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

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

Introduction

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

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

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

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

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

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

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

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

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

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

Context

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

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

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

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

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

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

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

Our Plan on a page

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

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Integrated Care Northamptonshire

Our shared 10-year vision

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

Our ICS aims

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

Our delivery focus areas

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

Multiple-impact interventions

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

Our approach to creating the conditions for success

Integration	Health inequalities	Data	Quality improvement	Prevention

Our delivery partnerships

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

Our enabling programmes

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

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

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

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

Live Your Best Life Ambition Outcome Metrics

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

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

Our multiple-impact interventions

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

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

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

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

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

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

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

Digital and Data

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

Supporting and recovering independence

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

Access to services

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

Children and young people

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

End of life

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

Multi-Impact Interventions
Summary of achievements for 23/24

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

Multi-Impact Interventions
High Level Metrics

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

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

Creating the conditions for success

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

Our approach to…

Integration

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

Health inequalities

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

Data

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

Quality improvement

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

Prevention

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

Our delivery partnerships

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

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Key Achievements for 23/24

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

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

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

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

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

Exceeding national targets for access to Specialist Perinatal Mental Health Services

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

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

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

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

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

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

Next steps

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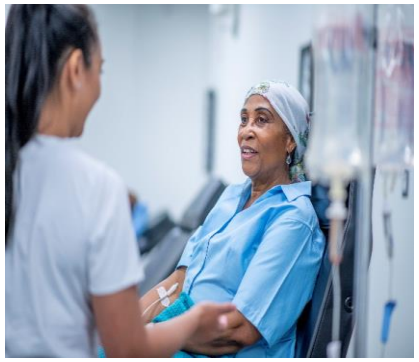
- Over the coming years, we will deliver our 5 multi-impact interventions at the same time as delivering progress on long term issues such as prevention and reducing inequalities.
- Whilst we have made progress in delivering our plan in 23/24, we recognise that as we move into 2024/25 there will be strategic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

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Appendix 1
Multi Impact Interventions Delivery Plans Updates

Digital Multi-Impact Intervention Year 1 achievements

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

Supporting and Recovering Independence Multi-Impact Intervention Year 1 achievements

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

Supporting and Recovering Independence Multi-Impact Intervention Year 1 achievements

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

Access to Primary Care Services

NHS
Northamptonshire
Integrated Care Board

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

Access to Primary Care Services

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

Our delivery plan for CYP Multi-Impact Intervention

NHS Northamptonshire

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

Our delivery plan for CYP Multi-Impact Intervention

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

End of Life Multi-Impact Intervention Year 1 achievements

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