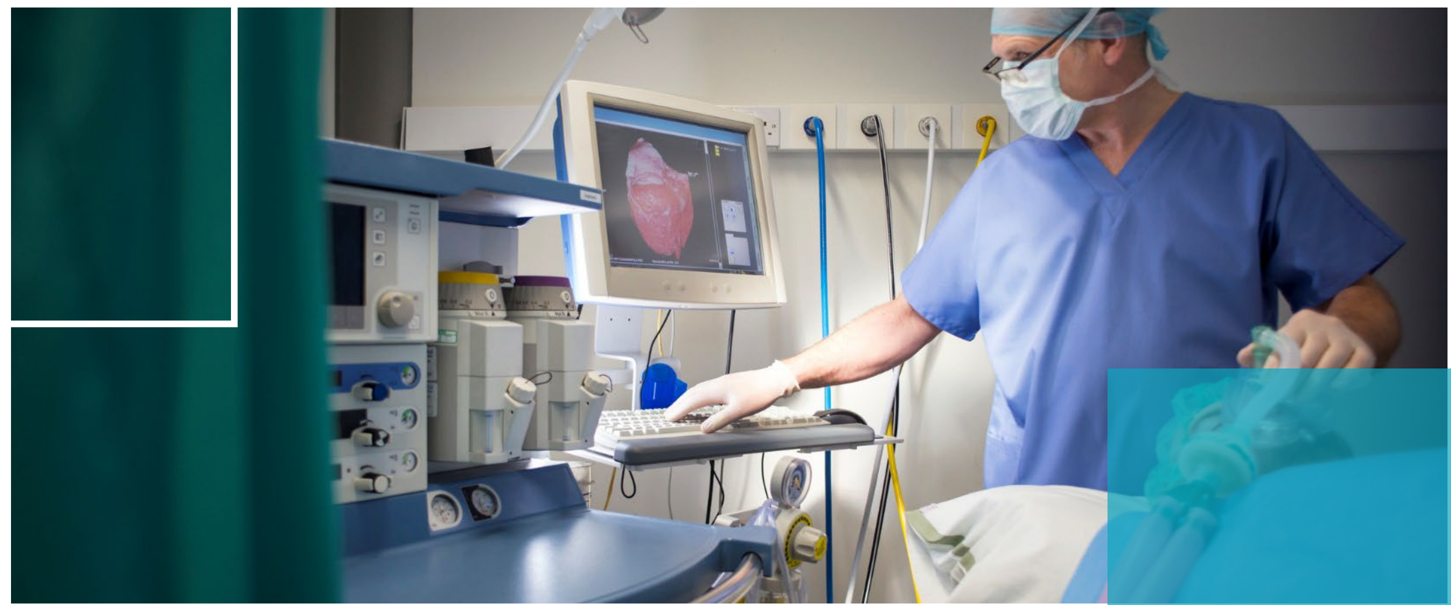
Where are we heading?

Plans already in place will mean that the system has plans to deliver a maximum wait of 65 weeks by March 2024. The major strategies to deliver this vision, and deliver a maximum wait of 52 weeks by March 2025 and ultimately the delivery of constitution standards by March 2026, include:

- Transforming care pathways, increasing efficiency by minimising steps in each pathway for each patient, for example, through the development of one-stop services to reduce the number of follow-up outpatient appointments by 25%
- Maximising productivity by setting out system pathways with:
    - Single points of referral to make referral from GPs easier and get the right patient to the right service and clinician
    - Single waiting lists, maximising patient choice, while fully utilising available capacity
    - Community Diagnostics Centres (diagnostic hubs) so that patient diagnosis is quicker, particularly with cancer care, and supports GPs to manage their patients
    - Community-based outpatient sites (outpatient hubs) bringing care closer to home
    - Surgical centres for high volume, low complexity (HVLC) work (surgical hubs) delivering safe and efficient care
    - Seamless interfaces with primary care, community functions and local authority services so that the patient experience is augmented
- Supporting active patient self-management, allowing the patient to feel in control
- Maintaining productive partnerships between NHS and independent sector organisations to promote patient choice and deliver shorter waiting times through increased capacity
- Restoring services inclusively and addressing health inequalities including by:
    - Managing and preventing digital exclusion (for example, use of virtual appointments)
    - Targeting preventative programmes at those with the biggest risk of poor health outcomes
- Focusing on workforce recruitment, retention and development so that staffing can meet patient need
- Stopping work that adds little or no value, building on the Evidence-Based Interventions Programme opportunities
- Promoting technologies that improve care and value for money, building on the Med Tech Funding Mandate programme

We will continue to develop our elective care collaborative, which comprises a wide range of system partners, including NHS acute hospitals, primary care, community and mental health provider, independent sector providers of care in the county, the VCSE sector, patient representatives and the ICB.

We will continue to work together to deliver our agreed transformational objectives, our operational and quality performance standards, excellent outcomes, efficient delivery, and to plan the services our local population will need in the future.



5.5 Cancer care

Where are we now?

The county's cancer programmes include a network of professionals based in provider organisations working with a cancer lead and GP clinical lead (GP role) based at the ICB and giving oversight.

Cancer has been a system priority during COVID-19 recovery. While it is recognised that we need to continue to improve, the prioritisation of cancer care across Northamptonshire post-pandemic is clearly reflected in its performance data when compared to the England average, outperforming both national and regional percentage achievement in cancer constitutional measures and regional colleagues expressing positive feedback on delivery. It has been agreed that cancer will remain a priority in planning for the next five years.

Where are we heading?

The Northamptonshire Cancer Board has agreed to align with the East Midlands Cancer Board and NHS England by focusing on:

- Clearing the 62-day+ backlog (the 62-day target requires all cancer patients to have both a confirmed diagnosis and commenced treatment within 62 days of starting the pathway. Since COVID this has only been achieved on monthly data review)
- Maintaining the 28-day Faster Diagnosis Standard (FDS) (all cancer diagnosed within 28 days of referral)
- Working towards the early diagnosis target of 75% of cancers being diagnosed in stage 1 or 2 by 2028
- Reducing inequalities
- Increasing personalised care

To achieve these aims a number of projects are in progress to:

- Improve referrals, supporting the FDS and releasing capacity at the start of the pathway, consequently allowing more time for diagnostics and planning before 62 days is reached
- Improve diagnostics
- Increase screening
- Targeting vulnerable groups
- Increased personalised planning

Schemes that will be running during 2023/24, and that will build over the next five years are:

- Breast mastalgia pathway
- Increased uptake of cervical screening project
- Upskilling programme for skin cancer referrals
- Bowel cancer screening – to include a cancer screening information tool for patients and the increased rollout of a screening test sent to patients, Faecal Immunochemical Test (FIT)
- GP decision support tool
- NHS Targeted Lung Health Checks Programme (TLHC) – a screening programme which aims to help diagnose lung cancer at an earlier stage when treatment is likely to be more successful. Expansion from the Corby pilot to all of Northamptonshire from 2024
- GP Direct Access – iRefer Currently, 21% of patients with cancer receive their diagnosis via a routine referral. Expanding the availability of direct access to tests means it will be possible to diagnose more cancers at an earlier stage, decrease pressure on acute hospitals and give more patients a better chance of survival
- Implement and maintain priority pathway changes for lower gastrointestinal, skin and prostate cancer
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity is prioritised for urgent suspected cancer
- NHS Galleri Trial – a research trial to see how well the Galleri blood test detects signs of many different types of cancer. Northamptonshire is a pilot site for this with testing set up in both Northampton and Wellingborough and is expecting to expand during 2023/24

5.6 Urgent and emergency care

Where are we now?

Our aim for urgent and emergency care in Northamptonshire is for patients to have access to the most appropriate urgent and emergency care in a timely way.

Linked to our wider four ICS aims, our six aims to achieve this vision are:

1. Co-ordination, planning and support for populations at greater risk of needing urgent and emergency care
2. Signposting people with urgent care needs to the right place, first time
3. Providing clinically safe alternatives to admission to hospital
4. Ensuring rapid response in a physical or mental health crisis
5. Optimal hospital care and discharge practice from the point of admission
6. Home-first approach and reducing the risk of readmission

The development and implementation of an integrated urgent care model is a key priority for Northamptonshire and will sit alongside a planned care and primary care model which aims to reduce the reliance upon and need for urgent care services.

Patients with complex needs should be supported by proactive services that enable early escalation in their care alongside an appropriate system response. Developments in remote monitoring, care planning and caseload management support this approach and can help reduce the reliance on urgent care services. To illustrate this need, in the 12-month period between December 2021 and November 2022, 510 patients with 12 or more Accident and Emergency or Urgent Care Centre (UCC) attendances utilised over 9,500 A&E/UCC attendances between them. Around 6,200 of these attendances did not require an admission.

Significant progress has been made to develop some of the foundations needed for an integrated urgent care model such as:

- Utilising NHS 111 as a first point of contact
- Appropriate referral to the community pharmacy consultation service for low acuity conditions through the existing referral routes of 111, general practice and urgent care
- A single point of access to urgent community services (i.e., rapid response, remote monitoring, virtual wards and a community based integrated care team)
- Implementation of a system control centre to monitor urgent care performance, bed capacity and system response
- Scaled-up primary care services through the delivery of extended access and respiratory hubs
- Crisis cafes and mental health professionals supporting East Midlands Ambulance Service (EMAS)
- Development of integrated services for patients being discharged but who need additional support to regain their independence
- A community-based urgent care centre and acute based minor injury / minor illness services
- Same Day Emergency Care (SDEC) and frailty services in our hospitals

Where are we heading?

There is a need to expand on these developments to bring them together into a single coordinated model that delivers the national and local vision for patients to have access to the right care in the right place in a timely way.

To achieve this, we will design a model that:

- Supports and enables general practice to manage its workload and to focus on supporting patients with complex health needs
- Enhances our Single Point of Access to truly integrate services across the county
- Is simple for patients to use and facilitates a timely and effective response to their presenting needs (without the need for multiple hand-offs between organisations and services)
- Co-ordinates and brings together our collective resources to create an affordable and sustainable service that can flex to respond to surges in demand
- Protects our emergency services so that they can respond quickly and reduce harm
- Supports timely rehabilitation or long-term care placement as alternatives to an acute admission or following an acute episode of care as close to home as possible
- Facilitates rapid discharge to the patient's place of residence or into intermediate care services

The model will be supported by effective digital solutions that enable a real-time system view of current system capacity and the ability to book or transfer care directly and immediately.

An Urgent and Emergency Care Strategic Transformation Group (UECSTG) has been established with representation from all system partners. Key responsibilities of this group include (but are not limited to):

- Leading the strategic development of an integrated urgent and emergency care system in Northamptonshire
- Ensuring best practice is adopted across Northamptonshire
- Overseeing the system response to the national recovery plan, designing a sustainable transformation and improvement work programme for implementation at Place level
- Monitoring the development and delivery of the transformation and improvement programmes, ensuring that these are in line with and driven by the vision and values of the ICS and support the delivery of national and local urgent and emergency care standards

An Urgent and Emergency Care Delivery Board will be the focal point for delivering the transformation, supported by a North and West Place Operational Delivery Group who will provide assurance against the delivery of plan.

Summary

In summary we will:

- Enhance our existing Ageing Well programme and align it with a redesigned Single Point of Access for all emergency care services (admission avoidance) to care for all ages
- Redesign Hospital at Home services and Pathway 1 (discharge to intermediate care and reablement services at home) beds
- Redesign Pathway 2 (discharge to residential care in the independent and community sector) beds to meet the needs of the service across the system
- Develop and deliver an Integrated Brokerage service working with partners to meet the needs of the population
- Implement system-wide dashboards
- Redesign dementia and delirium pathways and align to the Pathway 2 work

In addition to the above, we will deliver an urgent and emergency care strategy for Northamptonshire, co-designed with patients, that will set the vision and deliverables for 2024-28.

5.7 Mental health, learning disability and autism

Where are we now?

The national agenda for mental health, learning disability and autism (MHLDA) services is one of expansion, quality improvement, and parity of esteem with physical health services.

This national agenda has driven Northamptonshire's strategy since 2019, via the NHS Long Term Plan. This provides 19 ambitions for learning disabilities and autism, and a further 38 ambitions for mental health. The ambitions refer to end-to-end pathways of support (from early intervention to acute and crisis care) as well expanding access to services, driving quality improvements, addressing health inequalities and creating digital innovations. A significant aspect of the national agenda is in the integration of care pathways across our system, bridging historical gaps between:

- Universal services and specialist care services
- Physical health services and mental health services
- Health services and social care services

2023-24 will be the final year of the initial transformation phase, and the next phase of the NHS Long Term Plan for MHLDA is due to be published in 2023.

In April 2021, Northamptonshire launched the MHLDA Collaborative Programme, which constitutes a new way of bringing strategic partners, service leads, wider stakeholders and people with lived experience together to plan and deliver pathways of care in partnership. On 30 June 2022, we implemented an innovative new 'Outcome-Based Collaborative Contract', which brings multiple services under a single contractual framework with a lead provider model and an outcome-based framework for measurement.

Evaluating ourselves against the NHS Long Term Plan, and benchmarking with other systems, Northamptonshire has made variable progress. We perform well in providing high-quality specialist perinatal mental health services and have met targets to ensure access to evidence-based support for children and young people. Our NHS Talking Therapies demonstrate good referral to treatment wait times and recovery rates. Our transformation model for community care for people with severe mental illnesses was shared nationally as an example of best practice, and our mental health crisis pathway was an exemplar and pathfinder – particularly for providing alternatives to using emergency departments for those who require mental health crisis support.

Our Early Intervention for Psychosis service has achieved Level 3 NICE Concordance, and since 2019 we have implemented a range of new services, including enhanced support for transitions to adulthood, suicide bereavement support, a complex trauma service, a 24/7 phoneline for mental health support and navigation, and a mental health crisis response unit (also known as a mental health ambulance). We have made good reductions in the number of people with learning disabilities and/or autism in non-secure inpatient beds, as well as delivering annual physical health checks for people with learning disabilities.

Areas where we have made less progress are in delivering annual physical health checks for people with severe mental health illnesses. Also, while our dementia diagnosis rate was high, this fell sharply during the lockdown phases of the pandemic. We need to increase the number of people with mental health issues that require support to obtain and maintain employment. Furthermore, we are recognising high levels of acuity and need for mental health inpatient treatment, and this is driving up the need to use out-of-area hospital placements for our patients, as well as increasing length of stay in our local inpatient units. There is important work to do in reducing the number of people with learning disabilities and/or autism in secure inpatient settings, as well as reducing the wait times for autism diagnostic assessments for both children and adults.

Where are we heading?

The next phase of work for the MHLDA Collaborative will be in the following areas:

- We will continue to drive integration of mental and physical healthcare – embedding our Enhanced Primary Care Scheme to ensure physical health checks for people with severe mental illnesses, as well as ensure pathways of aftercare when physical health issues are identified. This falls within a wider workstream of population health and preventative work to focus on determinants of ill-health (including a focus on housing, employment, smoking cessation, deprivation, isolation and integration between health and social care)
- We will continue to embed our transformed model of community mental healthcare, focusing on neighbourhood models, ease of access, choice of therapies and interventions, and ensuring no gaps between primary and secondary care services
- We will drive up access to NHS Talking Therapies, embedding this in a wider programme of early intervention alongside primary care, social prescribing, and wider community support (physical activity, diet, sleep hygiene and access to green spaces)
- We will embed high-quality community and crisis care to prevent avoidable admissions to mental health inpatient settings, but we will also work more closely with social care colleagues to ensure rapid pathways of care for people who are ready for discharge (thus reducing length of stay and the need for out-of-area placement)
- We will work more closely with the NHS Provider-Led Collaborative for secure inpatient care, to ensure people with learning disabilities and/or autism have access to timely treatment and clear discharge pathways into robust community care packages
- We will continue to enhance and develop the MHLDA Equalities Strategy, building on our work to date to identify and understand why people might feel unable to engage with MHLDA services, and address these barriers
- We will create new opportunities within MHLDA services for people to obtain and maintain employment if this is their aspiration, or partake in volunteering for their wellbeing
- We will deliver against our Dementia Strategy, with an increased focus on awareness and lifestyle change to prevent causes of dementia, as well as rapid diagnosis, person-centred aftercare and robust crisis support for people with dementia and their carers
- Across many elements of our pathway, we will continue to develop and implement community hub models of care, bringing professionals from across pathways together to ensure clear access to support that is holistic and delivers the outcomes that our service users want

5.8 Palliative and end-of-life care

Where are we now?

The palliative and end-of-life care programme vision is to ensure individuals, their families and carers receive high-quality and compassionate palliative and end-of-life-care support (including bereavement) that is person-centred and coordinated. This includes patients who are approaching the end of life (when they are likely to die within the next 12 months) and those whose death is imminent (expected within a few hours or days). It covers those with:

- Advanced, progressive, incurable conditions
- General frailty and co-existing conditions that mean they are expected to die within 12 months
- Existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- Life-threatening acute conditions caused by sudden catastrophic events

The intention is that all individuals who need care in the last year of life can access palliative and end-of-life care in a time frame appropriate to the urgency of their current need and, where possible, in their preferred place of care. We will achieve this by system partners working together to ensure that the wishes and choices of individuals – irrespective of care provider, diagnosis, circumstance or place of residence in Northamptonshire – are met where possible.

'Ambitions for Palliative and End of Life Care: A national framework for local action 2021-2026' was developed by a partnership of national organisations across the statutory and VCSE sectors. It sets out NHS England's vision to improve end-of-life care through partnership and collaborative action between organisations at local levels throughout England. The ambitions include:

- Ensuring each person accessing palliative and end-of-life care is seen as an individual
- Ensuring each person gets fair access to care across Northamptonshire
- Maximising comfort and wellbeing to patients, families and carers
- Co-ordinating care across Northamptonshire
- Ensuring all healthcare professionals in Northamptonshire are prepared to care
- Ensuring each community in Northamptonshire is prepared to help

The NHS Long Term Plan (2019) committed to making palliative and end-of-life care more personalised and more accessible to everyone by addressing health inequalities and ensuring that everyone's wishes are discussed, and their needs met. More people should be able to die in the place of their choosing.

The Health and Care Act 2022 has incorporated a clear mandate for local health and care authorities to develop a bespoke service to address the issue of end-of-life services and clearly establish them as core services within the integrated care remit.

We commission a range of palliative and end-of-life services across the county, providing different levels of support to patients. There is a wide range of providers within health, social care and the VCSE sector that supports this element of work.

Where are we heading?

To achieve our vision for palliative and end-of-life care in Northamptonshire, we will:

- Raise awareness of and enable conversations around death and dying with the public and professionals both in health and in social care
- Support the identification of patients who are palliative or at the end of life and offer care which is coordinated
- Enable patients within Northamptonshire, and those who care for them, to identify their preferences and wishes towards the end of their life and for those wishes to be met regardless of disease condition or place of care
- Promote and enable equitable access to care guided by national guidance and best practice
- Ensure patients in Northamptonshire with palliative and end-of-life care needs, and the people who care for them, are supported by a competent, confident and capable workforce
- Not over-medicalise death
- Commission and provide high-quality, cost-effective integrated pathways for palliative and end-of-life care across Northamptonshire
- Ensure there is equity and consistency across Northamptonshire for palliative care provision – for example, equity in 24/7 professional advice line, carers' advice line, Hospice at Home, social care services, dedicated enhanced palliative care beds and psychological and bereavement services
- Be responsive to changing circumstances and provide person-centred care and support tailored to individual needs and wishes

Summary

In summary we will:

- Implement the recommended Summary Plan for Emergency Care and Treatment (ReSPECT)
- Launch ReSPECT across the system
- Scope and develop mapping Electronic Palliative Care Co-ordination System options (reliant on Northamptonshire Care Record being launched)
- Develop an implementation plan for Palliative and End-of-Life Care Strategy
- Undertake a scoping exercise for a 24/7 Palliative and End-of-Life Care Hub

We are committed to delivering the operational planning requirements and system partners have agreed operational plans for 2023/24. We are developing plans for future years which will be outlined the next iteration of our five-year plan.

6. Our enabling programmes

6. Our enabling programmes

To create the right conditions for the delivery of our key programmes of activity, we have identified the following enabling programmes of work. Each of these has its own distinct plans of delivery which will contribute to and enable delivery of each of our priorities.

It is these enabling programmes which put us in the best possible position to deliver our aims of improving health and health outcomes, tackling health inequalities, enhancing productivity and value for money, and supporting broader social and economic development.

As with the previous section of this document, you will see that we describe our enabling programme like this:

Where are we now? The current situation in the county

Where are we heading? What we are looking to achieve

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6.1 Our people

Where are we now?

The ICB has worked with partner organisations to deliver the NHS People Promise through delivery of the 2023 People Plan.

This provides a targeted approach to delivery of projects that directly mitigate key risks within the workforce, recruitment and supply and health and wellbeing.

Some of our key successes include:

- Accessible and meaningful wellbeing conversations are embedded within appraisal process and regular communications take place to encourage wellbeing conversations
- Introduction of a cost of living group exploring innovative ways to support staff with cost of living
- Spiritual wellbeing embedded in policies and spiritual team resource increased
- Delivery of system-wide Virtual Wellbeing Festival for 2022, with commitment in place for 2023 Festival
- Creating opportunities for people to feel connected through weekly Leadership Matters sessions and Staff Networks Wellbeing drop-in sessions
- Using our network of mental health first aiders to encompass the role of wellbeing champions, and the introduction of caring for doctors wellbeing group to look at initiatives for our medical and dental workforce
- Attraction and retention plans include the introduction and promotion of stay conversations, further development of employer brand, introduction of quarterly recruitment forums with staff side, review and increase of the use of recruitment incentives, stronger social media presence to further attract staff, introduction of Temporary Injury Allowance for Bank staff, Volunteer to Career pathway developed
- Flexible working policy revised ensuring staff access from day one of employment, new annualised hours contract implemented, and shift pattern review undertaken with proposals for new working patterns across clinical areas
- Work has begun on a collaborative bank across the acute group, and will continue to develop across 2023
- Launch of specific leadership development programmes for primary care and staff from ethnic minorities, ensuring we are focusing development for specific staff groups
- Focused healthcare support worker recruitment events promoting careers in health and social care through our Best of Both Worlds campaign
- Supporting placement capacity for student nurses and improving quality of placements
- Workforce sustainability and planning across social care to upskill the care market in people processes and planning

Where are we heading?

Recruitment and supply of appropriately skilled staff, sickness absence, and health and wellbeing of ICS staff remain key risks across the system.

This has considerable influence on our ability to:

- Deliver the recovery programme
- Fulfil our statutory duties by delivering the Long-Term Plan
- Maintain financial balance

The ICS People Board has oversight of the prioritisation and progress of the people programmes with clear understanding of how each programme ensures impact against attraction, retention, inclusion and productivity.

The System Workforce Improvement Model (SWIM) details the interventions planned for 2023 and beyond to mitigate against risk. The HR Executive, as a sub-committee of the People Board ensures that plans remain aligned current and emerging system issues and priorities.

Recruitment and supply

We constantly review our workforce profile to ensure it is as effective as it can be. We have a continued focus on learning and development, ensuring that all mandatory training is in place and leadership development that encourages staff to perform at the highest level.

We are strengthening our research and innovation offer to support and encourage recruitment and retention. We are working to ensure that agency use is minimised, we have innovative approaches to recruitment and continually focus to increase substantive staffing.

Minimise unavailability

To ensure we minimise unavailability there are extensive occupational health, counselling and restorative mental health support services in place. Similarly, we focus on developing healthy teams so staff are able to support each other, again ensuring they can continue to effectively deliver services.

We maintain strong flexible back-to-work support that is responsive to staff need as well as changing service needs. A task and finish group has been created to focus on flexible working, part of which will include a trial of self-rostering across system organisations.

Health and wellbeing

As part of our continued alignment with the national NHS People Plan for 2020/21, our ambition for 2023 continues under the People Plan's four pillars, taking into consideration the local landscape and provider priorities to develop key themes of action, which we are prioritising for 2023.

These include:

- With increased cost of living and financial wellbeing pressures growing significantly across our workforce, our focus will build on existing focus around financial wellbeing, and the support offer for our staff
- Enhancing our support for staff working through menopause, provide a framework through policy to ensure staff have access to the support they need
- Education around neurodiversity and understanding of how best to support staff working with neurodiverse conditions
- Enhancing our approach to compassionate and inclusive leadership through ongoing commitment and leadership investment across all organisations and together across health and social care
- Build 'A Good Day at Work' bringing together first 90 days and induction into ongoing support for leading teams remotely, reducing isolation in remote working and probation into this theme
- Future induction arrangements, ensuring that new staff have the best start to employment ensuring our values and behaviours are embedded from day one
- Proactive interview support provision for staff seeking promotion and support for external candidates, encouraging staff into health careers

Jointly, these priority areas will enable us to offer innovative, bold solutions that enable us to attract and retain the very best people to work for us.

6.2 Research and innovation

Where are we now?

We are strengthening our research and innovation within the system.

We are part of the East Midlands Evidence Based Repository, providing us with a platform to showcase our research.

Our Research and Innovation Group, which has representatives from primary care, mental health, acute hospitals, the University of Northampton and local authorities, will lead on the delivery of our Research and Innovation Strategy.

We have a number of research grants collaborating across the ICB we will focus on our under-served communities by involving diverse stakeholders including patients and the public as appropriate.

Where are we heading?

Our priorities are to:

- Build the capacity and capability of our workforce to become a 'research active' system, with research leaders in place for each of our priorities and where health and care staff can feel empowered to support and participate in clinical and applied research as part of their jobs
- Ensure our clinical and applied research meets our local population needs to reduce health inequalities
- Increase the diversity of our population involved in research

We have identified the following themes to support our priorities:

- A sustainable and supported workforce which has the capacity and capability to undertake the research to meet our population needs
- Streamlined and efficient research infrastructure to expand research knowledge
- Promote local adoption and spread of new pathways and technologies to reduce health inequalities. Support our workforce to become clinical entrepreneurs
- Involve our population in research and innovation to ensure we meet their needs
- Priorities for research and innovation are set by working with our system leaders to support increased targeting of funding and ensuring our research and innovation activities meet the needs of our local population

6.3 Digital and data

Where are we now?

The health and care system in Northamptonshire is undergoing a fundamental transformation in how we serve our population.

Digital and data technology and tools offer a solution to support new models of care and help address some of the challenges we face across our system.

Currently many of our systems are paper based, our electronic systems don't talk to each other very well and our staff don't have the right digital tools or access to data to support them to deliver the best care.

Time and time again people tell us they want to tell their story to us just once, regardless of where they receive their care. Supporting this through digital innovation, data sharing and best practice will remain a clear priority for us.

Where are we heading?

We will prioritise the following through our strategy delivery:

- **Integrated health and care services**
  We will continue to join up health and care services through integrated digital systems, improved information flow and collaborative working
- **Empowerment and access to services**
  We will provide more electronic access to health and care services that are personalised, accessible and support the proactive management of well-being
- **Data analytics and intelligence**
  Leveraging the power of information, data and analytics to redesign innovative health and care pathways, track outcomes, and support data-driven decision-making
- **Digital and data culture and leadership**
  We are cultivating a culture that champions digital change, drives collective ownership over digital delivery, and promotes a digital-first mindset
- **Digital and data workforce and expertise**
  We will expand on our core capabilities to embed digital and data expertise, defining clear paths to formal accreditation and integrating specialist functions
- **Sustainable and resilient ecosystem**
  We are investing in digital tools that are secure and sustainable, delivering health and care services that manage risk and minimise environmental impact

Population health management

While our digital developments, including the Northamptonshire Analytic Reporting Platform and Northamptonshire Care Record, provide the tools to transform care and outcomes for the people of Northamptonshire, population health management is the approach which applies these insights through targeted interventions at individual, group and population level.

6.4 Communications and engagement

Where are we now?

It is important to recognise that as our population ages and changes, we need to listen and change together.

It is relevant to other health and care organisations, including local government, to ensure that we work collaboratively to involve people and communities, in ways that are meaningful, trusted and lead to improvement.

Communications

In its first year of establishment, we have developed and delivered an updated communications approach including a new suite of channels for ICB and ICP. This includes a new public website and an updated, co-produced visual style. Our communications are shared across organisations and through our community channels.

Engagement

In preparation for the launch of our ICB in July 2022 and in line with proposed legislative changes to the Health and Care Act, through March to June 2022 we worked together to co-produce our Community Engagement Framework: a strategic approach for working together with people and communities.

The objective of our Community Engagement Framework is to enable ICN partners to work more effectively together, as it provides a clear expectation for working with people and communities in the design, delivery and improvement of health and care systems.

This framework also supports ICN (monitored via the ICB) to meet its obligations as set out in the NHS Working in Partnership with People and Communities statutory guidance.

Where are we heading?

Communications

Stakeholders

The ICB will be proactive in understanding the communications needs and requirements of its variety of audiences and stakeholders. Stakeholder mapping will be frequently reviewed to ensure external and internal audiences are effectively communicated and engaged with on the matters most important to them.

Channels

The ICB has a suite of communications it can utilise to communicate to target audiences and stakeholders. These range from 'owned' social media, digital and internal channels, through to managing 'earned' channels such as the news media and partner organisation publications and channels.

Work will take place to consistently review and refresh these channels to ensure they continue to cut through and reach the target audiences and communicate with people in the way that most suits their lives and needs.

Partner communications

The communications function of the ICB is developing a thriving and dynamic communications eco-system for the health and care system in the county. This involves seamless working among partner organisations to amplify communications messages and priorities and supporting organisations on proactive communications campaigns and reactive issues that emerge.

Community Engagement Framework

We will continue our unwavering focus on the delivery of the headline projects of the framework, and the themes are as follows:

Headline projects to support our priorities – the 'What'

- Project 1: Listening and working together to inform our strategic plans
- Project 2: Moving from hearing to doing
- Project 3: Working together to embed equality through emerging Health and Wellbeing Forums at Place levels

Community Engagement Framework themes – the 'How'

- Embedding a consistent approach to co-production
- Ensuring genuine diversity and inclusion is at the core of our approach
- Making best use of our insight around the health and wellbeing of all our people and communities
- Evaluating what we do, sharing the learning and celebrating our successes

6.5 Estate and environment

Where are we now?

The use of NHS estate to provide wider social and economic impact is a consideration for the ICB and partner organisations.

The estate not only has the potential to positively impact on our carbon footprint, through our Green Plan, but also our productivity, value-for-money duty and the wellbeing of staff and patients. All partner organisations have been undertaking many different actions in recent years to begin to tackle this, from installing LED lighting, improving waste and recycling measures, lowering use of harmful medicines, improving green spaces in our communities etc.

The Fuller Stocktake is clear on the potential impact of estate utilisation on integrated primary care and the need to consider capital investment.

Our goal is to provide fit-for-purpose, accessible, financially efficient and sustainable estate facilities.

Our Green Plan

Our ambition is to have a true system partner approach to all aspects of our response to climate change, including our actions to respond to extreme climate-linked events locally, and our actions to lower our carbon footprint and encourage and support healthier lifestyles in our communities.

We are not starting from scratch, however. All partner organisations have been taking action in recent years to begin to tackle this, from installing LED lighting, improving waste and recycling measures to lowering use of harmful medicines, improving green spaces in our communities and more.

Our NHS provider trusts have developed their green plans and responsibility for delivery of these sits at trust level. The Integrated Care Northamptonshire Green Plan does not repeat all the positive work taking place at organisational level, as this is available in individual organisational green plans. It aims instead to identify the commitments ICN will take and lead to contribute to our total system net zero trajectories.

We made 10 pledges for 2022/23 and, while we have made progress on some of these, we commit to reviewing progress in 2023/24, assessing our pledges and agreeing priority actions that would add value for the future. We will do this by the end of 2023/24, together with our system partners. Collectively, our agreed Greener NHS actions will sit at ICB level and we will work collaboratively with our partners to deliver our plans through existing governance groups.

During 2023/24 we will:

- Share the good practice already happening in our organisations to reduce our carbon footprint, and capitalise on opportunities for a system-wide approach
- Ensure sustainable models of care are built into all our ICN transformation programmes as part of their programmes and work plans
- Develop and promote our roles as anchor institutions with our local businesses and communities

Where are we heading?

The environment in which people live and work is one of the largest determinants of their health and wellbeing.

With our Northamptonshire population expected to continue growing and ageing faster than the national average, the demands on our public and health services will grow in parallel. Without concerted and coordinated actions to improve the sustainability of our services there will be a corresponding impact on our local environment and a health impact on the communities that live in it.

We will work closely with all system partners and NHS Property Services on our strategic review of estates aligned to our clinical service strategies and future operating model. We will use our estate to deliver better outcomes and address inequality in our most deprived areas to increase access to our health and care services.

Our digital programme of work includes a range of digital platforms to support patient care in a sustainable manner. For example, some of the current schemes being undertaken in our ICS which directly impact on the carbon footprint of our system are:

- Electronic patient records to reduce paper usage
- Digital correspondence to patients to reduce postage volumes
- Growing the proportion of consultations held virtually
- Increasing the availability and use of virtual monitoring / wards
- Supporting distributed working of staff through rolling out Office 365, which can be used anywhere in the county and in staff's own homes, to reduce travel impact and the requirement to run many costly buildings

This work will continue to align the estates priorities and vision with the overall priorities and vision of ICN. Work will include focusing on development and delivery of robust, affordable local estates strategies that include delivery of agreed surplus land disposal ambitions across our Places and system-wide.

Our role as anchor institutions

Our ICB and partners are rooted in our communities and we will contribute to the delivery of our aim to support broader social and economic development through a number of our delivery partnerships. We will do this by working across the ICS to address the social and economic factors affecting people's health and wellbeing through our contribution to the Live Your Best Life ambitions. We will also contribute through our role as major employers in the system.

Through its size and scale, the NHS is one of the main anchor institutions in our ICS, alongside our local authorities, university, colleges, VCSE sector organisations and local businesses. Through our anchor institutions and green plans we will prioritise a range of targeted interventions to add value, including:

- Purchasing more locally and for social benefit
- Using buildings and spaces to support communities
- Working more closely with local partners
- Widening access to quality work
- Reducing the environmental impact of the NHS

As anchor institutions, our ICB and partners influence the health and wellbeing of communities by making a strategic contribution to the local economy. By choosing to invest in and work with others locally and responsibly, we can have an even greater impact on the wider factors that make us healthy.

6.6 Finance

Where are we now?

Northamptonshire integrated care system delivered a deficit of £31.1m for the 2022/23 financial year.

All NHS provider organisations ended the year in deficit with the Integrated Care Board posting a non-recurrent surplus. The system also delivered £47.8m in efficiency savings across the year, although this was £12.6m less than was originally planned.

Agency expenditure across provider trusts was £52.3m for the year which is £20.1m in excess of the NHS England cap for this type of expenditure.

It is therefore the case that Northamptonshire starts 2023/24 with a challenging financial position and this context, combined with the national financial context, is likely to mean challenging decisions for us.

Where are we heading?

This plan lays out our ambitions and priorities over the coming years.

It is important that we achieve these in a way that delivers value for money, for taxpayers and patients, alongside making all of our organisations financially sustainable.

In order to deliver this ambition, we will construct a medium-term financial recovery strategy and plan which will look to address drivers of our underlying deficit, efficiency, productivity and financially fragile services.

Productivity and efficiency will form the core of this approach. The medium-term recovery plan will build on work already under way across a number of areas to ensure that value for money is achieved.

Work on productivity and efficiency is currently focused in the following areas:

- Continuing Health Care
- Medicines management
- Hospital discharge and length of stay
- Agency and temporary staffing
- Corporate and support functions
- Procurement

This work will align with the other enabling strategies highlighted in this document to ensure that Northamptonshire continues to deliver for its population, while at the same time ensuring value for money.

Our Capital Plan

Our system Capital Plan reflects the joint capital ambition of NHS Northamptonshire ICB and its partner NHS and foundation trusts. It recognises the requirement for the ICB to ensure that capital expenditure does not exceed allocations and sets out how the system will balance long-term affordability, maximising value for money and optimal capital financing. Our ICS is currently working in a number of areas:

- Routine and backlog maintenance of estates to ensure patients are kept safe and ageing equipment is replaced
- Medical equipment maintenance and refresh
- Continued digital improvements including clinical systems and work on electronic patient records

As we further develop the capital strategy we will ensure its alignment with our estates and sustainability plans for a triangulated approach.

Our procurement approach

Our procurement function supports the achievement of the following objectives:

- Securing the needs of the people who use the services
- Improving the quality of services
- Improving efficiency in service provision
- Ongoing cost reduction
- Supply market integration
- Ethical and sustainable sourcing
- Enhanced outcomes and performance metrics

We will ensure that our approach to procurement maximises efficiency, ensures aggregation of spend and demonstrates delivery of best value.

We will work with partners to ensure improvement in supply chain efficiency with a view to consolidation and leveraging savings.

7. Next steps

7.1 Next steps

This plan is the starting point for ongoing and meaningful conversations to take place.

Its publication is the start of a continuous process where we will engage with a wide range of communities, audiences and stakeholders to co-produce our activity, guided by the principles set out in our Community Engagement Framework. This robust plan of engagement will be ongoing to make sure meaningful conversations take place on what matters to our communities. Engaging with our communities and those with lived experience will support us to better understand services and support them.

We will develop action plans to drive delivery and measure our success through agreed outcomes, metrics and key performance indicators. These will be working plans which continue to evolve and kept under review.

Our delivery plans aim to provide clarity for our multiple-impact interventions and our delivery partnership programmes. They describe an overview of each plan, the problems we are trying to solve, the objectives for each area of the plan, the outcomes we aim to achieve, key metrics and milestones. Plans will include leadership and governance and will be aligned to delivering our overall vision and aims as set out in this Five-Year Joint Forward Plan.

Our 2023/24 Operational Plan sets out the plan and deliverables for the first year of this Five-Year Joint Forward Plan. There is more work to be done in this first year as we develop our Joint Forward Plan and refine and co-produce our delivery plans. We will align delivery oversight and governance within the existing structures of the ICB to ensure the most efficient and streamlined process to maximise delivery, measure progress and ensure our plans continue to evolve to be meet the needs of our population over time.

7.1 Summary

This NHS Northamptonshire ICB Five-Year Joint Forward Plan describes how we will work together to meet the four aims set out by NHS England and endorsed by our integrated care system. Our plan demonstrates how we will support delivery of the Northamptonshire Integrated Care Partnership 'Live Your Best Life' Strategy and will align with our West and North Health and Wellbeing Strategies currently being developed.

We will maximise the opportunities that true integration brings, working with our partners and communities across Northamptonshire to transform the way we provide health and social care to improve outcomes and experience for our local population.

We will focus in the first two years on our top multiple-impact interventions, which will have the greatest impact on our ability to meet our national and local priorities as well as ensuring the infrastructure is in place for longer-term improvements. We will scope, evaluate and develop clear delivery plans for these to ensure they deliver the greatest impact on our fulfilment of our NHS commitments and our local priorities and associated outcomes.

We have outlined our delivery partnership programmes describing how we will deliver transformation across each of these areas. Detailed five-year delivery plans are being developed for each of these programmes. Our delivery partnership programmes are underpinned by our enabling strategies, our focus on our people and the digital and data thread through all our programmes. It is these enabling programmes which put us in the best possible position to deliver our aims of improving health and health outcomes, tackling health inequalities, enhancing productivity and value for money, and supporting broader social and economic development.

Our plan and focus on our priority areas creates a framework for us to direct our resources and decision-making to have the maximum impact. Together we will understand and solve our challenges, we will collectively work to address inequalities and transform our health and care services to improve health and wellbeing outcomes for our local population. All this will contribute to our efforts to achieve our vision to work better together to make Northamptonshire a place where people are active, confident, and empowered to take responsibility for good health and wellbeing, with quality integrated support and services available for them when they need help.

Contact details

NHS Northamptonshire Integrated Care Board
Francis Crick House
Summerhouse Road
Moulton Park
Northampton
NN3 6BF

Phone: 01604 476900

Web: icnorthamptonshire.org.uk

Email: northantsicb.communications@nhs.net

ICNorthamptonshire

Integrated Care Northamptonshire

@ICNorthants

ICNorthamptonshire

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Jei pageidaujate šį dokumentą gauti kitu formatu arba kita kalba, susisiekite su northantsicb.communications@nhs.net

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Elérhetőségek, amennyiben erre a dokumentumra más formátumban vagy más nyelven van szüksége: northantsicb.communications@nhs.net

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Together

We're making health and social care better

Annual Report 2022–2023

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"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

Message from our Chair

Morcea Walker
Interim Chair

"Welcome to this year's annual report for Healthwatch North and West Northamptonshire (HWNW). It has been another very busy year for us with lots of challenges. I took up the post of Interim Chair, with Professor Will Pope as the Vice-Chair, and we expanded the Advisory Board at the same time to help support staff meet those challenges. More information about our Board can be found on page 30.

We engaged with the public this year on many issues. One of the main issues was, and still is, access to dentistry. We wrote to all our local MPs in the summer to raise this issue with ministers on your behalf, continue to attend the Northamptonshire Oral Health Alliance and feedback all the public concerns raised with us throughout the year. This will continue to be high on our agenda for 2023/24 too.

266 people completed our GP Access survey and many more of you contacted us throughout the year raising this as one of your major concerns. We will continue to discuss this with the local Integrated Care System in Northamptonshire (ICS), Local Medical Committee (LMC) and others to highlight the need for better communication between GPs and patients to work together to improve access to local services.

In January 2023 we used our statutory powers of Enter and View and carried out two unannounced visits to the A&E departments at Northampton General Hospital (NGH) and Kettering General Hospital (KGH).

We did an announced visit to Corby Urgent Care Centre in February 2023 with our neighbour Healthwatch Rutland, which is a good example of where we work with our partners on cross-border issues.

Young Healthwatch also completed its project in East Northamptonshire on health and wellbeing.

More detailed information about all our projects and visits is contained later in this report.

My special thanks go to my colleagues on the HWNW Advisory Board for all their help and support this year, our volunteers on our Planning Group who are the eyes and ears of the organisation, and to the staff that have stepped up to cover illness or absence to keep us on track."

Morcea Walker OBE

Interim Chair of HWNW

Deputy Lord Lieutenant

MA Walker

About us

Healthwatch North and West Northamptonshire is your local health and social care champion.

We make sure NHS leaders and decision makers hear your voice and use your feedback to improve care. We can also help you to find reliable and trustworthy information and advice.

Our vision

A world where we can all get the health and care we need.

"Healthwatch North and West Northamptonshire will be a strong, resolute, and independent community champion. We will give local people a voice and work in partnership to influence the design and quality of health and social care provision so that all local people have an opportunity for an improved quality of life"

Our mission

To make sure people's experiences help make health and care better.

We have five strategic priorities within our mission:

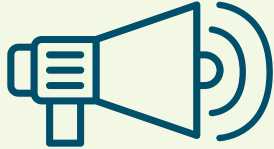
- To deliver our statutory functions
- To champion the views of all people who live in or use health, social care or wellbeing services in Northamptonshire and commit to prioritising issues related to health inequalities
- To recruit and develop staff and volunteers in Northamptonshire to continue to build the capacity of Healthwatch North and West Northamptonshire as an independent consumer champion of health, social care and wellbeing
- To work in co-production for improved health, social care and mental health outcomes for adults, including vulnerable adults and carers
- To work for improved health, social care and mental health outcomes for children, young people and families

Our values:

- We will be accessible and visible
- We will be independent and objective
- We will be open, honest, and transparent in all that we do
- We will be inclusive and embrace diversity and equality, reflecting the diverse needs of local people
- We will listen to and understand the views and needs of local people
- We will speak up for local people and enable people to speak for themselves
- We will be fair and credible
- We will seek out and use evidence, including that from the public, to inform our work
- We will strive to make a positive difference and champion the best possible health and social care for local people

Year in review

Reaching out



682 people
shared their experiences of health and social care services with us, helping to raise awareness of issues and improve care

1343 subscribers
to our monthly newsletters

22,569 impressions
on our social media pages, including Young Healthwatch Northamptonshire

2 appearances
at local focus groups

90 people
came to us for clear advice and information about topics such as mental health and the cost-of-living crisis

Making a difference to care

This year we published
5 reports
regarding the improvements people would like to see in local health and social care services.

Our most popular report was:

Accessing GP Appointments in Northamptonshire

Where we created a short survey to gather the public's views on the accessibility of GP services in the county.

To read our reports:
www.healthwatchnorthamptonshire.co.uk/news-and-reports

Health and care that works for you

We're lucky to have **14** outstanding active volunteers and lots more we can call on for other things. Our volunteers worked extremely hard throughout the year giving up their own time to ensure that the voice of the public was heard by commissioners and health service providers.

They voluntarily gave over **1200** hours of their time in 2022/23 by attending meetings and events, reading papers and commenting on documents, and visiting premises on behalf of the public. This equates to 160 days' work (7.5 hour per day) and a substantive cost saving to the county.

We're funded by our local authority. In 2022-23 we received

£195,000

which is the same as the previous year.

We currently employ

6 part time staff

who help us carry out our work.

"I love working across different communities and seeing the difference it makes. My work has been a kaleidoscope of activity. I haven't got a favourite moment but I love working with people."

How we've made a difference this year

Spring

Visited KGH and NGH A&E unannounced after issues were raised both locally and nationally.

Visited Corby Urgent Care Centre and made recommendations for improvement

Summer

Supported Young Healthwatch with their Health and Wellbeing Project in East Northamptonshire .

Responded to the Quality Accounts of all local health providers e.g. KGH, NGH and NHFT.

Autumn

Attended meetings with Integrated Care Northamptonshire (ICN) on the development of the 10-year strategy for the county.

Worked with the ICN on the development of the new Community Diagnostic Centres to ensure that they are publicly accessible.

Met with the ICN and Local Medical Committee (LMC) about our GP Access Report.

Worked with the ICN to upload all our reports to the new Insight and Engagement library.

10 years of improving care

This year marks a special milestone for Healthwatch. Over the last ten years, people have shared their experiences, good and bad, to help improve health and social care. A big thank you to all our Healthwatch Heroes that have stepped up and inspired change. Here are a few of our highlights:

How have we made care better, together?

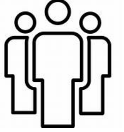
126 reports published

We have published 126 reports on topics such as mental health, hospital care, and COVID-19

Won and been shortlisted for numerous awards

We have won and been nominated for several awards for our hard work in making a difference

Worked with young people



We have pioneered several community projects in collaboration with Young Healthwatch Northamptonshire

Gained more than 12500 responses

We have received more than 12500 responses to our projects and surveys

Been awarded the Investing in Children accreditation

We were the first organisation in Northamptonshire to receive this accreditation

Healthwatch North and West Northamptonshire Recognition and Awards over the past 10 years

Over the past 10 years we have been recognised and awarded 16 times, you read about several of our achievements below:

Kate Holt, Chief Executive Officer, collecting an award for our work with volunteers

- In 2020 we were shortlisted for a national award for undertaking 43 visits to 50 wards and departments at Kettering General Hospital (KGH) between April 2019 and March 2020.
- Healthwatch Northamptonshire was a finalist in the East Midlands Academic Health Science Network Awards in 2015 for "Patient identified innovations" and received a "Highly Commended" for "Making a difference in diversity and inclusion". Both awards related to the engagement work with children, young people and families.
- Healthwatch Northamptonshire won the "Helping people have their say" category at the Healthwatch England awards for engaging with 500 new parents to gain and share their views on maternity services.

We have also gained many accreditations:

Investing in Children

Young Healthwatch Northamptonshire was the first group in the county to obtain the **Investing in Children** accreditation in 2018.

Cyber Essentials

Healthwatch North and West Northamptonshire were accredited with **Cyber Essentials** for the first time in 2023. This accreditation shows that we can protect against common cyber threats.

Investing in Volunteers

Healthwatch Northamptonshire again received the **Investing in Volunteers** accreditation in 2022. Investing in Volunteers is the UK quality standard for all organisations involving volunteers.

Listening to your experiences

Services can't make improvements without hearing your views. That's why over the last year we have made listening to all areas of the community a priority. This allows us to understand the full picture, and feed this back to services and help them improve.

Advocating for fairer NHS dentistry

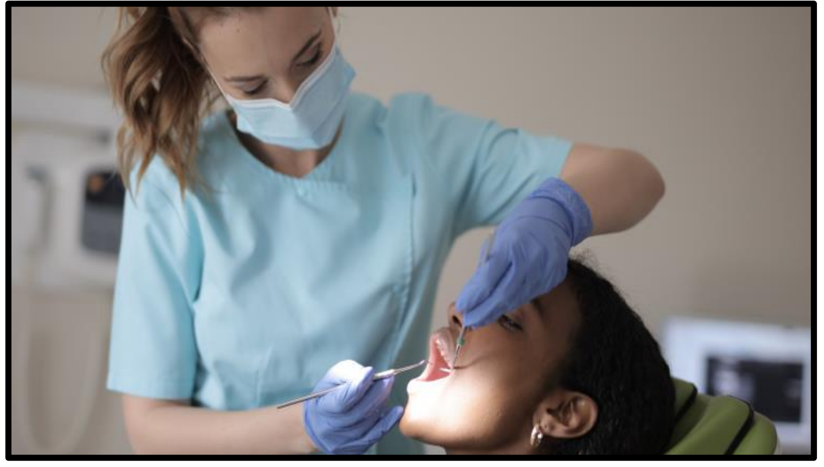
In 2022/23 access to dentistry was a big issue for everyone in Northamptonshire and across the country. 113 people contacted us raising issues about being unable to access a dentist for themselves or a loved one.

In September 2022 the HWNW Advisory Board wrote to all MPs in Northamptonshire to raise the issue with them. We received responses from 4 MPs in total, Philip Hollobone MP, Rt Hon Michael Ellis MP, Rt Hon Chris Heaton-Harris MP and Tom Pursglove MP. We received 1 response from NHS England via Philip Hollobone MP and were then invited to meet with Daisy Pierce the Chief of Staff for Rt Hon Chris Heaton-Harris MP in December 2022 who said they would raise the issue with Ministers. We then received a response via Rt Hon Chris Heaton-Harris MP from the Department of Health and Social Care regarding this matter in March 2023.

Dr Judith Husband BDS, from the Northamptonshire Local Dental Committee and an Executive Member of the British Dental Association General Dental Practice Committee, also attended our Healthwatch North and West Northamptonshire Planning Group meeting in September 2022 to give us an update on the situation and the issues with the NHS dentistry contract for services which were adding to the problem. Our Healthwatch volunteer, Chris Drage, also attends the Northamptonshire Oral Health Alliance meetings and the meetings with the NHS Commissioners and the Local Dental Network chairs

Along with Healthwatch England, we are calling for:

1. **A more rapid and radical reform of how dentistry is commissioned and provided** – recognising that the current arrangements do not meet the needs of many people who cannot access NHS dental care in a timely way and acknowledging issues faced by the dental profession.
2. **The use of the commissioning reform to tackle the twin crises of access and affordability** – ensuring that people are not excluded from dental services because of lack of local provision or difficulty meeting charges. Currently, there are significant inequalities that must be tackled. **New arrangements should be based on maximising access to NHS dental services, particularly reducing inequalities.**
3. **Greater clarity in the information about NHS dentistry**– improving information, including online, so that people have a clear picture of where and how they can access services, as well as the cost**. The reform must address dentistry 'registration' which causes significant confusion for both services and patients.**
4. **The possibility of using dental practices to support people's general health** – harnessing opportunities, like the development of Primary Care Networks, to link oral health to other key issues, such as weight management and smoking cessation.



Read about Healthwatch England's position on NHS Dentistry:

www.healthwatch.co.uk/news/2022-10-12/our-position-nhs-dentistry

How we made a difference

From 1st April 2022 until 1st April 2023 Healthwatch North and West Northamptonshire Published 5 reports.

These were:

- GP Access
- Unannounced visit to KGH.
- Unannounced visit to NGH
- Young People's health and well-being survey
- Corby Urgent Care Centre

Accessing GP appointments in Northamptonshire

In response to the issues raised about problems accessing GP appointments in the county, Healthwatch North and West Northamptonshire created a short survey in 2022 to ask the public their views about what was working well and what could be improved to enhance the accessibility of GP services in the county.

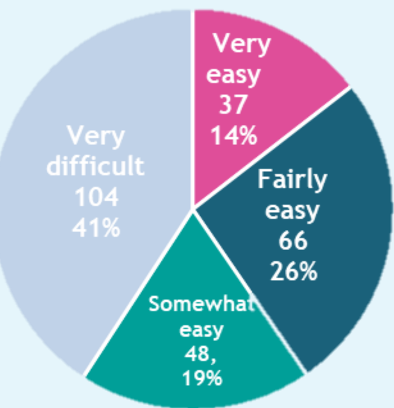
The survey was completed by 266 people in Northamptonshire. Additionally, another 53 pieces of feedback, both positive and negative, were received between April 2022 and December 2022. People told us about their experiences, from accessing appointments, to the care they were provided. Along with the issues raised, there were also some very positive comments about the patient experience.

We found the main concerns in Northamptonshire were related to difficulties in getting a response to telephone calls with the phone lines often being continuously engaged. Other issues highlighted were the difficulty in getting pre-booked face-to-face appointments, concerns about having a long wait for an appointment, and the inability to see the practitioner of their choice.

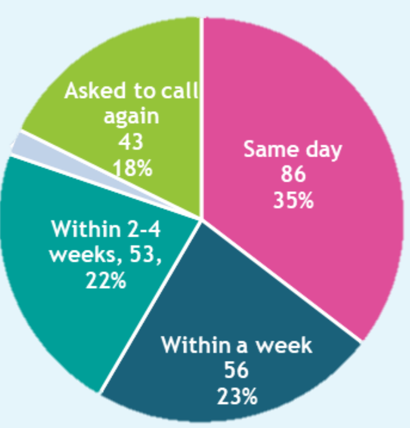
Suggestions for improvements included working to implement reduced waiting times when telephoning for an appointment; more face-to-face GP appointments, the facility to book online, better support for those with long-term conditions in securing appointments, and facilities for wheelchair users.

Unfortunately, this report reflected many of the same findings as our report 'Patient Experiences of GP Services in Northamptonshire' undertaken in 2015.

The ease of getting a GP appointment



How long after contacting the surgery patients received an appointment



As part of our report process, we sent the draft report to both commissioners and providers of NHS services in Northamptonshire on 5th January 2023. No formal response to the report was received by the time of publishing. (23rd March 2023)

- The telephone systems appear to be inadequate. Several patients spoke of long waits for a response - sometimes up to an hour, only to be told there were no available appointments and to ring back the next day
- Patients with non-urgent conditions said that they would have been happy to have a pre-booked appointment but accepted an on the day slot as that was all that was on offer
- Patients said waiting to be given an appointment and no indication when that would be caused anxiety
- There were occasions where patients tried to explain why they needed an appointment but were not listened to by the receptionist

"I'm a nurse and only call when I need to be seen. The GP needed to physically examine me, but the receptionist still put it down as a telephone consultation, even though I explained and it was obvious it would need looking at. I was then given an appointment with a nurse who then said I need to see a GP, but she couldn't book the appointment, so I then had to start the process of calling to book to see a GP."

To read the full report please follow the link:
Final GP Access Report March 2023.pdf (healthwatchnorthamptonshire.co.uk)

Unannounced visit to Northampton General Hospital Accident and Emergency Department

Volunteers from Healthwatch North and West Northamptonshire visited Northampton General Hospital's A&E department unannounced using their statutory power to conduct Enter and View visits on 31st January 2023.

Based on feedback from the public, and other service providers, including comments posted on social media platforms, the Healthwatch North and West Northamptonshire (HWNW) Advisory Board agreed to use their statutory powers to undertake an unannounced visit to the NGH A&E department.

The hospital was informed before the visit that it would be taking place and by whom but did not know the date or time of the visit before it happened.
The volunteers spoke to 15 patients about their experiences of the service, from the parking and waiting times to the care they were provided.

Three volunteers, including 2 Advisory Board Members (the team) from Healthwatch North and West Northamptonshire, visited the Northampton General Hospital Emergency (NGH) department for an unannounced visit on 31st January 2023, starting at 11.30 am.

The volunteers spoke to several patients about their experiences. This report, written by our volunteers, is a snapshot of the hospital's Emergency Department on that day along with the team's recommendations to improve the patient experience locally. It is not a comment on the situation nationally, Government policy or the need for additional resources in Emergency departments across the country.

We made 3 recommendations which were:

Recommendation 1: Signage appears to be a perennial issue for hospitals. There was not sufficient signage outside of the department to make it easy for patients or their relatives to know which entrance to use. We recommend that someone unfamiliar with the ED area is asked to say where the best place should be for signs to be placed so that anxious patients know immediately where to go.

Recommendation 2: Staff should be encouraged to continue to inform patients about what is going to happen to them next during their treatment or visit– they may find this a bit tiresome, but patients are understandably anxious and need a lot of reassurance whilst in the Emergency Department. Patients do not always hear what is said to them the first, or even the second time.

Recommendation 3: In the waiting areas, patients asked us what would happen to them next in regard to their treatment/ visit. We recommend a board be placed on the wall or leaflets made available describing the process.

We are conscious that the new Emergency Department Steaming Hub opened on 26th January 2023, which was shortly followed by the Healthwatch visit on 31st January 2023.

We have also been informed since the visit that the following actions are underway and are being overseen by the Director for Estates and Facilities:

- A review of all signage around the Emergency Departments including Springfield.

- Car parking and vehicle flow around the Nye Bevan and ED routes are to be reviewed

- A report of the car park ticket machines covering 3 months of performance will be requested and analysed for any specific recurring issues to relay back to the supplier / Estates team

- A request to be made of our NGH Communications team to create a holistic 'bumble bee' journey approach for patients with conditions such as learning disabilities, autism, etc

We also received the below response from the provider:

"Northampton General Hospital (NGH) welcomed the opportunity of this external review of our Emergency Department services by Healthwatch and we are grateful for the findings and recommendation made as part of the visit. This unannounced visit came within the same week as NGH opened its new Streaming Hub for the Emergency Departments as part of our plans to improve patient pathways and their experience whilst in our care. We have taken onboard the observations noted within the report and will be working with our nursing and clinical leads within the Emergency Departments alongside our Estates and Facilities team to enhance the service further. "

Christine Johnson Head of Patient Experience and Engagement

To read the full report please follow the link:
NGH A and E January 2023 (healthwatchnorthamptonshire.co.uk)

Unannounced visit to the Kettering General Hospital Accident and Emergency Department

This unannounced visit was conducted for the same reasons as the unannounced visit to NGH. Two volunteers, both Advisory Board Members (the team) from Healthwatch North and West Northamptonshire visited the Kettering General Hospital (KGH) Accident and Emergency (A&E) department for an unannounced visit on 31st January 2023.

The hospital was informed before the visit that it would be undertaken and by whom but did not know the date or time of the visit before it happened.

The volunteers spoke to 11 patients about their experiences.

We only had one minor recommendation:

At one point in our visit a patient was called to be triaged and tripped and fell over a low table that was situated at the end of a row of chairs. We suggest the table would be more appropriately placed between two chairs rather than at the end of the row.

Commissioner/provider response:

"Thank you for taking the time to complete the recent visit to our Accident & Emergency department. We always strive to improve our patients' experiences by listening and acting on feedback, so this is very helpful to us. We have noted the recommendations given to us by Healthwatch and can confirm that the table in our ED department has been moved accordingly. We note that some of the patients the volunteers spoke to raised issues regarding waiting times on recent visits, and we always try our best to keep waiting times to a minimum where we can. We are so pleased that our patients felt that they were treated with dignity and respect by our staff members and that our department was a calm environment. We will ensure we consider these findings to improve services as we believe that patients' voices can help to shape a better Healthcare Service for the future."

Lucy Jones Head of Patient Experience and Engagement

To read the full report please follow the link:
KGH A and E January 2023 (healthwatchnorthamptonshire.co.uk)

Corby Urgent Care Centre

Three volunteers and a member of staff from Healthwatch North and West Northamptonshire and Healthwatch Rutland visited the CUCC. The HWR team visited on Saturday 11th February 2023 and the HWNW team on Friday 17th February 2023. The visits were at the request of CUCC as part of their commitment to engage with, and get feedback from, members of the public as part of their programme of continuous improvement.

We spoke to 24 people/patients over the 2 days that we visited, and 14 people filled out our short online survey. Overall patients were very satisfied with the service received.

We made 9 minor recommendations for service improvement:

1: We suggest that the provision of hot drinks should be considered. The coffee shop closes at 2 pm and there are no other refreshments available except water

2: Two of the gel dispensers needed refilling in the Clinical waiting area, dispensers need to be checked regularly

3: In the Clinical waiting area toilets, one of the taps was wobbly and hard to use, and needs to be fixed

4: There is good disabled access. However, the chairs are joined together so you cannot move the seats around to sit next to a person in a wheelchair

5: The women's toilet did not have a cleaning schedule in it. We suggest that one is put up

6: The staff notice board at the end of the corridor was crowded with leaflets and posters and we suggest they could have been more tidily arranged and updated

7. There are male and female toilets at the main entrance but they are not well signed and some new signs would make it clear that the toilets are there

8: Staff need to be reminded that using terms of endearment to patients and visitors may cause offence and should not be used

9: Communications with patients could be improved to keep them better informed whilst waiting

"I was seen within an hour of arriving which was brilliant. The gentleman I saw was professional, capable, and very thorough with my eye injury. I am so very grateful to have this amazing urgent care facility in Corby"

Hearing from all communities

Over the past year we have worked hard to ensure we hear from everyone within our local area.
We consider it important to reach out to the communities we hear from less frequently, to gather their feedback and make sure their voice is heard and services meet their needs.

This year we have reached different communities by:

- Listening to children and young people through Young Healthwatch and their project
- Change Grow Live Project – Homeless and substance misusers views of the service

Young Healthwatch Northamptonshire (YHWN)

Young Healthwatch Northamptonshire ensures that the voice of children and young people is heard in health and social care services. They engage with and represent young people to help improve services in Northamptonshire.

This year Young Healthwatch Northamptonshire gathered the views of young people aged 11–19 year-olds living in East Northamptonshire using a short survey. The survey asked about young people's physical health, lifestyle, emotional health, and how they manage difficult emotions.

The young people provided important information about services and how they believe that they could help them to cope with anxiety and other issues. Many of the respondents commented on what they feel would work for them and how they would like to receive health and wellbeing services in the area.

This information received will help inform and shape services in East Northamptonshire to better care for young people's health and wellbeing.

Young people's mental health is extremely important. Mental health issues affect many people. One in four people will suffer from some sort of mental health illness at some stage of their life, including young people.

The demands on young people today have never been as high; from social media to exams to relationships. Many of these issues lead to poor health and wellbeing and the need for more and more support services.

Combined with this are young people living in areas of deprivation, which can be both social and financial deprivation and/or multiple deprivations, where they are exposed to poor diets, smoking and other substances, along with a lack of exercise and health inequalities are at more risk.

The survey included questions about how young people engage with leisure activities locally. The survey asked young people about their health and habits, and the health and emotional issues they think affect young people.

Taking into account the limitations of the project and the relatively small number of respondents, it was difficult to make definitive recommendations for commissioners and providers of children's services in East Northamptonshire.

There were several issues raised:

- Long waiting times and poor availability of support services outside of school hours.
- Over half the respondents answered 'yes' to suspecting a friend was self-harming.
- Self-harming is common for young people.

Teachers and parents, followed by counselling services (e.g., Service Six) are the top three choices for young people to approach to discuss issues with and therefore should continue to be where resources are focussed to support the mental health and wellbeing of young people going forward.

Commissioner/provider response:

'It is widely acknowledged that the early years of a child or young person's life will affect their health and care outcomes for life and how a range of factors, including health, education, community and family life, contribute to a child's sense of healthand wellbeing. We believe that the best way to fully understand these factors is through the voice of our county's children and young people. Engagement with our young people is central to our work in delivering better health outcomes and as such we welcome the publication of this report. It provides us with a powerful lens through which to reflect, focus and plan our work and many of the themes highlighted within the report; will be pivotal in addressing priority areas (including those outlined in the Northamptonshire Children and Young Peoples Mental Health Local Transformation Plan) and in the development of effective co-produced services and initiatives that best meet our children's needs.

We would like to extend special thanks to the young people involved in this valuable piece of work and congratulate you all on your tenacity in completing it during such an unprecedented time of challenge for all.'

Sian Heale - **Senior Transformation Officer on behalf of the Northamptonshire Integrated Care Board**

In total we received 28 responses to the survey between March 2020 and September 2022. To read the full report please follow the link below:

YHW report Feb 2023.pdf (healthwatchnorthamptonshire.co.uk)

Change Grow Live (CGL)

We were commissioned at the beginning of 2023 to do a small piece of work with the Change Grow Live organisation. (CGL drug, alcohol and substance misuse service).

They are keen to use the independence of Healthwatch North and West Northamptonshire as an opportunity to hear the voice of those that seek their support and to inform future service planning and provision to meet the needs of some of our most vulnerable people in Northamptonshire.

We designed and launched a survey and held two focus groups with service users in March. This work and the final report will be completed in 2023.

For more information on CGL and the Substance to Solution service please see the link below for their website:

www.changegrowlive.org/substance-to-solution-northamptonshire/northampton

Making Safeguarding Personal (MSP) Pilot

Making Safeguarding Personal (MSP) is a national programme that was started in 2010 by the Local Government Association and ADASS (Association of Directors of Adult Social Care). They are a sector-led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. Whilst much has been done to ensure that safeguarding for individuals is outcome-focused and not solely process-driven, Northamptonshire Safeguarding Adults Board (NSAB) were keen to evaluate how embedded MSP is in the county, to ensure that the individual's outcomes are at the heart of any interaction.

We were asked by the NSAB to undertake a pilot project to seek feedback from service users at the end of section 42 safeguarding enquiry. Social workers asked the adult, or their representative, if they would be happy to be contacted by Healthwatch on behalf of NSAB, to discuss their experience of going through the enquiry and whether they felt they were listened to, and now felt safer.

Although the response to this has been smaller than hoped, we will continue working with NSAB in 23/24 to ensure that service user feedback remains a priority.

To read about the Northamptonshire Safeguarding Adults Board's role in the community, follow this link: www.northamptonshiresab.org.uk/Pages/default.aspx

Advice and information

If you feel lost and don't know where to turn, Healthwatch is here for you. In times of worry or stress, we can provide confidential support and free information to help you understand your options and get the help you need. Whether it's finding an NHS dentist, how to make a complaint or choosing a good care home for a loved one – you can count on us.

This year we've helped people by:

- Providing up to date information people can trust
- Helping people access the services they need
- Helping people access NHS dentistry

Volunteering

We're supported by a team of amazing volunteers who are at the heart of what we do. Thanks to their efforts in the community, we're able to understand what is working and what needs improving.

This year our volunteers:

- Visited communities to promote Healthwatch and what we do
- Collected experiences and supported communities to share their views
- Carried out enter and view visits to local services to help them improve
- Attended meetings
- Wrote reports
- Responded to consultations and NHS provider Quality Accounts

The way we work

Involvement of volunteers and lay people in our governance and decision-making

Our Healthwatch Advisory Board consists of 9 members chaired by Morcea Walker OBE who all work on a voluntary basis to provide direction, oversight and scrutiny to our activities. Our Board ensures that decisions about priority areas of work reflect the concerns and interests of our diverse local community. Throughout 2022/23 the Board met quarterly and made decisions on matters such as raising the issue of access to dentistry with MPs and responding to consultations.

We ensure wider public involvement in deciding our work priorities.

Northamptonshire Health and Wellbeing Boards

Representatives from Healthwatch West and North Northamptonshire are invited to attend the Health and Wellbeing Board Meetings which are held quarterly.

These two Boards receive reports and proposed plans from Health and Care organisations across the county. The HWBBs hear presentations updating work in various areas, and proposed plans for new initiatives. Papers are considered by the Boards and noted or approved. Members are invited to ask questions about the presentations. Members of the public can also ask questions but these must be submitted in advance of the meeting.

Some of the papers will be relevant to both Boards when they refer to a countywide proposal or organisation. Some will be relevant to the North or the West only. These are some of the discussions we have been involved in this year:

- The Director of **Public Health Annual Report** giving feedback on the Health and Equalities was approved
- **The Direction of Travel** – **three-year strategy being put into place by Public Health across Northamptonshire was approved.**
- **Northamptonshire Safeguarding Children's Partnership Annual Report** was approved
- Information on the start of the **Community Wellbeing Forums and Local Area Partnerships** was noted in November 2022 and an update given in March 2023 was approved
- The **Better Care Fund Plan**, transforming North Northants Council Adult Services was approved in November 2022 and the **Additional Winter Discharge Fund** report in March 2023 approved in March when the CEO of Kettering Hospital thanked services in the community for the additional provision during winter months.
- In March 2023 the Board received **the Northamptonshire Integrated Care Board** 5 Year Forward Plan which was approved

Healthwatch Hero

Celebrating a hero in our local community.

Sheila White is a Healthwatch Hero, she has been a Healthwatch member since 2013.

Some words from Sheila about her time with Healthwatch:

“Friends who know me well will tell you that I am a ‘people’ person. Communication is my mantra. Over the last ten years of volunteering with Healthwatch, I have had so many opportunities to meet with people from all walks of life and to listen to what they had to say about the health and social care services and, sometimes more importantly, shared some of their personal experiences with me. It is not the meetings and committees I attend as a Healthwatch representative but the people I meet along the way. It is the friends I have made over the years. It is the relationships built up with the staff during the years we have undertaken the 15 Steps Challenge Audits at Kettering Hospital that will be the things that I will always remember.”

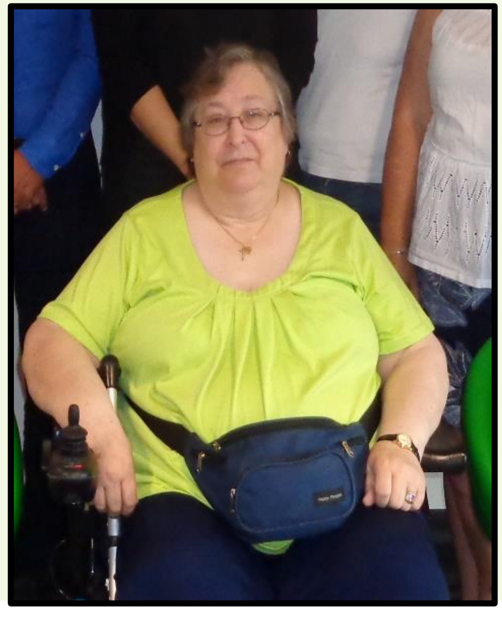
Our Advisory Board

Morcea Walker - Interim Chair

Morcea was born in Jamaica and moved to England when she was nine years old. She was a founder member of the Northampton West Indies Parents' Association and was heavily involved with the Northants Black History Association. Morcea was awarded an honorary degree from The University of Northampton in 2008 for her outstanding contribution to education and training in Northamptonshire and as a leading member of the African Caribbean community. Morcea also resurrected the Northampton Carnival in 2005 - She is a Trustee of Autism Concern and Northamptonshire Music and Performing Arts Trust and was a director of the Community Law Service (Northampton and County).

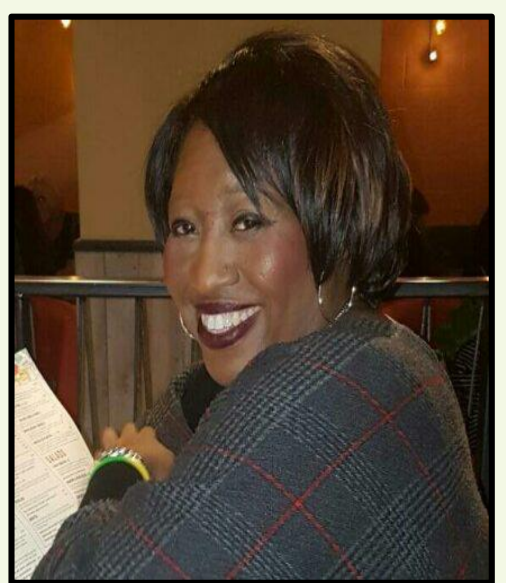
Professor Will Pope – Vice Chair

Professor William Pope is the Chair of Connected Together CIC and is currently the vice chair of the Healthwatch Northamptonshire Board. He has a wealth of experience, leadership and expertise gained from senior roles within industry, the NHS and academia, including at chairman and chief executive level. and was Chief Executive Officer of the UK's largest integrated health, safety and environmental business for 10 years. and is a four times winner of the "Technology Fast 50" awards for the fastest growing companies.), Chairman of Healthwatch Northamptonshire (2013-17) and is a Board member (now Vice Chairman) of East Midlands Pathology (2012-date).



Dora Shergold

Dora lives in Wellingborough and was the main carer for her late Husband for many years, she was a work-place first aider for 35yrs alongside working as a credit controller. She was a former secretary of the Kettering and District Prostate Cancer Support Group and Carers Voice member for several years, she has been a Carer representative with NHFT for 10yrs and counting, on the Health Watch Board since 2014, 3yrs ago she became a member of the East Midlands Academic Health Science Networks Peoples Senate, more recently becoming a Regional Representative for the EMAHSN. She has advanced Arthritis caused by Ehlers Danlos Syndrome and puts her wheelchair to good use by helping the NHS with accessibility inspections.



Dr Marcella Daye

Dr Marcella Daye is Senior Lecturer in Tourism Management and Co-Chair of the race equality network known as the Global Ethnic Majority at the University of Northampton. As Co-Chair of the GEM, Marcella is the coordinator the annual Black in the Ivory conference at the University of Northampton which is held in observance of Black History Month. Marcella holds a Masters with distinction in Tourism Planning and Development and a Ph.D in Tourism Marketing from the University of Surrey. Her research interests are in Place Branding, Risk Communication, Participatory Action Research and Race Equality.

Ishver Patel MBE

Ishver has worked in social care for over 40 years, moving into training and development and subsequently becoming Head of Organisation Development for one of the London authorities, overseeing training and development, across children and adult services. He has supervised social work student placements, as part of their undergraduate and postgraduate degree programmes and supervised/mentored newly qualified social workers during their first year in practice. As an independent organisation development consultant, he has worked across private, voluntary, and statutory sectors, delivering training. mentoring and coaching support. He is currently Patron to Better Lives Foundation, working in Sierra Leone and continues to support health and social care projects in UK and overseas

Susan Hills

After a successful career in the world of information science and project management at the British Library, Susan moved into the NHS as Chair and subsequently Non-Executive Director of Primary Care Trusts in Northamptonshire. She volunteered with Healthwatch Northamptonshire so that she could continue to help join up and improve the health and social care services provided locally. Susan has worked in the voluntary sector with the Citizens Advice Bureau, Northamptonshire Network 50+, and other organisations for some years. She believes that the voluntary sector can provide a lot to help an individual have a more fulfilled, active and enjoyable life.. Susan is also a lay member with the Employments Tribunals service.

Wendy Patel

Wendy is a retired registered General Nurse with vast experience in nursing and management. She has a particular interest in bringing quality care into the workplace. She trained at Kettering General Hospital where she held a series of senior roles before moving to South Wales where she obtained a degree to teach nursing. She has held a number of positions including Lead Nurse Education Independent Sector; Investigator of complaints in the health service and Investors in People Advisor. She undertakes a lot of voluntary work including work with the Samaritans, Healthwatch: 15 steps challenge at Kettering General Hospital as well as being a patient representative

Caroline Gooch

After working for 6yrs as a Ward Clerk at Princess Marina Hospital in the dementia assessment ward Caroline took her degree in Occupational Therapy graduating in 2011. She has worked within Age UK Northants (AUKN) since January 2012, initially managing volunteers before moving into roles managing paid staff. As Senior Coordinator for the Collaborative Care Team (CCT) she worked across Wellingborough, Kettering and East Northants. Receiving referrals from GP surgery staff: focussing on patients who needed support to access both statutory and voluntary sector services. Since April 2022 she has been a Senior Service Manager for AUKN with teams covering the county who visit people in their homes or their local community. They offer a similar type of broad support to the CCT. This includes the Age Well teams and Social Prescribing Link Workers across the GP surgeries in the North of the county.

"Being part of the Healthwatch team has been very rewarding, especially as I am a recent member. It is a pleasure to work with people who share the same passion in making a difference to the lives of people living across Northamptonshire." - Ishver Patel MBE

Finance and future priorities

To help us carry out our work we receive funding from our local authority under the Health and Social Care Act 2012.

Our income and expenditure

Income		Expenditure	
Local authority funding	£195,000	Staffing	£138,189.12
		Non-staffing costs	£61,410.68
Total income	**£195,000**	**Total expenditure**	**£199,599.80 a deficit of - £4,599.80**

In 22/23 the expenditure, even with staff vacancies, again exceeded the yearly local authority contract of £195k and left Connected Together CIC with a deficit of £4,599.80. Fortunately, during the year, we brought in additional income through commissioned work of approximately £31k to cover the shortfall.

Next steps

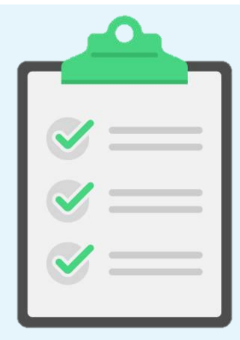
In the ten years since Healthwatch was launched, we've demonstrated the power of public feedback in helping the health and care system understand what is working, spot issues and think about how things can be better in the future.

Services are currently facing unprecedented challenges and tackling the backlog needs to be a key priority for the NHS to ensure everyone gets the care they need. Over the next year we will continue our role in collecting feedback from everyone in our local community and giving them a voice to help shape improvements to services.

We will also continue our work tackling inequalities that exist and will work to reduce the barriers you face when accessing care, regardless of whether that is because of where you live, your income or your ethnicity.

Top three priorities for 2023-24

1. Maternity visits
2. Dentistry remains high on our agenda
3. Mental Health Services



Statutory Statements

Healthwatch England, 2 Redman Place, Stratford, E20 1JQ.

Connected Together Community Interest Company is the legal entity and governing body for Healthwatch North and West Northamptonshire.

Healthwatch North and West Northamptonshire uses the Healthwatch Trademark when undertaking our statutory activities as covered by the licence agreement.

Methods and systems used across the year to obtain people's experiences

We use a wide range of approaches to ensure that as many people as possible have the opportunity to provide us with insight into their experience of using services. During 2022/23 we have been available by phone, and email, provided a web form on our website and through social media, as well as attending meetings of community groups and forums.

We ensure that this annual report is made available to as many members of the public and partner organisations as possible. We will publish it on our website, on social media and in our newsletters.

Responses to recommendations

We had 2 providers who did not respond to requests for information or recommendations. There were no issues or recommendations escalated by us to Healthwatch England.

Taking people's experiences to decision-makers

We ensure that people who can make decisions about services hear about the insight and experiences that have been shared with us.

In our local authority area, for example, we take information to patient experience groups at Northampton General Hospital (NGH), Kettering General Hospital (KGH) and Northamptonshire Healthcare Foundation Trust (NHFT) We also take insight and experiences to decision-makers in Integrated Care Northamptonshire (ICN), and all our feedback reports go to the CQC, commissioners and providers as well as sharing our data and information with Healthwatch England to help address health and care issues at a national level.

Healthwatch representatives

Healthwatch North and West Northamptonshire are represented on several different Boards and meetings across Northamptonshire.
For example:

- The Community Diagnostic Centre Programme Board
- Integrated Care Across Northamptonshire
- KGH, NGH and NHFT patient experience groups
- Place development, community wellbeing forums and Local Area Partnerships
- Mental Health, Learning Disabilities and Autism Executive Board
- ICP Strategy Development Board
- North and West Northamptonshire Health and Wellbeing Boards

The full list of meetings can be found in our annual workplan : www.healthwatchnorthamptonshire.co.uk/news/2023-04-26/our-annual-work-plan-2023-2024 .

Moulton Park Business Centre

Redhouse Road

Moulton Park Industrial Estate

Northampton

NN3 6AQ

Tel: 0300 002 0010

Website:
www.healthwatchnorthamptonshire.co.uk

Email:
enquiries@healthwatchnorthamptonshire.co.uk

twitter.com/HealthwatchNWN

www.facebook.com/Healthwatchnorthandwestnorthamptonshire

www.linkedin.com/in/healthwatch-north-and-west-northamptonshire-39981114b/