West Northamptonshire Council

NHS Northamptonshire Integrated Care Board

Integrated Care Northamptonshire

West Northants BCF 2023-25

Narrative Plan

DRAFT 0.1

1. Cover (1)

Integrated Care Northamptonshire

Board: West Northamptonshire Health & Wellbeing Board

Bodies involved in preparing the plan:

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

1. Cover (2)

Integrated Care Northamptonshire

How have you gone about involving these stakeholders?

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

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

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

Within the BCF activities we are bringing together services across our community partners, primary care leads, hospital front and back door activity, intermediate care and community services to make major improvements in outcomes, flow and efficiency. These have all been redesigned with a focus on keeping **more people well at home for longer and ensuring people get the right care in the right place**, aims aligned to the BCF national objectives.

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

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

2. Governance

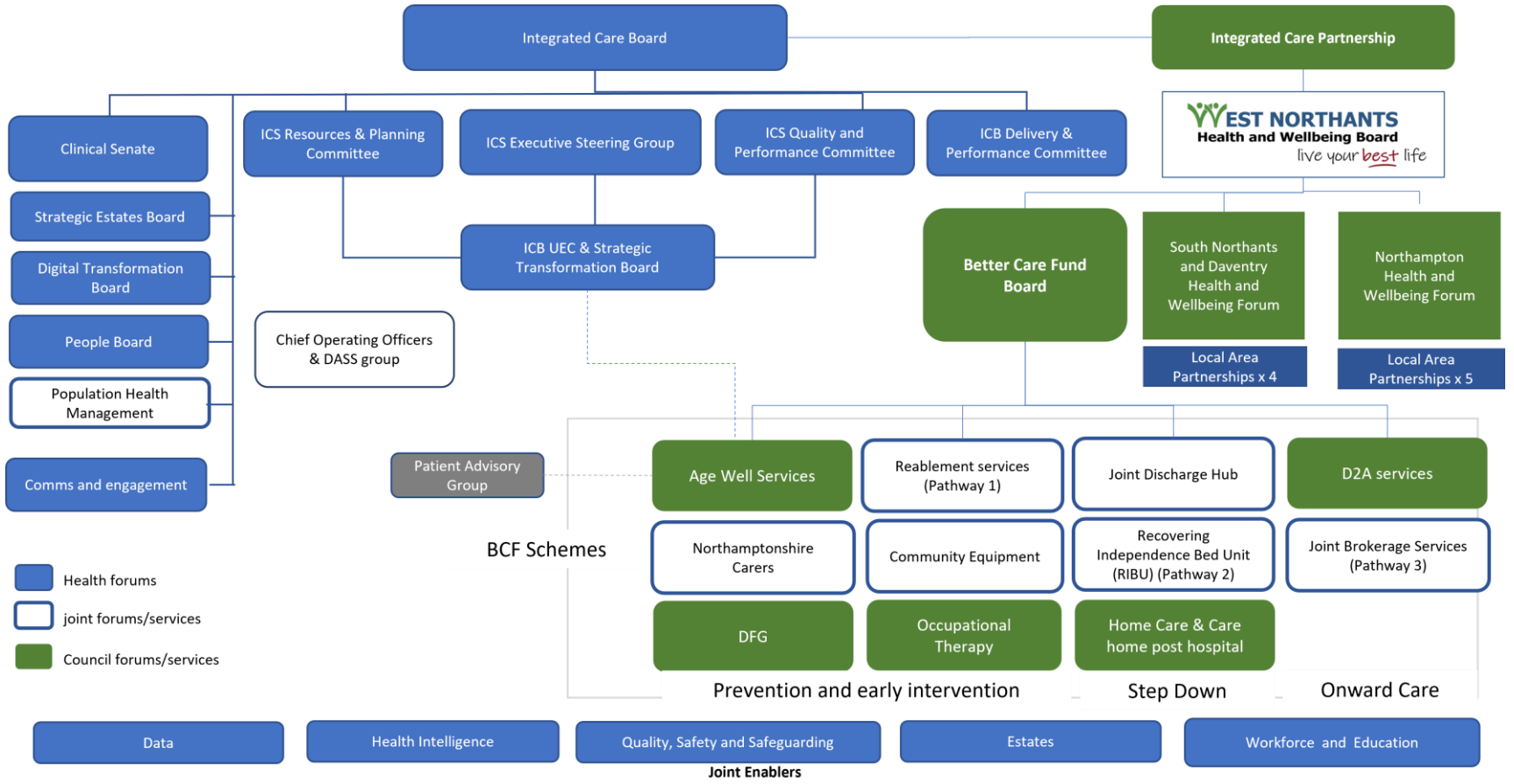
Integrated Care Northamptonshire

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

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

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

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



3. Executive Summary

Integrated Care Northamptonshire

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

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

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

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

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

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

3. Executive Summary (2)

Integrated Care Northamptonshire

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

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

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

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

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

3. Executive Summary (3)

Integrated Care Northamptonshire

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

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

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

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

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

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

RR Success of all Referrals		9267
as %		87.3

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

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

3. Executive Summary (4)

Integrated Care Northamptonshire

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

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

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

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

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

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

Integrated Care Northamptonshire

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

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

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

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

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

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

Integrated Care Northamptonshire

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

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

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

Our ICN strategy 10 system ambitions are shown opposite

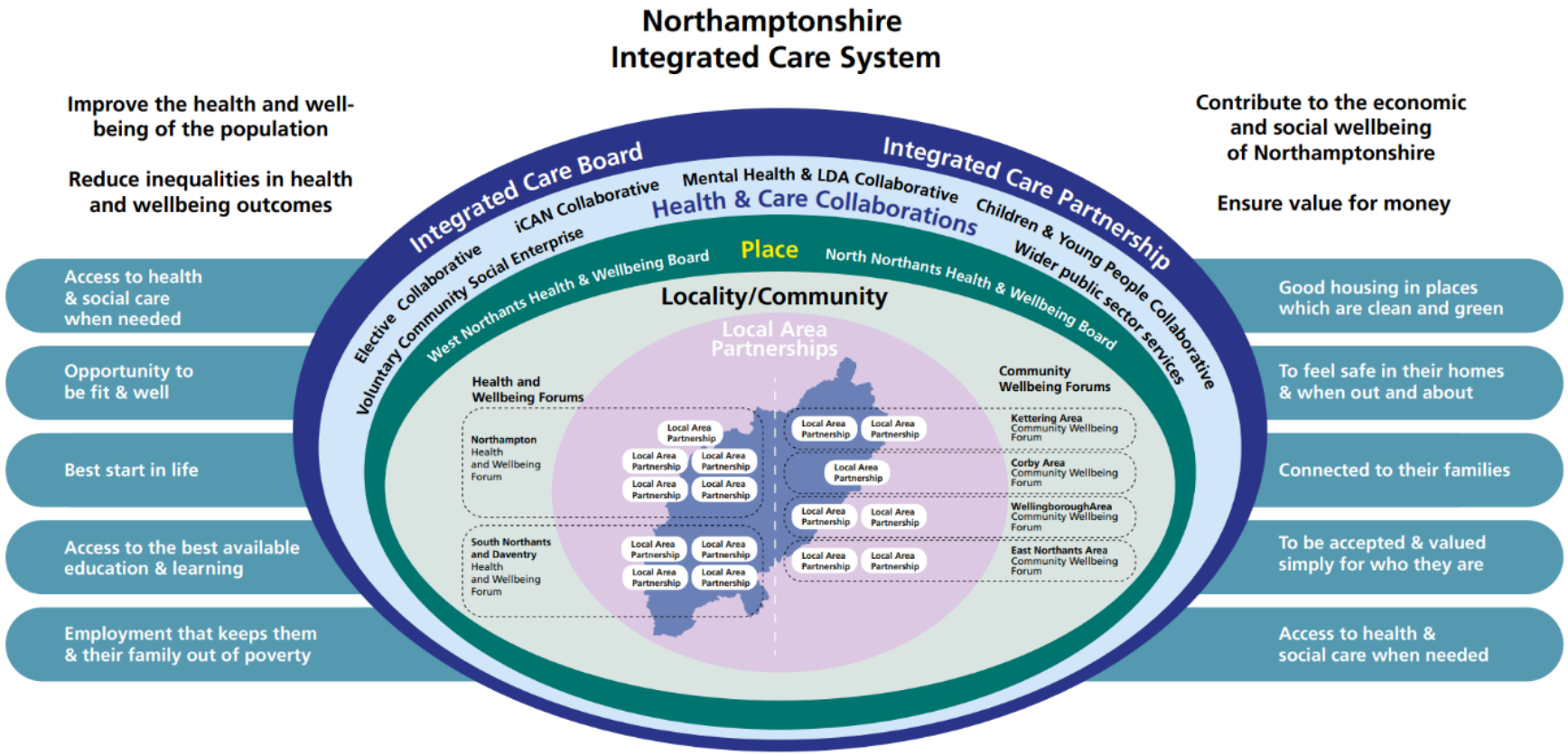
Ambition	Outcome
The best start in life	Women are healthy and well during and after pregnancy. All children grow and develop well so they are ready and equipped to start school.
Access to the best available education and learning	Education settings are good and inclusive and children and young people,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

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

Integrated Care Northamptonshire

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

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



National Condition 1 – Overall BCF plan & Approach to Integration

Integrated Care Northamptonshire

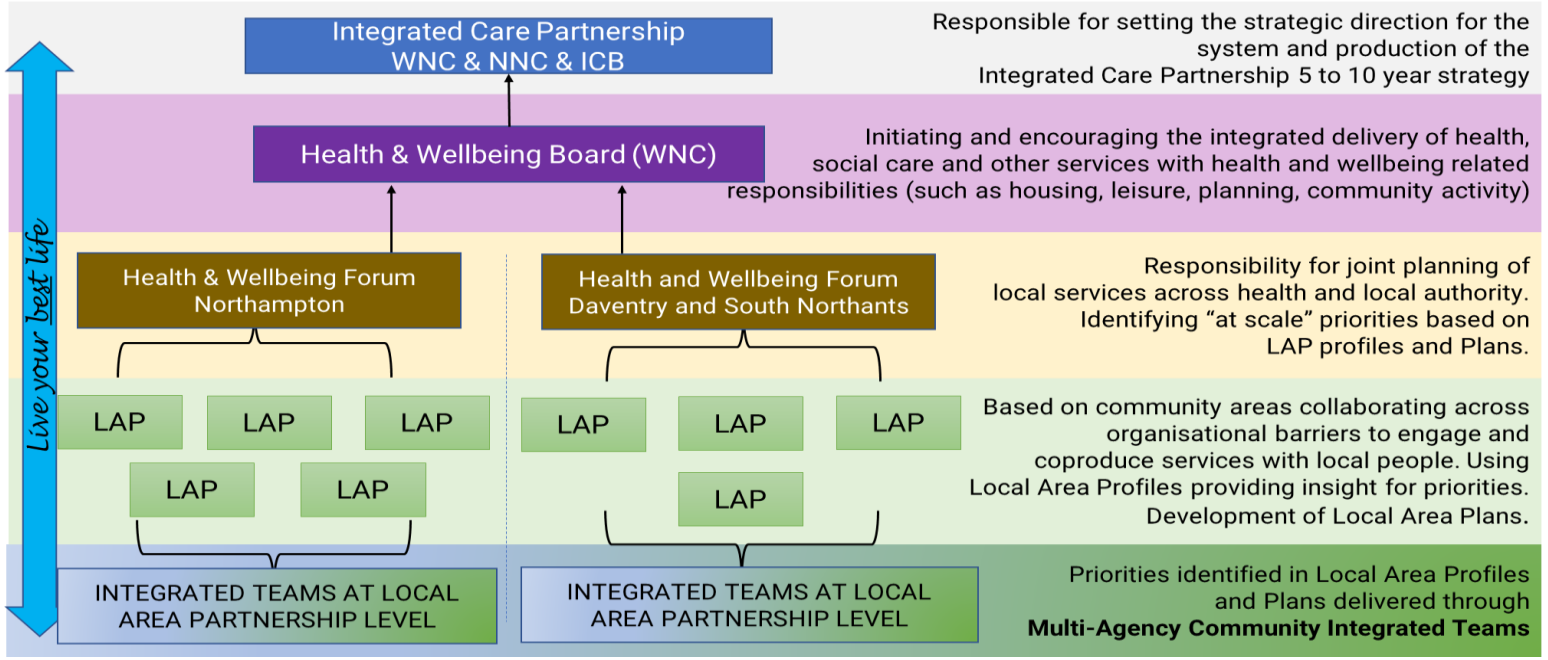
West Northants Place Development

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

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

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

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



National Condition 1 – Overall BCF plan & Approach to Integration

Integrated Care Northamptonshire

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

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

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

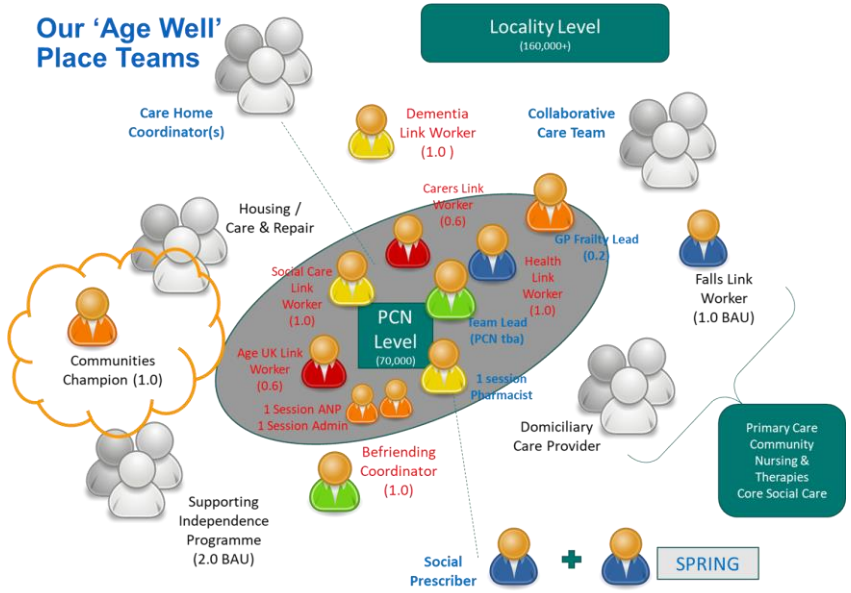
Integrated Care Northamptonshire

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

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

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

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



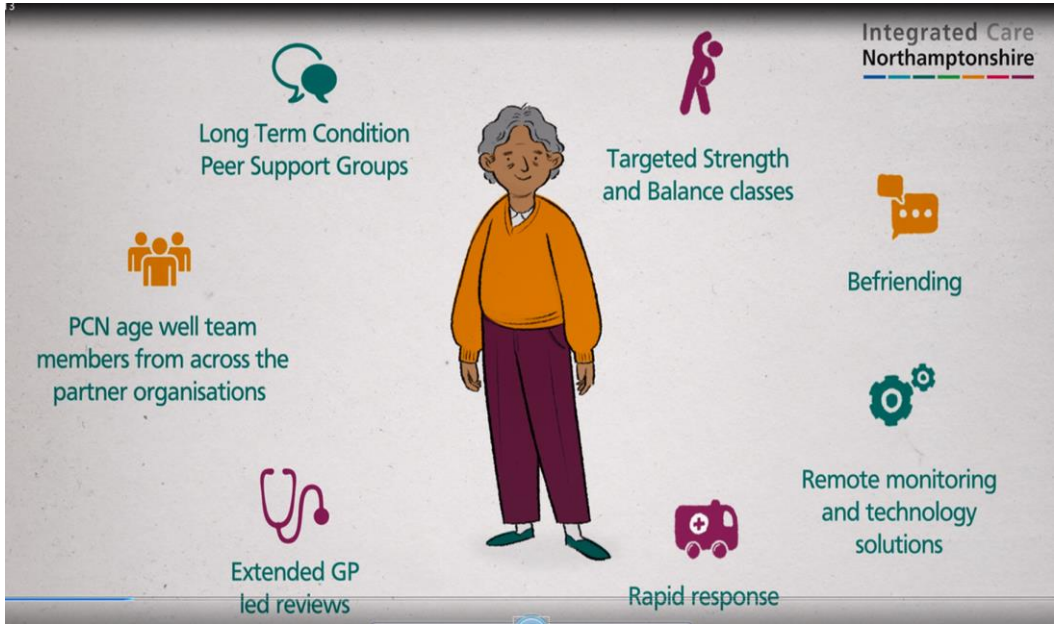
5. National Condition 2 – Enabling people to stay well, safe and independent at home for longer

Integrated Care Northamptonshire

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

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

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



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

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

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

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

Integrated Care Northamptonshire

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

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

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

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

Integrated Care Northamptonshire

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

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

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

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

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

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

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

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

Integrated Care Northamptonshire

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

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

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

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

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

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

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

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

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

Integrated Care Northamptonshire

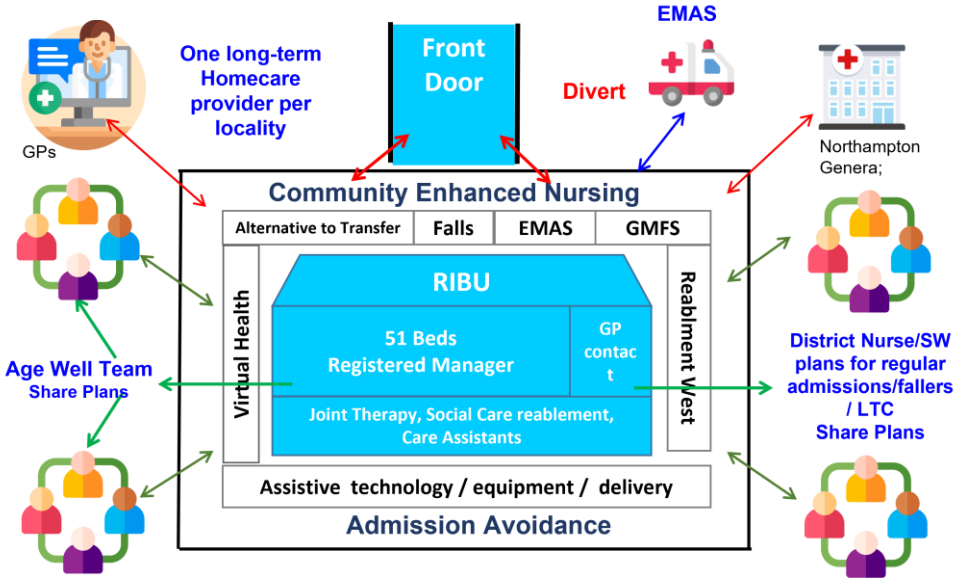
Please describe the approach to your area to integrating care to support people to receive the right care in the right place at the right time including, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support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

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

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

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

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



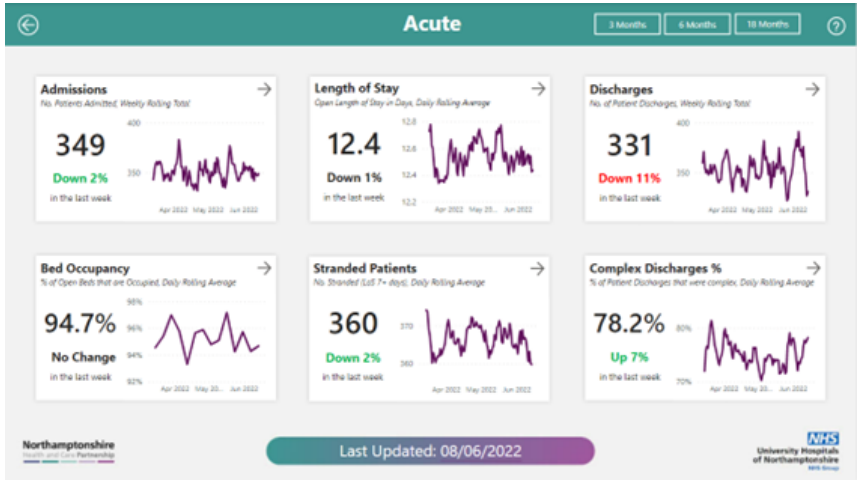
6. National Condition 3 - Provide the right care in the right place at the right time

Integrated Care Northamptonshire

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

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

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



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

Integrated Care Northamptonshire

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

Last year we made improvements across our discharge processes implementing good practice that ensures all patients will receive a letter on admission about their expected discharge expectations. In addition, we implemented a best practice model of 'What Matters to Me' when discussing expectations with patients. This created more focus on a strength based, home first focus for all patients so they don't stay in hospitals when they no longer need acute care. The ward referral and transfer of care hub processes were also improved to reduce the speed of the discharge decision making processes. Most of our delays in discharge queues, for both bedded and home-based intermediate care, are either when patients are waiting for capacity to become available, or when a patient becomes not medically fit, but the referral process is kept open. Our work in 2022-23 saw us make some significant improvements across our acutes

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

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

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

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

Integrated Care Northamptonshire

High Impact Change Model continued

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

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

Integrated Care Northamptonshire

High Impact Change Model continued

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

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

Integrated Care Northamptonshire

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

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

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

7. Supporting Unpaid Carers

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

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

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

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

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

8. Disabled Facilities Grant (DFG) and wider services

Integrated Care Northamptonshire

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

The BCF DFG plans and approaches within the plan has been agreed by West Northants Council as a Housing Authority and brings together Housing, DFGs, occupational therapy and social care come to ensure that DFG funding is used effectively to help people stay in their own homes longer. From a housing and accommodation perspective our health, care and housing leads have worked together to increase the capacity we have across the county that can support independent living through several lenses. Our occupational therapy teams are now working alongside the housing DFG teams as part of plans to invest in improving accommodation earlier, removing waiting lists and considering more significant conversions that can support complex care and be used by future residents. While we saw backlogs for adaptions in 2022-23 as a legacy impact from the Covid-19 pandemic, we have cleared this and we are now utilising all of our budgets including legacy underspend. In 2022-23 this saw the Council invest c£3.2m in major adaptations for owner-occupiers, private rented sector tenants, and residents of registered providers. This compares with the BCF DFG grant of £2.55m. We have also introduced some new elements of service including:

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

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

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

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

Integrated Care Northamptonshire

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

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

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

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

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

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

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

Integrated Care Northamptonshire

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

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

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

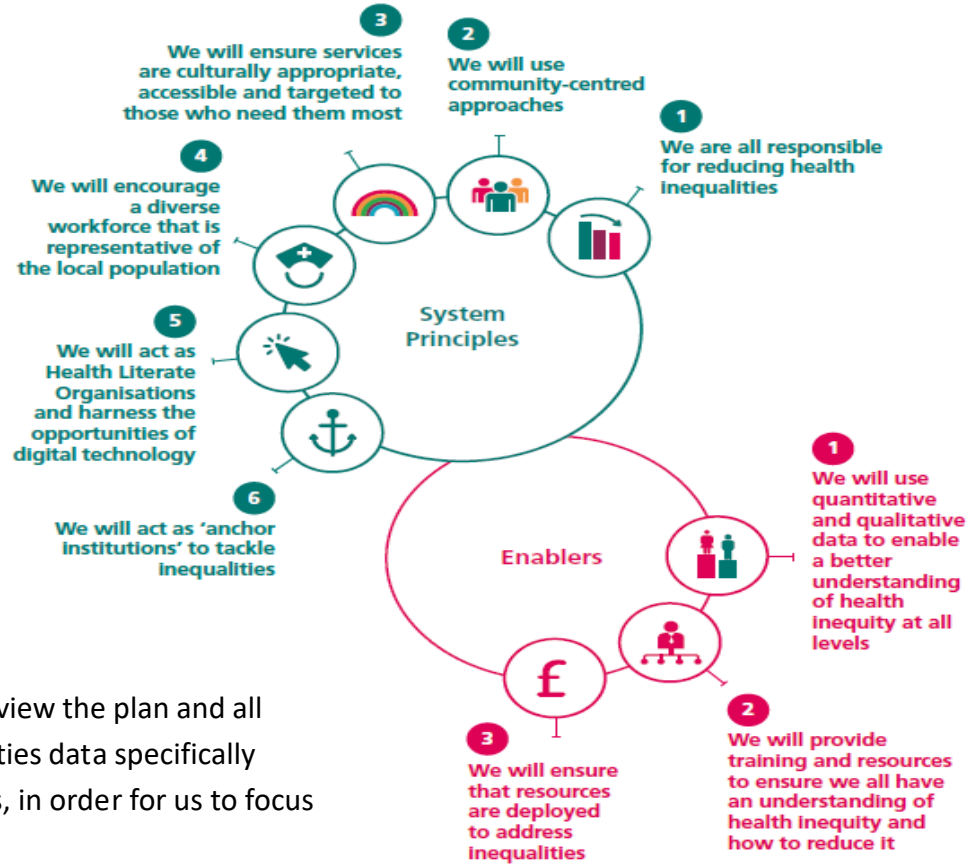
9. Equalities and Health Inequalities

Integrated Care Northamptonshire

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

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

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



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

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

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

9. Equalities and Health Inequalities (1)

Integrated Care Northamptonshire

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

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

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