1. Health and Wellbeing Board(s)

West Northants Council

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

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

2. How have you gone about involving these stakeholders?

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

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

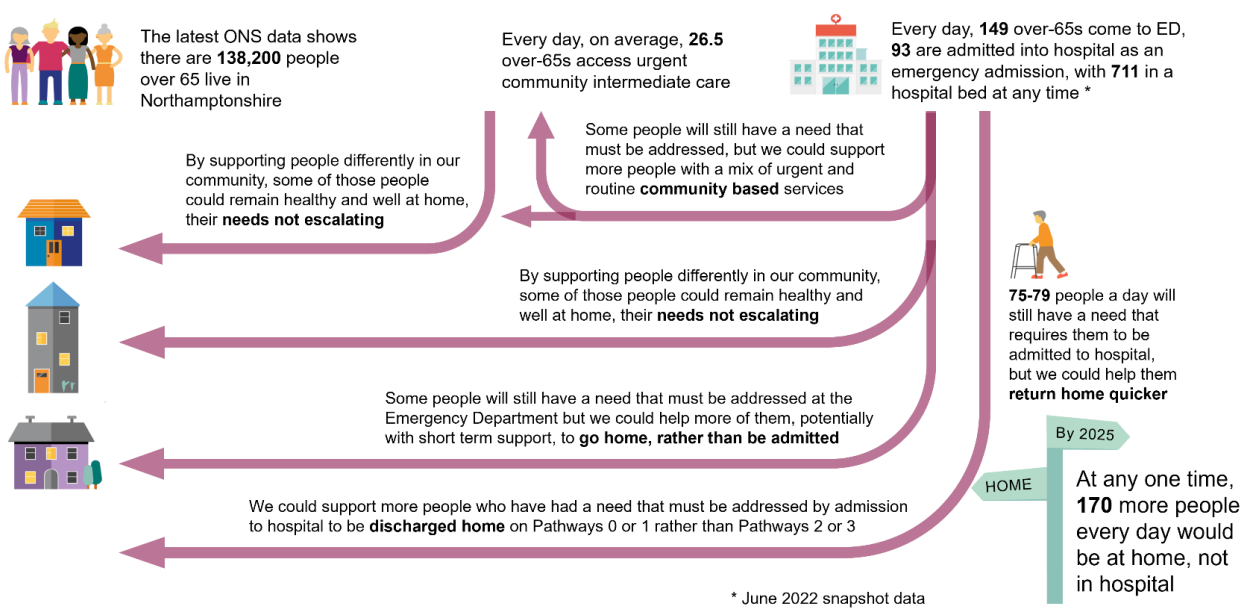
The ICAN BCF programme and budgets are overseen by joint health and care governance arrangements with all of the above partners engaged in monthly boards, weekly reviews and regular reporting to the ICB, HWBB and executives of all the partners listed. The programme is also working towards major improvement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

3. Executive summary

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

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

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



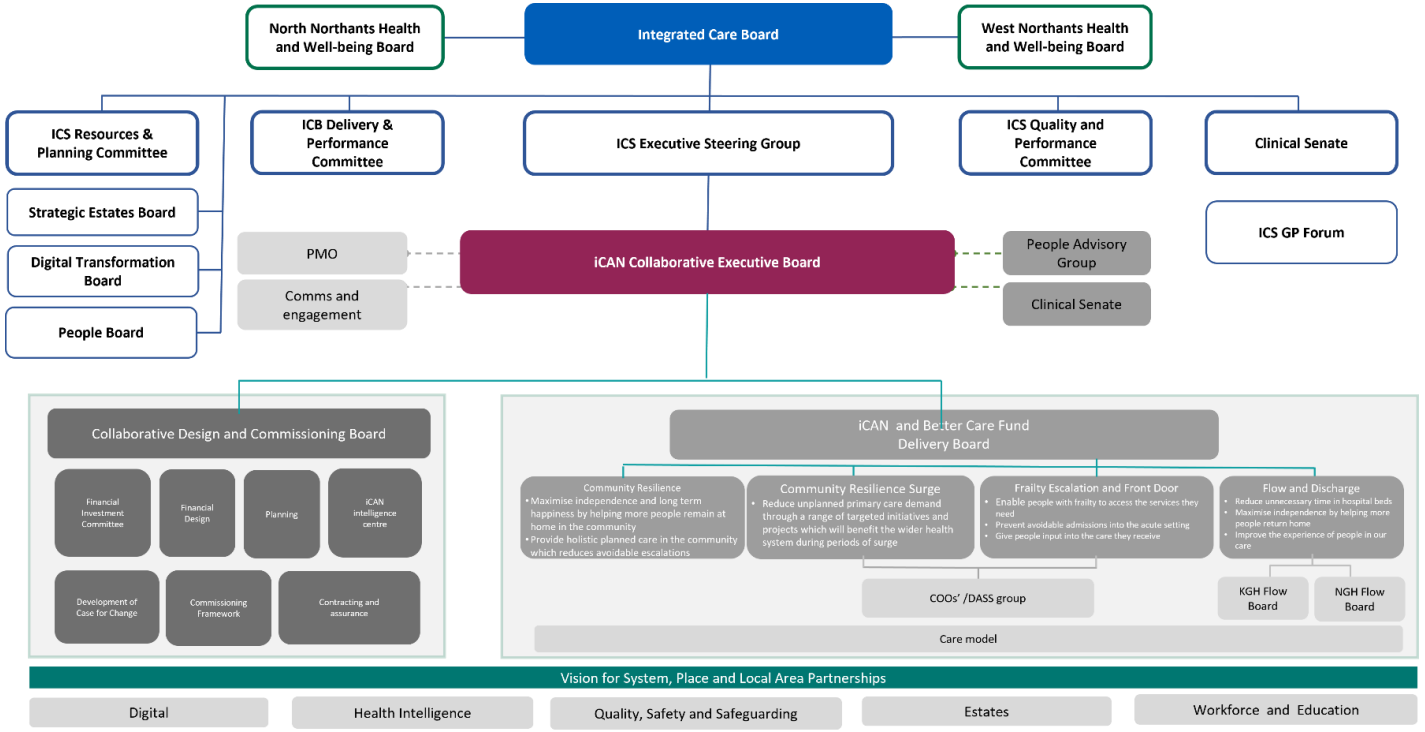
We are targeting over 65s within the BCF and ICAN and these specific improvements are designed to help us address our challenging demographic. Overall, the 2021 census showed that West Northants grew by 13% against a national average growth of 6%. But in the over 75s, West Northants saw growth of 58%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

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

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

4. Governance

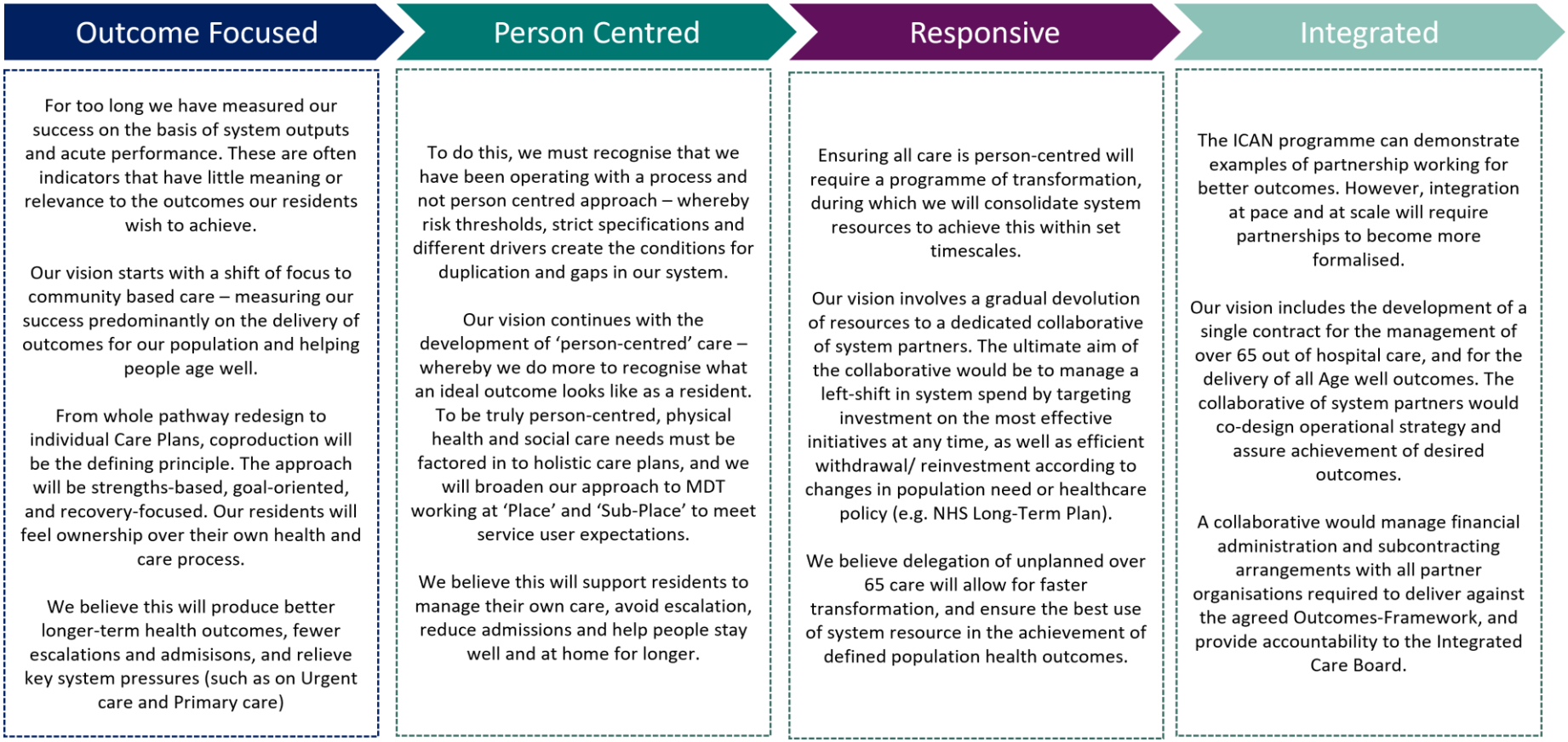
To deliver our ambitions, we have put in place the governance structure below that helps us oversee the BCF ICAN performance metrics and deliverables while also helping us transition ICAN from a transformation programme to an integrated service delivery model within a collaborative. This governance forms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



5. Overall BCF plan and approach to integration

5.1 Outline of Joint priorities for 2022-23

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



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

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

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

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

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

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

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

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

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

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

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

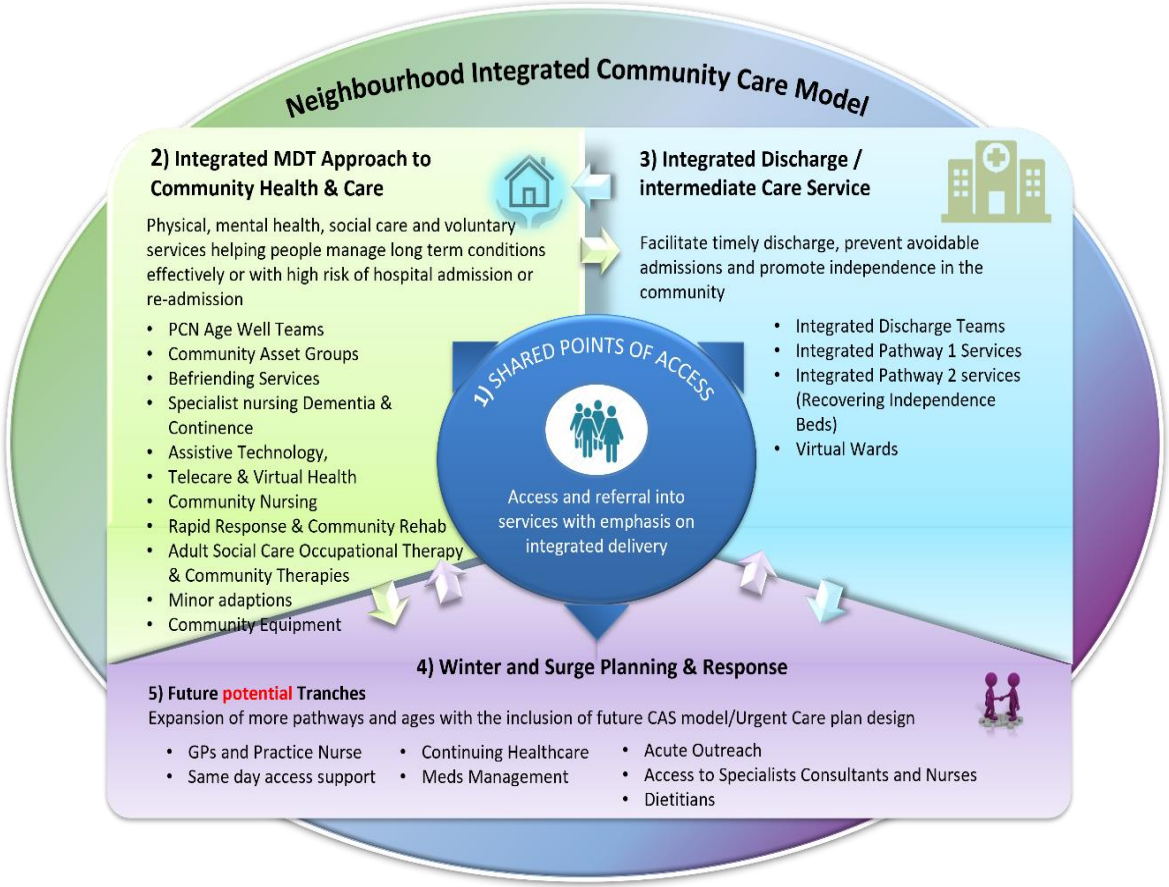
- **Board Rounds & Timely discharges -** Adopting new processes such as board rounds based on discharge best practice to enable a smooth and speedy flow through the hospital for our patients. The work here includes the development of an integrated Discharge Hub, improved early discharge expectations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

5.2 Approaches to joint/collaborative commissioning

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

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

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



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

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

The new shared remote monitoring hub

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

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

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

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

Redesigned intermediate care - pathway 1 services

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

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

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

New redesigned intermediate care - pathway 2 Pilot.

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

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

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

Who would the Integrated sites support?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.3 multidisciplinary teams at place or neighbourhood level.

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

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

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

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

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

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

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

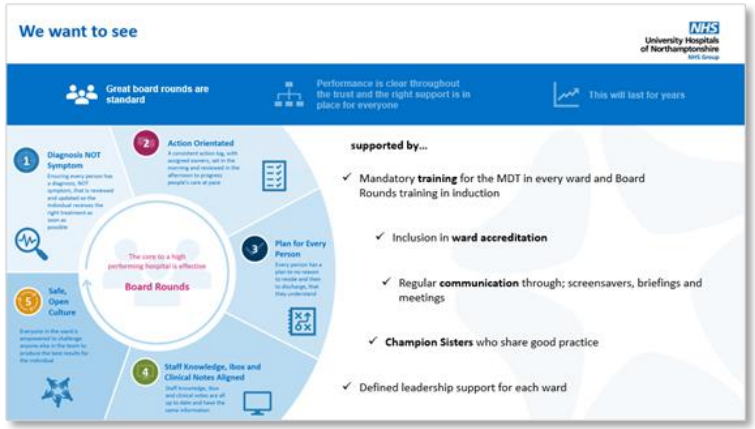
We are already seeing several of our PCNs moving to the next level of integration with their Care Home Coordinators attending shared team meetings with the Age Well staff and in some cases people with dual roles supporting people in their own home and a care home in their area. By having Age Well staff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

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

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

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

6.4 Support safe and timely discharge



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

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

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

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

6.5 Collaborative commissioning of discharge services to support this.

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

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

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

7. Supporting unpaid carers.

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

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

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

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

8. Disabled Facilities Grant (DFG) and wider services

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

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

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

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

9. Equality and health inequalities

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

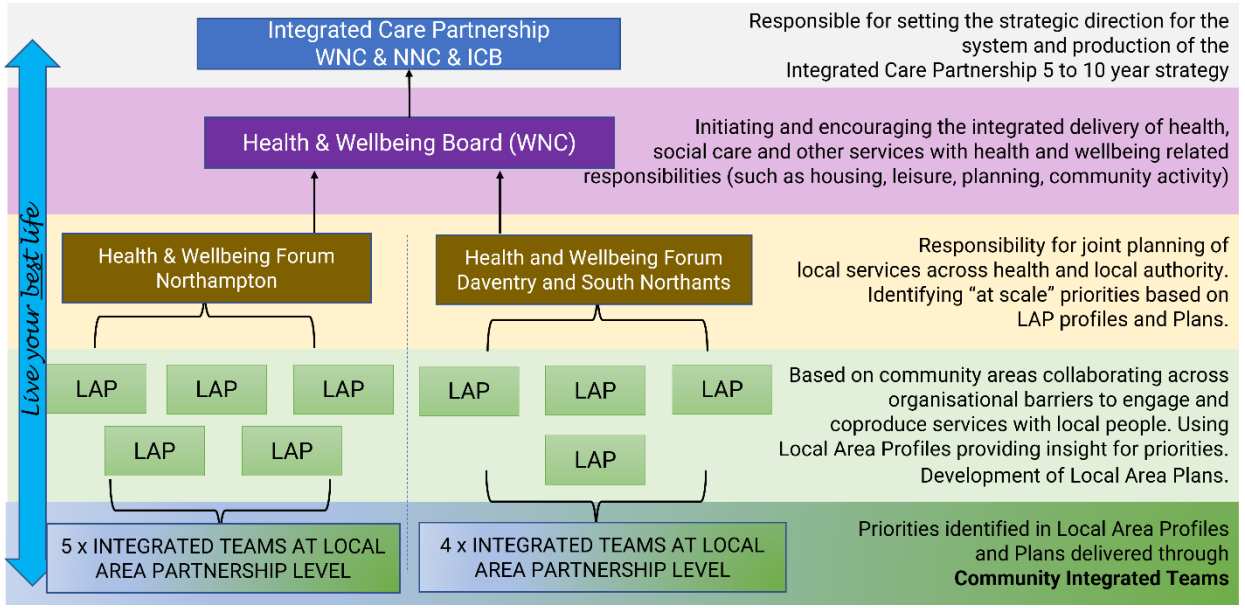
We have agreed 10 domains as part of our overall approach about people "**living their best life**" (LYBL) against which we will measure ourselves and identify and target identified inequalities.

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

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

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

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



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

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

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

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

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