NHS
Northamptonshire
Integrated Care Board

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.

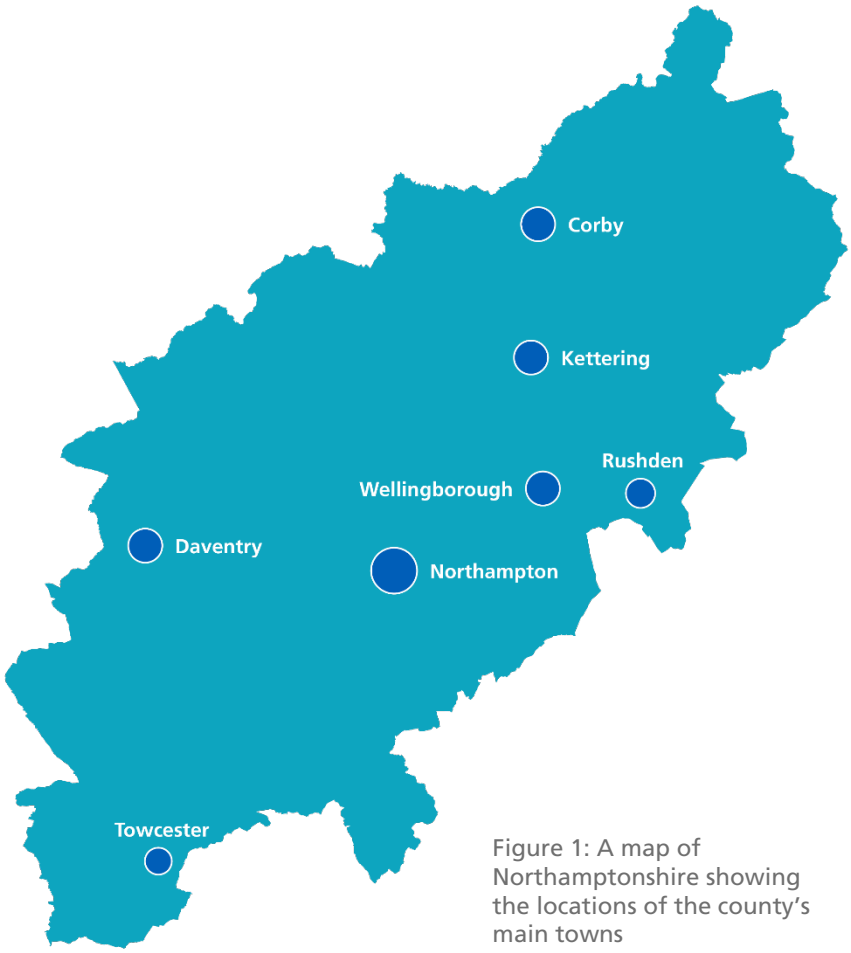


Figure 1: A map of Northamptonshire showing the locations of the county's main towns

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.

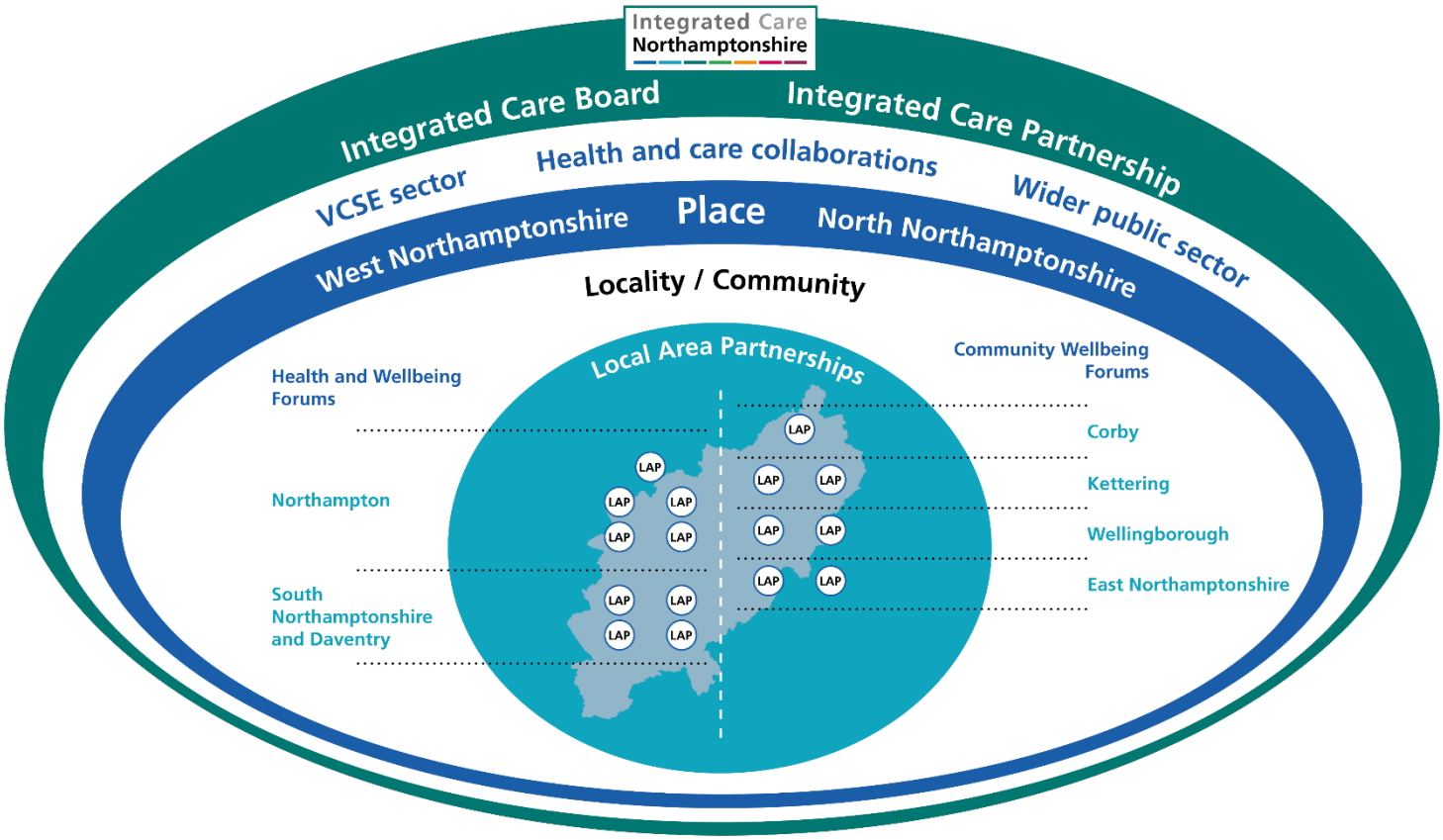


Figure 2: A summary of the Integrated Care Northamptonshire delivery approach

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:

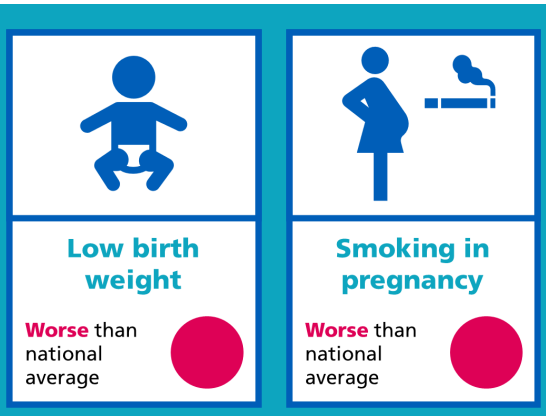
Pregnancy and birth

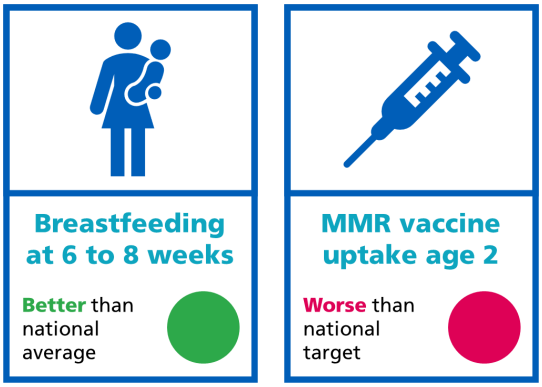
Maternal health and wellbeing before, during and after pregnancy are all critical indicators of child health outcomes

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.



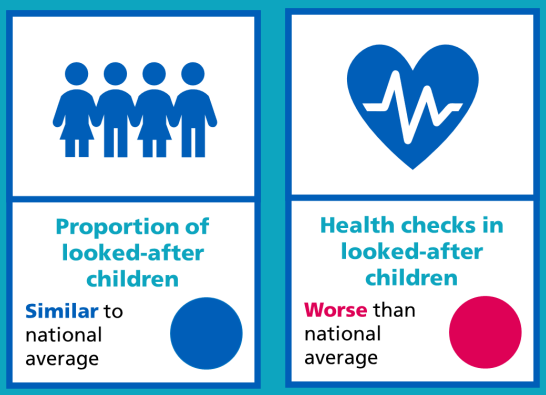


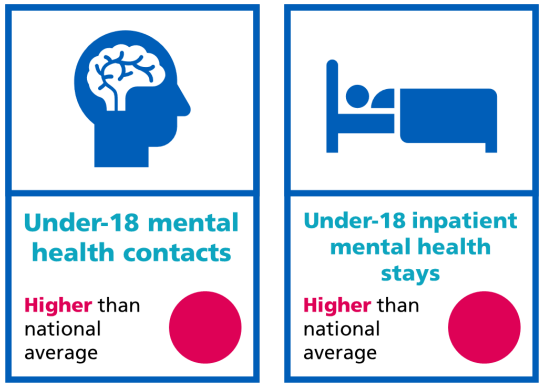
Early years

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

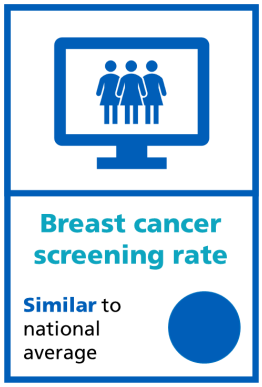
Future in Mind, the Children and Young People's Mental Health and Wellbeing Taskforce's report, estimates that half of mental health conditions in adult life start by the age of 14. An NHS Digital survey found that one in six children in England had a probable mental disorder in 2021, an increase from one in nine in 2017.

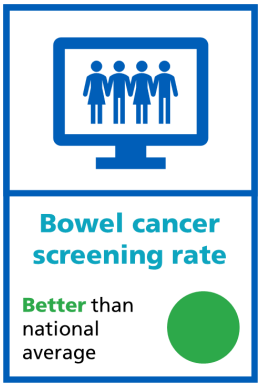
There were 50,000 contacts with community and outpatient mental health services among under-18s in Northamptonshire in 2019/20, a rate that is higher than the England average. The rate of inpatient mental health stays for under-18s was also higher in the county than for England.

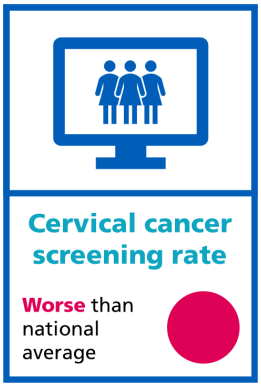
Living well

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.

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.

2.2 Our performance

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.

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.

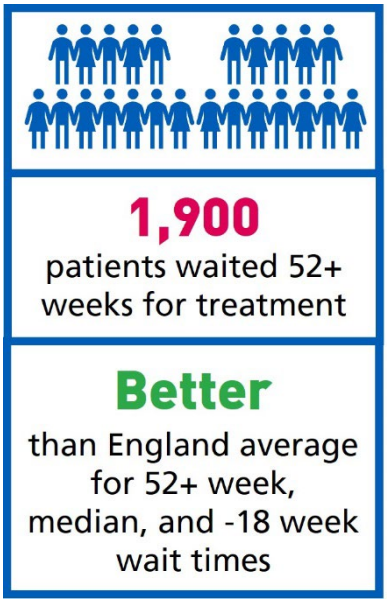
Primary care

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

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

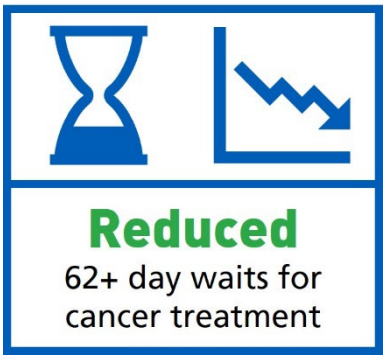
We have successfully reduced the number of patients waiting over 62 days for cancer treatment and have met the interim target set in March 2023, 62% of patients referred by their GP with suspected cancer had this confirmed, and started treatment, within 62 days.

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

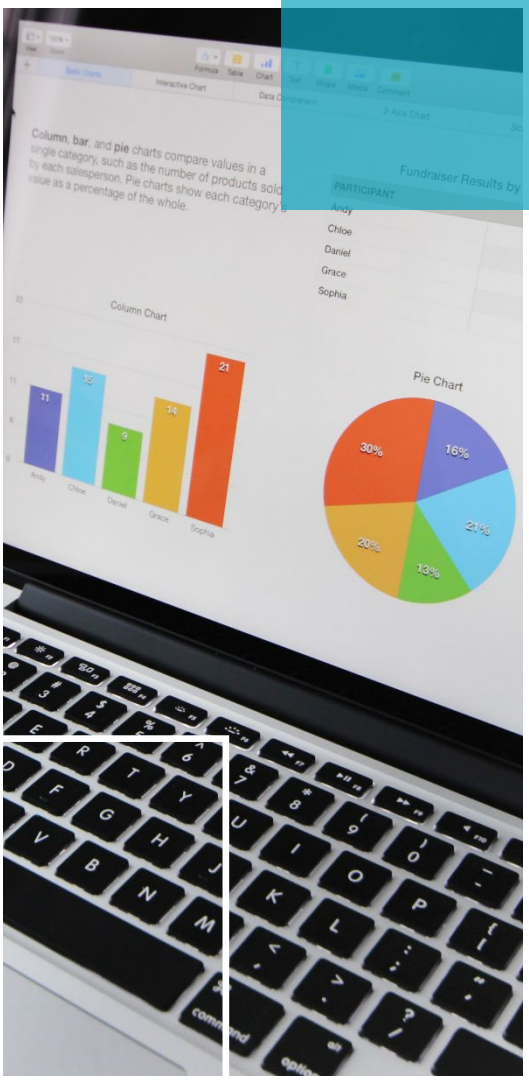
The focus across mental health services is on providing timely access to compassionate, trauma-informed crisis care as early as possible. This will enable us to prevent avoidable admissions to mental health hospitals, which will decrease the pressure on these services.

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.

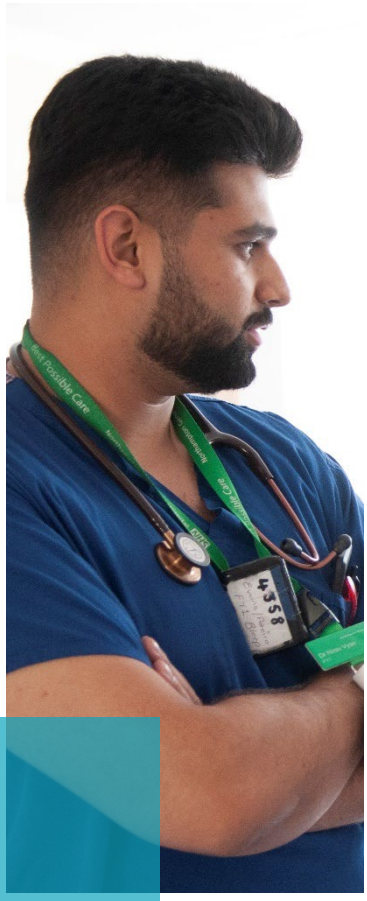


Our integrated care system in Northamptonshire is experiencing rising demand for services and increases in the complexity of people's needs, while at the same time needing to increase activity and productivity to recover services after the pandemic.

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.

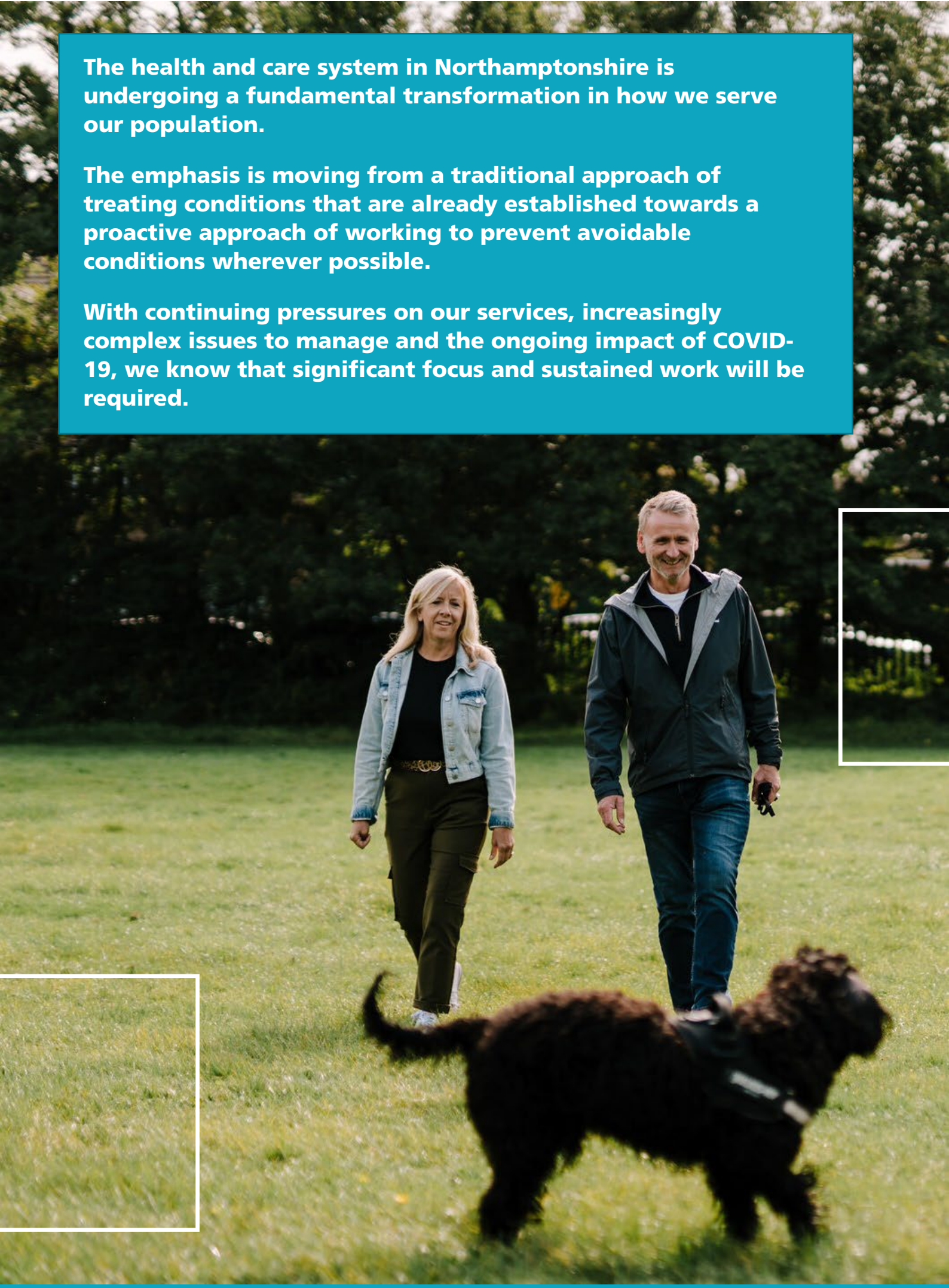
Our health and care landscape has changed significantly following the COVID-19 pandemic. Two years on, our NHS providers and their workforces are still navigating new ways of working, as well as needing to adapt to changing circumstances in their personal lives. We recognise that our staff feel the pressures 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

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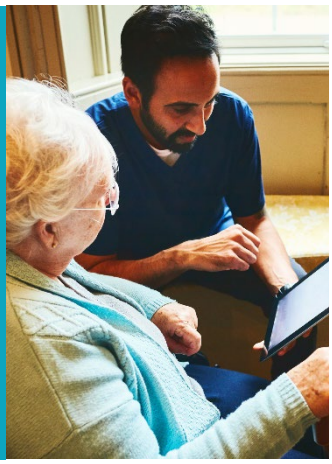
3.1 Our priorities will deliver our vision and aims

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.

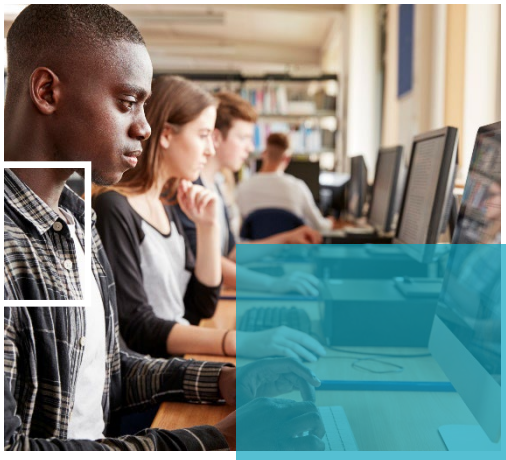
The digital programme is central to fulfilling our aims of improving health and healthcare outcomes, tackling inequalities, enhancing productivity and value for money and supporting broader social and economic development. Access to high-quality, joined-up data will support evidence-based decision-making, 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.

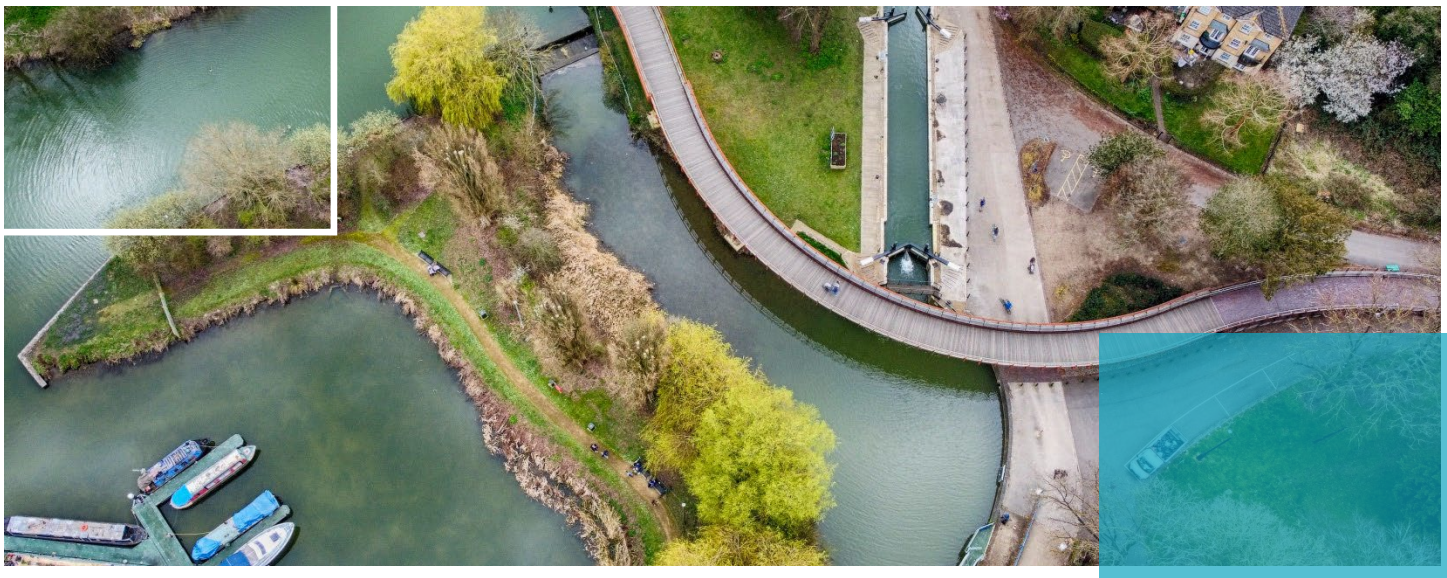
Our delivery partnerships vary in their maturity. We have examples of a range of partnerships from our mental health, learning disability and autism collaborative, through to transformation programmes. We will continue to work towards developing maturing partnerships that include multi-agency partnerships 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)

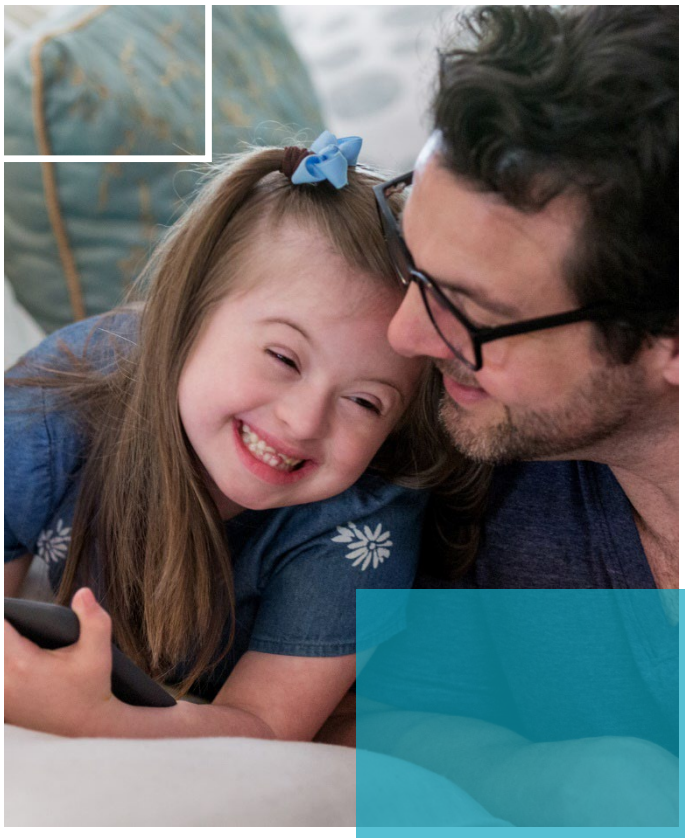
- Recovery action plan in place
- Deliver improvements to waiting times and access (SALT)
- Team reviewing operational practice and workflow
- Additional staff being recruited to target backlog
- Balanced System commissioned to undertake gap analysis of speech, language and communication needs and resource 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.

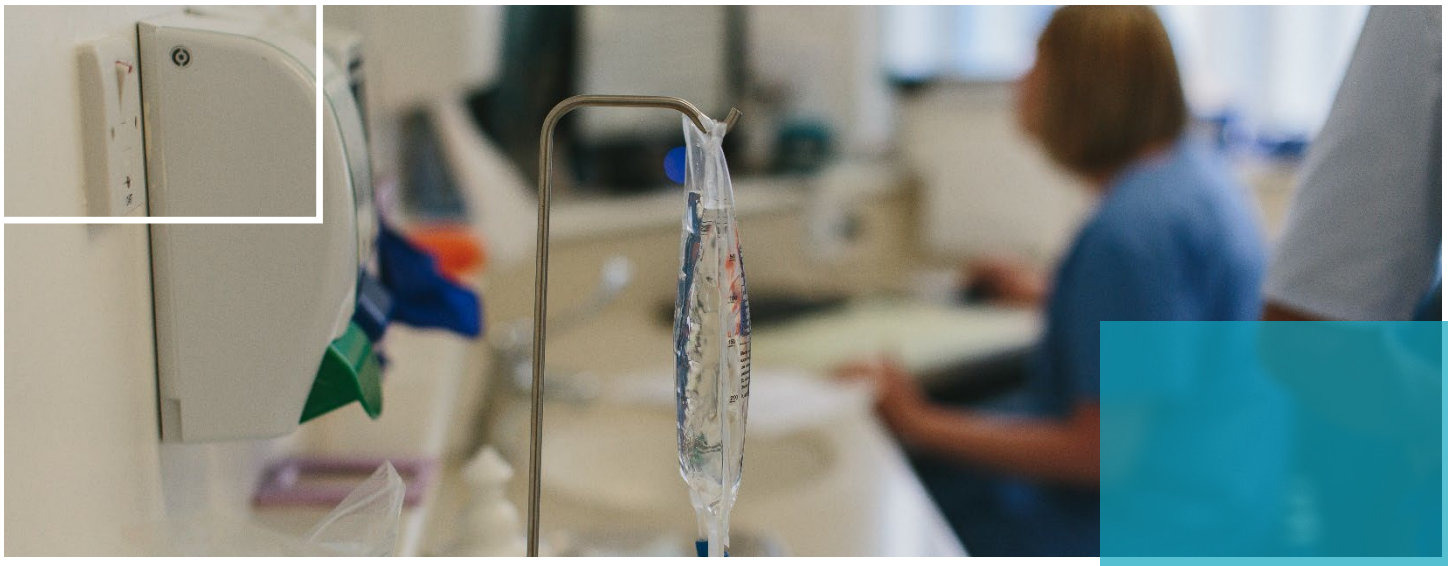
We will continue the development of the Assurance Framework (Medical Services) to drive improvement and address inequalities and necessary improvements to access across general practice. Further development will be required to incorporate pharmacy, optometry and dental functions (in line with ICB host).

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

6.1 Our people

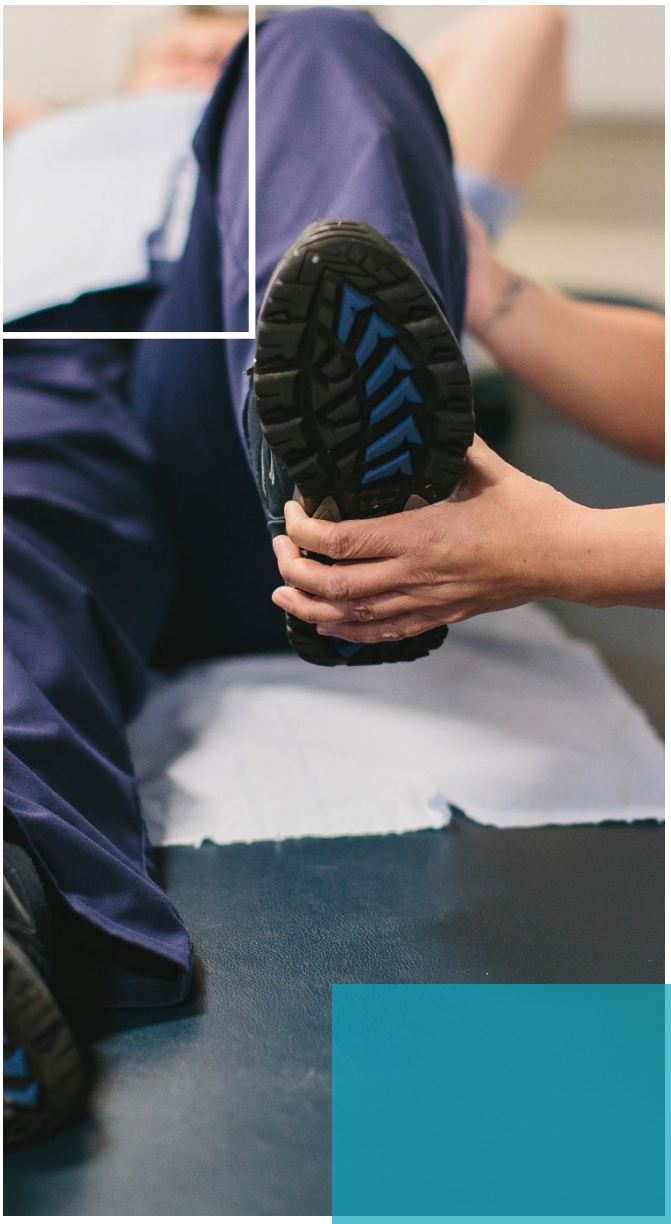
Where are we now?

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.

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