North Northamptonshire Council

Meeting: Health and Wellbeing Board

Date: Tuesday 5th July, 2022

Time: 1.30 pm

Venue: Alternate

To members of the North Northamptonshire Health & Wellbeing Board

Cllr Jon Paul Carr - Chair	North Northamptonshire Council
John Ashton	Director of Public Health
Alan Burns	Chair, KGH and NGH Group
Cllr Scott Edwards	Portfolio Holder Childrens, Families, Education and Skills, North Northamptonshire Council
Naomi Eisenstadt	Chair, Northamptonshire Health and Care Partnership
Colin Foster	Chief Executive, Northamptonshire Childrens Trust
Shaun Hallam	Northamptonshire Fire and Rescue
Cllr Helen Harrison	Portfolio Holder Adults, Health and Wellbeing, North Northamptonshire Council
Michael Jones	Divisional Director, East Midlands Ambulance Service
David Maher	Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
Cllr Macaulay Nichol	North Northamptonshire Council
Oliver Newbold	NHS England
Mike Naylor	Director of Finance, East Midlands Ambulance Service
Dr Steve O'Brien	University of Northampton
Dr Raf Poggi	Primary Care Network Representative
Toby Sanders	Chief Executive, NHS Northamptonshire CCG
Chief Superintendent Ashley Tucker	Northamptonshire Police
David Watts	Director of Adults, Communities and Wellbeing, North Northamptonshire Council
Sheila White	Healthwatch Northamptonshire

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06	Disabled Facilities Grant	Amy Plank	1.45	
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Adele Wylie, Monitoring Officer
North Northamptonshire Council

Proper Officer
Date Not Specified

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Health and Wellbeing Board
At 2.00 pm on Thursday 10th March, 2022
Held as a North Northamptonshire Council Offices, Cedar Drive, Thrapston, NN14 4LZ

Present:-

Councillor Jon-Paul Carr (Chair)	North Northamptonshire Council
Councillor Helen Harrison	North Northamptonshire Council
Alan Burns	Chair, KGH and NGH Group
Naomi Eisenstadt	Chair, Northamptonshire Health and Care Partnership
Shaun Hallam	Deputy Chief Fire Officer, Northamptonshire Fire & Rescue Services
David Maher	Deputy Chief Executive Northamptonshire Healthcare Foundation Trust
Professor Steve O'Brien	University of Northampton
Dr Raf Poggi	Primary Care Network
Professor Will Pope (via Zoom)	Northamptonshire Healthwatch
Toby Sanders	Chief Executive, NHS, Northamptonshire CCG
Chief Superintendent Ashley Tuckley	Northamptonshire Police
Dr Jo Watt	Chair, NHS Northamptonshire
David Watts	Director of Adults, Communities and Wellbeing, North Northants Council
Lucy Wightman	Joint Director of Public Health
Sheila White	Northamptonshire Healthwatch

Officers

Cheryl Bird	Health and Wellbeing Board Business Manager
Jenny Daniels	Democracy Officer (Democratic Services) (Minutes)
Darren Dovey	Chief Fire Officer
Sam Fitzgerald	Assistant Director of Adult Social Services
John McGhee	North Northamptonshire Council
Hazel Webb	Community Services Manager

13 Apologies for non-attendance

Apologies were received from Councillor Scott Edwards and Councillor Macauley Nicol as well as Ann Marie Dodds (Director for Education), Michael Jones (Divisional Director EMAS), and Oliver Newbold (NHS England)

14 Notification of requests to address the meeting

None had been received.

15 Members' Declaration of Interests

The Chair invited those who wished to do so to declare interests in respect of items on the agenda.

No declarations were made.

16 Minutes of the Meeting Held on 2 December 2021

RESOLVED that: the Health and Wellbeing Board approved the minutes of the meeting held on 2 December 2021.

17 Action Log

The Chairman introduced this item (copies of which had been previously circulated) which gave details of actions that had been and were yet to happen. He reported the following:

- The Director of Public Health's Annual Report 2020/2021 had been circulated to members of the Board for feedback.
- Performance Data against re-ablement metrics had been completed and Sam Fitzgerald would provide an update later during the meeting.
- iCAN updates would be provided by Sam Fitzgerald later during the meeting.
- An update was awaited from the Communications Lead within Public Health on whether a directory of services could be linked to the COVID-19 website.

RESOLVED that: The Health and Wellbeing Board notes the Action Log.

18 Better Care Fund and iCAN Update

At the Chairman's invitation the Assistant Director of Adult Social Services introduced this update highlighting the following:

- Starting with the Better Care Fund (BCF) the first metrics around unplanned admissions would be updated that month and brought to the next board meeting.
- There had been a slight increase to 15.9% on the 14-day length of stay but it was still within the plan.
- The 21-day length of stay hadn't changed much.
- There had been significant work undertaken in the iCAN programme to reduce the length of stay in hospitals particularly around stranded and super stranded patients at the 7 and 21 day indicator. KGH had got the number of super stranded patients back down to approximately 80. With early discharge planning they were getting the right outcomes for patients and whilst it was a difficult story it was a positive one.
- 95% of people had been discharged to their usual residence which was positive.
- The effectiveness of re-ablement services had taken a slight downward turn. It was an accumulative target so it could be recovered.
- Re-admissions was slightly higher but the department was working on it.
- Permanent admissions to residential and nursing care are on an upward trajectory. In Northamptonshire a discharge to assess model is used, if people are not discharged to their normal place of residence, there is another opportunity for them to be assessed upon discharge.
- Some workshops were happening the following week but one of the key priorities was to be the single system dashboard so that they knew how many there were at any time. A surge in admissions for example who equate to a surge in discharges at a later date so they could deal with it.
- The adult social care team had not split on vesting day and had been created later in the year, so they were a relatively new service. There were 1,325

referrals to date which averaged approximately 120 per month. 60% of these came from acute discharge. Since September approximately 40% were around admission avoidance. So they were now working on discharge and avoiding admissions.

- There had been some challenges. An increase in the timescale that offered a like for like offer in reablement from admissions. Those who have had a need for long term input had created some issues in the throughput.
- In the last quarter there had been a 20% re-admittance rate, but they had taken some mitigating actions and the department was looking at how they could take advantage of more opportunities so that people could be kept at home.

Queries on the update were answered as follows:

- Data for those still undertaking treatment was recorded daily. Discussions were around a person's identified needs. Those working in therapy, social care and medical services had input to ensure the patient was sent home once it was deemed safe to do so and with the right support. There was also a mechanism for checking on them once they were at home.
- Chief Executives across the health sector had reviewed late discharges to see how they could be improved for the autumn and winter. A fuller conversation on this would be appreciated so as not to repeat the previous winter experience and improve the patient experience.
- There were care co-ordinators to help patients who had just left hospital and to assist in avoidance of hospital admissions by supporting patients and their families.
- The patients where delays had been caused were in their own homes. On average the department was aware that they were reducing people's need for care and support by 4.9 hours. However, they were reliant on the home care service to have their residual care needs met. It was a national challenge and something they were attempting to work on locally. This statistic was being monitored very closely. A pay increase had been offered and a retention payment but more reablement for avoidance as well re-admittance to hospital was required.

RESOLVED that:

a) The Health and Wellbeing Board notes the update; and
b) Sam Fitzgerald would bring data on the unplanned admissions metric to the next meeting.

19 COVID19 Update:

At the Chairman's invitation the Director of Public Health provided an update noting the following:

- There had been an increase in the last 7 days. This had been replicated in the East Midlands. In North Northamptonshire there had been a 4% increase in the last 7 days. There had been a 23.4% increase in those over 60 years old.
- The case rates had decreased from a couple of days previously. The key was for people to practice safety measures like wearing masks.
- At the end of February there were 12 outbreaks, mostly in health and care settings, with approximately 10 cases were seen with each outbreak.
- Free lateral flow testing would cease at the end of March. Health and care settings would still be required to undertake PCR testing. There was a need for Public Health Teams to work with the UK Health Security Agency to ensure they were proactive in their management of any identified variants.

- Testing sites would remain until the end of March and were noted on the Council's website.
- Of all the vaccinations delivered the previous week half of them were still first doses. Targeted preventions to reach the hard to reach were beginning to work and the number of boosters given was increasing.
- The number of hospital admissions due to COVID19 complications had been steadily falling. There had been an increase the day before in the number of admissions, but this demonstrated the variability rather than a trend.
- The national guidance was that people were not required to self isolate or test regularly if they did not wish to. However, the public were advised to continue using COVID19 safe practices recognise there was a beneficial impact to them still doing it.
- Vaccinations were still available even though contract tracing had now ceased.
- Those supporting particular targeted people were also supported.

The Chief Executive, NHS Northamptonshire Clinical Commissioning Group added the following comments:

- There had been 1.48million jabs administered to people across Northamptonshire. These had been provided by Primary Care Networks, community pharmacies and the mass vaccination centre. The booster programme had vaccinated over 80% of the eligible population.
- The focus of the vaccination programme was second doses for 12-15 years, first doses 5-11 years, and cohorts of the population where vaccine uptake has been low.
- 15,000 jabs had been administered in a single day in the week before Christmas. They were now administering 400 or 500 a day.
- There would be a springtime booster programme and there could be an autumn programme. The lease had been extended at the vaccination centre at Moulton Park for a further 12 months. Some of the capacity would be stepped down over the summer and increased as and when required.
- Peaks in the need for vaccinations were expected as they were required if someone wished to go abroad.
- Work was also being undertaken with schools to get the message through to people that those wishing to go abroad would need a vaccination. They would ensure it was included in Headteacher newsletters.
- A new service had been made available to 12 to 15 year olds so that they could access proof of a COVID vaccination without their parents requesting access to the entire notes.

In answer to queries on the update the following was confirmed:

- Sewage testing was a way of monitoring prevalence of the virus, but not new variants and this is also being stepped down.
- Following the decision by central government to revoke the mandatory requirement for all health and social care staff to be vaccinated against COVID19. Adult Social Care were doing all they could to contact those that had left the service and entice them to return. Many people chose care as a profession because they genuinely wished to make a difference and whilst many had obtained other jobs the grass may not be greener, and they may wish to return to care. Many also could not afford to live on the wages offered in the care sector and more was required for people to see the benefits and feel valued. Many did not see it as a career and whilst there were opportunities more had to be done to ensure people could see them. They were undertaking

some work with colleges, and they would work with the new Assistant Director for Education around the relationship with schools to ensure they were aware about jobs in healthcare and career paths.

- Some high-level demonstrations on how a career in social care could start were being undertaken. Ways to see a pathway within the system. Building their own was a big part of it and offering apprenticeships, management opportunities and training was included. They aimed to 'make a difference in an everyday' campaign and reach out to those who would like to work in social are.
- The message that was required had to be strong enough to let people know that flu would not close a hospital ward, but COVID did.
- The public need to be reminded that national guidance is they must still wear face coverings in health and care settings, to protect vulnerable patients. This has led to confusion and some staff members have experienced frustration from members of the public when reminded.
- The opportunity to tap into the Kettering General Hospital bank staff and provide them with opportunities would be exploited. They could be offered a change of setting and environment as a way of moving on within their career.

The following was also noted:

- There was a need to ensure that messages given were provided as simply as possible.
- In all NHS settings it will be continued to be emphasised that front line staff have a responsibility to be fully vaccinated against COVID19 to reduce transmission.
- As COVID was experienced for longer they were beginning to understand it better and were beginning to understand the impact of long COVID.

RESOLVED that:

a) The Health and Wellbeing Board notes the updates;
b) The Director of Public Health will ask for a media campaign to be included in Head Teachers newsletters; and
c) Steve O'Brien and Sam Fitzgerald to discuss opportunities for a PhD student.

20 Director of Public Health Annual Report 2020-2022

At the Chairman's invitation the Director of Public Health provided an update stating a white copy of the report had been shared in January. One of the reflections made in it was around COVID. It had been delayed because the Public Health team had been focussed on countywide COVID19 response so with the relevant portfolio holders had agreed they would publish it as a 2-year report. This was being finalised and would be brought back to the next meeting.

RESOLVED that: the Health and Wellbeing Board agrees to the addition of information to cover 2022-2022.

21 Critical Incident Update

At the Chairman's invitation the Chief Fire Officer provided the following update in his position as the Chairman of the local resilience forum:

- The local resilience forum was the forum by which local incidents were managed on behalf of Central Government. The areas were based on police areas, so this forum was the Northamptonshire local resilience forum.

- The previous summer Central government had started to talk about taking away restrictions and focussing on recovery. There was a recovery workshop held in October 2021, and the recovery co-ordination group changed to a multi-agency co-ordination group to be able to share information more efficiently between partners.
- At a meeting held on 6 January 2021 everyone had come together and all agencies had reported on the pandemic, and it became clear that staff absences had really increased across the whole spectrum. They had therefore stepped up to a major incident and very quickly they struggled to create the capacity that was required.
- Those in social care had struggled to take people in from hospital. There wasn't a lot of support from Central Government, and they had learned a lot in terms of the importance of having the capacity to deal with it and sharing information when declaring a major incident.
- Not everything had been discussed in a debriefing yet but having spoken to other local resilience forms in the country it appears to have been a regular issue. People struggling to be able to offer assistance to other agencies whilst delivering business as usual. It did not get as bad as they thought it might and the outlook had begun to improve from 26 January 2021.
- Health and Social Care settings managed to sort things out themselves, so they stepped down from the major incident. Structures they would generally use had been used to deal with short term issues like fires and floods but the pandemic has been 2 years so it was felt there was a need to review structures and training could be needed.
- The military had stated they were providing assistance, but the local resilience forum had not requested any. The regional director of health was thought to have requested it.
- It was felt correct to have called a major incident when they had but they needed to ensure everything was in place should things deteriorate, and they had struggled to create the capacity that was required.

In answer to queries on the update the following was confirmed:

- There were more challenges faced in the west Northants team. The original request came from West Northamptonshire Council and was thought to enable them to move and bolster care services.
- There was a need to think widely around how communities were utilised to assist them better. They could be used to assist domiciliary care for example by checking on neighbours. This would free up professionals to see more vulnerable people.
- Until the ongoing challenges were addressed adequately there would be peaks and troughs.
- Colleagues including the police were assisting other colleagues and it was easy to see the added value of that. They really struggled despite people's best endeavours however to create the capacity really required by the service. Something had to be done to change the underlying issues.
- The arrangements had worked well but the national learning from the experience would be about the suitability to deal with incidents over a longer period. The good thing was that the Local Resilience Forum was a partnership so there was an integrated review of what had happened. The Local Resilience Forum could be tasks to review what the risks were for future use.

RESOLVED that:

a) the Health and Wellbeing Board notes the report;

b) the Health and Wellbeing Board notes the purpose of the Local Resilience Forum (LRF) and its role within planning, preparing and responding to a health emergency, nationally or locally; and

c) Notes category one responder's responsibilities in relation to the Local Resilience Forum.

22 Health Inequalities Plan.

The Director of Public Health gave a presentation on Health Inequalities Plan for Northamptonshire and highlighted the following:

- Addressing heath inequalities was one of the statutory functions of Health and Wellbeing Boards.
- NHS England required that all ICS Systems had a Health Inequalities Plan. The draft plan must be submitted to NHS England by 31 March 2022.
- Production of the plan would be co-ordinated by the Director of Public Health, but this would be a system-wide plan and needed to articulate how partners would work together to address health inequalities, that is fully embedded in ICS systems
- Between April and June 2022, the draft plan would need to go through the Board approval process, with all key ICS Boards required to sign off the agreed strategic approach and the plan needed to align with existing Joint Health and Wellbeing Strategies and Joint Strategic Needs Assessments.
- The draft plan would have an introduction to health inequalities, setting out the national and local context.
- There was a new health inequalities framework being produced by NHS England: 'CORE 20+5' framework. This set out the approach to address health inequalities. This framework would focus on 20% on the most deprived populations, any other local priority populations and five areas that needed to be addressed
  - Maternity
  - Cancer
  - Respiratory
  - Cardiovascular disease
  - Mental health
- A data pack would be produced which reflected where we are now in terms of inequalities,and the plan would set out a broad guide of principles of actions all needed to take across the system, these would include:
  - Everyone needed to understand what health inequalities are and their role in this, and how we support staff to do this.
  - Included a collection of data and understanding of needs, working with communities to understand their needs as well as a community led approach in co-production of services.
  - Building health inequalities into our quality improvement processes.
- The plan would reference priority areas, including the Core 20+5 Framework, as well as how the system will work together to address the wider determinants of health:

➢ environmental impact,

- considering physical and mental health,
- ill health prevention programmes,
- vaccination and screening, health care services,
- social care services
- end of life support.

- This plan would be high level strategic aims around each of the areas and setting out commitment and vision but alongside this there would be PLACE based plans being developed with associated actions.
- Also included in the Plan would be how to monitor progress, how this would link in with the ICS Outcome Frameworks and ensuring health inequalities was embedded into the governance structures.
- Health inequalities was already embedded in the work of the four collaboratives.

RESOLVED that: the Health and Wellbeing Board notes the update.

23 Integrated Care system Outcome Frameworks

The Director of Public Health gave a presentation on the Integrated Care System Outcome Frameworks and highlighted the following:

- Locally they had been tasked to identify what the core issues were in communities to improve outcomes, by doing this through an outcomes framework.
- They used information available at this time to identify areas to improve the outcomes local people experienced across health and care, based on benchmark data.
- They used an outcomes framework to inform the 2022/23 ICB strategy
- There would be different ways of cutting the data to provide insights for targets set, these included national and local data.
- The outcome list was based on a life course approach, cost effectiveness of services and would align with some of the work already completed.
- A multi criteria analysis tool was adapted to prioritise outcomes. It looked at:
  - reducing health inequalities,
  - health gain,
  - improving the care process,
  - improving access to services,
  - achievability,
  - sustainability.
- A short list of outcomes was produced using a life course approach. To take an equitable approach across the different stages of a life course and each of these outcomes aligned to one of the four collaboratives for delivery:
  - mental health,
  - children and young people,
  - elective care
  - iCAN.

The Board discussed the presentation, and the following was noted:

- It was felt that having a clear methodology behind prioritisation of outcomes was important as it assisted them to understand why certain priorities were more important than others.
- A lifecycle approach was about being preventative at every stage.
- It was felt that people working on population health management at a primary care network level, by identifying families in need interventions could be created for them to improve their outcomes.

- It was felt that applying an outcomes framework to the PLACE based work and working with the community safety partnership and local authorities to contribute the right environments for people to get out and exercise and keep mobile would lead to a positive impact.
- It was felt that work in the communities would deliver the scale needed improve these outcomes.

RESOLVED that: the Health and Wellbeing Board notes the presentation

24 Integrated Care System Update

The Designated Chair of the Integrated Care Board gave an update on development of the local Integrated Care System highlighting the following:

- The Integrated Care Board (ICB) would operate in shadow form from 1 April. Dr Jo Watt would continue to chair the CCG until 1 July.
- 3 of the 4 NEDs had been recruited.
- Local authority chief executives would be sitting on the ICB with NHS executives to make decisions on NHS spend.
- The ICB would be a federation of key partners who would have an equal role to play in the decisions on NHS spend and the decisions would be based on what was agreed as the priorities from the outcomes framework; not what was best for individual organisations.
- A strategic change from 1 July would be Oundle coming back into Northamptonshire.

The Director for Adult Social Services gave an update on the PLACE based element of the Integrated Care Partnership and highlighted the following:

- Two previous workshops on how new formed integrated care partnerships would work and align with local authorities had taken place.
- Challenges were how the organisations with different governance functions would work together.
- North Northamptonshire had a different set of proposals to West Northamptonshire.
- For the North there would be four area wellbeing forums: Wellingborough, Kettering, Corby, and East Northants. For each wellbeing forum there would be 2 local area partnerships.
- To work with PLACE, there was the need to work with communities and neighbourhoods that local people recognised.
- To deliver at PLACE there needed to be a group of individuals and organisations that would become the delivery group, and this was represented by the North Northamptonshire Health and Wellbeing Board Delivery Group. The Health and Wellbeing Board delivery group would look at ward population levels and needs to determine the final wellbeing forum and local area partnership boundaries.
- Wellbeing forums would be where partners came and discussed health and wellbeing services, and how to support these. The local area partnerships would be the delivery organisations. There needed to be strong relationships between the wellbeing forums and the local area partnerships.
- The Wellbeing Forums would act as an information conduit between the Local Area Partnerships and this Board, to provide feedback on what strategies and policies would mean for local communities.
- Local area partnerships would have a population size of approximately 50k and would have individual priorities depending on local area need. They would be small

enough to provide personalised support. Support required would be identified through a local area profile.

- The wellbeing forums would represent a population size of approx. 60-100k. Membership of the Wellbeing Forums would include statutory organisations, elected members, voluntary sector, schools, and those who wanted to contribute.
- The Health and Wellbeing Board delivery group would look at ward population levels and needs to determine the final forum and lap boundaries.
- There was a need to consider expanding membership of this Board to include representative(s) from the Community Forums.
- There was a wish to encourage local communities to think about what they could bring to the table; particularly around local neighbourhood needs.
- Discussions on how monies may be devolved would take place over the next two years, and how local areas could tap into this.
- Discussions on the size and location of community hubs were ongoing.
- North Northamptonshire corporate priorities would develop in consultation with the public as well as with strategic partners. These priorities should be the principles that he community hubs ultimately should approach.
- There was a need to consider development of the terms of reference for the four wellbeing forums, and how they would work.
- There was a need to consider development of a North Northamptonshire Health and Wellbeing Strategy and how this would align with the ICB strategy.
- Social capital needs would tap into this model to mobilise communities. The approach should be to empower individuals from the bottom up on how they think the Local Area Partnerships should look.
- There was a need to ensure there was commonality across both West and North Northamptonshire for those delivering countywide services but recognising individuality.

The Board discussed the update, and the following was noted:

- The Wellbeing Forums and Local area Partnership approach would help services across areas and neighbourhoods.
- There was a need to evolve the previous Health and Wellbeing Forums rather than re-develop Community Wellbeing Forums, as this could lead to a loss of impetus and engagement with communities.
- There was a need to make North Northamptonshire a more attractive area to work in.
- Northants Police were building a new neighbourhood policing model and the timescales could align with development of the Local Area Partnerships.
- More clarity was needed on who the representatives would be on the Health and Wellbeing Board Delivery Group.
- The Health and Wellbeing Board's ambition should be to have a more expansive workplace based agenda and holding the delivery to account.
- The Health and Wellbeing Board needed more representation from community groups and primary care networks.
- The Health and Wellbeing Board needed a broader membership not necessarily a larger membership, as there was a risk the Board could become too big and unwieldy.
- The focus of the collaboratives was more around prevention and local based delivery of services.
- The Wellbeing Forums could have a rotating membership at the Health and Wellbeing Board.

- There was a need to consider the current Board membership and the purpose of them being on the board, to focus on PLACE.
- There was also the need to consider how representation from schools and leisure providers were involved in wellbeing discussions apart from the contractual ones and housing.

RESOLVED that:

a) **The Board agreed with the principles/model of having 4 Community Wellbeing Forums, 8 Local Area Partnerships and a Health and Wellbeing Board Delivery Group.**
b) **David Watts would contact individual organisations on the Board to discuss in more detail, representation on the Board.**
c) **David Watts would produce a proposal and Terms of Reference for the Health and Wellbeing Board delivery group and how to evolve the Health and Wellbeing Forums into the Community Wellbeing Forums.**
d) **David Watts and Ashley Tuckley would discuss creation of Northamptonshire Police Neighbourhood policing and Local Area Partnerships in a dual timeline.**

The meeting closed at 4.43pm

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North Northamptonshire Health and Wellbeing Board Action Log

Action No	Action point	Progress	Status
100322/01	Sam Fitzgerald would bring data on the unplanned admissions metric to the next meeting	This is still not available and is a shared issue across Northamptonshire it an annual metric which we hope to have soon	
100322/03	Steve O'Brien and Sam Fitzgerald to discuss opportunities for a PhD student		
100322/04	David Watts would contact individual organisations on the Board to discuss in more detail, representation on the Board.		
100322/06	David Watts and Ashley Tuckley would discuss creation of Northamptonshire Police Neighbourhood policing and Local Area Partnerships in a dual timeline.		

Actions completed since the 10th March 2022

Action No	Action point	Progress	Status
100322/02	The Director of Public Health will ask for a media campaign to be included in Head Teachers newsletters;	Lucy Wightman asked the Communications Team 10th March.	**Completed**
100322/05	David Watts would produce a proposal and Terms of Reference for the Health and Wellbeing Board delivery group and how to evolve the Health and Wellbeing Forums into the Community Wellbeing Forums	On the agenda 5th July	**Completed**

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North Northamptonshire Council

Item no: 7

NORTH NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

5TH July 2022

Report Title	**Director of Public Health Annual Report 2020-22**
Report Author	**Sally Burns, Director of Public Health, West Northamptonshire Council**

List of Appendices

Appendix 1 – DPH Annual Report 2020-22

1. Purpose of Report

1.1. To note the content of the annual Director of Public Health (DPH) statutory report for Northamptonshire.

1.2. To endorse the key recommendations made in the DPH annual report.

1.3. To note the requirement of the Health and Wellbeing Board to agree publication of the DPH annual report, which will then be disseminated to partners, stakeholders and residents in order to fully engage everyone in the Health & Wellbeing agenda.

2. Executive Summary

2.1 The contents of the DPH Annual Report explore the Northamptonshire response to the COVID-19 pandemic and how the 'organised efforts of society' helped to deliver an effective response in what is the biggest Public Health crisis in our generation. Partnership working is at the heart of the report, particularly highlighting how these partnerships and associations were developed as a result of the pandemic but it also demonstrates some of the exceptional work that was already being done through partnership working, which has evolved and developed in light of the situation. The report explains how the combined efforts of services such as Health Protection, Environmental Health, Business Intelligence and Communications, amongst others, came together to provide advice, support and reassurance at a particularly unsettling, confusing and sometimes traumatic time in a lot of our citizens' lives. This annual report covers the period from 2020 to 2022 as this is main timespan of the pandemic.

3. Recommendations

3.1 For the Health & Wellbeing Board to note the contents of the report and recommendations made.

3.2 For the Board to also note the progress made with regard to the recommendations in the previous annual report.

3.3 For the Board to agree publication and distribution of the report.

4. Report Background

4.1 The core purpose of the Director of Public Health (DPH) is to be an independent advocate for the health of the population and system leader for its improvement and protection. DPH's across the country are required to produce an annual report and the Health and Wellbeing Board has a duty to publish their report. The DPH annual report provides an opportunity to:

- Raise awareness and understanding of the wellbeing of the county
- Identify key issues and challenges relating to the wellbeing of the local population
- Provide added value over and above intelligence and information routinely available
- Reflect on work already undertaken and the continued impact
- Identify recommendations for future courses of action to improve health and wellbeing locally.

5. Issues and Choices

5.1 Each year the DPH must decide on a topic that the annual report will cover in that period. At the time of making this decision the pandemic had already begun and was clear it was going to be a dictating factor in the Public Health world for some time. Great examples of collaborative working were already apparent, and this seemed to be a natural, but important focal point in the fight against Covid. Working with our partners, both internal, external and in the community, is something that Northamptonshire is proud of and is keen to advocate and develop for the benefit of all, now and in the future. Learning from the experiences that were had over the last two years to ensure the effective relationships and working arrangements continue, seemed to be a perfect focus for the DPH Annual Report. It is therefore hoped that sharing this learning with partners and the community will help people to understand how partnership working can be effective, how it can be developed and also give an understanding of the incredible work that went on behind the scenes in Northamptonshire to keep people informed and supported in this particularly difficult time in our history.

5.2 As much of the work done over the last two years has been focussed on COVID-19 it felt sensible to have the report span the majority of the pandemic which is why the report is a two year report.

6. Implications (including financial implications)

6.1 **Resources and Financial**

6.1.1 The production of an Annual Report is a statutory function that should be executed by the Director of Public Health. A budget is therefore put aside for this annually and comes from the Public Health Grant. There are no additional financial implications or Council resources required as a result of this paper.

6.2 **Legal**

6.2.1 There is a statutory obligation for the Health & Wellbeing Board to agree publication and distribution of this report.

6.2.2 There are no other legal implications that will result from carrying out the recommendations in this report.

6.3 **Risk**

6.3.1 Should this report not be agreed and published, the Council and the Director of Public Health would not meet the relevant statutory duties.

6.3.2 There would be a risk of reputational damage to NNC and the Public Health team.

6.3.3 There would be a lack of guidance to local communities/ organisations in relation to health and wellbeing in the county.

6.4 **Consultation**

6.4.1 Not applicable

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Not applicable

6.6 **Climate Impact**

6.6.1 Not applicable

6.7 **Community Impact**

6.7.1 Not applicable

7. Background Papers

7.1 DPH Annual Report 2019-20

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North Northamptonshire Council

Item no: 7

NORTH NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

5th July 2022

Report Title	**Northamptonshire ICS Health Inequalities Plan**
Report Author	**Chloe Gay, Public Health Principle – Health Improvement**

Contributors/Checkers/Approvers		
Other Director/SME	John Ashton, Director of Public Health, North Northants Council	26th May 2022

List of Appendices

Appendix A – Northamptonshire ICS Health Inequalities Plan
Appendix B – Health Inequalities data

1. Purpose of Report

1.1. To NOTE the Northamptonshire ICS health inequalities plan and next steps for implementation.

2. Executive Summary

1.2. NHS England requested that all ICS' in the East Midland develop a health inequalities plan that sets out the approach the system will take to address health inequalities.

1.3. This plan should be approved by the Integrated Care Board by end of Q1 2022/23 and submitted to NHS England.

1.4. This paper presents the final version of the health inequalities plan and next steps for implementation.

3. Recommendations

3.1 To NOTE the Northamptonshire ICS health inequalities plan and next steps for implementation.

3.2 For all members of the HWB identify executive health inequalities leads in their organisations to join the Health Inequalities Oversight Board and oversee the implementation of the plan.

4. Report Background

4.1 Addressing health inequalities is a core principle behind the establishment of Integrated Care Systems (ICS) and new ways of working. NHS England requires local systems to develop a local Health Inequalities Plan which sets out how the system will work together to address health inequalities.

5. Issues and Choices

5.1 The health inequalities plan describes Northamptonshire's vision to work with communities to ensure that people living in Northamptonshire have the opportunity to thrive, to access quality services providing excellent experiences and optimal outcomes for all. The long- term ambition is to see:

- An increase in healthy life expectancy
- A reduction in health inequalities
- A reduction in premature mortality
- Improved community cohesion

5.2 To achieve this vision Northamptonshire ICS has developed a set of Guiding Principles which sets out the how we need to work as a system to understand and address health inequalities. These principles will be embedded across all organisations working in the ICS.

5.3 Alongside the implementation of these principles the system will develop specific actions at ICS, place and neighbourhood levels to address health inequalities. The key areas of focus for 2022/23 are set out in the health inequalities action plan for 2022/23. These will be reviewed annually.

5.4 Next steps to implement the plan include:

5.4.1 Finalise the governance arrangements

As the ICS governance structures are finalised we need to finalise the arrangements for health inequalities. The ICP will be responsible for setting the strategy for Health Inequalities and the delivery will be through the system transformation programmes and at place. Governance of system-level principles and actions will be via the ICS and a Health Inequalities Subgroup of the Population Health Board will be established to oversee the implementation of the health inequalities plan. Governance of place-based plans and strategies will be via Health and Wellbeing Boards. Governance of plans and actions at geographical footprints beneath place level will be agreed between local partners using the most appropriate structures consistent with effective representation and oversight.

5.4.2 Identify an executive nominated executive lead for health inequalities in each organisation who will be responsible for driving this agenda forward in their own organisation.

5.4.3 Establishment of the Health Inequalities oversight group, bringing together stakeholders from across Northamptonshire's health and care system our ICS, to focus on this important programme of work. This will include links with health inequalities leads for each organisation and the ICS transformation priority programmes collaboratives to develop the Health Inequalities Programme plan for short, medium and long term initiatives. This group would also monitor

health inequalities data, further develop the health inequalities indicators, respond to emerging evidence and develop recommendations.

5.4.4 Review capacity in the system to develop this programme of work and ensure sufficient leadership, analytical and programme management capacity.

5.4.5 Finalise the ICS outcomes framework

5.4.6 Development of place and neighbourhood plans

6. Implications (including financial implications)

6.1 **Resources and Financial**

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

6.2 **Legal**

6.2.1 There are no legal implications arising from the proposals.

6.3 **Risk**

6.3.1 For the vision set out in the plan to be achieved we need to ensure that we have capacity and resources across the system to enable the principles to be embedded. This requires leadership in each organisation and system-wide governance and oversight of the programme to ensure that we are delivering the objectives of the plan.

6.4 **Consultation**

6.4.1 A Health and Wellbeing Board Development Session was held in March to engage with stakeholders across the system. In addition, the draft health inequalities plan has been shared with a wide range of stakeholders and discussed at a number of meetings and boards, set out below. Feedback has been taking into account when finalising the report.

- CCG Governing Body
- ICS Steering Group
- System Transformation Delivery Board
- Transformation Directorate Integrated Commissioning Meeting
- Transformation Steering Group
- Strategy and Planning Committee
- Partnership Board
- Health and Wellbeing Boards
- Senior Leadership Teams for Adults, Communities and Wellbeing
- Informal transformation delivery group meetings
- Meetings with key contacts in collaboratives
- Narrative submission working group
- Clinical & Care Professional Leadership Working Group

- Workshop for UHN
- Population Health Board

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Not applicable

6.6 **Climate Impact**

6.6.1 Not applicable

6.7 **Community Impact**

6.7.1 It is expected that through the implementation of the health inequalities plan the ICS will address health inequalities, having a positive impact on local communities.

7. Background Papers

Appendix A – Northamptonshire ICS Health Inequalities Plan
Appendix B – Health Inequalities data

Northamptonshire Director of Public Health

Annual Report 2020/21 - 2021/22

Appendix

Public Health Northamptonshire

North Northamptonshire Council

West Northamptonshire Council

Contents

Introduction

Public Health is defined as “the science and art of preventing disease, prolonging life and promoting physical and mental health and well-being.” (Winslow CEA, 1920 The Untilled Fields of Public Health)

The previous annual report focused on identifying the underlying causes of poor health and providing ideas for action that could be adopted locally to address health inequalities that exist across Northamptonshire.

Since that time, we have been living through the biggest public health emergency in generations. We’ve seen a pandemic further highlighting the issue of health inequalities with a spotlight on public health itself. Never has there been more interest in and engagement with the work of public health by everyone.

Broadening the understanding of public health and its place within public services is something we continue to strive for. We often refer to wider determinants of health and by this we could mean transport, housing, environment or employment. These are all things that can impact on the conditions for healthy lives and given the breadth of issues that can affect the quality of lives and not just the longevity, we can appreciate this is an all-encompassing topic, wider than just public health teams and really does need the organised efforts of all of us if it is to have an impact.

With that in mind, this annual report will explore the work done over the last two years in our response to the pandemic from the perspective of the above definition and in particular the ‘organised efforts of society’.

The World Health Organization declared a global pandemic on 11 March 2020 and measures to control the spread of COVID-19 followed. Directors of Public Health and their teams, up and down the country, have worked with partners across local government, the NHS (National Health Service), the voluntary and community sectors to stop the spread and impact of the virus and it truly has been a dynamic and bonding (as well as intense, unprecedented, and challenging) experience.

Social distancing, testing and vaccination programmes have all impacted our lives but give hope of a return to normality, despite new variants posing an ongoing risk. What we learned in this time is to value relationships and connecting with people and communities.

This report provides an overview of the work done by my public health team, other council teams, health partners and other public services over the last two years. Each chapter highlights a different area of expertise that came together, creating a collaborative public health response for the populations of North and West Northamptonshire.

Lucy Wightman
Joint Director of Public Health for North and West Northamptonshire Councils

Demographics

The following diagram gives a snapshot of health and wellbeing outcomes across a person's life in North Northamptonshire.

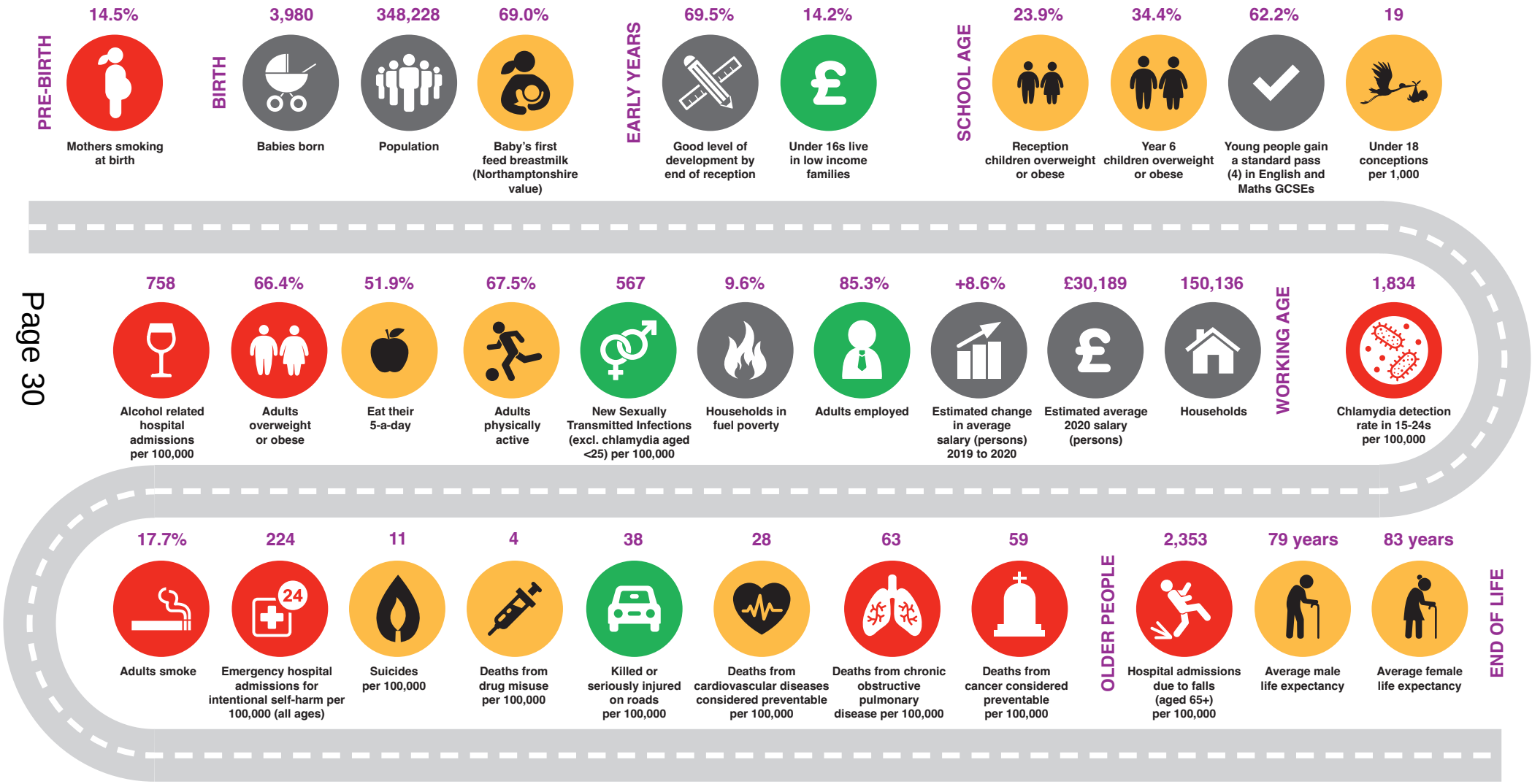


Figure 1. Health and Wellbeing in North Northamptonshire, February 2021

Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Compared to England average:

BETTER | SIMILAR | WORSE | NOT COMPARED

Demographics

The following diagram gives a snapshot of health and wellbeing outcomes across a person's life in West Northamptonshire.

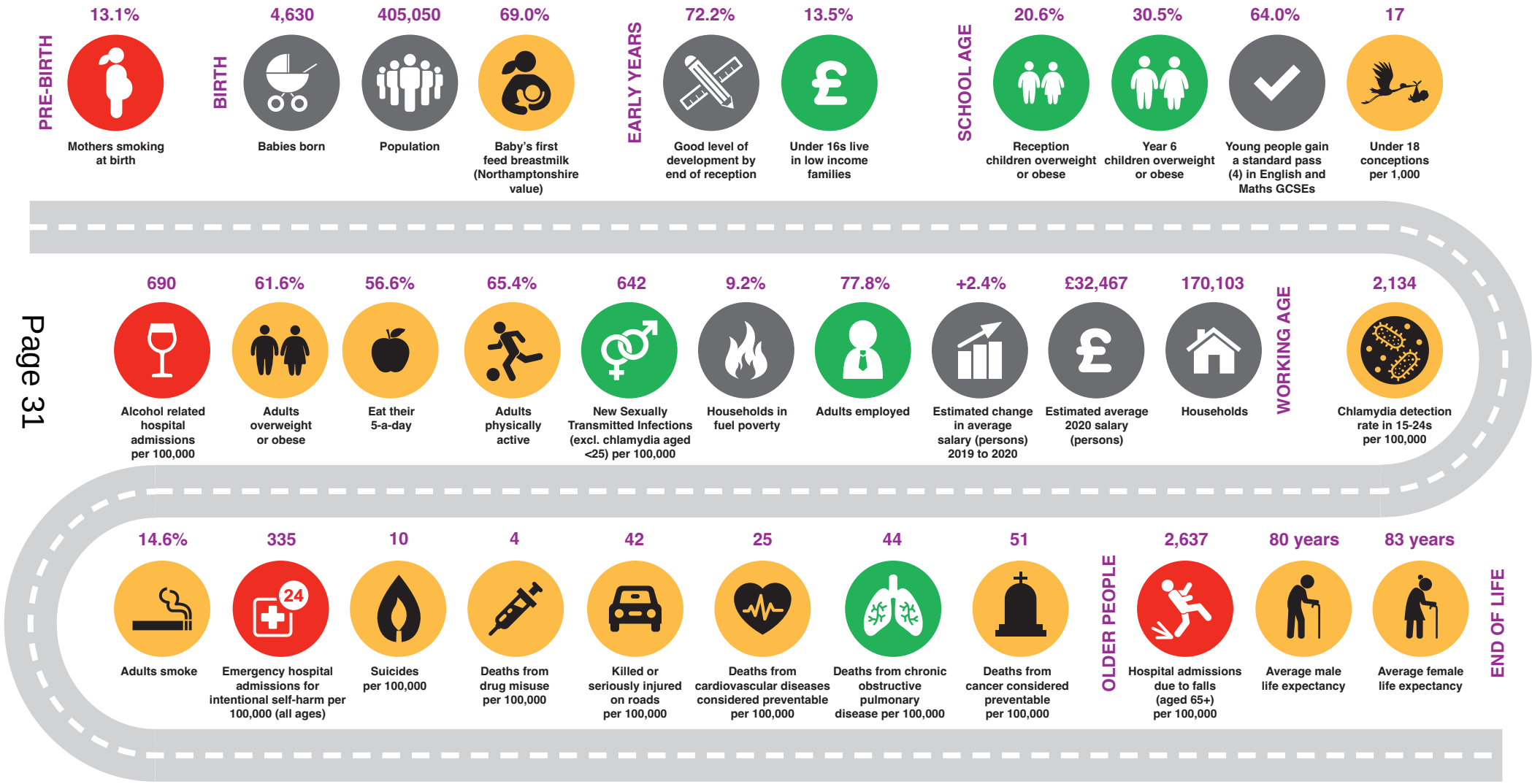


Figure 2. Health and Wellbeing in West Northamptonshire, February 2021

Source: Northamptonshire County Council; Fingertips; ONS. Based on infographic produced by Lincolnshire County Council. Please note data displayed has been calculated based on the latest data publicly available in February 2021 and has been rounded to nearest whole number where applicable.

Compared to England average:

BETTER | SIMILAR | WORSE | NOT COMPARED

Overview of COVID-19 Data

Very sadly some families and communities in Northamptonshire have lost loved ones to COVID-19 and some people are still suffering with the ongoing effects of long Covid. Many residents have experienced incredibly challenging times because of unemployment, fear, anxiety and the isolation as a result of lock downs.

Our response locally to the pandemic has been and still is being managed at a significant scale. I would like to acknowledge and thank everyone involved, particularly my team, colleagues, our partners, the voluntary and community sector, local community leaders and businesses and workplaces across the county. Finally, I would particularly like to thank the residents of Northamptonshire. It has certainly been an 'organised effort of society'.

The COVID-19 pandemic is still very much with us, and we must not be complacent and must continue to build on our knowledge and learning. In this report I have focused on the major themes and elements involved in our response so far to highlight and share this journey, and to continue to build on our learning and to make recommendations for the future.

PCR testing and positivity

PCR means polymerase chain reaction, this test is designed to look for genetic material associated with a virus. A sample is collected and tested for the presence or remnants of SARS-CoV-2. This was a turning point in controlling the spread of COVID-19 and uptake of testing had a very significant impact on curbing the spread.

This graph shows the number of people who received a polymerase chain reaction (PCR) test in the previous 7 days, and the percentage of those who had at least one positive COVID-19 PCR test result in the same 7 days. Data is shown by specimen date (the date the sample was collected from the person). People tested more than once in the period are only counted once in the denominator. People with more than one positive test result in the period are only included once in the numerator.

During the period of 1st April 2020 to 8th February 2022, the highest weekly number of PCR tests undertaken was 45,647 in early January 2022, equal to 6,521 per day and the test positivity was 30%.

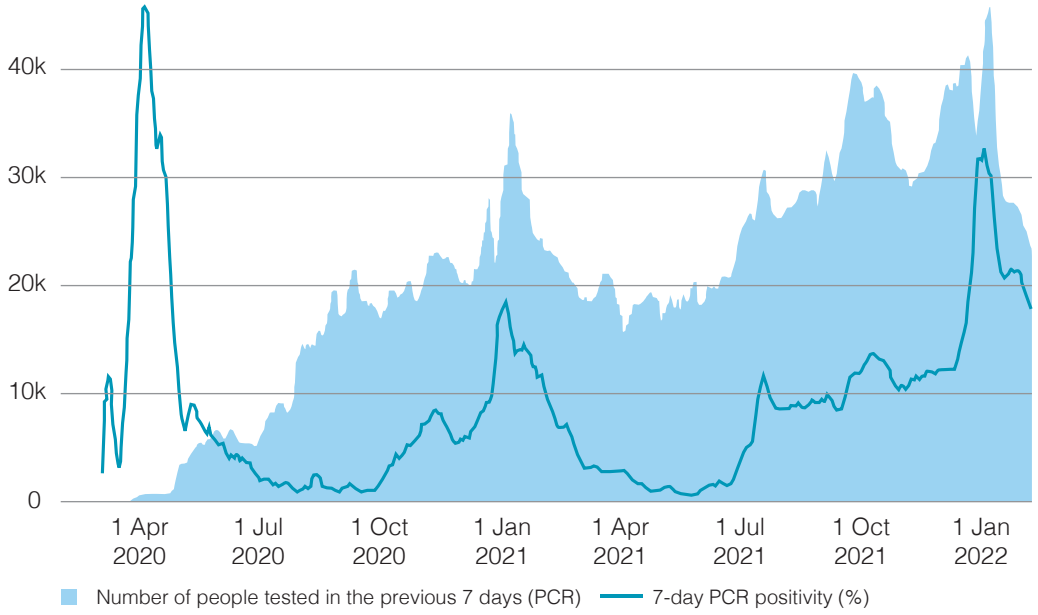
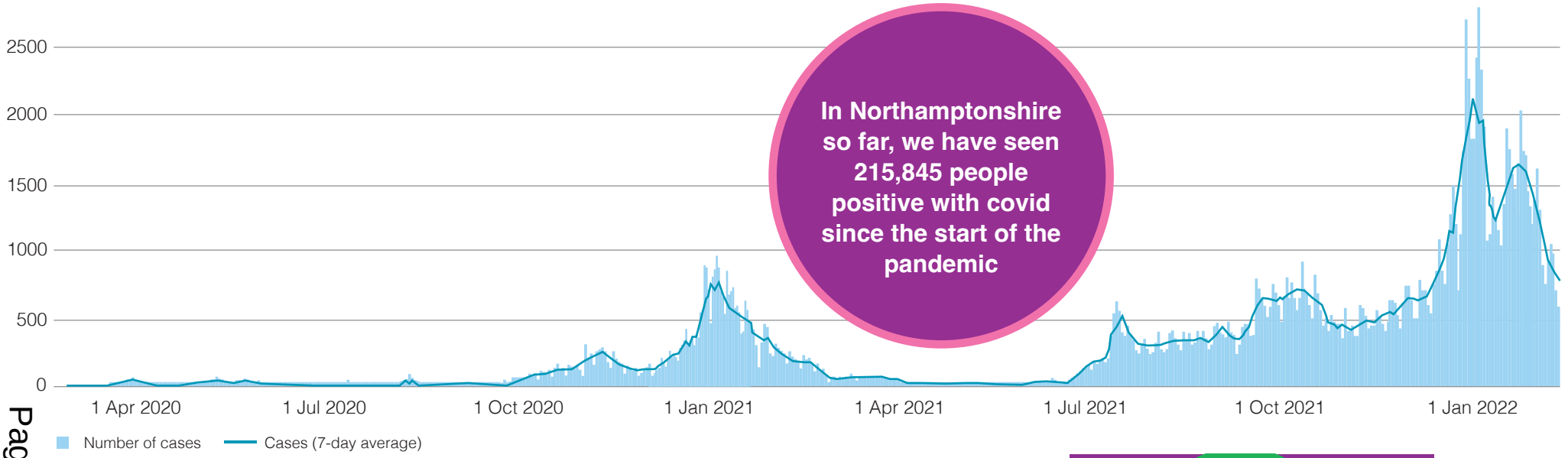


Figure 3.
Source: coronavirus.data.gov.uk

Identified cases



In Northamptonshire so far, we have seen 215,845 people positive with covid since the start of the pandemic

Figure 4a.
Source: coronavirus.data.gov.uk

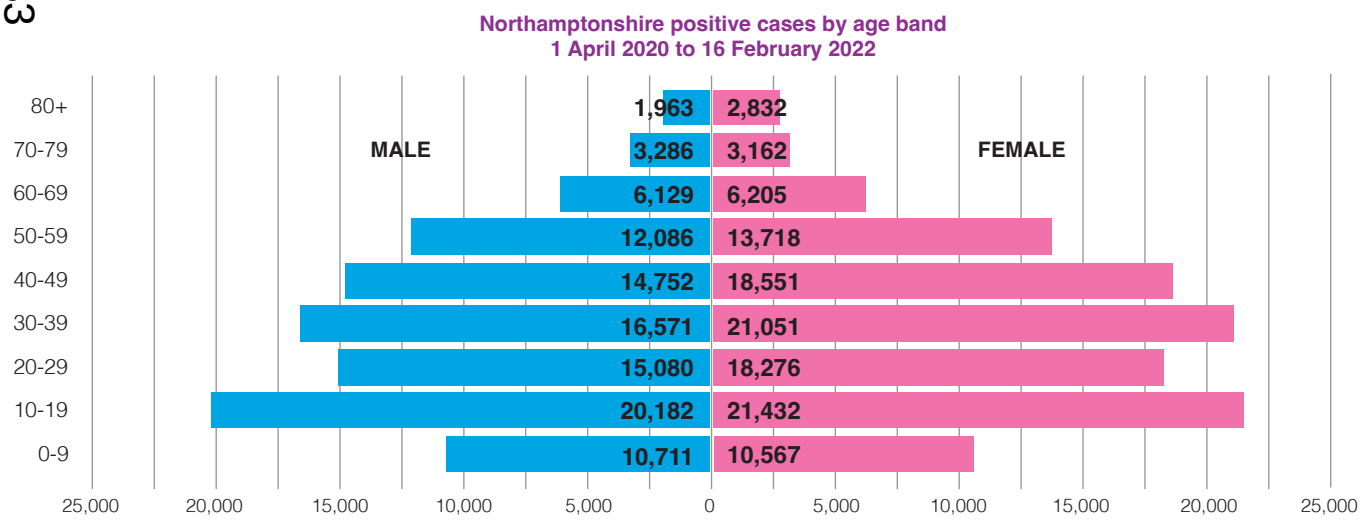


Figure 4b.
Source: PHE COVID-19 Situational Awareness Explorer, 2021 – cases by population

Hospital admissions

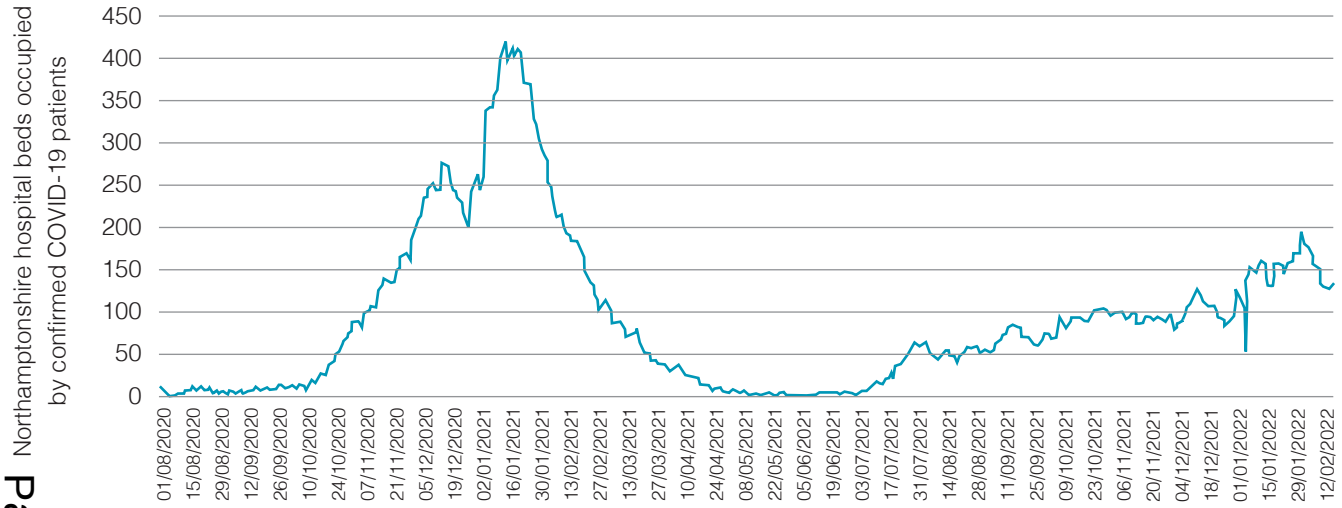


Figure 5.
Source: Weekly COVID surveillance report, Nov 2021

Hospital admissions due to COVID-19 increased sharply in late October 2020 and reached the peak in mid-January 2021, they then remained at the low level over the spring 2021. Admissions steadily increased from the beginning of July 2021 and peaked in late January 2022. Numbers seen are lower than during the winter of 2020/21.

Death

As at 9th March 2022, there were sadly 1,782 deaths within 28 days of a positive test from COVID-19 in Northamptonshire. The highest number of deaths in Northamptonshire occurred in mid-April 2020 and again mid-January 2021.

This information serves to remind us that while we can learn to live with this virus we should not take for granted the severity and ongoing impact of this or other diseases and we all have a part to play in ensuring we keep each other safe and well.

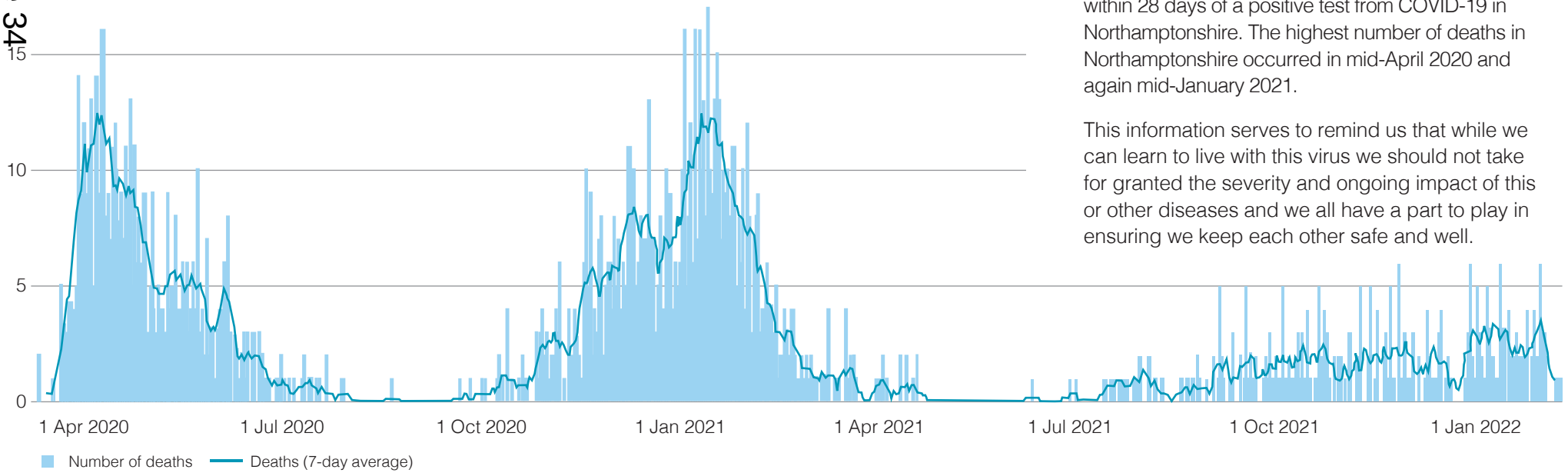


Figure 6.
Source: coronavirus.data.gov.uk

Communications

Order your free regular COVID-19 home testing kits today

Communications

Our Communications team ensures that key messages about health and healthy lifestyles reach the right people across Northamptonshire (and often beyond). These messages can have several aims, from simply increasing knowledge about an identified health concern to inspiring behaviour change or promoting a new service and use a range of channels to reach the target audience right down to a very local level.

Prior to COVID-19 the team's work was split between seasonal campaigns targeting topics including the flu or Winter Wellness, more strategic activity focused on specific issues which have been identified (for example safer sleeping for parents and babies), and general health issues such as losing weight, alcohol awareness and staying physically active.

A great deal of the work is about delivering the message in the right way, so this team needs an in-depth understanding of the audience, the potential channels available (particularly social media) and to have strong relationships with similar organisations who can help each campaign's reach and impact. As a result, we are often working closely with the media, arranging awareness days (for mental health for example) and exploring new ways to reach people effectively in addition to traditional communications channels.

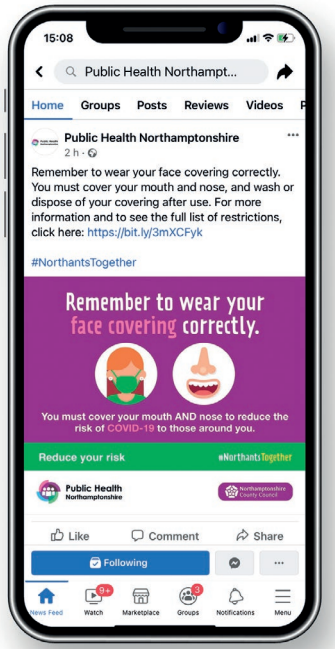
Communications

Information overload

By the time COVID-19 first started making the news and Northamptonshire started seeing its own cases, the communications team was already at its limit dealing with new information on the disease and working with the media to arrange interviews with myself as the Director of Public Health, and other spokespeople. Team members were asked to directly support NHS teams who were already working in collaboration with the Clinical Commissioning Group (CCG) and the Northamptonshire Healthcare Foundation Trust (NHFT) in order to deal with the sheer volume of COVID-19 news and information.

This 'initial' period lasted for a year as the local area navigated the increase in cases, then deaths, and then with a big spike in infection rate. During this time, our teams could only focus on absorbing new information, and delivering it to spokespeople, the media and the general public in the most effective ways possible.

The first chance the communications team had to take stock came with the lockdown, when there was finally an opportunity to work proactively and more creatively rather than simply reactively. At this stage the team had moved on from relaying information as it came in from Public Health England, central government and the NHS and could spend some time producing resources that could help manage the disease, a prime example being the messaging the team produced about wearing face masks.



Communications

Prioritising through procedure

During the first year of the pandemic, the team introduced a very procedure-driven way of working, to ensure that it wouldn't become overwhelmed by the need to react to everything as it came in.

The focus of this was a series of meetings and briefings to keep everybody up to date with the latest advice and information this included briefings for the public, twice-weekly media briefings, watching the daily government briefing and ensuring all colleagues were aware of what was said, and regular briefings for the network of comms colleagues, including the Local Resilience Forum (LRF).

This structured approach helped the communications team get ahead of the flood of enquiries, particularly from the media as it meant they would schedule their questions and requests for the agreed time, rather than send them on an ad hoc basis. This gave us the space needed to tackle the issues more proactively.

The communications team used this extra time to focus on outbreak management, adopting an evidence-based approach to identify exactly what kind of communication was needed to address a particular situation. For example, an outbreak was triggered by a group of workers travelling down to London in two cars. Of the eight people travelling, seven contracted COVID-19. This led the team to produce a poster for workplaces (translated into several languages) about car sharing, advising strongly against it, but also providing some clear do's and don'ts if it was absolutely necessary.

Northamptonshire was one of the first counties to identify car sharing as high risk, and the work received widespread support, particularly from Environment Health Officers (EHOs) who were on the ground at these workplaces and used the posters to reinforce their own advice, and through a range of business seminars which were used to promote safer working practices.

The impact of our press conferences

During the summer of 2020, the communications team started to share a Surveillance Pack, which collected all the key messages in one place. This was promoted on social media, shared on our website and used as the springboard to begin a weekly press conference which re-iterated those key messages.

This live streamed press conference proved invaluable when it came to the Greencore outbreak which saw a total of 294 cases of COVID-19 recorded in a food manufacturing warehouse in Northampton. At this stage it was the largest outbreak in the country so it attracted a great deal of national as well as local media coverage. Our regular briefings with the communications network meant we had developed very supportive relationships with the police, the NHS and Environmental Health colleagues among others, so the team could quickly gather lots of information about ways the outbreak could have been triggered, including car sharing, families working different shifts, and a staff barbecue.

Communications

Reaching specific audiences

Outside of press conferences and regular radio interviews, the communications team used 'Out Of Home' media to deliver key localised messages in places including Northampton, Corby, Wellingborough and Kettering. These were supplemented by i-Vans, essentially a flat-bed truck with a large digital screen for displaying messages. These were used to deliver even more locally-focused messages, and could reach people in supermarket car parks or country parks (for example) as necessary, showing different messages depending on the need of the location.

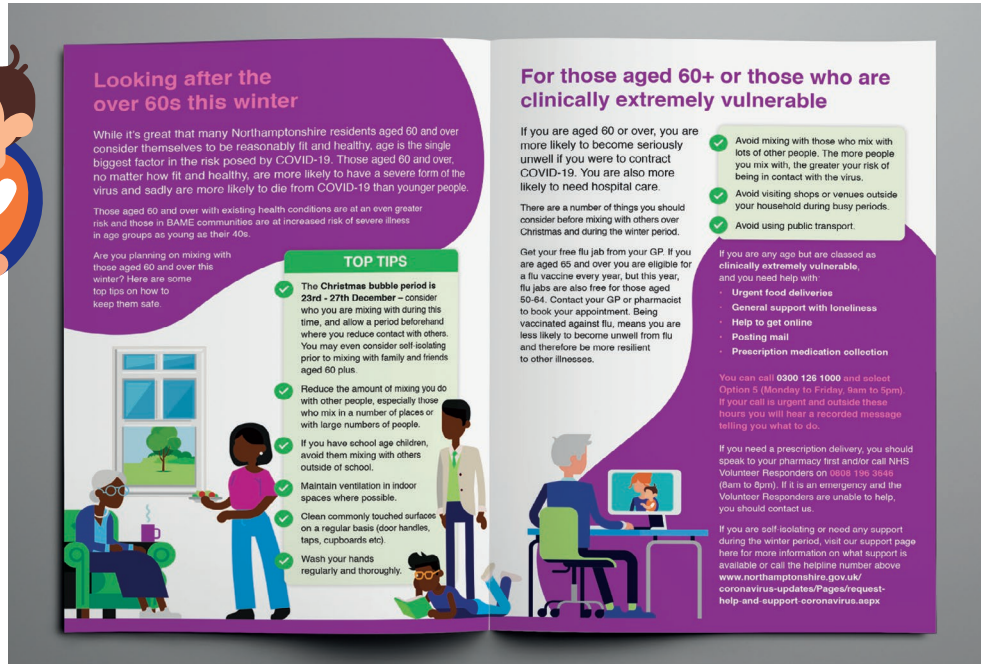
In the run up to Christmas 2020, when it initially seemed that there was going to be a five-day window when families could mix, the team produced a leaflet that was delivered to every household in Northamptonshire, full of ways to stay safe over Christmas. This was driven by the concern that the county's over 60s were going to be particularly vulnerable at this time, with grandparents mixing with younger members of their family they hadn't seen for months. The back of the leaflet featured a feedback form, and many people who responded indicated that they would be changing their behaviour in line with what the leaflet advised.

This was followed up with a Corby-specific leaflet designed to address the working patterns of many people in the town, which were resulting in child bubbles being mixed to meet childcare needs and consequently in higher transmission. This received a big response from the people of Corby on social media and notably the Corby Chats Back Facebook Group. Understandably the feedback was a mix of support and frustration, but as case rates came down, I was asked to feature in a video to the people of Corby, thanking them for helping us.

Partnerships

Our press conferences continued on a weekly basis following Greencore, chaired by our Cabinet Portfolio member, with the focus of each being determined by what was going on in the county at the time. The main topic also determined who spoke at the press conference too, and along with myself, we had NHS colleagues, hospital chief executives, the Lead GP Chair and a range of representatives from the CCG, adult social care, schools & universities and the Environment Health department. The press conferences often generated up to 140 different pieces in the media over a week.

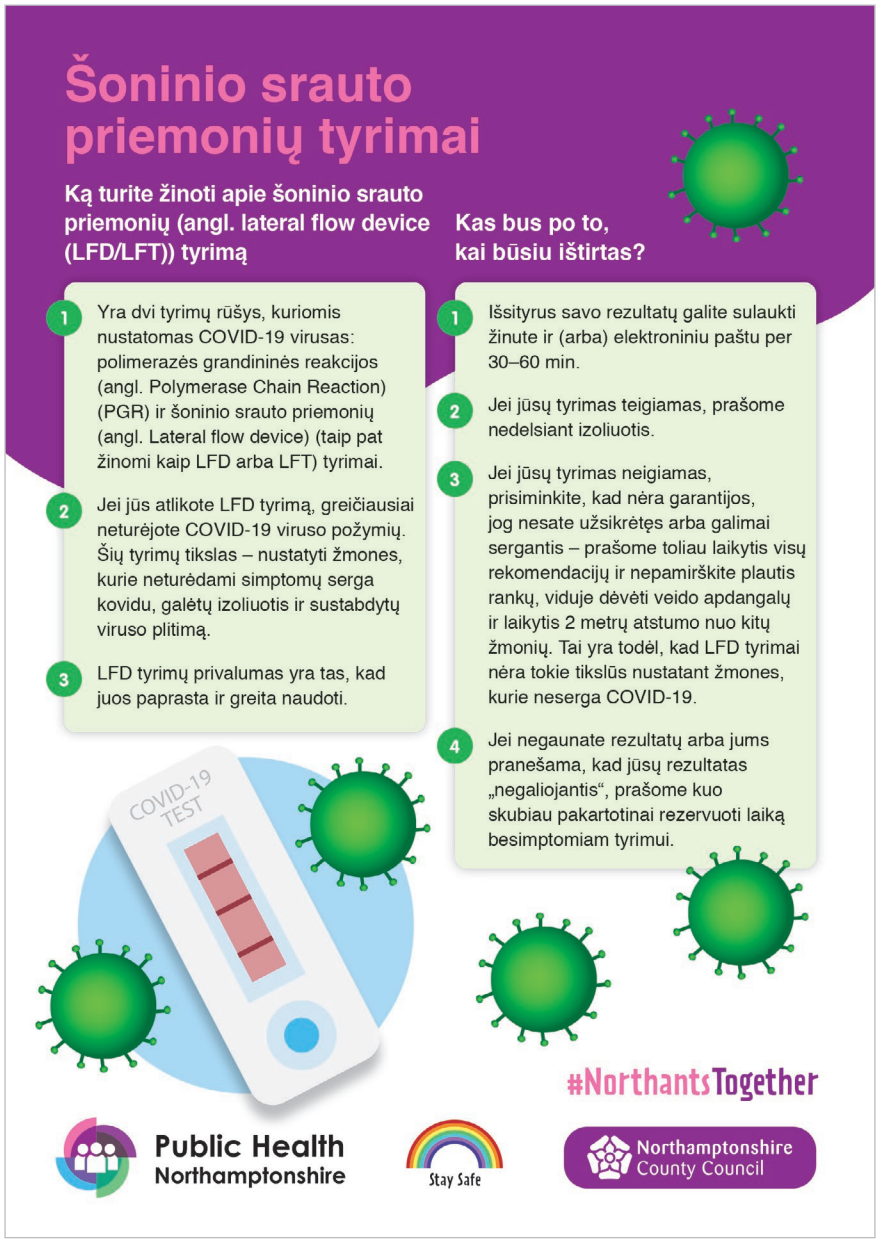
This strong partnership with a range of organisations and experts was just one example of how people in the county worked together at the height of the pandemic. Everybody was willing to share their information and to reinforce each other's messages for greater impact and to create a big picture of what was going on county and nationwide.



Communications with more breadth

For people working in our communications department, the pandemic has demonstrated what health inequalities mean on the frontline, particularly relating to 'hard to reach' groups. Often the target audience for the key messages weren't English speaking, so the team needed to work closely with translators, engagement teams and a range of community leaders to find the most effective way to reach the audience. For example local mosque leaders recommended that video messages shared via WhatsApp were the best way to reach their community.

This has resulted in valuable knowledge about the ways different communities communicate, and even the different ways they view things. This is a lesson in inclusivity, and it's something we intend to explore much more deeply.



Community Resilience

Community Resilience

Building on community resilience is one of the many responsibilities that sits under the broader heading of Emergency Planning. It's a service that can be hard to quantify as its focus is on ensuring that groups within the community are prepared to respond to, and lend their support in, emergency situations. It's driven by the adage that the first people on the scene of any incident are witnesses and bystanders, not the emergency services.

A great deal of the Community Resilience work is therefore focused on building a network of voluntary organisations who can be called on to help in any particular situation, from internationally-recognised names like the Red Cross and the Salvation Army, to more locally-focused groups like Northamptonshire Search and Rescue. Time and effort is dedicated to getting to know these groups, their capabilities and availability; arranging training and exercises; and ensuring that they're engaged and ready to respond if and when we need their expertise. Additionally, the team also spends time getting to know the communities it's responsible for, earning trust, building confidence and understanding their issues and concerns so that we can address them.

From planning to action

Because our Community Resilience team had been so focused on developing relationships with voluntary groups, it already had an exhaustive network of people, organisations and skills that it could call on to help support the population as COVID-19 began to impact our lives.

Although this team wasn't prepared specifically for COVID-19, it had been preparing for situations like this. As a result, the pandemic caused a shift in focus, rather than an upheaval. It changed from planning and being prepared, to tackling an actual incident and triggering the steps to manage it as effectively as possible.

Responding effectively

The pandemic had a significant impact on the usual work of the department, with the focus being put on COVID-19 related responses as much as possible. Of course, the team still needed to respond to Business As Usual incidents, but with lockdown and shielding, the majority of the Community Resilience network was suddenly off limits, making it much harder to respond effectively. As a result, the team needed to continually assess incoming reports to prioritise whether they needed to be addressed immediately, or could be dealt with later.

As part of this need to prioritise, a call centre was established as part of the central Customer Service Centre. The staff helped to direct requests for help (ranging from requests for food deliveries and help to get online, to loneliness and prescription collection) by triaging each call to establish needs, before passing the details on to the right responder, whether that was a local Facebook group, a voluntary organisation or a statutory partner. The call centre was majority staffed by librarians, whose usual work had stopped and were looking to donate their skills to help the county's COVID response. At its peak in May 2020, the call centre received more than 2,500 calls.

Shifting priority to managing the pandemic also meant that the usual proactive and planning work needed to be more in the background and proactive projects just couldn't be continued.

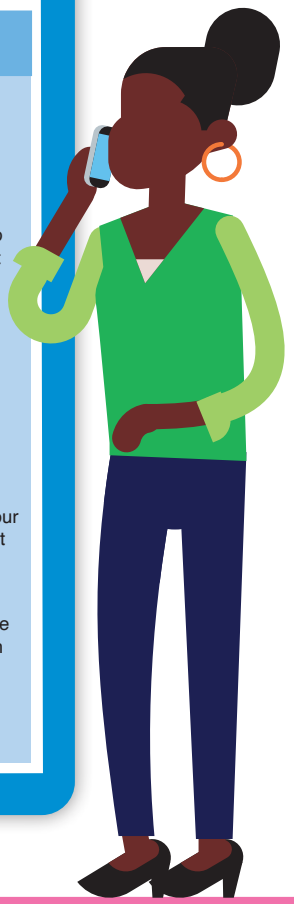
Stay at home check list and support

Self-isolation means that you cannot leave your house for 10 days. It is important that you stick to these rules to help protect those around you.

Here's a handy checklist of items to think about when staying at home

My isolation check list

Item	Options if you need any help with these:
☑ Food deliveries	The Council's Community Resilience Hub can help you to get support. Call **0300 126 3000** and select Option 1, 3, 1 (Monday to Friday, 9am to 5pm). If your call is urgent and outside these hours you will hear a recorded message telling you what to do. **www.northamptonshire.gov.uk/coronavirus-updates/Pages/request-help-and-support-coronavirus.aspx** If you're struggling with your mental health, you can get support 24/7 directly by calling **0800 448 0828**. Children and young people struggling with their health and wellbeing can get advice and support by texting the school nurse service on **07507 329600**.
☑ Help to get online	
☑ Prescription medication	
☑ Help with utilities (e.g. topping up energy meters)	
☑ Posting mail	
☑ Care of pets (e.g. someone to walk my dog)	
☑ Financial support (e.g. self-isolation support payment)	
☑ I have arrangements in place to support my wellbeing	
☑ Friends, families or co-workers I can connect with	
☑ Know where to access support if I feel lonely, anxious or overwhelmed or need specific help	



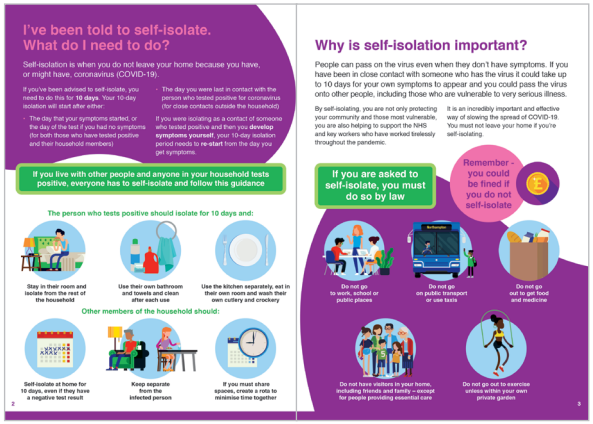
Reaching everyone

Usually, Community Resilience work would be carried out face to face, primarily with the voluntary network, but also often with the general public too. This would be supplemented with other communication channels, including print and social media.

During the pandemic, the face-to-face work was impossible, but the team found alternative ways to make a positive impact. Perhaps the clearest example is in the case of the call centre. As a new initiative, the population needed to know about it and the more people who called this dedicated central centre, rather than call a local hub, the better our response could be.

To spread this message, a leaflet about the support available and how to access it, was put through 325,000 letterboxes in the county. This led to more calls being made direct to the call centre, but equally important was the number of people who simply felt reassured to receive this leaflet; to know that there was a place they could turn to if they ever needed help.

This relationship-building and reassurance work was supported by more measurable activities, designed to pinpoint and help specific groups or individuals. For example, the team introduced free school-meal vouchers that ran during the holidays (during the summer holidays 2021, 19,844 vouchers were given out across Northamptonshire, with each child receiving £90), and a hardship fund which helped people financially if they were struggling with bills or with putting food on the table.



Community Resilience

Proactive calls

As well as encouraging inbound traffic to the call centre, the team proactively introduced an outgoing system once it had obtained the shielding list, which listed every single person in the county who was shielding. Using this list, the team called every one of the 23,000 people on it simply to check they were doing okay, had everything they needed and had people to check on them.

Spontaneous volunteers

An unforeseen issue that the team needed to react to, was the rise of spontaneous volunteers across the county. The majority of these took the form of local Facebook Groups which made themselves available for things such as food shopping and prescription pick-ups.

To try and harness this valuable new resource effectively and safely, we mapped these groups across the county and created a register to ensure that there weren't multiple groups doing the same thing in the same area. When the team identified areas with a lack of groups, it tried to stimulate the formation of one.

New partnerships

Community Resilience is a service built on partnerships, from hobby groups who want to help others through their passion, through to voluntary organisations and statutory partners. Even so, during the pandemic the team found itself forging new relationships with organisations whose usual work streams had been stopped or significantly altered by the pandemic. Community spirit was at an all-time high.

Examples include the librarians who worked in the call centre; the staff of Northamptonshire Sport who couldn't carry on with their normal activities, so volunteered their services for tasks like delivering leaflets or moving stock from place to place; and the military which provided expert planning and logistics skills, and played the role of a 'critical friend' in order to stress-test solutions our team was going to implement.

Our team was particularly proud to have worked with Housing Managers and the Single Homelessness Team on the Everyone In programme. Simply, its aim was to put as many of Northamptonshire's rough sleepers as possible into temporary accommodation, whilst also delivering a wraparound package of care to help them avoid a return to the streets. Working with the Hope Centre charity and other local services, this was a joint effort which saw 135 of the vulnerable people who were initially housed in temporary accommodation (including local hotels and student accommodation) later moved into suitable settled housing.

Community Resilience

The power of being prepared

The pandemic has made it very clear that the time and effort put into building relationships is an investment that more than pays off when it is needed. It's always been a very difficult area to make a business case for, as it's almost impossible to prove prevention, but the team's response to COVID-19 has shown the power of the network the team has built.

It has also shown the importance of planning and looking ahead. As we saw from the flu pandemic plan, this doesn't just mean the content of the plans themselves, but the confidence and expertise that comes from the process of planning. This meant that when the COVID-19 pandemic arrived, the team understood how to plan for it, and was fully aware of all the things it should consider and include.

Lessons learned

Moving forwards, we've seen how effectively the community can come together in a crisis, but also how we as responders do the same. At the start of the pandemic, we were still structured as a County Council and seven districts and boroughs. These separate groups came together and committed to tackling COVID-19 as one, something which highlighted the way the two unitary authorities could and should work following the restructuring.

Health Protection

Health Protection

Health Protection covers an incredibly broad range of activities designed to keep everyone in the county as healthy as possible, and to take steps to safeguard that health. Although it has traditionally worked under the radar, it plays a major role in everybody's life, from conception to old age. It helps to facilitate everything from vaccinations, NHS screening services, and the detection & management of chronic diseases (such as tuberculosis, blood-borne viruses and HIV) and communicable infections (including meningitis, mumps and the flu), to suicide prevention, ensuring the homeless have access to good health and running clinics for disadvantaged residents.

COVID-19 vaccination in our population

The vaccination programme began in late December 2020. By the 14th of February 2022, 80.9% of Northamptonshire population have had their 1st dose of COVID vaccine, 75.8% have had the 2nd dose, and 59.7% have had the 3rd dose or a booster (figure 7 Source: coronavirus.data.gov.uk). Of the population eligible for a vaccination as outlined by JVCI this presented a significant number of people coming forward to protect themselves and those around them.

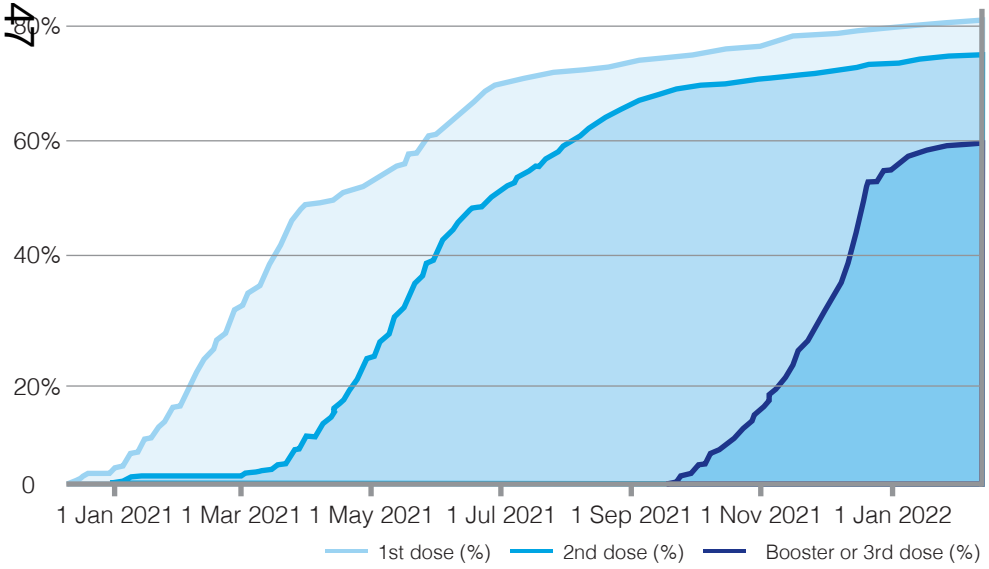


Figure 7.
Source: coronavirus.data.gov.uk

Figure 8.
Source: coronavirus.data.gov.uk

- 1st dose (80.9%)
- 2nd dose (75.8%)
- Booster or 3rd dose (59.8%)

Health Protection

Best laid plans

To succeed, this team needs specialist knowledge across multiple disciplines and to be dynamic and responsive to whatever is happening in the county at the time.

Of course that dynamism has never been challenged more than during the COVID-19 pandemic. As part of a network of Health Protection Teams (HPT) across the country and overseen by the government, we had established plans to deal with epidemics at national, regional and local levels. These plans primarily used influenza as their foundation, but as COVID-19 began to get a foothold in the first quarter of 2020, it soon became apparent that these plans were not able to cope with the sheer scale of this 'health disaster'.

Our small HPT found itself stretched to the limit, needing additional resources, funding and information in order to manage the high rate of infection. At one point, this team was addressing 100 outbreaks (defined as 2 or more test-confirmed cases in a non-residential setting) in a single week. By the end of February 2020, an Incident Command Cell had been established as the centre of Northamptonshire's response, and resources were pulled in from other services so the team could begin addressing the immediate needs. By early March, we were able to deliver a COVID-19 focused service.

This meant of course that the normal work of the team was severely disrupted. Essential priorities continued to be delivered, but with all available resources redirected towards the COVID-19 response.

Reacting to a pandemic

With such a new disease having an all-encompassing impact on the health of all, the HPT was initially focused on reacting to the disease and the way it behaved, working with the communications team to disseminate new information and continually-evolving guidance from the government.

This was a learning situation for everybody: information from the government was in constant development and at times slow to reach the teams on the ground, who were having to adapt to the situations in front of them. This meant that everyone in the team needed a very flexible and fluid approach to the way they worked, knowing that the way a situation was dealt with one day, could completely change by the next week, or even the next day.

The scale of the pandemic meant that this 100% reactive approach continued for at least the first year of the service, before a more proactive approach began to become more feasible. The bulk of this proactive work was focused on training for service providers in high-risk settings such as care homes. Where in the previous reactive phase the team was being called to an outbreak, then providing training to the staff there, now there was some time dedicated to identifying those high-risk settings and minimising the chance that an outbreak would occur there.

As time progresses and we enter the 'recovery' phase of the pandemic, our team is embedding COVID-19 into our future way of working and moving away from a reactive position to a more proactive one.

A deeper understanding of Health Protection

One unforeseen impact of the pandemic is that it has seen the work of Health Protection become better understood by other service providers (including care homes, learning disability units and mental health units) and the public. For example, at the height of the pandemic, when one of the main messages was to stay safe by staying socially distant, our HPT team often had to work hard to convince care home teams that the team could advise and assist safely. Understandably care home teams were reluctant to open their doors to new people.

As time moved on and the team continued its work, the level of trust in our Health Protection team and what it could achieve increased steadily, with other services becoming more transparent and willing to not only accept, but seek help from the HPT. They now know that the team isn't there to criticise, but to lend its expertise in whatever ways it can.

Stronger partnerships

In order to face the challenge of this new disease, the response saw diverse groups pooling their resources to understand, manage and counter COVID-19. Organisations working together under a single umbrella meant that everyone shared the same agenda and could focus on the same goal. As a result, the Health Protection team forged powerful bonds with groups including the police and fire services, NHS Trusts, the ambulance service, independent healthcare providers, social care providers, local authorities, Environmental Health Officers (EHOs), education groups, community leaders, faith leaders and politicians.

Each group gained a deeper understanding of the others and their expertise. These are strong relationships that continue to this day, not just organisation to organisation, but person to person.

One particularly noteworthy collaboration was triggered by an early major outbreak at a large supermarket distribution centre. The Health Protection Team worked alongside the Health and Safety Executive (HSE), which is the regulatory body for health and safety in businesses, and was able to share a tremendous amount of valuable information. Through this collaborative working, the HSE was also able to lend support which was critical in surveilling and managing the outbreak. With this lesson learned, the HPT set out to work with more regulatory bodies including the Care Quality Commission (CQC), the HSE, more EHOs and commissioners, all of whom could contribute to delivering a more connected COVID-19 service as one team.

Stronger links with education services are another unforeseen benefit. There's now a greater understanding of how the HPT's work needs to adapt to meet the particular needs of schools. For example, previously the team would produce an Infection Protection Control (IPC) pathway from a clinician's point of view. Realising that a different approach was needed to get head teachers on board and up to speed, the team worked with education colleagues to create something that used language, images and instructions which would support schools more effectively, enabling the schools to understand the HPT's clinical requests to them on a much deeper level.

Impact on the team

The nature of COVID-19 and its transmission saw the way people work change significantly. It challenged our close-knit team to work, meet and interact remotely, but much of the team's work necessitated going to outbreak sites, or potential outbreak sites, and working safely face-to-face with people.

This not only meant using PPE equipment, sterilising environments and following new guidance as it emerged, but it also gave the team the opportunity to appreciate our county's beauty and get to know it, as members travelled from place to place on relatively clear roads. With resources in short supply, the HPT also found itself providing support beyond Northamptonshire's borders in places including Leicester, Oxford and Buckinghamshire, mostly new locations to the team.

An important lesson during this highly pressured and stressful period, when long hours, seven-days-a-week working and no annual leave were a necessity, was how crucial it was to take time to look after one's self. With resources stretched beyond the limit, even one member of the team away due to sickness would have a significant impact on the services and therefore on the population.

A new way of thinking

COVID-19 has helped demonstrate to the team that these are not solely clinical problems. Hygiene, cleanliness and simply travelling with less clutter are all things that can have a positive impact on controlling infections moving forwards. By keeping many of the habits we now have, the population will be able to better protect itself from other infections including norovirus, influenza and measles.

The experience has also given the team added confidence to deal with the future. New ways of working, the ability to adapt quickly, to think on our feet, to deal with pressure and a large support network of specialists have all proven to be invaluable over the period of the pandemic, and we'll ensure this is the norm in the future, no matter what it holds.

Perhaps the most powerful lesson is collaboration. The HPT has seen that its clinical point of view, when combined with other approaches (for example the more scientific approach from Environmental Health Officers) is the most effective way to reach the best solution, and is committed to continue working in this way in the future.

Infection Prevention and Control

Infection Prevention and Control

Infection Prevention & Control (IPC) underpins everything in healthcare settings as it focuses on creating and implementing policies, procedures and practices that can reduce the risk of contamination and cross infection. Its primary goal is to ensure that service providers in a healthcare setting adopt IPC behaviours as part of their day-to-day activity to keep themselves and the people they're caring for as safe as possible.

An IPC team's work can vary from running training courses covering topics including hand hygiene, to running in-depth assessments of a nursing home (for example) following an outbreak and putting together an action plan to avoid something similar happening in the future.

Forming the IPC team

Before the COVID-19 pandemic, Northamptonshire didn't have a single clearly defined IPC team. Instead Northamptonshire Healthcare Foundation Trust (NHFT) had a team which supported community hospitals, whilst both Northampton and Kettering General Hospitals had their own teams working across the acute and mental health settings.

Care homes, learning disability units and nursing homes however organised their own IPC training from a range of providers. This meant that there was no universal IPC offer – each setting would have different ways of approaching it, and often this meant very different standards from organisation to organisation.

As COVID-19 began to impact the people of Northamptonshire, this proved to be a key issue. In the early stages of the pandemic, we had a single nurse taking Personal Protective Equipment (PPE) out to care homes and teaching staff how to use it effectively. Very quickly it became clear that care homes in particular would need a great deal of support moving forward, and highlighted to the Health Protection Team (HPT) that IPC would need a focused and connected approach.

As a result, a specific IPC team was formed, pulling in people from HPT, but also nurses from many of the private hospitals in the county which, due to the pandemic, were not running. With this new team in place, we were in a position to lead on IPC care in care homes across the county with a seven days per week service.

Reacting to the greatest need

The team's work was driven by where the need was greatest. So the largest outbreaks or cases where there had been a death were prioritised. As the situation was continually escalating, this could mean that members of the team were travelling to one outbreak, but were diverted to an even more pressing situation en route.

This meant that the teams sometimes arrived with very little information about the care home or the outbreak. This though was often an advantage as the teams could enter with an open mind and carry out their inspections with no preconceptions.

A typical visit would include an in-depth room-to-room walkaround of the care home, an analysis of the staff and residents (capacity, numbers of people with symptoms versus those without, sudden deaths or people recently hospitalised) and the movement of people and equipment throughout the home to identify potential transmission dangers. This looked at where staff worked (did they only work over one floor or all floors of the building? And did they work at more than one care home?), and how or where they entered and exited the building. It also analysed the cleaning procedures at the home and the hygiene in the kitchen.

By doing all of this and keeping an extensive tracking document of every visit to every home, IPC could not only help to identify the most likely transmission routes in the homes, it could also see clear patterns which helped to show the kind of training that was needed most urgently, and high-risk locations to focus on.

This kind of reactive work continued throughout the first year of the pandemic, but as the pressure began to ease, the team's leaders could begin to take a more structured approach, focused on raising the level of IPC training care home staff had received.

Training, educating and staying safe

With COVID-19 taking hold, NHS England gave a directive that every care home and care setting should have IPC training. Over the next three weeks, our team offered training to over 450 care settings, and delivered this through a combination of face-to-face and Zoom sessions.

Working in some of the hardest-hit care homes across Northamptonshire (and often over its borders), the IPC team could see that existing IPC training standards varied wildly, with some care home providers running their own IPC training, bringing in outside trainers, or simply doing online courses.

Our training looked to raise standards up to the same bar. With poor IPC practices often leading to outbreaks, it was clear that there needed to be a universal standard for IPC. Care home staff were often surprised at how specialised IPC training is, at even its most basic level. For example, working safely with PPE. There are clearly defined methods for putting on and taking off PPE properly. Removing PPE in the correct way is particularly important as this is the time the wearer is most at risk of transferring COVID-19 to themselves, a colleague or a service user. Hand hygiene was another basic area in which knowledge was lacking. For example the importance of being bare below the elbow (no watches, rings, bracelets etc) to minimise the chances of transmission.

A coordinated response

As knowledge of the disease evolved, our IPC response to it evolved too. The first stage was getting Environmental Health Officers (EHOs) more heavily involved. IPC is a part of their day-to-day responsibilities as they review workplaces, but where our nurses see situations through a clinical lens, EHOs have a scientific approach. The combination of the two viewpoints and the sharing of expertise meant we could see a clearer picture of COVID-19 transmission in care homes and deliver a more thorough review on each visit.

The IPC team also began working closely with Adult Social Care, Quality and Safeguarding teams, as well as the Care department at the CCG. Through meetings and briefings, the flow of useful information between all of these groups helped to keep IPC as informed and prepared as it could be – and with IPC's knowledge our partners could also benefit from insights on the ground.

The Weekly Outbreak meetings held, saw the expanded team, along with Public Health England (PHE) working together to see if there was anything we could have done differently at new outbreak sites. If there was a large outbreak (one example saw 20 staff and inmates at a prison contract the disease) IPC would hold an Outbreak Control Meeting involving PHE, EHOs and stakeholders from the outbreak site. This group would work together to review the timeline of the outbreak and determine the best way to tackle similar situations in the future.

Another key partner was the military, which not only supplied medics (Kettering General Hospital had access to 14 at one point), but often helped with the logistics of moving vast amounts of PPE around. Its ability to streamline processes and focus on meeting needs in the most effective way proved invaluable, particularly in cases like the Greencore outbreak. This was the largest outbreak in England up to this point, and was initially handled by PHE, public health consultants, HSE and EHOs. IPC then carried out a clinical review and focused on educating staff in using PPE correctly. The military helped to ensure that all resources were exactly where they needed to be, when they were needed.

Infection Prevention and Control

Understanding IPC

The more of these outbreaks our team tackled, and the more education and training they delivered on the frontline, the more care homes began to understand and value the work of IPC. This resulted in stronger relationships with service providers across care settings.

Care homes which were initially reluctant to engage with our team, now often request support to keep them operating safely. And this transparency wasn't limited just to care homes: Northampton General Hospital was having regular outbreaks and asked our community IPC team to come and do a 'critical friend' review to ensure there wasn't anything they had missed in their own IPC practices.

Piloting a universal standard of IPC training

The pandemic has highlighted that the standards of care in Northamptonshire's care homes is generally high, but that IPC training needs to be standardised. With private hospital nurses now returned to their careers, the first part of that standardisation was to present the business case for a dedicated community IPC team to deliver it and continue responding to COVID-19, not just in care homes but also in schools and other educational settings.

With that team funded from December 2020 onwards, we now have the capacity to start defining a national IPC standard in care settings, and are currently piloting these standards in some care homes in the county.

Staying prepared

Although the team's work has understandably focused on COVID-19, it's clear that the renewed focus on hand hygiene has had a positive impact on other communicable diseases. As people perceive the threat of COVID-19 to have lessened, they are not washing their hands so often. As a result, the team is beginning to see cases of diarrhoea & vomiting and Legionella once more on the rise and will continue to stress the importance of hand hygiene.

The rapid spread of COVID-19 saw the team working under unprecedented time pressure. Working at pace and having to deprioritise Business As Usual work highlighted the need for a 'whole system' approach. Rather than small silos of specialist knowledge, our aim is to integrate every team so that working together becomes the norm rather than something that's implemented under duress. Our multi-agency, multidisciplinary approach was essential during the pandemic and will be going forward.

Engagement and Enforcement

Remember to wear your face covering

Engagement and Enforcement

The goal of Engagement is to work with business owners and members of the public to ensure they are not only aware of legislation and guidelines, but to provide all the support and advice they need to understand them and therefore engage with them.

If legislation is consistently ignored, then Enforcement deals with the actions agencies can take to resolve the situation, and may include Trading Standards, food licensing, building control and of course the police. Enforcement is always a last resort. It's more desirable to build relationships with people and help them see that the rules are there to protect people, rather than to penalise them and damage any prospect of a positive relationship in the future.

Normally if there is an issue, it involves more than one agency, so this is an area in which working together to solve a problem is the norm rather than an exception. For example dealing with a badly run pub could involve the nuisance causes to the neighbourhood, selling alcohol to underage drinkers, violent conduct and other crimes which could escalate as a result. The team therefore has good relationships with– and strong knowledge of – lots of other departments and agencies in the council.

Reacting to new legislation

As has been mentioned previously, the then County Council had prepared a flu pandemic plan as an exercise to stress-test the system and to highlight areas of concern. When COVID-19 reached the county, this plan proved invaluable as a great deal of its predictions and recommendations were accurate and could act as the foundation for our work.

However, one element that was not contained in the plan was a potential lockdown. The plan had considered enforceable isolation, but this total 'suppression strategy' was completely unexpected, and required the team to interpret and implement a new enforcement regime almost overnight.

This need to react and adapt became a regular occurrence in the early days of the pandemic. On average, new legislation would be announced every three days and the team was usually seeing it for the first time just as the public was.

The first priority was to understand the rules and then provide a thorough briefing to leadership the next morning, detailing the impact of the regulations. Then it needed to plan ways to help the people of Northamptonshire live by them, whilst thinking through every variation of each rule to define if and when enforceable action would need to be applied.

Engagement and Enforcement

An engagement-first approach

There were likely to be many inadvertent breaches so an Education, Engagement and (as a last resort) Enforcement approach was agreed. The key to getting the general public to stick to the rules was to ensure they understood them and could see the value in them - not in penalising people at every turn and losing their trust as a result.

Even in cases where the legislation was not being followed, there was another layer of complication to understand. Were people not complying because they didn't understand the rules? Because they didn't want to follow the rules? Or because they couldn't follow the rules? All of this needed to be considered for every new piece of legislation.

Multi-agency coordination

It became clear immediately that an effective coordination and planning structure would need to be established in order to move smoothly from receiving and interpreting rules, to identifying potential issues and putting plans into action throughout the county. This resulted in four regular meetings, which continued throughout the pandemic.

The first was the weekly Tactical Coordinating Group (TCG) which considered the issues from a top-down perspective and mapped out broadly how to deal with problems. This involved representatives from all agencies so strategies could leverage the strengths of all agencies.

The Partnership Tasking Group (PTG) looked at what was currently happening and what was in the immediate future. This could involve changes to legislation, but also might focus on predicting public behaviour – for example if the weather forecast was good for the weekend, there would be more people in the country parks. The focus of the PTG was to predict where and when engagement and/or enforcement teams would be needed and to ensure they were there.

The daily Joint Enforcement Team (JET) was a problem-solving forum. It was responsible for looking at areas with particular issues or breaches, identifying any patterns or learnings, and planning enforcement activity to tackle them. This could range from a geographic area of the county right down to specific individuals. For example, JET addressed a period of problems along the Wellingborough Road in Northampton by coming up with a series of coordinated multi-agency activities which involved all the licensees and shops in the area. By tackling each individual issue as a group over several weeks, the area became much better at operating within the COVID-19 regulations.

The final group didn't meet to a set routine, but convened every time there was a regulatory change. Informally known as the FAQs Group, it was made up of experts in a range of subjects relevant to the change, who would review the new rules and prepare answers to questions which were likely to be asked, the most basic of which were always 'What does this mean practically?' and 'Are there any exploitable loopholes?'

Boots on the ground

With the unplanned lockdown, much of the team's early work was focused on reacting to new legislation as it was introduced. However, even during this period, Engagement and Enforcement found ways to solve problems proactively.

The team saw that producing comms for people to read had very clear limits. With legislation changing regularly, even if people read guidance at the start of the week, it may have changed by the weekend. Leadership determined that we needed boots on the ground, people who were out and about and could spread information directly, and where needed, remind people of the rules.

To fill these important roles, we contracted an events management company, and used their teams (who would usually be working as marshals and security at festivals and shows) as our own frontline team. This group was chosen as the events staff were used to dealing with the public and had some training in conflict resolution. We supplemented that with regular briefings on the most recent rule changes, and then used them in teams across the county.

Engagement and Enforcement

Gathering intelligence

Over time it became clear that these 'Blue Bib' Marshals could be a key source of intelligence, as they had experience of what was happening at ground level, including how legislation was being interpreted and followed. To harness this potential, the Marshals received more specific training, so they could report back with the kind of intelligence that would help Environmental Health identify and tackle breaches that fell under its responsibilities, particularly when it came to selling food.

The key to maximising the Marshals' reach was to use them appropriately: they had no enforcement powers, so were primarily an engagement and information gathering resource. It was essential that if they were ever in enforcement situations, they were working in tandem with the right enforcement agency.

Setting an example

Our Marshals could be found wherever the public was likely to be. In country parks they approached groups who were not two-metres apart and provided a gentle reminder. By riding buses with their masks on, they ensured that other passengers kept their masks on too. At Black Lives Matter demonstrations, they worked alongside the police to help people stay safe. They checked that people isolating were where they were supposed to be. And as the vaccination programme began to roll out, they worked with the public at the vaccination centres themselves. With around 40 Marshals on patrol at the peak of the pandemic, they carried out more than 30,000 spot checks up to July 2021.

But perhaps the most tangible impact they had was as lockdown restrictions on retail began to lift. The Engagement and Enforcement leadership set itself a target: to visit every retail environment and shop in the county in the first week of reopening to ensure the people working in them understood the rules and were operating within them. Around 90% of premises were found to be compliant. Those that weren't received additional support and checks to help them become compliant. In the rare cases where shops simply refused, then action was escalated and formalised to include Environmental Health, again operating using the intelligence gathered by the Marshals.

Later, when the night-time economy began to open once more, the Marshals were a common sight. Because the team had set out to use specific teams of Blue Bibs consistently in specific areas, they had already built up familiar relationships with people in those areas. This meant that instead of being seen as some kind of threat, they were seen as supportive friends, who could be asked for advice by door staff or pub goers.

When COVID-19 Marshals were announced nationally, our Blue Bibs were used as a case study for how best to deploy this new resource.

Engagement and Enforcement

Working with the public

Partnerships were a key part of the department's success, as evidenced by the range of multi-agency meetings, strategies and activities during the pandemic. But perhaps the most important 'partnership' was the one with the general public.

It's long been known that it's impossible to 'enforce your way to compliance', so the emphasis must be on education and engagement. This was something the team and its Marshals embraced, with a lot of its work focusing on 'soft' skills – simply interacting with people and helping them to understand and engage with the rules at all stages of the lockdown and shortly afterwards.

The future

This period in our history has demonstrated how important it is to state rules simply, clearly and consistently. With the multitude of rule changes and amendments (particularly in the first few months of the lockdown), engagement was not only more important, it was much harder as there was often a lack of clarity internally.

We've stressed often that while the external pressure of COVID-19 pushed the seven districts to come together and work as a united force, it's now important that we find the energy, motivation and channels to keep that togetherness going in the future. It's clear that our Engagement and Enforcement team and its multi-agency approach can act as the catalyst that drives it.

Environmental Health

Environmental Health

Environmental Health covers factors in our business and personal lives that can have an effect on our health. Commonly this sees the team working with local businesses to ensure they're aware of and comply with Health & Safety and hygiene legislation, working with the public following noise or bonfire complaints, investigating accidents at work, and administering licences (including alcohol and taxi).

Because it covers such a range of activities, it calls for a very practical approach to problem solving, often with the ability to apply common sense and life experience proving as crucial as a scientific background. This unique set of skills proved absolutely essential when it came to working with other departments and the public across the county during the pandemic.

Environmental Health

Focusing on COVID-19

As with other service areas in the Council, the majority of Business As Usual tasks for the team were halted. Firstly the majority of businesses that were the focus of the team's work were not operational, and secondly, the team quickly saw the need to dedicate all of its efforts and resources towards tackling the pandemic. All Health Protection staff (including Environmental Health Officers) were involved from the start, but these were very quickly joined by staff from wider Environmental Health areas and other teams (including warden control, community safety and CCTV) who could help with the Covid effort.

The businesses that were still open had new COVID-19 legislation that needed to be abided by. Understandably however, legislation was often rushed out which created grey areas, loopholes and often a lack of knowledge as to what a business could or could not do. For example, supermarkets remained open for food and household goods, but was it illegal for them to sell greetings cards? Our Environmental Health team has a lot of experience in interpreting legislation and applying it to real life situations, so often took the lead advisory role when it came to applying it across the county.

The changing face of business

Many businesses also changed the nature of their work so they could remain open, including pubs which became takeaway-food suppliers in many cases. This was compounded by businesses which looked to exploit loopholes to continue operating. A notorious example of this is the policy that stated that pubs could only open if their patrons could order a 'substantial' meal with their alcoholic beverage. In one case this led to a menu change which saw 'substantial chips' served with every drink.

Due to this new stream of work, our Environmental Health team utilised Neighbourhood Wardens (later Covid Marshals) to act as an extension of its eyes and ears throughout Northamptonshire. By gathering intelligence, this group helped the Environmental Health Officers build an accurate picture of what was actually happening on the ground. This continual flow of information proved to be an essential pillar when it came to understanding the impact the pandemic was having on the businesses in the county.

Environmental Health

Information and trends

During the initial stages of the pandemic, most of the work was reactive and focused on guidance and support for businesses in the county. Thanks to the way our Environmental Health team has always worked, it had strong relationships with businesses throughout Northamptonshire and as a result, they were open to help from EHOs and requested advice right from the start – a dialogue that continued throughout the pandemic, with a great deal of the team's time dedicated to ensuring businesses had the most up-to-date information and knew where to turn to for additional support.

Daily briefings were initiated which allowed teams across the council to share the information they'd gathered and to plan & action a response. The Environmental Health team was a key contributor, bringing the intelligence its 'boots on the ground' had gathered, and helping to bring some of the raw data on the disease to life. This insight, situation reports and calls/reports directly into the team (triaged by its expanded staff) helped the team to identify trends and prioritise the work, with internal weekly meetings used to plan the response.

Examples varied wildly, from regularly needing to engage with the public to stress the importance of self-isolation, hand hygiene and masks, to tackling the risk of outbreaks among big employers on industrial estates. With the team's experience of assessing hazard and risk and its ability to step back from a problem that business owners may be too close to, it identified that this workforce relied on car sharing and bus travel to get to work. Our Environmental Health team then focused not just on targeted messages (translated into multiple languages) to encourage safer travel but worked with colleagues in Transport to convince Bus Operating Companies to provide extra buses during peak times so that fewer passengers needed to be on each service.

Test & Trace became a particular priority as it provided such valuable information on the spread of the disease, as did addressing high infection rates in care homes. This brought the Environmental Health team into more regular contact with our IPC staff further building on their working relationships.

Becoming more proactive

The team championed partnership working as fundamentally essential. This approach helped to usher in a more system-focused approach, with working groups formed with other agencies across the council facilitating much better information sharing. This ultimately led to quicker, more informed decisions, whether relating to COVID-19 communications, the creation of procedures and plans for business checks, or helping care providers to continue to operate safely. The support of the system and the build-up of knowledge was a key factor in being able to move to more proactive work.

When proactive work was feasible, the team spent more time working on the best way to disseminate pertinent information to businesses in the county. Spearheading this were newsletters which went out to thousands of businesses, providing useful information, explaining legislation and signposting avenues for additional support; and a questionnaire for care homes, devised with Public Health colleagues, to help educate on, and check compliance with, COVID-19 safety.

The person who tests positive should isolate for 10 days and:

Environmental Health

Countywide and councilwide impact

For an indication of the impact the team had across the county, we can look at an Environmental Health record that was set up just before the first lockdown. All of the COVID-19 work undertaken was noted and to give a taste of the level of work undertaken, in the East Northants area alone, there were 2076 entries, which resulted in around 2750 interactions.

These interactions covered the whole spectrum, from helping to trigger behaviour change through education (i.e. to make mask-wearing widely accepted), to keeping manufacturing facilities working safely by reorganising the factory floor, redefining the flow of people or simply introducing a new rota system to limit the number of people in the building.

As a key influencing service in the decision-making process, this record doesn't show the reach the work of the team had on a fundamental level. Its knowledge of local businesses and population demographics, and from seeing how our communications and national legislation were received and interpreted, helped to shape the county's response as a whole – from top-level decisions to the messaging on a leaflet. So from a granular level to a bird's-eye-view, Environmental Health expertise was a critical factor in the way we tackled the disease.

While this team continued to develop its relationships with businesses and the general public, it also enhanced its reputation internally thanks to its range of complementary skills and ability to work effectively with other agencies. With its more practical approach and expertise, prior to the pandemic, Environmental Health was not always seen as central to Public Health. Its work over the last 18 months has seen a widespread, deeper understanding of its strengths develop internally and moving forwards it will be an integral part of Public Health work.

Working together

As has been made clear, Environment Health is all about working with other people, whether that's supporting local businesses, or partnering with other internal agencies. Environmental Health has supported the more clinical side of the pandemic co-ordinated by the NHS, Public Health England and our Public Health department with its scientific, practical and intelligence-gathering expertise.

This has seen it working with some unusual partners such as Transport, strengthening working relationships with other services such as IPC, Community Engagement and Communications, and building new relationships with pub-watch groups, charities and a range of support groups who all played a part in our COVID-19 response.

Perhaps the closest working relationship was with the police. As legislation around COVID-19 continued to develop, there was a need to define not just what the legislation meant practically, but also how it could be enforced, particularly as the reopening of pubs approached. Rather than leave grey areas, the two worked together to clarify which agency would take the lead in specific situations. As these conversations progressed, it became clear that the two would need to work very closely together to cover all eventualities.

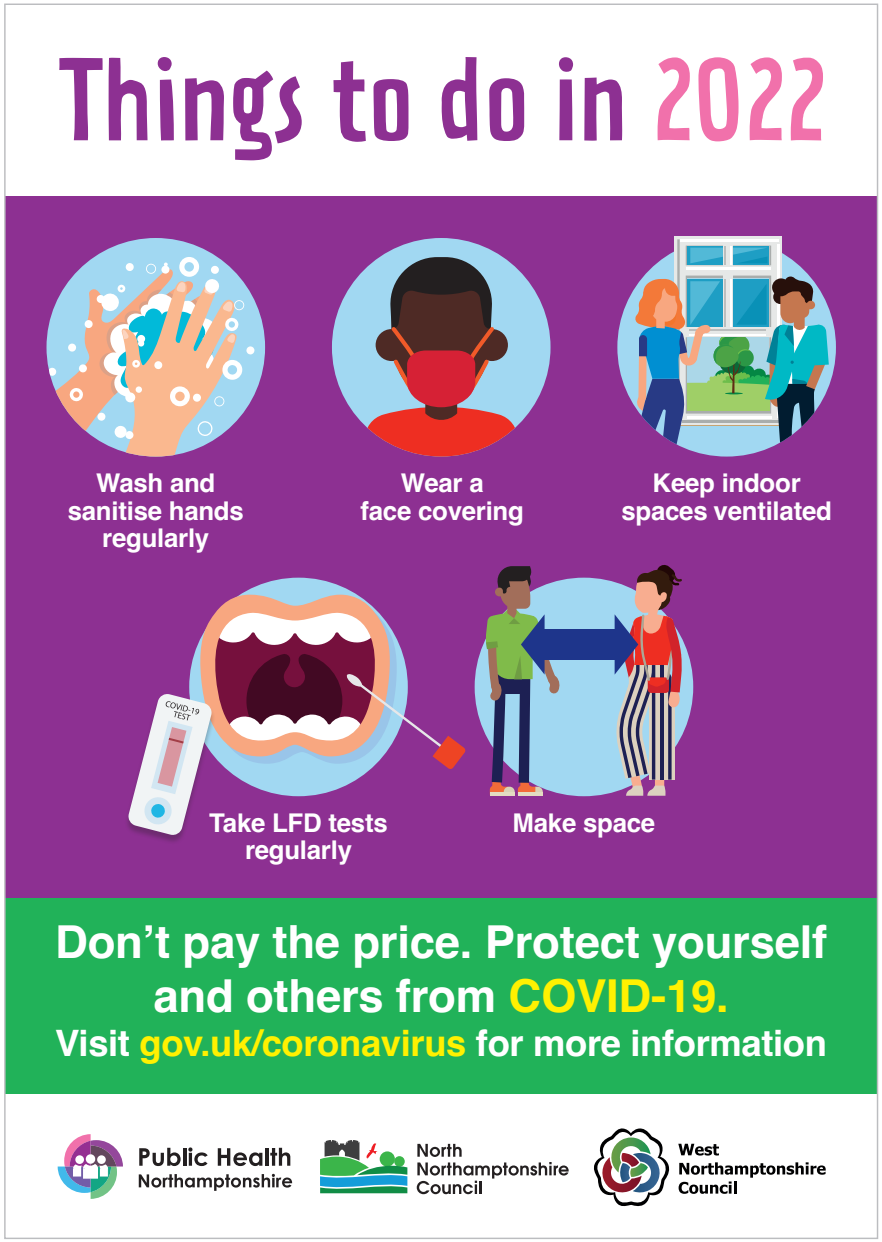
In order to facilitate this approach on the streets, a Joint Operations Team was formed which allowed joint patrols of the police and Local Authority Officers. This meant that EHOs could lead in commercial properties, whilst the police would lead in domestic settings. Having joint patrols would ensure that together they were equipped and legally able to deal with whatever enforcement situation arose.

It is worth stressing at this point however that enforcement was rare, and used as a last resort. The focus remained on education and support, and enforcement was only used for persistent offenders or those openly flouting the law.

The future

As with many aspects of Public Health, the pandemic has reinforced the validity of an intelligence-led approach. The combination of intelligence from the Covid Marshals, data gathered from other agencies and the ability of our Environmental Health team to bring insight to every situation helped businesses from care homes to pubs operate within the legislation and safely.

Many of the other departments within this report have stated that their work was enhanced by the support of Environmental Health Officers, which speaks to a wider appreciation of everything this department can bring to Public Health. It also reiterates the fact that a multi-agency approach is an essential part of an effective and informed response to any disaster. Although we were still organised as a local council and seven districts as the pandemic struck, everybody came together to tackle the disease as one. This is an approach which must continue as we adapt to being two unitary authorities. The relationships and information sharing of the last 18 months must continue.



Intelligence

Intelligence

The Intelligence department can be described as the eyes of Public Health. It helps the council to better plan and commission services by analysing data to show the potential impact of decisions, and to monitor and track the performance of any element within Public Health.

Its evidence-based approach helps to predict trends and future needs and identify areas that we could perform better in; as such, it's a department that can help every other department across Public Health do its best work. From monitoring the success of the local recovery service to producing school profiles for school nurses, and from producing deep-dive reports on a single issue like substance misuse, to modelling a multitude of future outcomes to identify the best course of action, Intelligence is behind all of the decisions we make.

Responding to COVID

The team was very used to working on a 'planned' basis, with regular reports produced on a monthly or quarterly basis, and requests for specific work coming in with lead times that gave the team time to think, do all the necessary research, speak to colleagues and produce the work within the established work plan. COVID-19 put an end to that.

When the UK began to experience its first cases, our Intelligence team was already looking for ways that it could reliably predict the way the county would be affected. This was a new disease however, with no precedent the team could use as the basis of its modelling. The team had previously produced a prediction model exploring likely outcomes for a flu epidemic, but with the lack of data on COVID-19, it was unknown how accurate it would be as the basis for the pandemic.

Imperial College London was part of the Government's Scientific Advisory Group for Emergencies (SAGE) and had been tasked with producing a prediction model with all the knowledge available at the time. Once this was published, it became the basis for our team's Northamptonshire prediction model, taking national information and applying it on a local level.

This was an incredibly important and intense task as our response to COVID-19 would be based on this model. Mission-critical parts of the system would use it to make key decisions, such as how many hospital beds and ventilators the county would need, and in a worst case scenario, would mortuaries have enough capacity?

The model was therefore the highest priority within the team in the pandemic's early stages. The pressure to complete the work was balanced with the need to do it accurately. The Imperial model needed to be understood and deconstructed in order to produce our own model using the same methodologies and in all, this process took around two weeks.

A new way of working

From this point on, there was no capacity within the team to work on Business As Usual tasks – all energy was put into Covid-related work. And as the focus of the work changed, the nature of the work changed too. The team had to forget its planned approach, and adapt to a new, fast-turnaround, urgent way of working.

Requests for data needed to be dealt with immediately, whether from myself, the media or other parts of the system such as the Strategic Coordination Group (SCG). For example if there was a rapid increase in rates in a local area, the team needed to do a rapid analysis of all the factors that could have influenced that rise so that we could plan a response. A prime example of this is the Greencore outbreak.

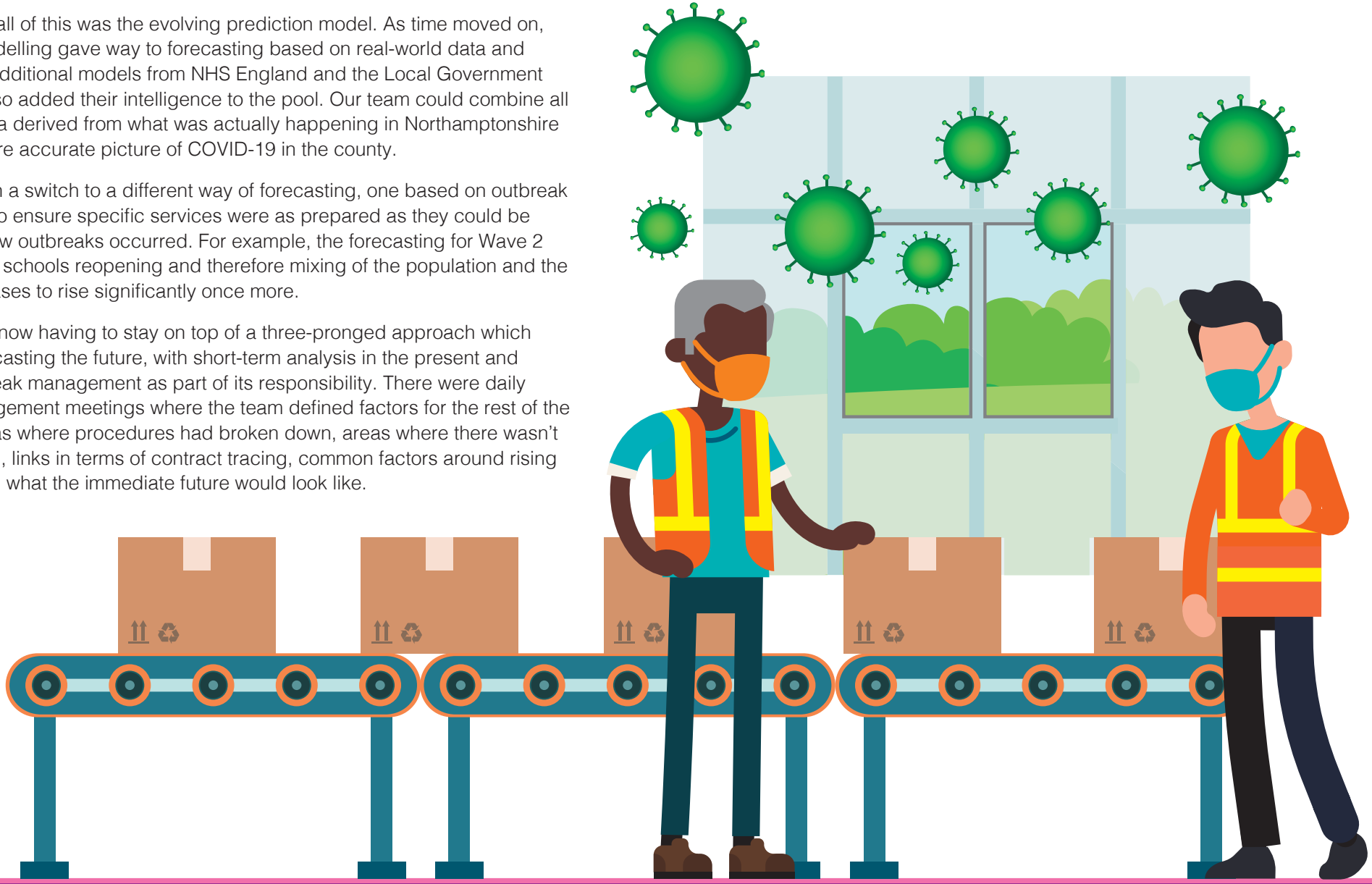
Working under this pressure became the norm. As new data on the pandemic was coming to light on a daily basis, new requests were coming into the Intelligence team rapidly, often requiring answers within just a few hours. To cope with this new workload the team implemented an evening and weekends rota, so whenever analysis was needed, it was available and used to help save lives.

Outbreak management

Underpinning all of this was the evolving prediction model. As time moved on, theoretical modelling gave way to forecasting based on real-world data and surveillance. Additional models from NHS England and the Local Government Association also added their intelligence to the pool. Our team could combine all of this with data derived from what was actually happening in Northamptonshire for a much more accurate picture of COVID-19 in the county.

This resulted in a switch to a different way of forecasting, one based on outbreak management to ensure specific services were as prepared as they could be if and when new outbreaks occurred. For example, the forecasting for Wave 2 coincided with schools reopening and therefore mixing of the population and the potential for cases to rise significantly once more.

The team was now having to stay on top of a three-pronged approach which balanced forecasting the future, with short-term analysis in the present and reactive outbreak management as part of its responsibility. There were daily incident management meetings where the team defined factors for the rest of the system, such as where procedures had broken down, areas where there wasn't enough testing, links in terms of contract tracing, common factors around rising case rates and what the immediate future would look like.



Intelligence

Intelligence in the spotlight

Throughout this pandemic people have seen Chief Medical Officers and Chief Scientific Officers on television regularly talking about the data and how they are making decisions based on it. People are now familiar with terms like case rates and understand the state of the epidemic curve, and even if they're not familiar with terms like epidemiology, they're speaking in data terms.

This wasn't the only route the team's work took to reach the public. Throughout the pandemic, we published a weekly Surveillance Pack that was available to the media and the general public. This kind of pack would usually only be for internal groups, who would use it to make planning decisions, but we believed it was important for everybody to have full knowledge of the situation, week by week as the pandemic progressed.

This transparency has seen a huge number of people connect with data and understand its power. As a result, internally more and more departments are asking Intelligence to guide projects, and there's more interest in the work the team does from the general public than ever before.

Partnerships

From the very early days of the pandemic, it was clear that sharing data between departments and organisations was the most effective way of working and is something we're continuing to do. As a result, our Intelligence team and the CCG's own Business Intelligence team began working together as one, immediately helping to increase the resources the stretched team had at its disposal.

Another internal department Intelligence worked closely with was Emergency Planning. This relationship became so critical to the Emergency Planning team, that it proactively secured funding for two additional posts within Intelligence to boost the team's reach, clearly recognising the impact that data was having on its own efficacy.

Again the Greencore outbreak is a key point in the county's COVID-19 story. Whilst PHE was overseeing activity across the whole of England, it relied on local teams like our own to support it by analysing outbreaks in their own areas. With Greencore in the national spotlight, our Intelligence team prepared data into factors such as who was testing positive, whether there was an ethnicity link, travel-to-work arrangements and a multitude of factors which could help to understand how the outbreak had happened, how to break the chain and how to apply these learnings in future similar outbreaks. This resulted in a longer-term partnership with PHE which facilitated more in-depth epidemiology work.

Other partnerships helped the team engage with communities like never before. Environmental Health Officers and their 'lived' experience helped to add context to the Intelligence team's data. Together the two groups could join the dots and turn data into real life situations, helping not just to identify trends, but to pinpoint the detail behind them.

Intelligence

Strong links were established with Coronial teams, which needed accurate data on deaths due to COVID-19, other contributory factors, which socio-economic or ethnic group they'd been a part of etc. This also extended to mortuary teams, who needed accurate forecasts as to potential death rates to ensure they would have enough capacity as the pandemic reached a peak. As a result, Northamptonshire was prepared for the worst when it happened, and had established a temporary mortuary to handle the increased number of deaths.

New strands of data were created in collaboration with departments such as the IPC team. Intelligence created a care-home dashboard, an extensive tool that collated data on positive cases, residents, staff, and local-area factors on a care-home by care-home basis, helping to prepare teams on the ground.

Moving forwards

As we've seen, the work of our Intelligence team has had a direct impact on the work of many other departments and the lives of the general public during the pandemic. Its appetite for working closely with others, not just to share data but to share energy, ideas and workloads is something that we intend to nurture and encourage moving forwards – something made easier by the fact that so many other departments want Intelligence and evidence-based decisions to be driving their services.

The pride the team has taken in its work is reflected in the stronger network it has established across the system. When difficult questions need to be answered, Intelligence now has the connections it needs to get the data and deliver those answers.

This more resilient network is matched by the resilience of the team itself, which, like many other teams, needed to adapt rapidly to brand new ways of working, and also a new pace of working. This proven ability to succeed beyond the confines of the office environment and the routine of only planned work, is something which will be the foundation of Intelligence's higher profile within the system in the future.

Summary

At the time of writing in February 2022, rates of COVID-19 infection and deaths are continuing to decline. The Government is developing plans for living with COVID-19 and has implemented changes to legislation. Life for many is starting to feel more normal, and business as usual operations are starting to return to many organisations. However, the pandemic has not gone away. Many people are still being affected by illness, with continued impact on education, employment and social activities. The scale of longer term physical and mental ill health created by the pandemic has become evident. Disadvantaged communities continue to be hardest hit by the pandemic.

One thing we have learnt during the pandemic is that it is difficult to predict what will happen next, however it is almost certain that we will have further waves of infections and new variants. It is also likely that there will continue to be improvements in vaccination and development of effective treatment. Our understanding of what interventions work to support behaviour change aimed at reducing risk of infection in individuals and high-risk settings will continue to grow.

This report has described the remarkable journey we have been on over the last couple of years in Northamptonshire. We have developed expertise in many areas to respond to the pandemic. As a result, our expertise in a range of functions including communication, infection prevention and control, intelligence, community resilience and working with communities puts us in a strong position to continue to respond to the pandemic. Retaining this expertise and the collaborative work will be vital in the medium term. Addressing the indirect impacts of the pandemic, including recovering from the disruption to services and reducing the inequalities made worse by the pandemic, will take time and require strong partnership working to ensure an effective response.

Recommendations and Progress

Recommendations

1. The exploration and delivery of health-related messaging with a sense of inclusivity.
2. The continuation of collaborative working alongside other public and voluntary services to ensure the safety and wellbeing of the population in North and West Northamptonshire.
3. The Health and Social Care system across North and West Northamptonshire should further utilise data and intelligence about the impact of COVID-19 and other health related matters to inform services or initiatives and meet the needs of local communities.
4. Priority should be placed on addressing the health inequalities exacerbated by the pandemic within and across the two Unitary areas by ensuring access to services for all, particularly those who are rurally or socially isolated.
5. Investment in services which improve physical and mental health and wellbeing of the local populations which are key to supporting the recovery from the pandemic and the future health of the population.

Progress since the previous report for 2019/20

Recommendation	Update
Local leaders and organisations to explore opportunities to adopt and implement a Health in all Policies approach.	Public Health Northamptonshire have led on raising awareness of and embedding Health in all Policies across the Local Authorities and the local Integrated Care System. This has included working with other council services and systematically considering the health impacts in all decision making and working with planning, transport, housing and climate change teams to develop health promoting strategies and policies.
As Local Government Reform continues to progress, priority should be placed on addressing the health inequalities within and across the two Unitary areas.	There is a requirement for all partners across the ICS (which covers both unitary areas) to understand and address health inequalities in Northamptonshire leading to improved access to services, better outcomes and improved experiences for all. To support that an ICS Health Inequalities Plan is being developed and this will set out the joint actions that need to be taken across the system to address health inequalities, including preventing ill health and addressing the wider determinants of health. The local authorities are a key partner in developing and implementing these plans at a Place level. Furthermore, a health inequalities toolkit is being developed which provides partners with data, training and toolkits including how to do an impact assessment and health equity audit, to be used as part of a quality improvement process, as well as tools for engaging with communities. The tools will also help partners to take a health and equity in all policies approach and the use of these tools should be embedded across the system.
All partners to actively work with and engage communities, to identify the skills and resources required or already in place to improve health and reduce inequalities.	Key to addressing health inequalities is taking a community-based approach and working in partnership with our local communities. This will provide a better understanding of what these populations needs and enable commissioners and services to co-produce interventions and services that better meet their needs. To aid this community development workers have been recruited to enable community based programmes of work to be developed with our most vulnerable groups and areas, targeting the most deprived parts of the county.
Public Health to work with decision makers and communities to identify the needs in terms of green spaces as a means to address health and wellbeing issues.	The previous Director of Public Health Annual Report started this journey by mapping how far people live from green spaces to assess the need. Developments have included an Active Parks programme, bringing a range of new activity to our local country parks to encourage physical activity. Another example is the local development of multiple 'Beat the Street' programmes, connecting green spaces to local community assets through physical activity in a game format.

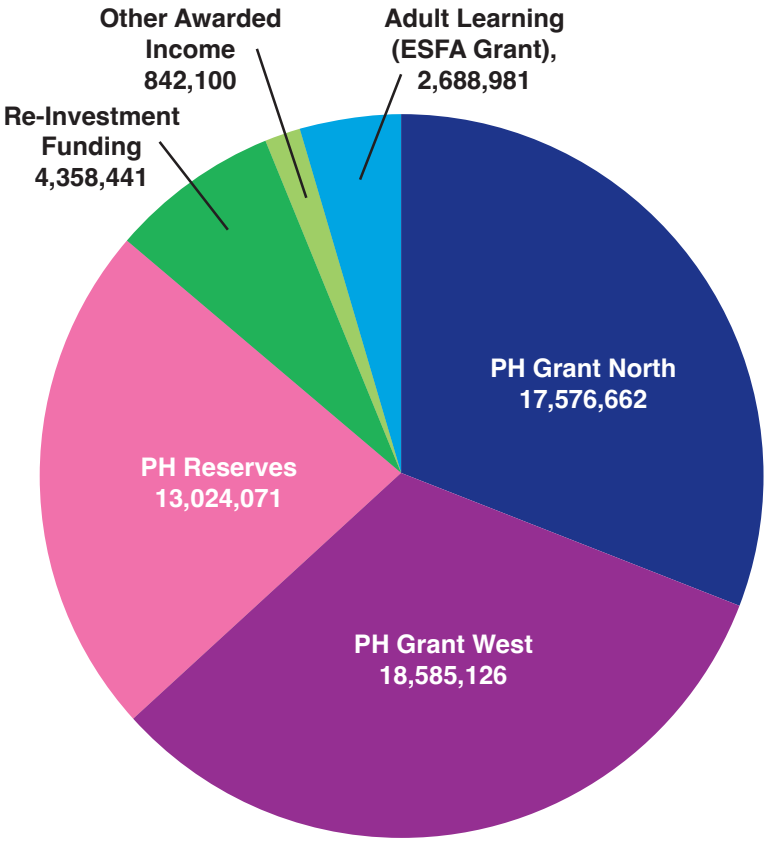
Progress since the previous report for 2019/20

Recommendation	Update
Work with Children First and local schools to help reduce the number of young people who are not in employment, education or training (NEET).	Following Local Government Reform activity in the county, Children's Services are now delivered as follows; Education and SEND are delivered by WNC and NNC independently, Children's Social Care and Early Help across Northamptonshire are delivered by Northamptonshire Children's Trust commissioned by NNC and WNC under Government direction Public Health have commissioned the following 3 projects with Children First and NCT to address the needs of those who are considered NEET: • An initiative focused on care leavers and is a mentoring project that provides emotion coaching for the staff and young people, alongside mentoring, and ring-fenced apprenticeship roles, to provide working and learning opportunities for this cohort of young people. • Wellbeing for Education Recovery (WER) in schools • Healthy Schools Service, which supports teaching staff and young people to manage their wellbeing. This in turn supports their learning and development to achieve the desired grades for future employment opportunities • Broadening the scope of our work with Children's services, initial health assessments for children coming into care is an area that requires focus and improvement, this is work that Public Health will support.
Create closer links with key agencies to work together to build partnerships and develop an integrated response to reduce the impact of homelessness and poor housing.	During COVID-19, partners have rapidly worked towards short term solutions to reduce homelessness by providing accommodation in hotels. Partners are reviewing the learning from COVID-19 to identify longer term solutions, focusing on the causes of homelessness. Additionally, this population have been supported by a targeted screening and immunisation programme.
Continue to develop Northamptonshire as a place of 'good work' by supporting businesses to complete evidence based Healthy Workplace Standards and to make decisions that consider the health and wellbeing of their employees.	We have supported businesses to develop initiatives and interventions that are appropriate to both their size and the needs of their staff. Additionally we have identified the needs of underserved parts of the workforce, such as night shift workers and HGV drivers who use local truck stops and work with partner agencies across the county to help businesses to support the improvement of their health and wellbeing and address health inequalities.
Work with partners to shape services within the unitary authorities by ensuring economic development and inclusive growth are embedded throughout.	Both North and West Northamptonshire Councils have helped bring Public Health and Economic Development departments closer working together on joint priorities. As strategies are developed across the new authorities, Public Health are working across departments to embed principles set out in the recent Public Health England publication - Inclusive and Sustainable Economies: leaving no-one behind.
Work with planning departments to ensure fast food outlets are not over concentrated in new or existing developments	Public Health have been working with all planning departments to identify opportunities to reduce over concentration through planning policy. We have developed a policy restricting fast food takeaways within close proximity to schools in Northampton, which is in the latter stages before adoption. If adopted, we will look at developing similar policies in the other planning areas.

Public Health Finances 2020/21

As Local Government Reform continues, changes to the Public Health grant allocation for 2021/22 will take effect. The grant remains ring fenced for exclusive use on public health functions and allocations were £17,576,662 and £18,585,126 to North Northamptonshire Council and West Northamptonshire Council respectively. The combined total sees an increase of £424,341 from the previous year's allocation to Northamptonshire County Council. Allocations for 2022/23 are expected to be £18,070,429 for North Northamptonshire Council and £19,107,223 for West Northamptonshire Council. This further increase addresses the cost of challenges arising directly or indirectly from COVID-19.

A summary of the public health finances for 2020/21 can be seen in the chart below.



Acknowledgements

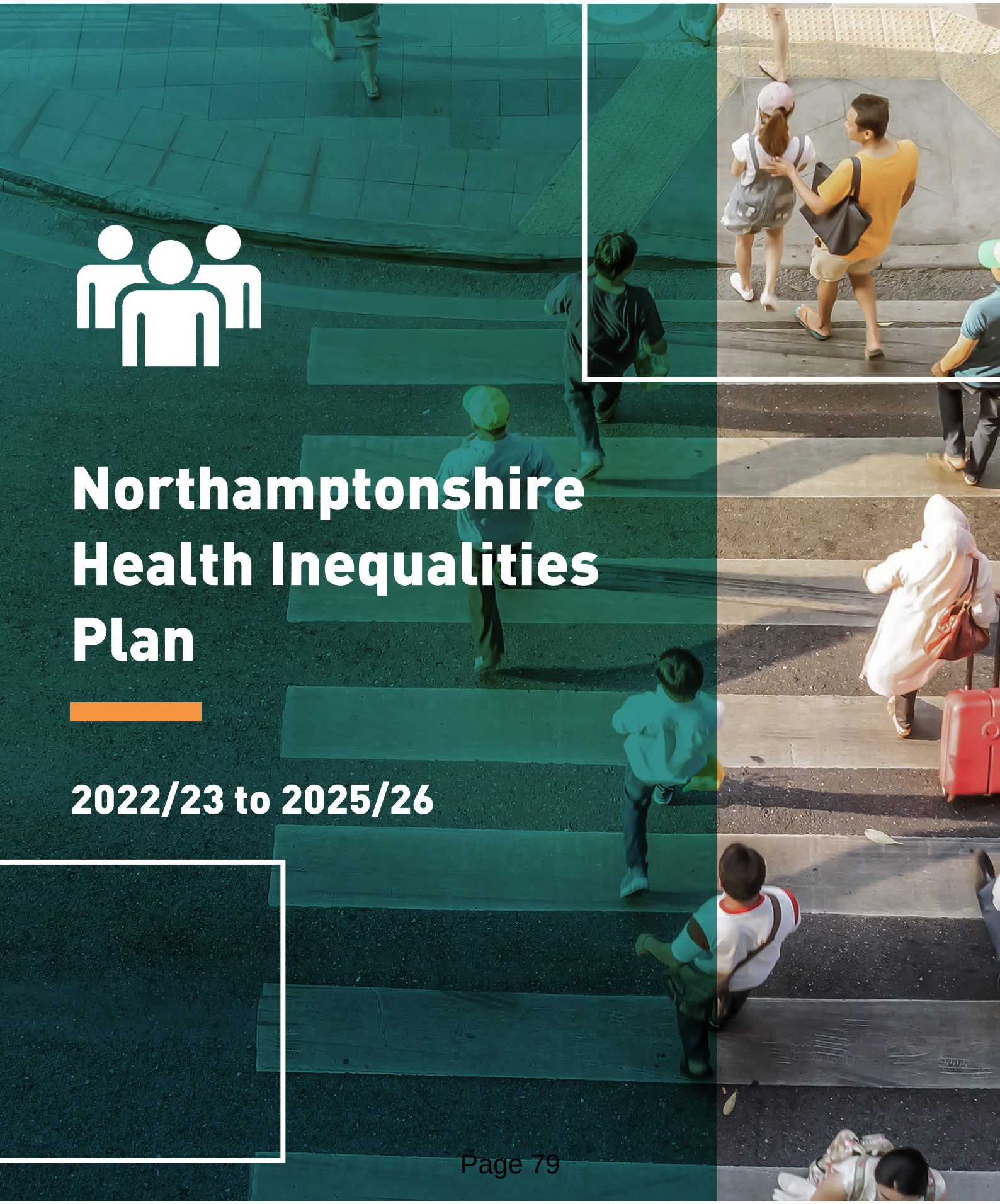
Thank you to those who have contributed to the production of this report:

Ruth Austen, Nina Billington, Sally Burns, Kathryn Hall, Mary Hall, Susan Hamilton, Rhosyn Harris, Paul Holder, Matt Hoy, Nisha Patel, Inge Pye, Annapurna Sen, Chenyu Shang, Iain Smith, Annette Walker, Sarah Ward and Nikita Wiseman

And a very special thank you to our wider Public Health Team who have responded to the pandemic with endless compassion and hard work alongside all our partner organisations who continue to work with us to protect and improve the health and wellbeing of our residents.

Appendix

Northamptonshire
Integrated Care System



Northamptonshire Health Inequalities Plan

2022/23 to 2025/26

Contents

Executive summary

Health inequalities are 'unfair and avoidable differences in health across populations and between different groups within society' (The King's Fund 2020). The unequal distribution of the social factors which affect our health – such as education, housing and employment – drives inequalities in physical and mental health, reduces people's ability to prevent sickness, or to get treatment when ill health occurs.

Addressing health inequalities is a core principle behind the establishment of Integrated Care Systems (ICS) and new ways of working. NHS England and NHS Improvement require local systems to develop a local Health Inequalities Plan which sets out how the system will work together to address health inequalities.

This plan describes Northamptonshire's vision to work with communities to ensure that people living in Northamptonshire have the opportunity to thrive, to access quality services providing excellent experiences and optimal outcomes for all. The long-term ambition is to see:

- An increase in healthy life expectancy
- A reduction in health inequalities
- A reduction in premature mortality
- Improved community cohesion

To achieve this vision Northamptonshire ICS has developed a set of guiding principles describing how we need to work as a system to understand and address health inequalities. These principles will be embedded across all organisations working in the ICS. Our guiding principles are summarised in Fig. 1 on the following page and described in detail on pages 18 to 21.

Alongside the implementation of these principles the system will develop specific actions at ICS, place and neighbourhood levels to address health inequalities. The key areas of focus for 2022/23 are set out in the health inequalities action plan for 2022/23 (see Appendix). These will be reviewed annually.

Key actions over the next six months

1. Finalise governance arrangements
2. Establish Health Inequalities Oversight Group
3. Review capacity in the system to develop this programme of work and ensure sufficient leadership, analytical and programme management capacity
4. Finalise the ICS Outcomes Framework
5. Develop place and neighbourhood plans that reflect local assets and needs

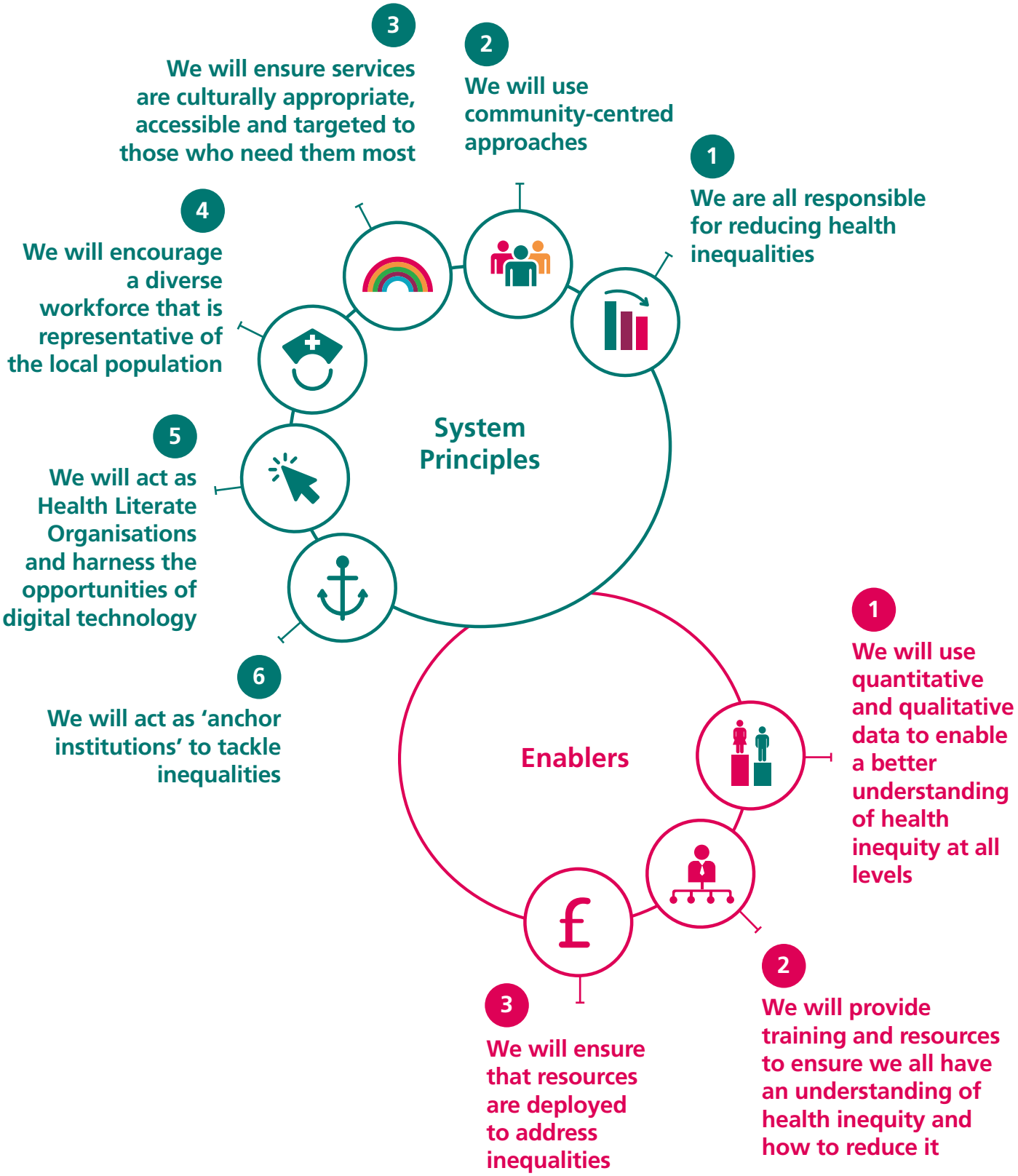


Fig. 1: Principles of our approach to reducing health inequalities in Northamptonshire

Purpose

Addressing health inequalities is a core principle behind the establishment of Integrated Care Systems (ICS) and new ways of working. We are required to develop a local Health Inequalities Plan which sets out how the system will work together to address health inequalities. This document sets out the plan for Northamptonshire ICS.

Our vision is to work with communities to ensure that people living in Northamptonshire have the opportunity to thrive, to access quality services providing excellent experiences and optimal outcomes for all. The long-term ambition is to see:

- An increase in healthy life expectancy
- A reduction in health inequalities
- A reduction in premature mortality
- Improved community cohesion

Objectives of the Northamptonshire Health Inequalities Plan

1. To develop a set of broad guiding principles which describe practical actions for the Integrated Care System to reduce health inequalities.
2. To set out key areas of focus and next steps for developing these.

What are health inequalities?

Health inequalities are preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies. These determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs[i].

Health inequalities can result in differences in:

- Wider determinants of health, e.g. quality of housing, employment opportunities, education, air quality
- Behavioural risks to health, e.g. smoking or healthy diet
- Health status, e.g. life expectancy and prevalence of health conditions
- Access to services, e.g. availability of treatments
- Outcomes, quality and experience of care[ii]

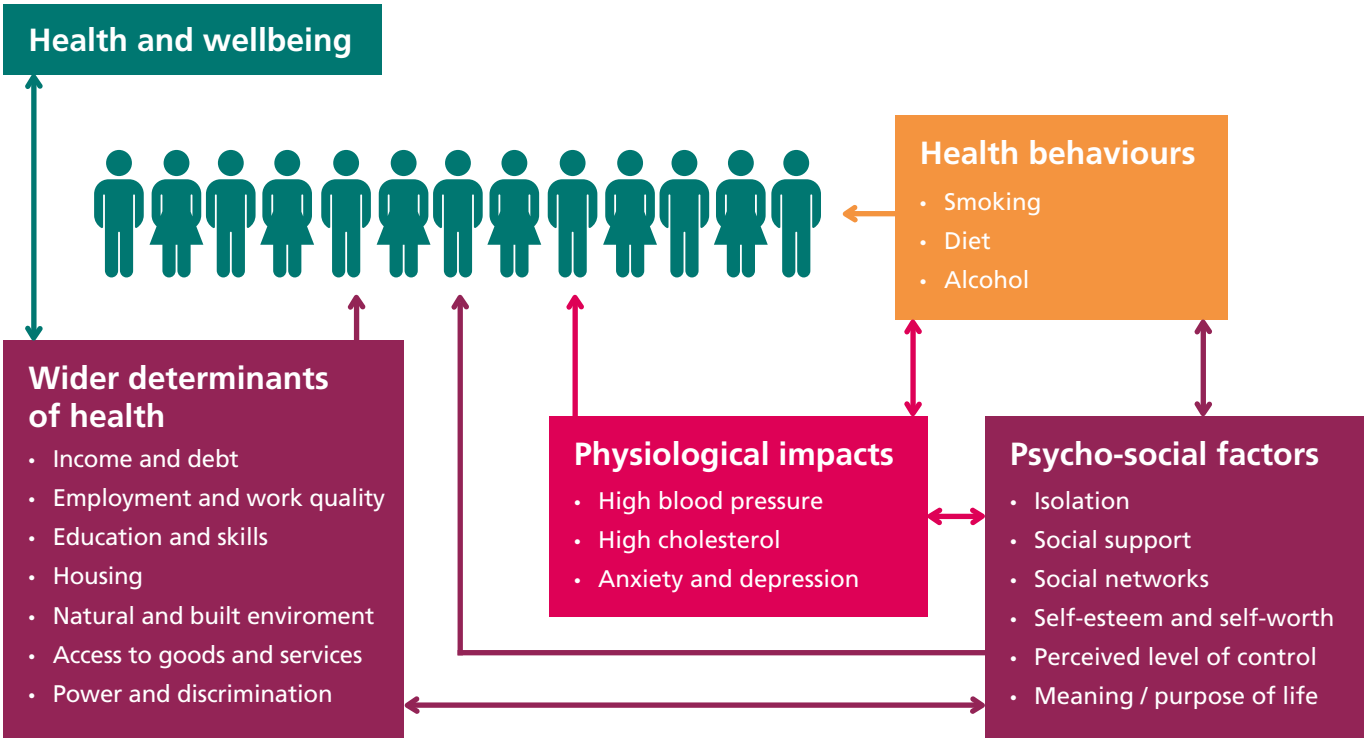


Fig. 2: System map of the causes of health inequalities

i NHS England and NHS Improvement: Reducing health inequalities https://www.england.nhs.uk/about/equality/equality-hub/resources/

ii The King's Fund: What are health inequalities? https://www.kingsfund.org.uk/publications/what-are-health-inequalities

People do not have the same opportunities to be healthy. Inequalities are driven by a range of factors, including variations in the wider determinants of health and the presence of, or access to, psycho-social mediating and protective factors.

Health inequalities are not inevitable and can be significantly reduced. Most effective actions to reduce health inequalities will come through action on the wider determinants of health. It is estimated that only 20% of health outcomes result from clinical interventions, with the remaining 80% driven by healthy lifestyle factors, wider determinants of health (such as social networks) and environmental factors[iii].

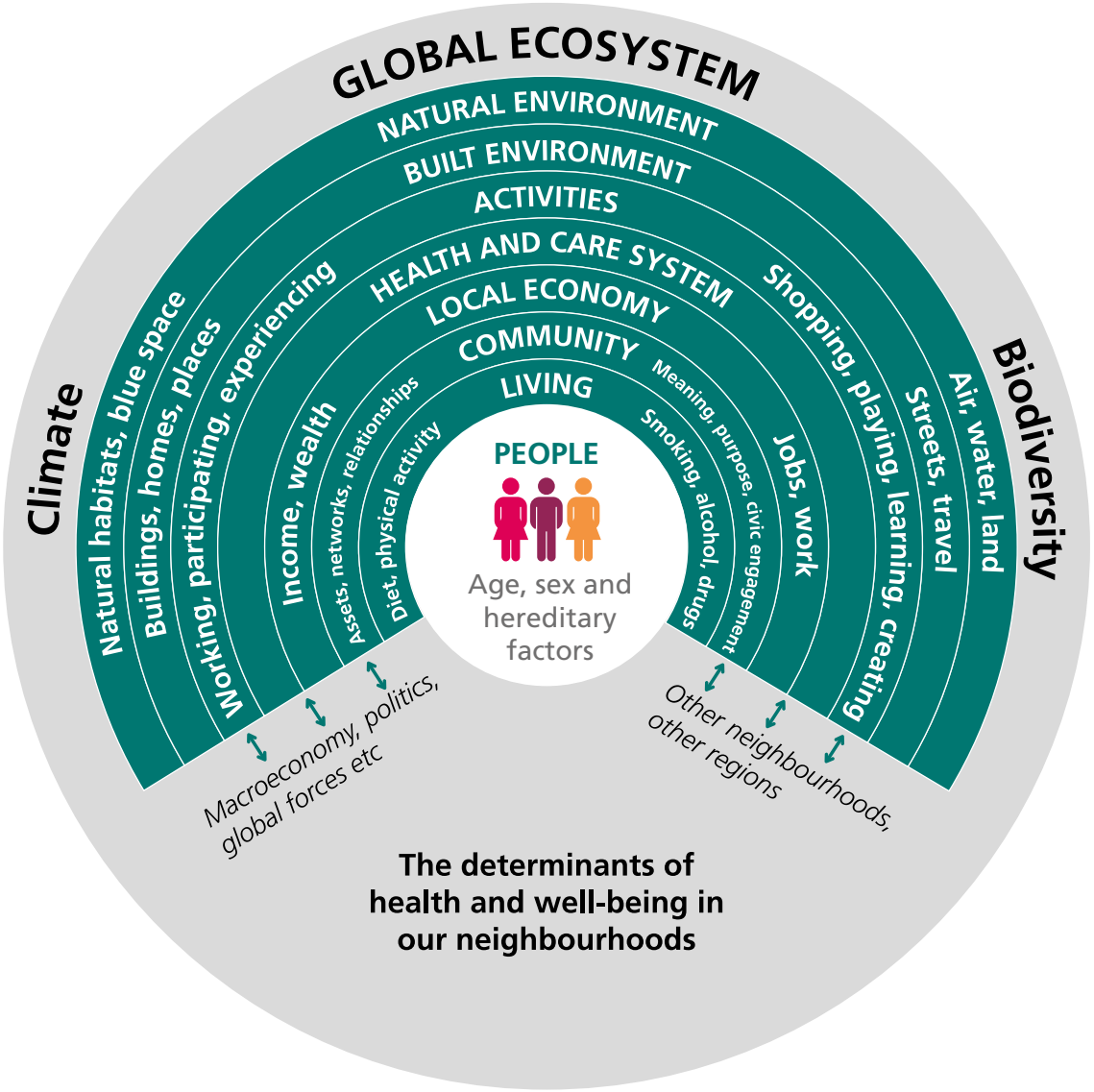


Fig. 3: The determinants of health and wellbeing in our neighbourhoods.

'Health inequalities' is the commonly used term – however, we are actually referring to health equity and inequities. Equality means treating everyone the same or providing everyone with the same resource, whereas equity means providing services relative to need to ensure equality of outcomes. This will mean some warranted variation in services for different groups.

iii Marmot M (2010) Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010 https://www.gov.uk/research-for-development-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010

Health inequalities are determined by social circumstances largely beyond an individual's control. The dimensions of inequality show the different groups that are most vulnerable to health inequalities and how these overlap, as shown in Fig. 4 below. Legislation underpinning efforts to reduce inequalities includes the Equality Act 2010 and the Public Sector Duty, which sets out key characteristics of communities that are subject to inequalities. However, the Act does not include socio-economic status, which remains a fundamental contributor to inequalities in health and wellbeing outcomes, as well as other factors such as where people live.

Some groups in society are particularly disadvantaged: for example, people who are homeless, refugees and asylum seekers, including those who receive no financial support and for whom absolute poverty remains a reality. In the UK, the concept of 'inclusion heath' (an approach which aims to address extreme health and social inequities) has typically encompassed groups including homeless people; Gypsy, Roma and traveller communities; vulnerable migrants; offenders; and sex workers[iv]; but other groups can also be included, such as care leavers. These groups can be socially excluded, which means processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions[v].

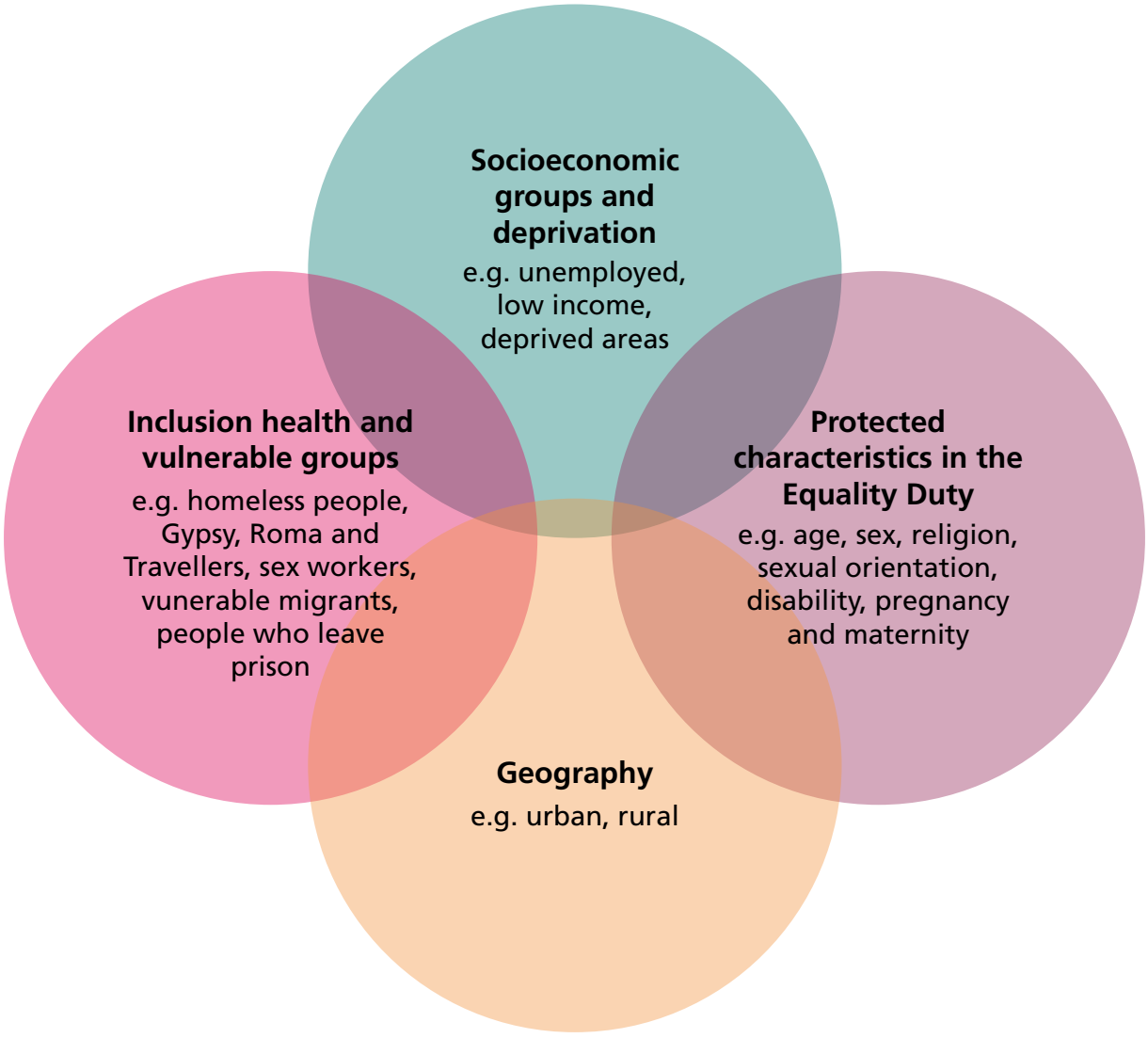


Fig. 4: The overlapping dimensions of health inequalities.

iv Department of Health 2010. Social Exclusion Task Force and Department of Health Inclusion Health: Improving the way we meet the primary healthcare needs of the socially excluded. Cabinet Office, Department of Health, London https://webarchive.nationalarchives.gov.uk/ukgwa/+/http://www.cabinetoffice.gov.uk/media/346571/inclusion-health.pdf

v Popay J, Escorel S, Hernández M, Johnston H, Mathieson J, Rispel L (2008). Understanding and tackling social exclusion: final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network. World Health Organization, Geneva https://www.researchgate.net/publication/244919409_Understanding_and_tackling_social_exclusion

National context

The Health and Social Care Act 2012 sets out the need to reduce inequalities in access to care and outcomes of care. The Care Act 2014 establishes the 'wellbeing principle' as the guiding principle for local authorities, which means that they should promote wellbeing when carrying out any of their care and support functions for any individual, whether they are people receiving care or their carers.

The NHS Long Term Plan[vi] sets out a widely supported route map to tackle our greatest health challenges, including closing the gap in health inequalities in communities, recognising the important role the NHS has in addressing this in partnership with local authorities and the voluntary and community sector.

Health and care services worldwide have faced an unparalleled challenge in responding to and managing the impact of COVID-19. The disproportionate impact of the virus on different groups and communities has highlighted longstanding health inequalities. Recovery from the pandemic presents both a real challenge and a real opportunity to address health inequalities.

The white paper 'Integrating Care[vii]: Next steps to building strong and effective integrated care systems across England' describes the role of Integrated Care Systems (ICS) in the delivery of integration to serve four fundamental purposes:

a. Improving population health and healthcare
b. Tackling unequal outcomes and access
c. Enhancing productivity and value for money
d. Helping the NHS to support broader social and economic development

It is clear that health inequalities are a priority nationally. Locally Northamptonshire's ICS presents an opportunity for leadership to ensure that we work collaboratively across the system to understand and address health inequalities in Northamptonshire.

Given the range of causes, a joined-up, place-based approach is necessary to tackle the complex causes of health inequalities. While action on the behaviours and conditions affecting health is a necessary part of the solution to reduce health inequalities, these also need to be addressed within the context of their root causes: the conditions under which people are born, grow, work and live.

Reducing health inequalities and workforce inequalities is a responsibility of all partners across the system.

vi NHS Long Term Plan https://www.longtermplan.nhs.uk/

vii DHSC, 2022, Health and social care integration: joining up care for people, places and populations https://www.gov.uk/government/publications/health-and-social-care-integration-joining-up-care-for-people-places-and-populations

The Core20PLUS5 approach

Core20PLUS5[x] is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level.

The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' clinical focus areas requiring accelerated improvement.

Core20

Core20 refers to the most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health: income, employment, education, health, crime, barriers to housing and services, and living environment.

PLUS

The 'PLUS' element of the Core20PLUS5 approach refers to Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data.

Inclusion health groups include ethnic minority communities; coastal communities; people with multi-morbidities; protected characteristic groups; people experiencing homelessness; drug and alcohol dependence; vulnerable migrants; Gypsy, Roma and Traveller communities; sex workers; people in contact with the justice system; victims of modern slavery; young carers; and other socially excluded groups.

5

The final part of the Core20PLUS5 approach sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes, with national and regional teams co-ordinating local systems to achieve national aims.

These areas of focus are maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis and hypertension case-finding.

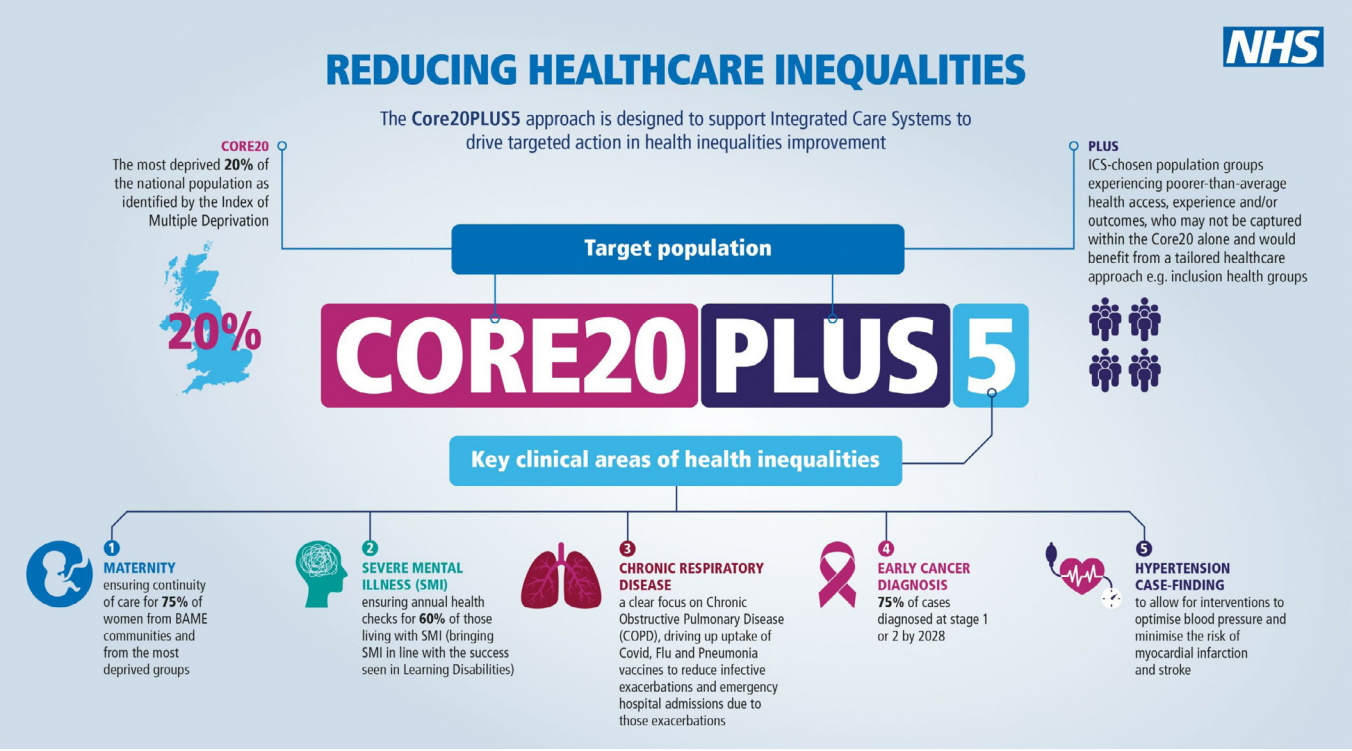


Fig. 5: The Core20PLUS5 approach to reducing healthcare inequalities.

Five Key Priorities – Strategic

Restore NHS services inclusively

Assessing performance by patient ethnicity and Index of Multiple Deprivation (IMD), focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations.

Mitigate against 'digital exclusion'

Ensuring providers offer face-to-face care to patients who cannot use remote services; and ensuring more complete data collection on how people access consultations, broken down by patient age, ethnicity, IMD, disability status, etc.

Ensure datasets are timely and complete

Continuing improvement of data collection on ethnicity, across a range of health and care settings.

Accelerate preventative programmes

Covering flu and COVID-19 vaccinations; annual health checks for people with severe mental illness (SMI) and learning disabilities; supporting the continuity of maternity carers and targeting long-term condition diagnosis and management.

Strengthen leadership and accountability

Supporting system-wide health inequalities leads to access training and wider support, including use of the NHS Confederation Health Inequalities Leadership Framework.

Core20PLUS – Population Groups

Core20

(most deprived 20% of the population)

PLUS

(ICS-determined population groups experiencing below average health access, experiences and/or outcomes but not captured in Core20 alone)

5 Clinical Focus Areas

- Maternity
- Severe mental illness
- Chronic respiratory disease
- Cancer
- Hypertension

Fig. 6: The Core20PLUS5 approach sits alongside the five strategic priorities set out in the NHS Long Term Plan

viii NHS England and NHS Improvement (2022): Core20PLUS5 – An approach to reducing health inequalities
https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

Local context

The development of Northamptonshire's Integrated Care System (ICS) presents a unique opportunity to shape the partnerships that will have a fundamental role in supporting and working with our diverse communities and creating the right environments for people, families and communities to thrive.

The Integrated Care Partnership (ICP) will set the system-wide strategic priorities, which will be implemented through the ICS transformation priority programmes and at place, neighbourhood and Primary Care Network (PCN) levels, with a focus on ensuring needs are understood and addressed at the most appropriate local level.

Place-based approaches recognise the importance of addressing the wider determinants of health (the conditions under which people are born, live and work) across all stages of life. It is an approach which considers critical stages, changes and settings where large differences can be made in population health, rather than focusing on individual conditions at a single stage in life.

Directors of Housing, Communities and Wellbeing from North and West Northamptonshire Councils are leading the development of place-based plans for their local authority areas. These plans will set out how we will work in those areas to understand local needs and develop actions to address health inequalities, working with local communities.

Within these places community wellbeing forums will be created to enable local leaders and communities to influence policy and strategy development, bringing together the voices of populations of between 60,000 and 100,000 people. Each community wellbeing forum will have representation on the Health and Wellbeing Board for their place.

Sitting under these forums will be neighbourhood partnerships supporting populations of between 30,000 and 50,000 people. Each local area will be recognised as unique and individual with a variety of assets (people, organisations and buildings and physical places). Services and support will be organised around the profile of the local areas, including wider determinants.

These partnerships should be mainly represented by people and organisations that deliver and are able to shape and mould support to best meet desired outcomes. Community and family hubs will be key to local plans to improve early access to services for our communities and ensure that we take a 'prevention first' approach.

Neighbourhood profiles are being developed to inform the priorities and areas of action for each of these neighbourhoods. These action plans will recognise the differences between and within places and neighbourhoods and ensure that services are targeted and appropriate to meet population needs.

Local Area Wellbeing Forums and Partnerships

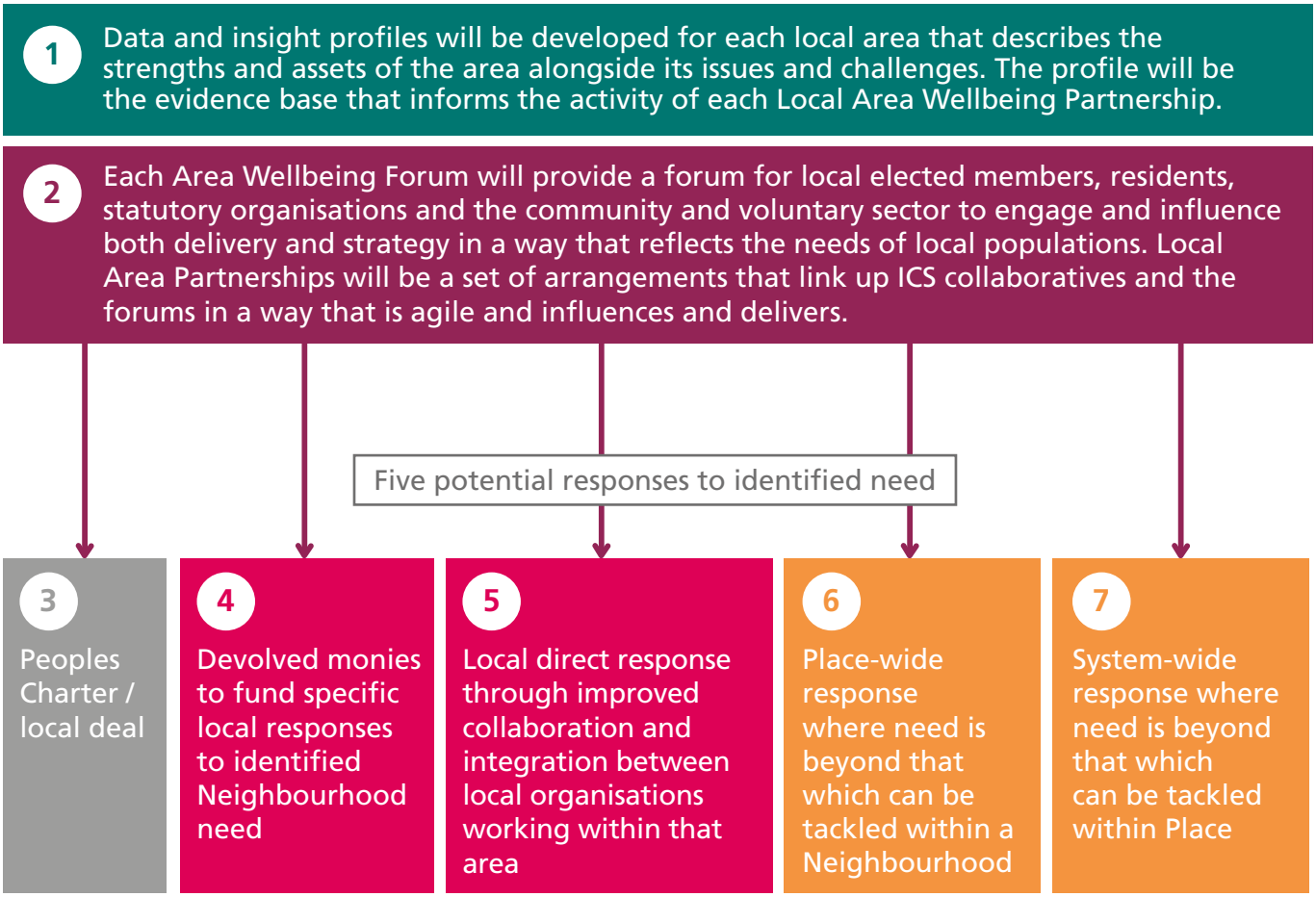


Fig. 7: Development of place-based plans, Wellbeing Forums and neighbourhood partnerships

How Neighbourhood Partnerships would work:

- Local Area Wellbeing Partnerships, which bring together elected members, residents, voluntary and community and statutory organisations to help co-ordinate and respond to identified local needs to deliver the integrated care strategy.
- Underpinned by a co-produced People charter / local deal which outlines commitments between citizens and partners to work together.
- Resource-light in terms of administration to support functioning of partnership within each area.
- Some responsibility in directing funding to priorities based on identified need – but not all services would be commissioned or budgets devolved at a the most devolved level when scale makes sense.
- Local Partnership leadership from elected members residents (school governor type model), statutory / voluntary providers and/or PCN Clinical Directors.

Health inequalities in Northamptonshire

A data pack has been produced to understand health inequalities in Northamptonshire, which is available to access online at northamptonshirehcp.co.uk/health-inequalities. Below is a summary of the Core20PLUS5 framework applied to Northamptonshire.

The Northamptonshire ICS will focus actions on these five areas, alongside other existing priorities that have been identified as a system. The ICS Outcomes Framework, together with other data and insights, will help further inform neighbourhood profiles, which will set priorities for the system

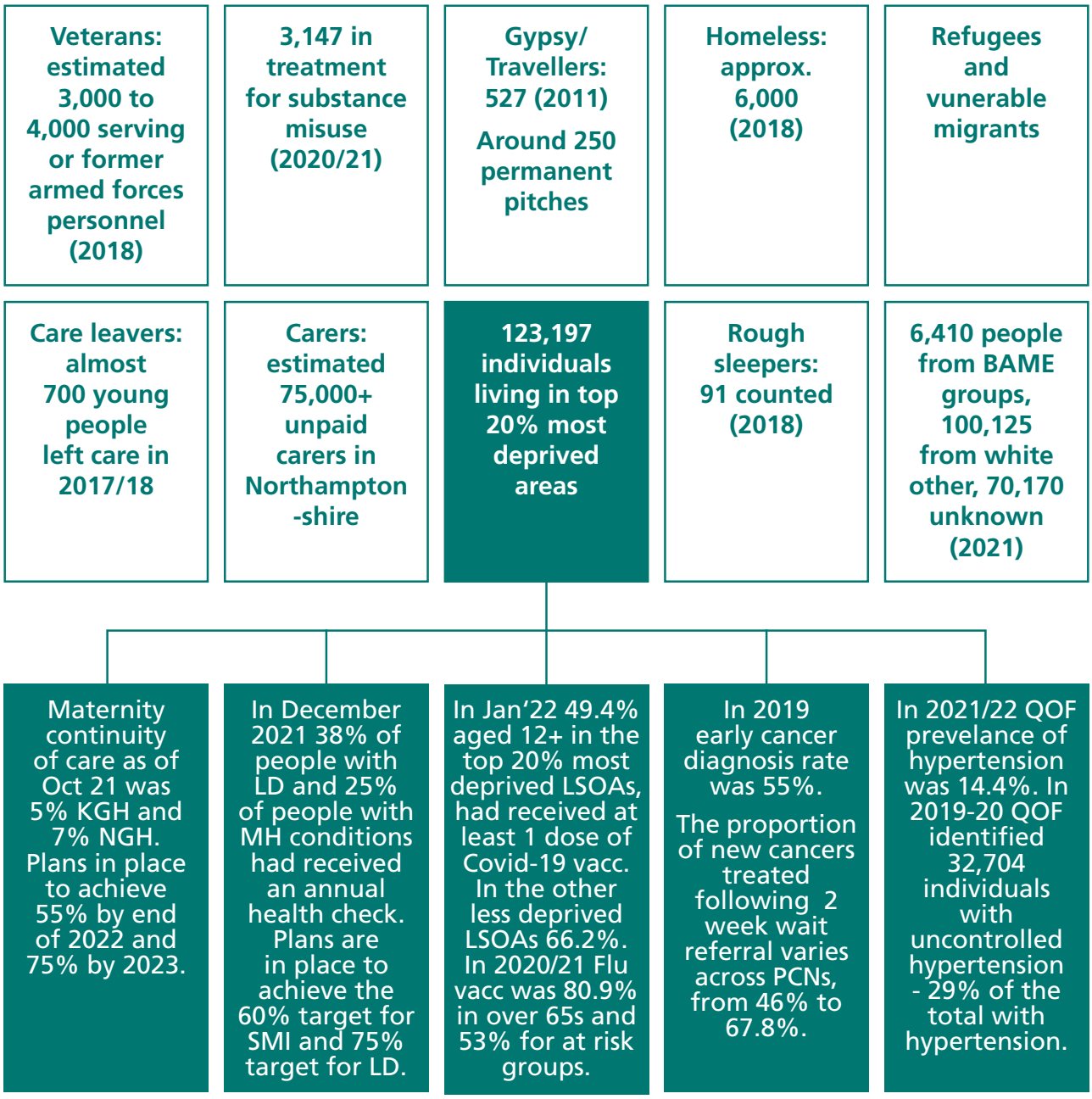


Fig. 8: Core20PLUS5 applied to Northamptonshire

The ICS has four existing system transformation priority programmes:

1) Mental Health, Learning Disabilities and Autism

Collaboration in mental health, learning disability and autism is enabling NHS providers, primary care and the voluntary and community sector to work successfully together with service users and carers over a number of years to really make a difference delivering better care for our communities.

2) Children and Young People

The NHCP Children and Young People Transformation Programme (CYPTP) is working to transform children's health and care services via four key areas of focus, or 'pillars'. These are Healthy Lifestyle; Complex Needs; Healthy Minds, Healthy Brains; and Accessibility.

Collectively, the CYPTP pillars provide the infrastructure for a strategic plan to identify needs and deliver joined-up, proactive and personalised services which provide high-quality care for children, young people and families at all levels of our ICS.

The pillars are also the means by which Northamptonshire will deliver on the commitments set out nationally for children and young people in the NHS Long Term Plan and the Department of Health and Social Care's 'The best start for life: a vision for the 1,001 critical days' – as well as create a framework to develop, implement, deliver and monitor children's services based on achieving the best possible outcomes for our younger population.

Each pillar will be guided by the THRIVE Framework, which keeps the voice of the child and their parents or carers at the centre of innovative service design, ensuring they are supported to access services based on their identified level of need with an emphasis on safeguarding them from harm throughout life.

By working together in partnership across health, care, education and the voluntary sector, the gaps in health inequalities will be reduced and better outcomes achieved for our children and young people through the integration and improvement of services.

3) Integrated Care Across Northamptonshire (iCAN)

iCAN's purpose is to deliver a refreshed focus and way to improve the quality of care and achieve the best possible health and wellbeing outcomes for older people across our county, supporting them to maintain their independence and resilience for as long as possible. The three core aims of the iCAN programme are to:

- Ensure we choose well: no one is in hospital without a need to be there
- Ensure people can stay well
- Ensure people can live well: by staying at home if that is right for them

4) Elective Care

Our vision is to improve health outcomes, inequalities and quality of care through a single patient-centred system approach across the whole elective care pathway. We will achieve this through:

- Improving the efficiency and quality of care
- Commissioning high-quality clinical services
- An effective, well-led and governed collaborative
- Developing, empowering and retaining our workforce
- Adopting a system approach to outcomes

These four priorities have been identified through data insights as part of the long-term plan work in 2019/20. These priority areas have full governance structures and workplans in place, which are varied in their maturity and readiness to implement plans. We are fully committed as a system to delivering service improvements in these areas for the citizens of Northamptonshire.

Planning and delivery within these priority programmes will be supported through the development of the ICS Outcomes Framework to help further inform prioritisation and resource allocation across the system.

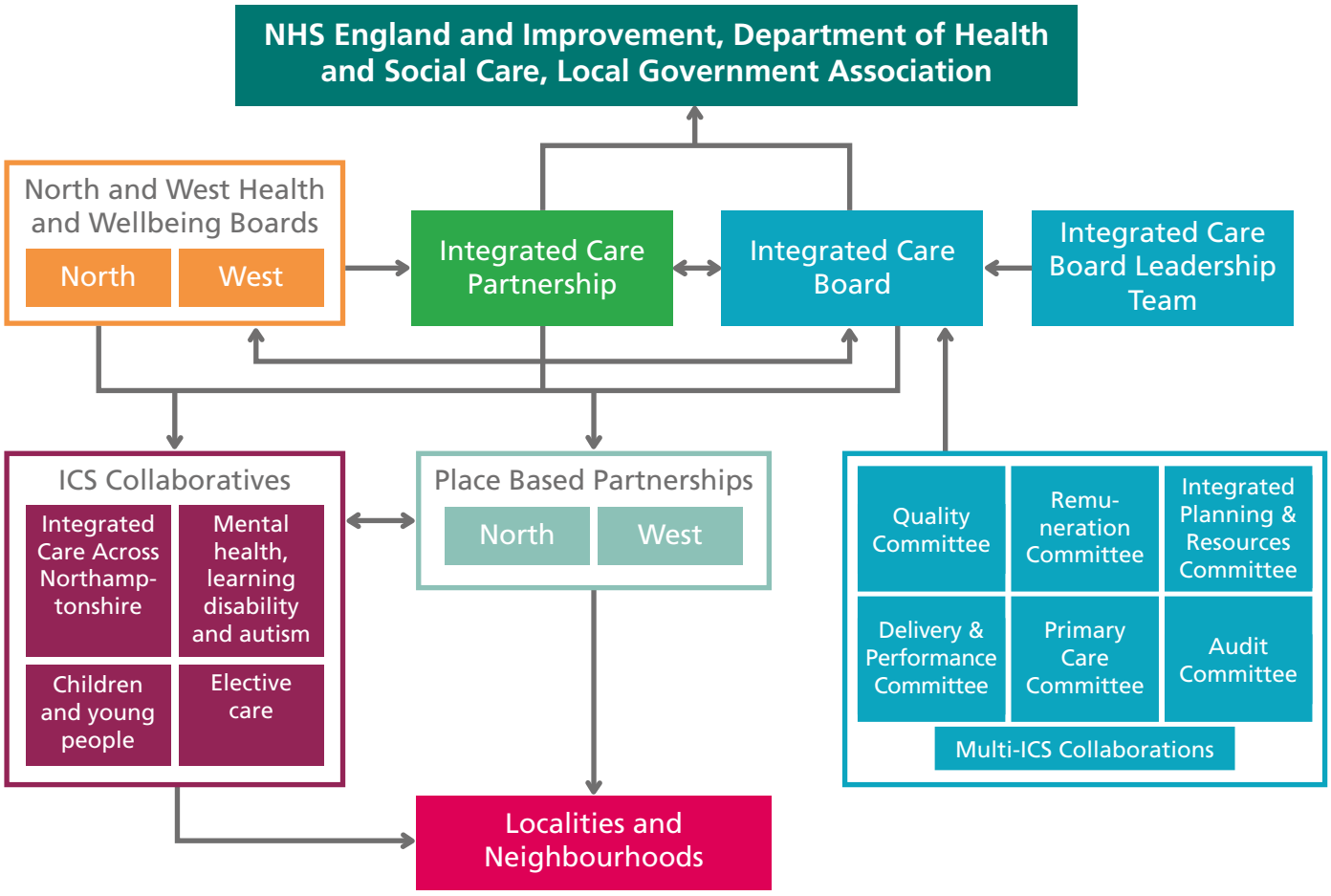


Fig. 9: DRAFT structure of the Northamptonshire Integrated Care System (correct as of May 2022)

Aims and objectives of the Health Inequalities Plan

Addressing health inequalities is a core principle behind the establishment of ICSs and new ways of working. NHS England and NHS Improvement require each local system to develop a local Health Inequalities Plan which sets out how the system will work together to address health inequalities.

This Health Inequalities Plan is aligned to the ICS Population Health Management Strategy[ix], which outlines the ICS commitment to taking action to reduce health inequalities across Northamptonshire.

This plan sets out the strategic approach for how the ICS will reduce health inequalities. This will be the overarching vision that will inform the development of detailed plans which will establish, implement and monitor actions to reduce health inequalities.

The Population Health Management system principles and actions include:

1. Developing system-wide focus on prevention
2. Reducing health inequalities
3. Embedding health in policy
4. Evidence needs-based public health
5. Developing strong systems leadership
6. Responsibility to future generations

Objectives of the Northamptonshire Health Inequalities Plan

1. Develop a set of broad guiding principles which describe practical actions for the Integrated Care System to reduce health inequalities.
2. To set out key areas of focus and next steps for developing these.

ix Northamptonshire ICS (2022) Population Health Management Strategy
https://northamptonshirehcp.co.uk/wp-content/uploads/2021/07/NHCP-PH-Strategy-V-5-Jan-2022.pdf

Guiding principles of approach to reducing health inequalities

The Northamptonshire Integrated Care System, and all partners within it, will sign up to and be guided by the following principles to embed addressing health inequalities in everything we do. These guiding principles cut across all areas of work in all parts of the system.

System principles

We are all responsible for reducing health inequalities

Reducing inequalities and improving health should run through all work programmes at all levels as a 'golden thread' from system to place to neighbourhood to individual. Everyone will understand their role in addressing health inequalities and commits to taking action. This means that, as a system, we will all commit to taking a 'Health and Equity in All Policies' approach.

We will use community-centred approaches

Community-centred approaches help people to have more control and confidence when it comes to their health and wellbeing. This is achieved through meaningful and constructive contact with others, helping people to build resilience and stay as healthy and productive as possible. We will work together to take a place-based approach to address health inequalities, taking into account all of the factors that influence health, including the wider determinants.

All partners will always try to listen to what really matters to people rather than focusing solely on 'what is the matter' with them. All partners will prioritise working with citizens to find the right approaches to reach and support them and involve them in decisions about services.

We will step away from established top-down approaches to bring people and communities together so they can decide and deliver what is right for them. We will develop relationships of trust with communities and work with them to integrate formal and informal care provision. We will ensure that services are personalised and person-centred. We will include communities and local partners in governance arrangements for health and social care services.

We will ensure services are culturally appropriate, accessible and targeted to those who need them most

The ICS will recognise and value the diverse communities we serve, understanding their different assets and needs. Services should be designed with community needs in mind and ensure that they are delivering exceptional quality for all while maintaining equitable access, excellent experience and optimal outcomes. Although there will be a universal offer of services to all, there will be justifiable variation in services in response to differences in need within and between groups of people. Where there is variation in services that is not justified by variation in need, the ICS will take action to 'level up' the way the services are offered and outcomes achieved.

We will encourage a diverse workforce that is representative of the local population

The importance of ensuring our workforce is representative of local communities cannot be over-emphasised. Workforce diversity is important for rooting services in local communities and maximising the influence and impact of services within communities. We will value staff through parity of recruitment, promotion and employment, ensuring staff are representative of the cultural, racial, and ethnic backgrounds of the patients they serve.

We will act as Health Literate Organisations and harness the opportunities of digital technology

Health literacy has been defined as "the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health." All organisations will aspire to become Health Literate Organisations, ensuring that information and communications are delivered in a way that makes it easier for people to navigate, understand and use information and services to take care of their health.

Our COVID-19 response has included the rapid implementation of technology to enable delivery of care and support for residents and patients. This has highlighted opportunities to improve access for those who are willing and able to use the technology – particularly those who find it difficult to physically attend health and care settings, such as those in rural areas or those with conditions preventing attendance in person. Digital technology also provides opportunities for people to self-manage their condition, acting as an enabler.

However, expanding the use of technology brings with it clear health inequality risks, particularly for groups with limited access to technology and/or limited willingness or skill to use it. Many people find access to healthcare challenging and would prefer to visit GPs and other services in person. We will:

- Mitigate access risks for services using new technology and provide accessible services that suit everybody
- Mitigate any assessed impact on inequalities in access and outcomes resulting from virtual access to services, online portals and other access points that require computer literacy
- Consider, and mitigate, the impact of loss of personal contacts and trusted relationships for deprived patients and their health outcomes

We will act as 'anchor institutions' to tackle inequalities

Anchor institutions promote health equity and reduce health inequalities by offering 'social value' through their employment, training, procurement and volunteering activities, and as major estate owners to influence social and economic development and environmental sustainability.

The ICS will identify a lead for this work and develop an action plan to develop the potential of the NHS and other partners to lead by example as anchor institutions and focus on what the collective public sector can do.

Enablers

We will use quantitative and qualitative data to enable a better understanding of health inequity at all levels

In order to improve health and reduce inequalities it is important to understand local population health and health risks for groups and areas. As an ICS we will work together on data and analytics to develop a collective understanding of health inequality gaps and contributing issues using a population health management approach. Health assessments will include the broader social and economic drivers of health as well as a focus on, and inclusion of, communities at particular risk of poor health. We will recognise the different communities, producing information and gathering intelligence to understand their demographic and other characteristics, such as epidemiology and the risks of poor access to, and experience of, services and outcomes.

To do this we will draw upon the best evidence and listen to what communities tell us about the services they need. This will inform and enable effective action to reduce inequalities and to evaluate the impact of our services, with qualitative approaches supporting quantitative data to provide insights into communities' experiences and recognising their importance. Any services failing to reduce inequity – or inadvertently increasing it – will be adjusted accordingly.

To enable the ICS to better understand health equity at all levels, all services must ensure completeness and consistency of data. The aim is to most appropriately reflect population need, including levels of deprivation, vulnerability and the experience of different groups (including the use of qualitative methods). Key partner organisations will develop plans for having ethnicity, accessibility and the communication needs of their populations appropriately coded in records.

Using integrated and shared data through the Northamptonshire Analytical Reporting Platform, we will be able to risk-stratify the population to identify vulnerable groups and individuals. This will enable us to offer proactive, holistic care involving a variety of system partners and enable commissioning and outcome frameworks to incentivise reductions in health inequalities and improve equity.

We will provide training and resources to ensure we all have an understanding of health inequity and how to reduce it

All roles across the ICS can make a difference to health inequalities, whether that is about supporting an individual during a consultation, influencing the design of services or advocating for wider changes. To achieve this we will:

- Have a clear focus on health inequalities in organisational culture, with clear leadership. Organisations will have a named executive board-level lead for tackling health inequalities and overseeing adoption of these principles
- Promote equality and address health inequalities at the highest organisational level, including chief executives or equivalent posts
- Embed capacity at all levels to promote and address equality and health inequalities
- Embed addressing health inequalities in quality improvement and decision-making processes
- Provide a suite of resources including information, data, training and guides to support all staff across the ICS. This can be found at northamptonshirehcp.co.uk/health-inequalities

Health Equalities Assessments will be used for all levels of decision-making, planning, commissioning, service redesign and evaluation across the ICS and within partner organisations. They will include the broader social and economic drivers of health as well as a focus on the communities that are at risk of poor health.

Conducting a health equalities assessment helps organisations to understand the adverse or positive impacts of system and service design and delivery on health inequalities for particular groups. Analysis can support the necessary strategic approach and actions required to promote equality and reduce health inequalities. This includes engaging with different groups and providing tailored, more accessible and appropriate services.

It will also help to ensure health and health equity perspectives are a core part of ICS business. This is particularly important to enable the system to understand the influence of the wider determinants of health such as housing, education and employment. Health Equalities Assessments will:

- Explore the impact of decisions on health inequalities early in the decision-making process
- Be at a proportionate scale to the work being conducted
- Be an integral part of policy development and reporting and provide an opportunity to consider whether a policy or practice could be revised or delivered to advance equality and reduce inequality
- Include rigorous assessments of equality and inequality duties, at both local and national levels, ensuring that these cover plans, processes, outcomes and annual reporting
- Be included in contracts as a key requirement for service providers

We will ensure that resources are deployed to address inequalities

We will ensure that resources are deployed to address inequalities within existing programmes and transformation funding for key priorities. This may require additional resources and actions for some deprived communities and areas.

The ICS will agree a framework to collectively manage and distribute financial resources to address the greatest need and tackle inequalities in line with the system plan, having regard to the strategies of the ICS. This framework will enable the ICB to collectively exercise its functions in a way that does not consume more than its fair share of NHS resources.

The existing ICS transformation priority programmes are already exploring ways of pooling resources across the system and addressing health inequalities. These will be continually assessed with lessons about resource allocation feeding into any future collaborations. The ICS will adopt a phased approach to develop a comprehensive system that will:

- Make clear the cost of doing nothing – if the ICS does not develop methods for identifying and addressing health inequalities then the demand for health services will accelerate above capacity within the system
- Determine how well resources are distributed to different groups within the population, which might be between or within programmes
- Determine how well allocated resources are used to achieve outcomes for all of the ICS population

As the tools and methodologies necessary for this are put into place, all investments and business cases that the ICB are to consider will need to demonstrate:

- The expected impact on health inequalities within the population
- The expected impact on health outcomes
- An economic assessment
- An accounting assessment on all organisations within scope – this will demonstrate the cashable impact on each relevant organisation

Areas of focus and actions to address inequalities

Health inequalities result from a complex range of interrelated causes – and the causes of those causes, which are the conditions under which people grow, learn, work and live.

In some cases, actions will be mainly the responsibility of one partner. In other cases, reducing inequity will require close collaboration between several organisations across the ICS. At each level of the ICS, partners across the NHS, local authorities and the voluntary and community sectors will come together to plan in detail the actions they are going to take, individually and collectively, to reduce health inequity.

The ICS agrees to work together to adopt the health inequalities principles outlined above to develop an action plan informed by data and insights.

These actions will need to be across the drivers of health inequalities as the areas of focus described below. This plan is accompanied by an action plan document (see Appendix) which will be reviewed annually and sets out the areas of focus and actions we need to take to implement this plan.

ACTION 1: The ICS will take action on the wider determinants of health as well as medical treatment

Local authorities and the voluntary and community sector are key partners and we will come together as an ICS to address the wider determinants of health. This aligns with the Government's commitment set out in its Levelling Up white paper[x], along with its strategy to tackle the core drivers of health inequalities through an upcoming Health Disparities white paper.

As two new local authorities, West and North Northamptonshire Councils are developing their corporate plans and strategies and many of these align with this strategic objective to take action on the wider determinants of health.

The NHS also needs to ensure it plays a role in addressing the wider determinants of health. It can do this through its role as an anchor institution as well as through a commitment to understanding and considering the impacts of the wider determinants of health, working across the system to address these and aligning work programmes to have maximum impact.

As an ICS we will come together to ensure:

- Every child has the best start in life
- Everyone has access to good education and learning
- Residents have employment that keeps them and their families out of poverty
- Housing is affordable, safe and sustainable in places which are clean and green
- People feel safe in their homes and when out and about
- Our communities are connected, cohesive and thriving

x Department for Levelling Up, Communities and Housing (2022) Levelling Up the United Kingdom https://www.gov.uk/government/publications/levelling-up-the-united-kingdom

ACTION 2: The ICS will ensure that residents can access health and wellbeing services to promote good health and prevent ill health

Prevention is essential for improving health equity and we will work together as an ICS to address the causes of inequalities. As well as treating ill health we need to focus more on preventing ill health and supporting good health. This means providing more services that work to improve the conditions in which people live – which, in turn, will improve their health – rather than just reactive services focusing solely on treating people who are already ill.

Our ambition is to create an offer for the population of Northamptonshire, using a place-based approach, to ensure that everyone is able to access clear advice on staying well and a range of preventative services. The ICS will take a whole-life approach, supporting children to have the best start in life and providing parenting support to families in the early years, focusing on diet, physical activity and mental health support for school-age children. Health promotion services will support good nutrition and physical activity and offer help to reduce smoking and use of alcohol and recreational drugs, promoting parity between mental and physical health. This is alongside supporting adults to maintain good mental health and prepare for a healthy retirement and later life by keeping well. These services are provided by a range of providers across the NHS, local authorities and the voluntary and community sector and require joint working to ensure that they are aligned, accessible, appropriate and targeted to those who need them most. All partners will adopt a 'making every contact count' approach to maximise opportunities for people to improve their health and wellbeing.

The development of local neighbourhood partnerships will improve partnership working across the NHS, local authorities and the voluntary and community sector. This is essential to ensure we can work with our communities to join up services and improve accessibility for our residents.

Each of the ICS transformation priority programmes includes a focus on prevention to ensure that this is embedded in their work. Alongside this the NHS Long Term Plan sets out requirements for the acceleration of preventative programmes and proactive health management for groups at greatest risk of poor health outcomes, focusing on the Core20PLUS5 priority areas. Specific actions we are taking as an ICS are outlined in our action plan (see Appendix). The ICS commits to ensuring that prevention interventions are included in all clinical care pathways, with strategic boards including representation of partners across the system. A Prevention Board will be established to oversee this work.

Corporate Parenting

The Children and Social Work Act 2017 defines in law the responsibilities of local authorities as corporate parents to secure positive and nurturing experiences for the children they look after and the care leavers they continue to support. As corporate parents we will ensure that children in care and care leavers are able to live happy and healthy lives and reach their full potential. We believe it is everyone's responsibility to help children and young people in care and those who have been in care to overcome the difficulties they have experienced in their childhoods, so that they can lead successful adult lives.

ACTION 3: The ICS will work to prevent ill-health by providing vaccination and screening programmes that are accessible to all

The Northamptonshire Health Protection Plan sets out the commitment to address inequalities in screening and immunisations and there are associated boards in place to ensure oversight of these commitments.

The ICS has developed a COVID and flu vaccination plan for a clinically, operationally and financially viable provider-led delivery mechanism for COVID and flu vaccination. COVID vaccination uptake across the region is linked to a variety of socio-economic factors, including age, affluence, mobility and cultural elements (e.g. religion). The localities requiring focus for future vaccination provision are Corby, Wellingborough, Kettering, Northampton and Daventry, once vaccination uptake by ethnicity and deprivation are considered. The model will ensure that our services will be welcoming, easy to access and available to all in society, delivered consistently and equitably via delivery models that reflect our diverse communities.

ACTION 4: The ICS will make health and social care services accessible to all and targeted to those most in need or at risk of poor outcomes

All partners across the ICS will ensure that residents have access to simple, joined-up care and treatment when they need it, as well as access to digital services (with non-digital alternatives) that put the citizen at the heart of their own care. Services will ensure that people have access to proactive support to keep as well as possible where they are vulnerable or at high risk.

Services will be delivered in the right place at the right time. The development of community and family hubs will ensure that people can access services in their locality. Primary Care Networks (PCNs) will ensure that primary care services are accessible and, as part of the Directed Enhanced Service, will identify priorities and plans for addressing health inequalities.

Personalised care is particularly beneficial to address health inequalities as it gives people choice and control over the way their care is planned and delivered based on what matters to them and their individual strengths, needs and preferences. It ensures that services are specific to local area need, available resources and strengthens the focus on social determinants of health and the services that address them.

The Northamptonshire Community Resilience Pillar, part of the iCAN programme, is leading the expansion of a personalised approach, giving individuals more choice and control over the way their care is planned and delivered.

ACTION 5: The ICS will ensure that end of life services support a dignified and pain-free death

The ICS is committed to ensuring that the people of Northamptonshire can access the most appropriate palliative and end-of-life care at the right time, irrespective of who they are and where they live. The ICS and all specialist palliative care providers across the county will promote equitable access and work collaboratively to achieve a dignified and pain-free death for our patients.

The ICS understands that individuals from marginalised communities may require additional focused services and support to ensure that they are able to access care when and where they need it. As approximately one in six deaths are people with a diagnosis of dementia, a regional working group is underway to better understand what is required for people with a diagnosis of dementia, and involvement in this will better identify how services within the county will better inform their processes. The Strategy for End of Life and Palliative Care is in development and will identify plans to better understand what is required for people with a learning disability, people in prison, people experiencing homelessness and those from Gypsy and Traveller communities.

ACTION 6: The ICS will work to understand the full effect of the COVID-19 pandemic on health inequalities, to allow effective and equitable system recovery

The system will take action to:

- Identify those communities and groups of all ages which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Ensure vaccine uptake is equitable
- Ensure a primary prevention focus to recovery that considers the wider determinants of health and causes of the causes including education, employment, housing and poverty
- Promote parity of esteem between mental and physical health to those groups worst affected by the pandemic

Outcomes

Specific measures and indicators to demonstrate success will be developed as actions are developed at place and neighbourhood levels, recognising that developing outcomes which matter to different groups will take time.

These will link to the ICS Outcomes Framework currently in development. Metrics will be jointly developed to support the continuous shaping of services to meet the needs people most affected by health inequalities.

For these health inequalities outcomes, the focus will be on:

Short term

Monitor progress of actions (have we done what we said we were going to do?).

Medium term

Monitor improvements in service access and usage for population segments with low uptake.

Long term

Increase life expectancy and quality of life for people living in Northamptonshire and reduce the gap between the healthiest and least healthy populations within our county by:

- Reducing Potential Years Life Lost (PYLL) for conditions amenable to healthcare
- Improving Healthy Life Expectancy (HLE)
- Increasing years lived with disability in good health

Next steps

Much of the implementation of work to reduce health inequalities will occur at place and neighbourhood levels. Within the requirements of our ICS, places will be expected to influence the priorities for their populations.

This is about understanding the population, how factors such as education, economy, housing and health are impacting local communities and ensuring local engagement and co-production of strategies and plans.

The development, delivery and evaluation of place-based plans will be led by Directors of Adults, Communities and Wellbeing at North and West Northamptonshire Councils for their respective areas and will be accountable to Health and Wellbeing Boards. The plans will apply the guiding principles to address health inequalities and be based on local data and intelligence – qualitative and quantitative – derived from public health, local authority services, the NHS, the voluntary and community sector, other public sector partners, and communities themselves. Multi-disciplinary team working, the sharing of information and engagement of individuals and communities around their assets and strengths will ensure that action is direct, person-centred and sensitive to feedback and revision from the teams and the people those teams serve.

Each organisation will have an executive nominated lead for health inequalities who will be responsible for driving this agenda forward in their own organisation. Indicators to demonstrate success will be developed as the actions are developed at place and neighbourhood level, and will link to the system outcomes framework currently in development.

Key actions over the next six months

1) **Finalise governance arrangements**. As ICS governance structures are finalised we need to finalise arrangements for health inequalities. The Integrated Care Partnership (ICP) will set the system-wide strategy for health inequalities, which will be implemented through the ICS transformation priority programmes and at place level. A Health Inequalities Oversight Group of the Population Health Board will be established to oversee implementation of the Health Inequalities Plan. Governance of place-based plans and strategies will be via Health and Wellbeing Boards. Governance of plans and actions beneath place level will be agreed between local partners using the most appropriate structures for effective representation and oversight. Each organisation will have a nominated executive lead for health inequalities who will be responsible for driving this agenda forward in their own organisation.

2) **Establish the Health Inequalities Oversight Group,** bringing together stakeholders from across our ICS. This will include links with health inequalities leads for each organisation and the ICS transformation priority programmes to develop the Health Inequalities programme plan for short, medium and long term initiatives. This group would also monitor health inequalities data, further develop health inequalities indicators, respond to emerging evidence and develop recommendations.

3) **Review capacity in the system** to develop this programme of work and ensure sufficient leadership, analytical and programme management capacity.

4) **Finalise the ICS Outcomes Framework**

5) **Develop place and neighbourhood plans**

For enquiries relating to this document, please email Chloe Gay, Public Health Principal for Health Improvement, Public Health Northamptonshire, at chloe.gay@northnorthants.gov.uk

Appendix: Health Inequalities Action Plan

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
Health Inequalities Leadership	Implement the HI toolkit, ongoing adaptation of the approach based on feedback	Improved understanding of HI and the tools available to support this	Population Health Management	Ongoing
	Ensure that there is adequate capacity and resource to understand and address HI, including how to engage with communities	Improved system response to health inequalities	Population Health Management	July 2022
	Recruit Health Inequalities lead and programme management support to lead operationalisation and implementation of the HI Plan	Improved system response to health inequalities	Population Health Management	September-22
	Work across system to develop proposal for HI funding allocation and oversee implementation of this	Reduction in health inequalities	Population Health Management	May-22
	Work with Place based leads to develop Place based action plans	Development of place and neighbourhood action plans to reduce health inequalities	Population Health Management and Public Health	Sept 2022
	Set up Inequalities sub-group	Improved system response and leadership to reduce health inequalities	Population Health Management	July-22
	Identify Inequalities leads in all organisations	Improved system response and leadership to reduce health inequalities	HI Lead	Jun-22
	Develop training programme to improve awareness and understanding of HI across the system	Improved understanding of HI and the tools available to support this	People Board	Summer 2022

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	Finalise the outcomes framework	Data to inform system prioritisation and plans	Population Health Management	Summer 2022
	Development of neighbourhood profiles ensuring that these include data and insights on the groups most vulnerable to inequalities as shown in the 'dimensions of inequality', including those living in deprivation, protected characteristics, inclusion health groups and rural populations	Data to inform system prioritisation and plans	Public Health	Summer 2022
	Launch of Decision Support Unit	Data to inform system prioritisation and plans	Population Health Management	2022/23
	Provide ongoing support to primary care to deliver the HI DES	Improved system response to health inequalities	Population Health Management and Primary Care	Summer 2022
	Identify a system lead for anchor institutions work	Increase social value	Population Health Management and Public Health	Summer 2022
Principle 4: We will use quantitative and qualitative data to enable a better understanding of health inequity at all levels Aligning to LTP priority: Ensuring datasets are complete and timely	Data Quality Group established to review the use of 'unknown' and 'not-stated' values throughout clinical systems (linked to stage approach above)	Improved understanding of inequalities	Elective Care Board and Population Health Management	Jun-22
	Health Inequalities lead to work with commissioners and providers to improve data collection on ethnicity, across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS)	Improved data collection and understanding of health inequalities	Health Inequalities lead	2022/23
	Develop project with primary care to improve completeness of datasets	Improved data collection and understanding of health inequalities	Health Inequalities lead	Summer 2022

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	Launch of Northamptonshire Analytical Reporting Platform (NARP)	Improved data analytics	Digital lead	Summer 2022
Guiding Principle 8: We will encourage a diverse workforce that is representative of the local population	Increase the number and diversity of our volunteers and starting to build our career paths to ensure volunteering is an effective route into healthcare careers in Northamptonshire	Increasing diversity in the workforce	People Board	2022/23
	Joint working between the OD and EDI leads and the EDI networks to ensure the successful implementation of the EDI strategy and actions to support improvements in experience and provide greater awareness within the group through programmes such as reverse mentoring	Increasing diversity in the workforce	People Board	2022/23
	Talent management programmes to support talent and ensure the leadership pipeline is diverse and inclusive	Increasing diversity in the workforce	People Board	2022/23
Priority 9: **We will act as Health Literate Organisations and mitigate against digital exclusion** LTP Priority: Mitigating against 'digital exclusion'	Recruit a lead for digital exclusion	To reduce digital exclusion	Population Health Management and Digital lead	September-22
	Develop approach to understanding who is accessing face to face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status and other vulnerability factors to monitor trends and to identify actions to address any concerns	To reduce digital exclusion	Digital Exclusion lead	Oct-22
	Pilot Patient Knows Best which interfaces to the NHS App, staring with maternity and advance care planning, and supports patient views of their record and communication channels	Improved access to services	Digital Lead	2022/23
The ICS will ensure that all partners work together to prevent ill-health through the	Ensure the delivery of childhood and adult immunisation programmes in accordance with national and local targets	Improved uptake of immunisations	Immunisation Steering Group	2022/23
	Ensure that inequities in vaccination uptake is investigated and actions put in place to address these	Reduction in inequalities in uptake of immunisations	Immunisation Steering Group	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
provision of vaccination and screening programmes that are accessible to all Immunisations				
	Improve the uptake of the COVID vaccination programme across all groups targeting those most at risk of inequalities	Improved uptake of COVID vaccination	COVID vaccination programme team	2022/23
The ICS will ensure that all partners work together to prevent ill-health through the provision of vaccination and screening programmes that are accessible to all Screening	Improve uptake and coverage of the three NHS cancer screening programmes. This includes identifying the population groups with low screening uptake locally (with a primary focus on their 'CORE 20' population) and developing action plans in response	Improved uptake of NHS cancer screening programmes	Northamptonshire Cancer improvement group	2022/23
CYP Transformation cuts across all of the areas of focus	Develop family hub model that supports access to services at place and neighbourhood with emphasis on the 1001 Critical Days, Best Start for Life and support children, young people and their families from conception to 19 years	Improved access to prevention and early intervention services	CYP	2022/23
	There are six areas of CYP that has been identified initially as priority areas to focus on, these will help to identify the unmet need and action plans will be developed to reduce the health inequalities and improve outcomes for CYP: The CYPTP priority areas are: • Promoting Healthy Lifestyle Choices	Improved outcomes for CYP	CYP	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	• Supporting children to achieve well educationally • Reducing incidence of emotional wellbeing and mental health needs for CYP and supporting children who self-harm • Promoting outcomes for CYP with long term conditions • Promoting outcomes for children in care while in care and when they leave care by delivering holistic support • Securing ease of access to the right help, at the right time and in the right place (This aligns with our case for change and pillars of work)			
The ICS will ensure that residents are able to access health and wellbeing services to promote good health and prevent ill health Aligns to LTP Priority: Accelerating preventative programmes	Set up system Prevention Board	Improved system response and leadership for prevention	Population Health Management and Public Health	Jun-22
The ICS will ensure that residents are able to access health and wellbeing services to promote good	Complete mental health needs assessment to understand the mental health and wellbeing of people of all ages living in Northamptonshire, to identify those groups who are most vulnerable understand the risk factors	Improved understanding of MH needs	MHLDA	2022/23
	Develop a joint action plan to improve mental health and wellbeing for all	Improved mental health and wellbeing for all.	MHLDA	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
health and prevent ill health Aligns to LTP Priority: Accelerating preventative programmes CORE20+5 Priority: MH				
	Implement the new model for delivering health checks for people with severe mental illnesses. This includes additional resource, training and development for our Primary Care staff in order to develop the skills and infrastructure required	80% of people with severe mental illness access physical health check	MHLDA	2022/23
	Delivery of the Northamptonshire all age Learning Disability and Autism 3-year strategy	Improved outcomes for people with learning disability and autism	MHLDA	2022/23
	Improve data monitoring and data sharing and provide a more detailed understanding of the health needs and experience of treatment and care of people with learning disability and autism across the life course	Improved understanding of the health needs and experience of treatment and care of people with learning disability and autism	MHLDA	2022/23
	Complete a needs assessment to understand the needs of people with learning disability and autism of all ages.	Improved understanding of the health needs and experience of treatment and care of people with learning disability and autism	MHLDA	2022/23
	Develop action plan to increase physical health checks of people with a learning disability	Annual health checks for 60% of those with LD	MHLDA	2022/23
	Develop the Equalities Enabler Group to support the four pillars of the Mental Health, Learning Disability and Autism (MHLDA) ICS Collaborative in surfacing and driving health inequalities within and across pathways and to set in motion quality improvement actions to address them	Improve access, patient experience and outcomes	MHLDA	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
The ICS will ensure that residents are able to access health and wellbeing services to promote good health and prevent ill health Aligns to LTP Priority: Accelerating preventative programmes CORE20+5 Priority: Respiratory	Implement the Tobacco Dependency Treatment pathway that offers timely, effective, specialist support to ensure that patients remain smoke free whilst under the care of the NHS in acute, maternity and community settings. A pathway into community stop smoking services will be developed so that many of these individuals will continue on this path once discharged from care	Reduction in smoking	Public Health	2022/23
The ICS will ensure that residents are able to access health and wellbeing services to promote good health and prevent ill health Aligns to LTP Priority: Accelerating preventative programmes	Improve access and uptake of NHS Health Checks	Improved health and wellbeing	Public Health	2022/23
	Improve uptake and access to weight management services	Reduction in obesity	Public Health/ CCG	2022/23
Health and social care services will be accessible to all	To map the existing diabetes pathway	Improved outcomes for diabetes	Diabetes Collaborative Care Board	May-22

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
and targeted to those most in need or at risk of poor outcomes Diabetes				
	To use shared data to develop diabetes pathways to reduce risks, maximise opportunities and ultimately improve care	Improved outcomes for diabetes	Diabetes Collaborative Care Board	2022/23
The ICS will ensure that residents are able to access health and wellbeing services to promote good health and prevent ill health **Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes** CORE20+5 Priority: CVD	Set up system programme board for CVD	Improved outcomes for CVD	CVD Clinical Lead	2022/23
	Develop CVD strategy for the ICS	Improved outcomes for CVD	CVD programme board	2022/23
	Develop action plan to improve identification of hypertension, working with partners across the system to target priority groups, taking a making every contact count approach and working within communities	Reduction in hypertension	CVD programme board	2022/23
Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes	We will complete a service review including an equity audit to understand which groups have poor uptake and outcomes and will inform which communities we need to engage with	Improved access to respiratory services	Respiratory Care Board	Jul-22
	Set up a task and finish group to complete a needs assessment which includes understanding which groups have poor uptake and	Improved access to and experience of respiratory services	Respiratory Care Board	Jul-22

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
CORE20+5 Priority: COPD	outcomes and then engaging with these groups to inform service design an improve uptake			
	Restart pulmonary rehab and develop personalised care approach	Improved respiratory outcomes	Respiratory Care Board	2022/23
	Use the STAR tool to complete an economic evaluation of COPD services	Improved respiratory outcomes	Respiratory Care Board	Sep-22
Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes Cancer	Develop plans to improve Quality of Life including implementation of psychosocial support, plus one other priority to be identified for local intervention from the Cancer Data Dashboard	Improved experience and outcomes	Cancer Lead	2022/23
	Ensure that existing personalised care activities are being offered to everyone	Improved experience and outcomes	Cancer Lead	2022/23
	To complete any outstanding work on post-pandemic cancer recovery objectives to return the number of people waiting for longer than 62 days to the level in February 2020, and to meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments, including a particular focus on the three cancers making up two thirds of the national backlog (lower GI, prostate and skin)	Increased access to services	Cancer Lead	2022/23
	Northamptonshire will make progress against the ambition in the Long-Term Plan to diagnose more people with cancer at an earlier stage, focusing on: • Timely presentation and effective primary care pathways • Faster Diagnosis • Targeted case finding and surveillance	Earlier diagnosis of cancer	Cancer Lead	2022/23
	Ensure that recovery is delivered in an equitable way, using the COVID-19 Cancer Equity Data packs and other relevant data to	Reduction in inequalities in access and outcomes	Cancer Lead	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	identify and take action to address any gaps in the rate of referral and/or treatment recovery for particular patient groups			
	System and trust level analysis of cancer waiting times disaggregated by ethnicity and deprivation to understand and address any variation among different patient groups	Improved understanding of inequalities	Cancer Lead	2022/23
	Reduce unwarranted variation in access to cancer treatment, including using treatment variation data to prioritise and implement specific targeted action to ensure equitable access to treatment, including for older people	Reduction in inequalities in access and outcomes	Cancer Lead	2022/23
Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes	Ensure that we support residents to age well, remain healthy and active, prevent frailty, support people to have independence and remain in their community	Improved health and wellbeing	ASC/ iCan	Ongoing
	Identify areas in the community, and care homes, that are more at risk of health inequalities	Improved understanding of health inequalities	iCan	2022/23
	Ensure that residents in our care homes and supported accommodation have access to regular health checks and health action plans, including national or local screening programmes	Improved health and wellbeing	ASC	2022/23
	Facilitate smooth transfers back from hospital with a plan of care/plan of recovery and follow up where this is required	Improved access to services	ASC	2022/23
	Ensure residents have access to equipment that enables, including assistive technology	Improved health and wellbeing	ASC / iCan	2022/23
	Ensure that older people services are appropriate, taking a person-centred approach considering language, culture, age, gender, and LGBT appropriateness, including access to other community services to advise or support as required	Reduction in inequalities	ASC	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	Develop commissioning principles ensuring that we are commissioning for health and addressing health inequalities	Reduction in inequalities	ASC	2022/23
	Develop Community Hubs model that aligns with Family Hubs work	Improved working with communities	Director for Adults, Communities and Wellbeing and Children's Trust	2022/23
	Provision of and scaling up of peer support groups for Dementia, to include Dementia Hubs, CHD and Heart failure, Diabetes, COPD	Improve patient experience and outcomes	iCan	2022/23
	Develop model for remote monitoring linked into the remote monitoring Hub	4,000 home-based residents set up by Nov 2022 and 1,000 care home residents	iCan	Nov-22
	Maximise independence and long-term happiness by helping more people remain at home and thriving in their community	Improve patient experience and outcomes	iCan	2022/23
	Provide holistic planned care in the community which reduces avoidable escalations	Improve patient experience and outcomes	iCan	2022/23
	Create a range of digitally accessed content to support good management of long-term conditions (videos with top tips, frequently asked question sheets, live q&a sessions with professionals)	Improve patient experience and outcomes	iCan	2022/23
	At scale deployment of home-based remote monitoring equipment and assistive technology (5,000 additional year one) - 24-hour monitoring of readings and proactive outreach contact from monitoring team – building on 7,000 existing persons with lifeline support	Improve patient experience and outcomes	iCan	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	Identification of key community 'hub' sites and expand range of outpatient clinics delivered and diagnostic capacity at each location	Improve access, patient experience and outcomes	iCan	2022/23
	Increased used of virtual wards and remote monitoring to follow up patients recently discharged	Improve access, patient experience and outcomes	iCan	2022/23
Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes CORE20+5 Priority: Maternity	Ensure women most likely to experience poorer outcomes are provided with continuity of care. The LMNS in partnership with the Maternity services have developed an extensive Midwifery Continuity of Carer (MCoC) Long-term plan for the delivery of MCoC across Northamptonshire. The plan includes all elements identified by the national team where MCoC should be focused and clear building blocks to support the future development and sustainability of this model of care	51% women have CoC	LMNS	Nov-22
	Ensure women most likely to experience poorer outcomes are provided with continuity of care	75% women have CoC	LMNS	Nov-23
Health and social care services will be accessible to all and targeted to those most in need or at risk of poor outcomes Aligned to LTP priority: Restoring NHS services inclusively	Develop waiting well interventions that provide a proportionate universal approach to support physical, social, and mental health needs of the longest waiters. This needs to be co-produced with communities and maximising personalised care and social prescribing throughout, including opportunities for shared decision-making conversations and supported self-management	Reduction in inequalities	Elective Care Board	2022/23
	Planning and mobilise Community Diagnostic Centres across two locations in the county. These locations will be based on both demographic and operational needs	Improved access to services	Elective Care Board	2022/23
	Set up Elective Care Health Inequalities working group and identify leads across the system	Improved system response and leadership to reduce health inequalities	Elective Care Board	May-22

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
	Establish an Elective Care Health Inequalities working group across business intelligence and population health management to develop reporting capacity specifically for Elective Health Inequalities	Improved system response to health inequalities	Elective Care Board and Population Health Management	Jun-22
	Phase One: collection and analysis of data Identification of population segmentation and assessment of PTL data Data quality/completeness mapping	Improved understanding of inequalities	Elective Care Board and Population Health Management	Jun-22
	Phase Two: identification of approach/actions	Reduction in inequalities	Elective Care Board	Sep-22
	Design the interventions to address the drivers of inequalities such as engage more patients in prevention strategies			
	Phase Three: embedded rolling programme of review/action	Reduction in inequalities	Elective Care Board	Mar-23
	Test outcomes of agreed interventions post implementation and ensure continuous feedback loop for further development			
	Develop action plan to identify unmet need with proactive case-finding and collaboration across acute, primary care and VCSE	Reduction in inequalities	Elective Care Board	Mar-23
	Launch Northamptonshire Analytical Reporting Platform (NARP). This platform will and embed inequalities into quality improvement processes through improved access to data on equity of access and outcomes for service providers and commissioners to use to inform service improvement	Increase access to quality assured data, turned into intelligence to inform actions to address health inequalities	Digital Lead	Jul-22
Health and social care services will be accessible to all	Expansion of a personalised care, giving individuals more choice and control over the way their care is planned and delivered	Increases in Shared Decision Making	Personalisation Board	2022/23

Northamptonshire Health Inequalities Action Plan

Alignment with area of focus or guiding principle	Objective	Outcomes	Lead	Delivery date
and targeted to those most in need or at risk of poor outcomes Personalised care		Increased number of Personalised Care & Support Plans Increased number of supported self-management activities		
	Implementation of social prescribing at scale through Spring to provide the necessary local infrastructure to empower individuals to better manage social exacerbations of their Long-Term Conditions. This is a service for adults	Engagement Assessment (Individual action plan) Improvement in general wellbeing (Wellbeing Star improvement) Improvement in Mental Health (WEMWS improvement) Improvement in physical health (reduced GP consultations)	Personalisation Board	2022/23
The ICS will ensure that end of life services support a dignified and pain free death	Develop the Strategy for End of Life and Palliative Care	Improved end of life care	iCan	2022/23

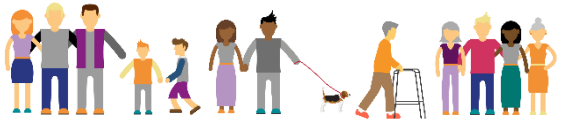
Northamptonshire
Health and Care Partnership

Health Inequalities and CORE20plus5

Introductory Data Pack

March 2021, Anne Holland

Appendix



Context

Northamptonshire Health and Care Partnership

- This slide-pack is intended to be read alongside the Northamptonshire ICS Health Inequalities Plan (March 2022).
- The purpose of the slides is to illustrate some of the health inequalities issues relating to Core20+5 in Northamptonshire. It is not intended to tell the reader about the detail pertaining to every health inequality issue in our County.
- The first section summarises issues relating to ‘Core20’ by looking at 20% most deprived LSOAs
- The second section looks at the ‘5’ key clinical areas of health inequality

- **Key**
  - Within this document, the summary findings can be found in green boxes, an explanation of the data can be found in grey boxes.

Core 20: Deprivation PLUS other areas

Life expectancy

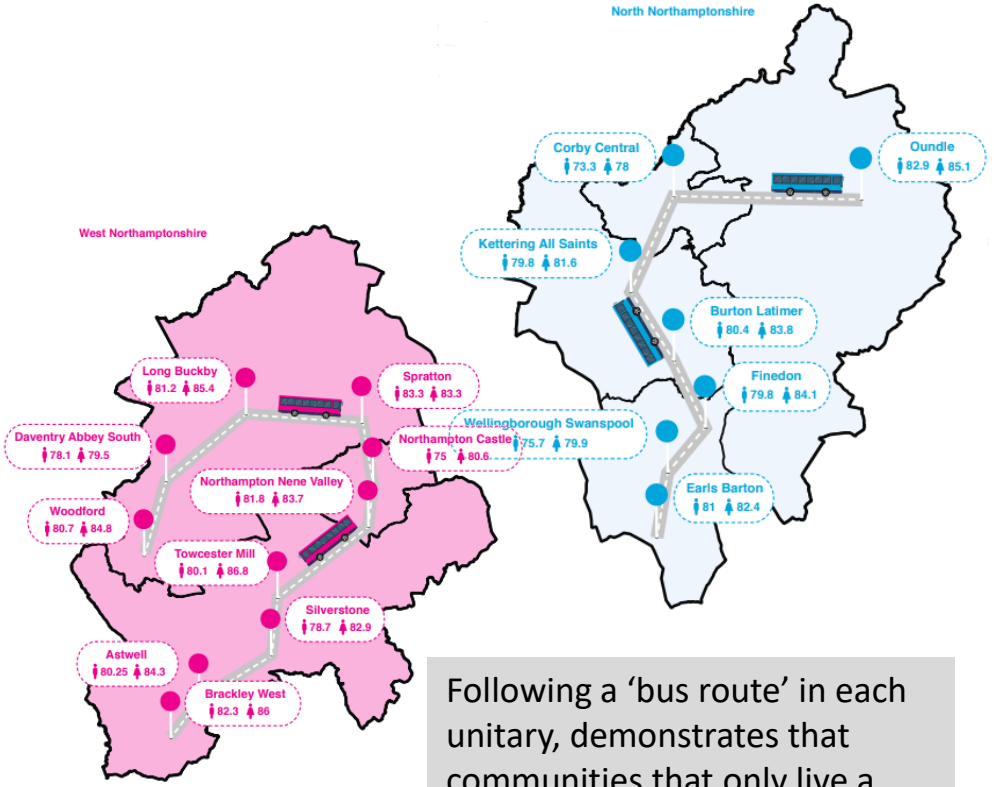
The top 3 broad causes of death that contributed the most to the life expectancy gap between the most and least deprived areas across both North and West Northamptonshire are:

- Circulatory disease
- Cancer
- Respiratory disease

Life expectancy for males and females, 2018-20

	West Northants	North Northants
Males	79.8 years at birth 18.9 years at 65	79.2 years at birth 18.3 years at 65
Females	82.7 years at birth 21.1 years at 65	82.4 years at birth 20.7 years at 65

In 2017 – 19 healthy life expectancy in Northamptonshire was 63.4 for males and 63.6 for females.



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

Areas of Northamptonshire that are in the top 20% most deprived nationally and ethnicity

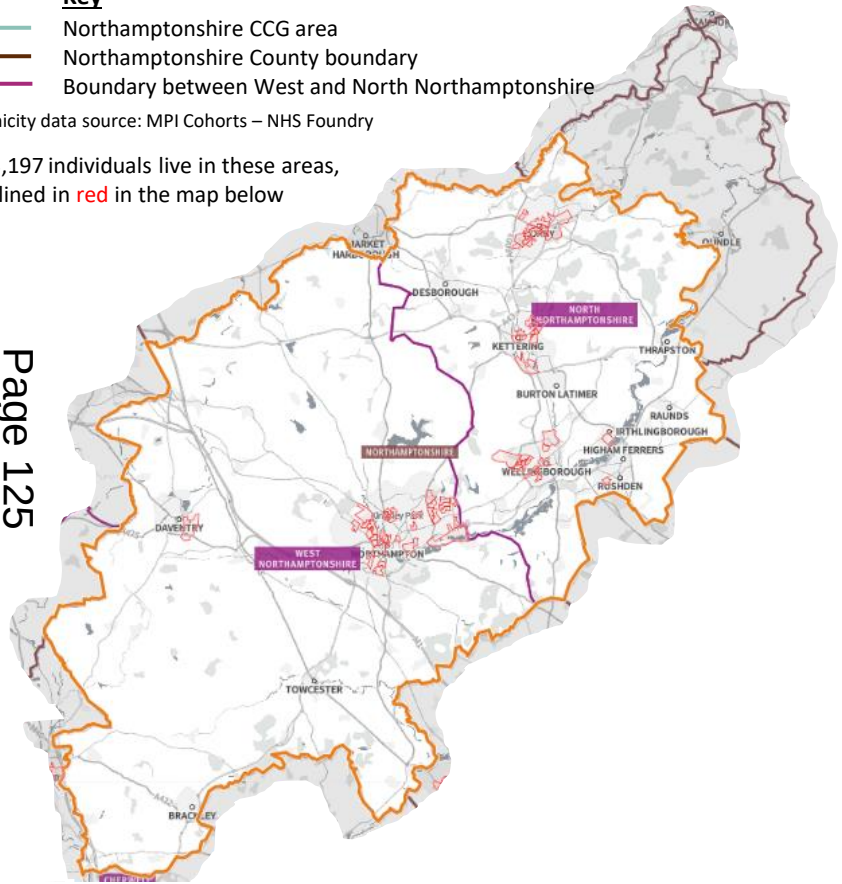
Northamptonshire Health and Care Partnership

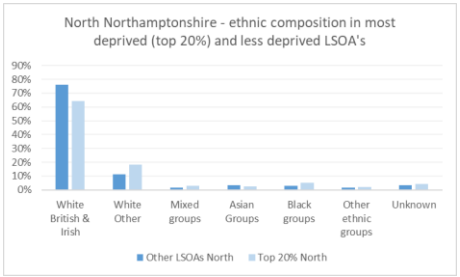
Key

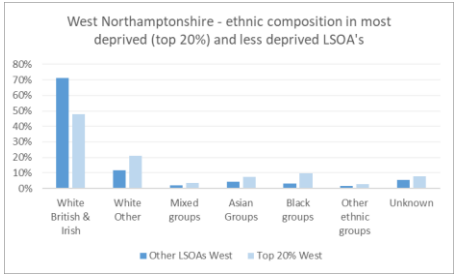
- Northamptonshire CCG area
- Northamptonshire County boundary
- Boundary between West and North Northamptonshire

Ethnicity data source: MPI Cohorts – NHS Foundry

123,197 individuals live in these areas, outlined in red in the map below







The most deprived 20% of areas have a higher proportion of non-white British/Irish groups than less deprived areas.

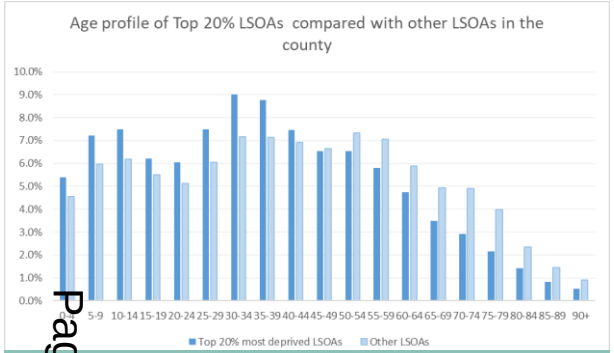
The level of deprivation and ethnic composition of geographically close LSOAs can vary within a small area e.g. The LSOAs in the table below are all within Castle ward in Northampton:-

LSOA	IMD decile	White British & Irish	White Other	Mixed groups	Asian Groups	Black groups	Other ethnic groups	Unknown
E01032979	1	27.0%	26.4%	4.6%	13.5%	15.2%	5.7%	7.6%
E01032978	2	25.3%	21.3%	3.9%	15.3%	23.5%	4.4%	6.4%
E01027226	2	31.9%	33.4%	3.3%	11.8%	8.1%	3.3%	8.2%
E01027155	2	18.7%	36.4%	2.6%	19.7%	7.3%	4.0%	11.2%
E01027228	3	28.2%	32.8%	2.7%	15.3%	7.7%	3.8%	9.6%
E01027227	3	21.7%	35.5%	2.8%	17.3%	9.4%	3.5%	9.9%
E01027223	4	32.1%	26.4%	3.2%	15.7%	9.4%	7.0%	6.3%
E01027225	4	31.2%	34.5%	2.8%	10.1%	6.9%	4.2%	10.3%

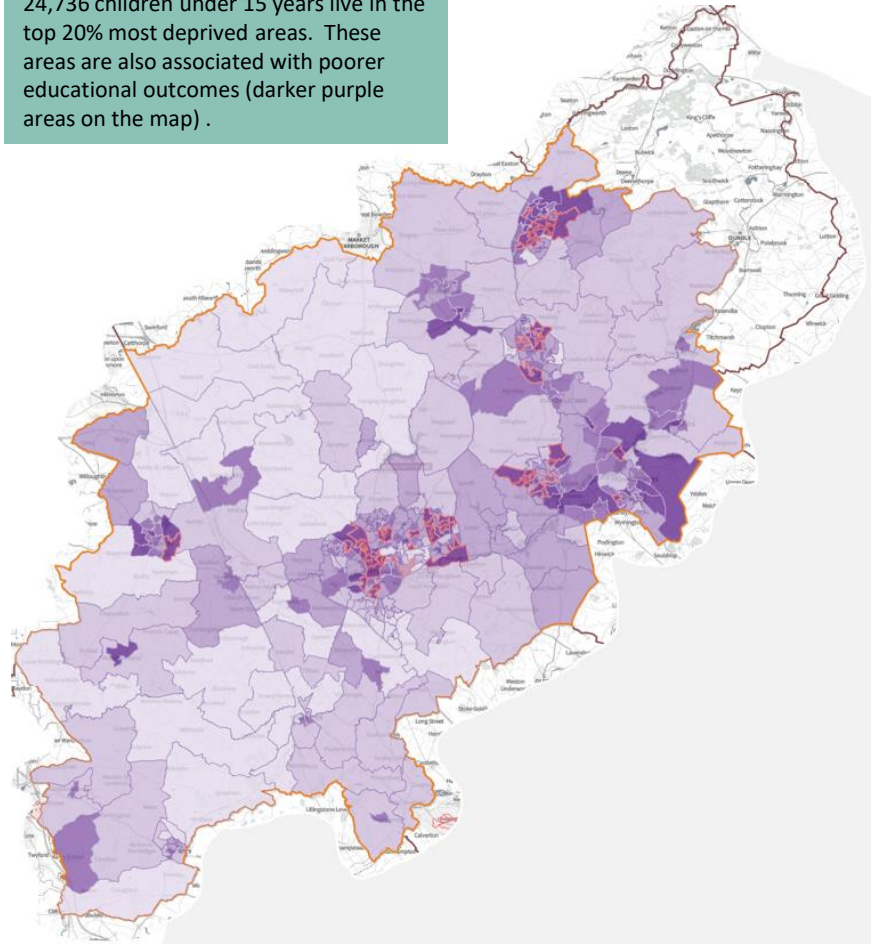
Microsoft Excel Worksheet

Areas of Northamptonshire that are in the top 20% most deprived nationally (Age and Gender)

Northamptonshire Health and Care Partnership

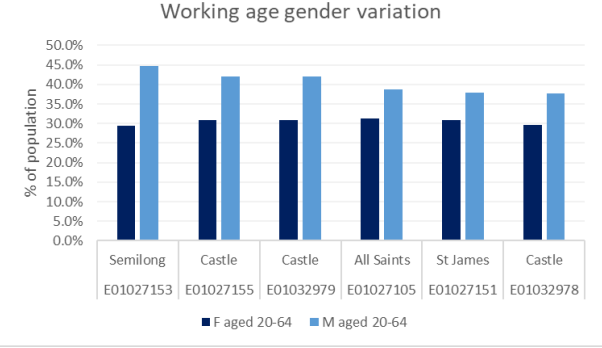


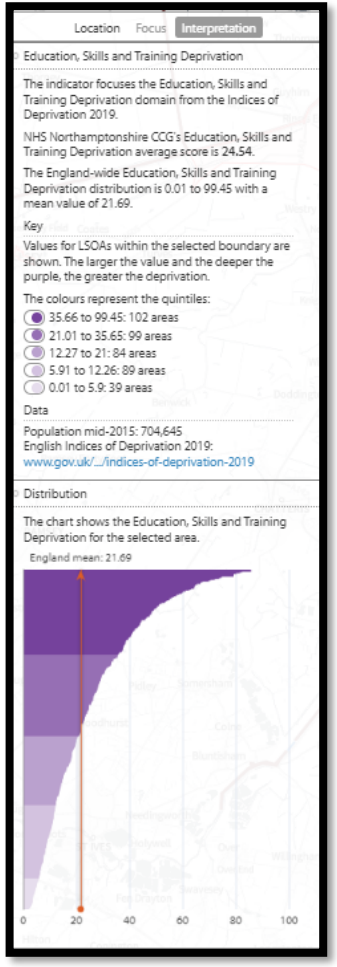
24,736 children under 15 years live in the top 20% most deprived areas. These areas are also associated with poorer educational outcomes (darker purple areas on the map) .



The population of the most deprived LSOAs tends to be younger than that of less deprived areas. This has an impact on the quantity and type of health needs in the population.

In some of the top 20% LSOAs, there is a gender imbalance, particularly in the working age population. In the LSOAs below, Males make up 54% or more of the population.





Top 20% most deprived areas and populations at risk of health problems in future

Northamptonshire Health and Care Partnership

Wellbeing Acorn category: At Risk

The analysis focuses on the percentage of the estimated population in 'Wellbeing Acorn category: At Risk'.

These neighbourhoods do not generally have high incidences of illness. However, multiple unhealthy behaviours, as a result of their lifestyles, could put their health at risk in the future. They have the highest rates of smoking in the country along with some alcohol concerns. Social issues such as unemployment, debt and dissatisfaction with life overall contribute to one of the lowest scores on the mental wellbeing scale.

Corby, Daventry, East Northamptonshire, Kettering, Northampton, South Northamptonshire, Wellingborough's estimated population in 'Wellbeing Acorn category: At Risk' is 21.67% within a range of 0% to 94.5% across 422 LSOAs.

The England-wide LSOA distribution is 0% to 100% with a mean value of 22.12%.

Key

The colours represent the quintiles:

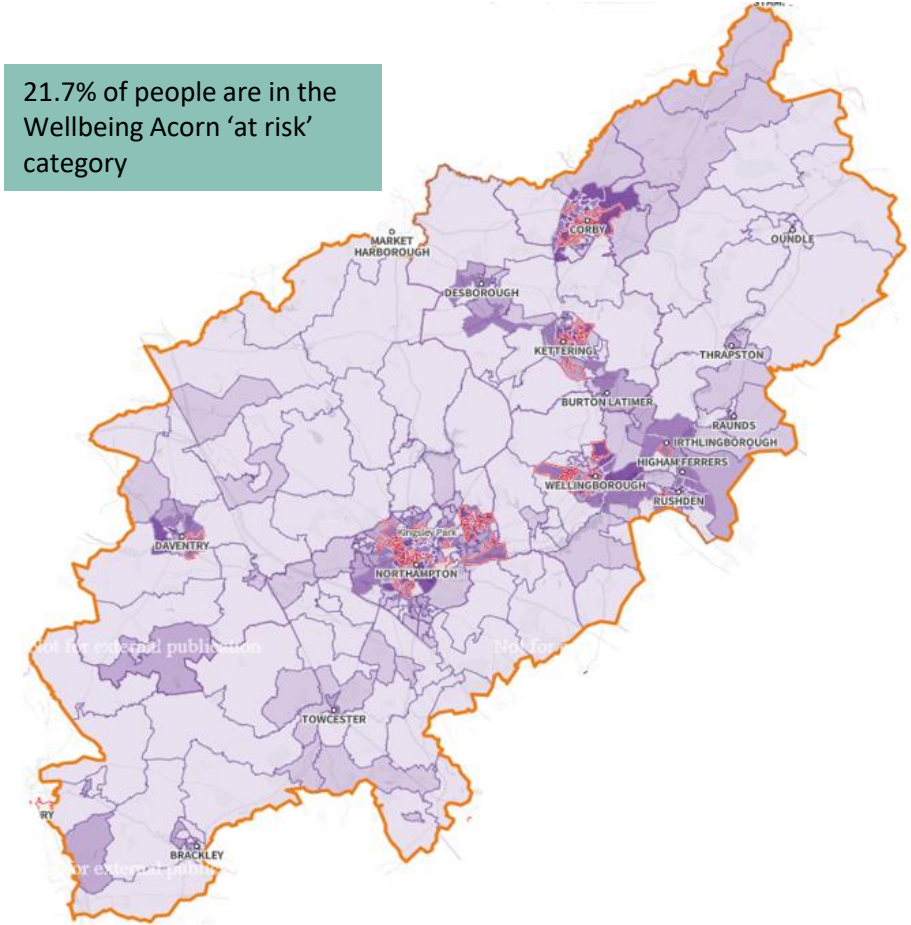
- 44% to 100%: 93 areas
- 21% to 44%: 66 areas
- 7% to 21%: 63 areas
- 0% to 7%: 67 areas
- 0% to 0%: 133 areas

Data: July 2021

Numerator: Population in 'Wellbeing Acorn category: At Risk': 164,567

Denominator: Total population: 759,512 living in 319,793 households.

21.7% of people are in the Wellbeing Acorn 'at risk' category



The Covid-19 vaccination program has shown us that populations from the top 20% most deprived LSOAs are less likely to engage with preventive healthcare.

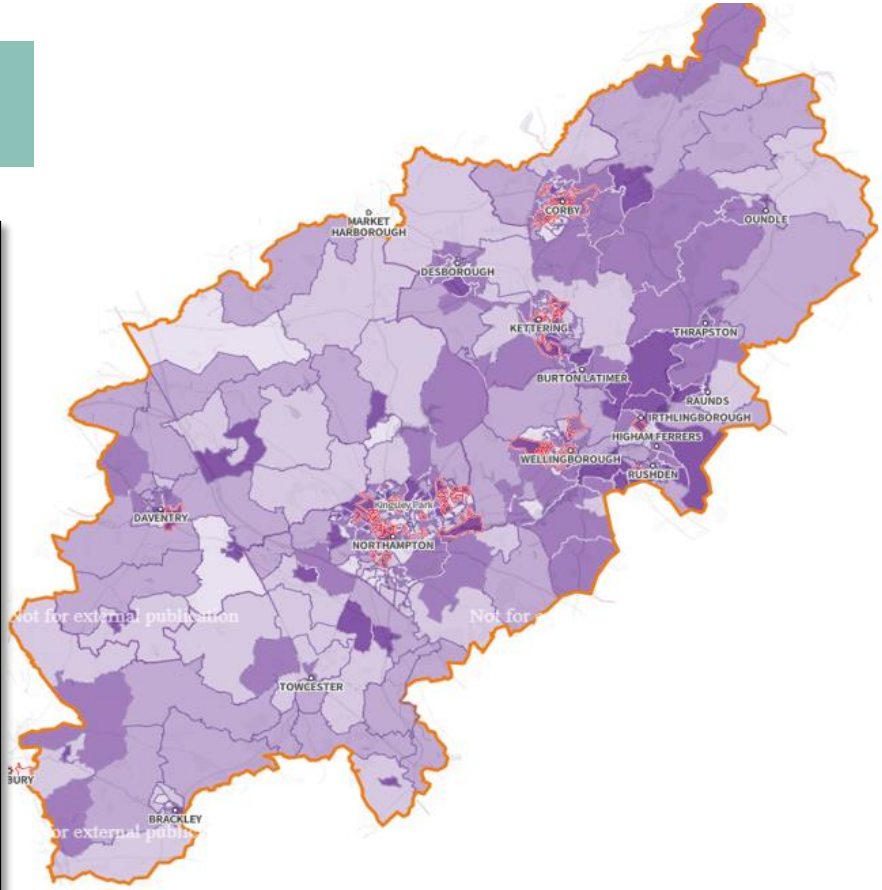
In Northamptonshire, 49.4% of people aged 12+, living in the top 20% most deprived LSOAs, had received at least 1 dose of Covid-19 vaccine by the end of January 2022. The proportion in all the other, less deprived LSOAs was 66.2%.

There are various factors involved in this, including Ethnicity, Age and Gender but deprivation adds another element that leaves people exposed to greater health risks.

Top 20% most deprived areas and populations experiencing current health challenges

Northamptonshire Health and Care Partnership

17.8% of people are in the Wellbeing Acorn 'health challenges' category



Wellbeing Acorn category: Health Challenges

The analysis focuses on the percentage of the estimated population in 'Wellbeing Acorn category: Health Challenges'.

These areas contain the population with the greatest levels of illness and consequently, those with the greatest health challenges and risky behaviours now and in the past. They contain some of the coldest people in the most deprived neighbourhoods. This group contains some of the highest levels of smoking and the lowest levels of fruit and vegetable consumption. Issues around isolation and mental wellbeing are most prevalent here with many lacking a support network in their communities.

Corby, Daventry, East Northamptonshire, Kettering, Northampton, South Northamptonshire, Wellingborough's estimated population in 'Wellbeing Acorn category: Health Challenges' is 17.97% within a range of 0% to 88.1% across 422 LSOAs.

The England-wide LSOA distribution is 0% to 100% with a mean value of 16.22%.

Key

The colours represent the quintiles:

- 30% to 100%: 94 areas
- 15% to 30%: 113 areas
- 6% to 15%: 92 areas
- 0% to 6%: 72 areas
- 0% to 0%: 51 areas

Data: July 2021

Numerator: Population in 'Wellbeing Acorn category: Health Challenges': 136,447

Denominator: Total population: 759,512 living in 319,793 households.

22.7% of adults (18+) living in the top 20% most deprived LSOAS were within the 'At Risk' cohort (C6) identified by JCVI in relation to the Covid 19 vaccination roll out.

For the less deprived LSOAs, the percentage was lower at 17.4%.

This is significant, given that the populations of the top 20% of LSOAs tend to be much younger.

JCVI 'At Risk' groups include people with clinical conditions such as:

- a blood cancer
- diabetes
- dementia
- a heart problem
- a chest complaint or breathing difficulties(e.g.bronchitis, emphysema or severe asthma)
- a kidney disease
- a liver disease
- lowered immunity due to disease or treatment
- rheumatoid arthritis, lupus or psoriasis have had an organ transplant
- had a stroke or a transient ischaemic attack (TIA)
- a neurological or muscle wasting condition
- a severe or profound learning disability
- a problem with the spleen e.g. sickle cell disease, or splenectomy
- are seriously overweight (BMI of 40 and above)
- are living with a severe mental illness

Average Gradient of Inequality in emergency admissions for Chronic Ambulatory Care Sensitive Conditions (ACSCs)

Northamptonshire Health and Care Partnership

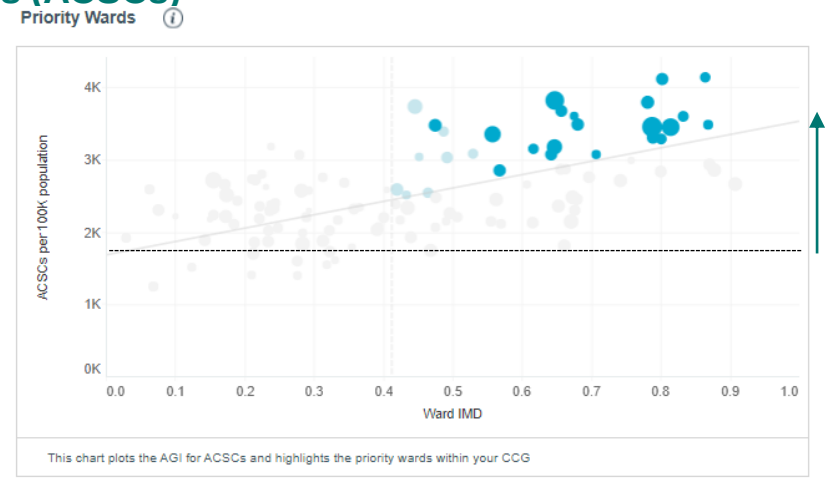
The Average Gradient of Inequality (AGI) measures the inequality across a CCG area.

Ward level deprivation scores and the rate of emergency admissions for ACSCs are plotted on a graph to give a general trend line.

The gradient of the line represents the level of inequality, with steeper lines representing greater inequality.

The darker blue dots on the graph represent the wards shown in the Table below.

The Wards highlighted in red in the table below are those which include at least one LSOA in the top 20% most deprived nationally.

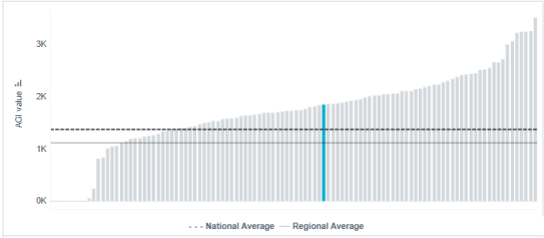


The height of this line is the AGI score.

The AGI score as at September 2021 was 1848. This was an 8.7% drop on the previous year, which indicates a reduction in inequality.

At a score of 1848 it is higher than the national average of 1366 and the regional average of 1119.

In the graph below Northamptonshire CCG is highlighted in blue.

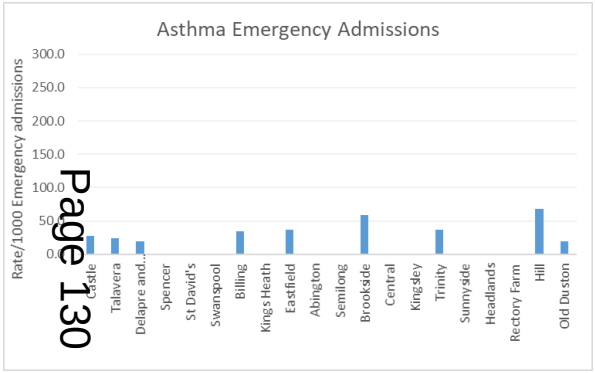


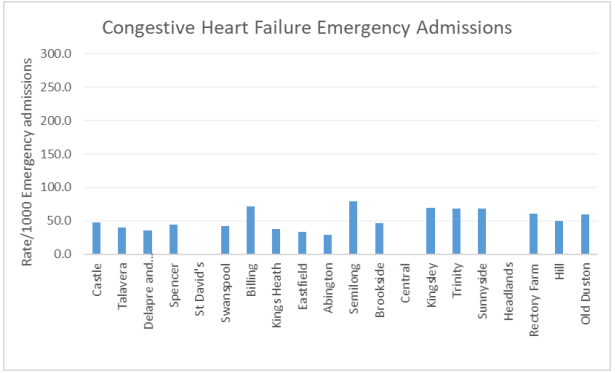
Ward Name	Rank	Town	Ward includes a Top20% LSOA	ACSCs per 100000 pop	Percentage of emergency admissions that are ACSCs	Opportunity for saved ACSCs
Castle	1	Northampton	Y	3454	26.8%	103
Talavera	2	Northampton	Y	3450	27.1%	89
Delapre and Briar Hill	3	Northampton	Y	3819	29.4%	76
Spencer	4	Northampton	Y	4115	31.5%	63
St David's	5	Northampton	Y	3794	32.7%	53
Swanspool	6	Wellingborough	Y	3288	30.1%	50
Billing	7	Northampton	Y	3178	26.3%	48
Kings Heath	8	Northampton	Y	4139	29.8%	47
Eastfield	9	Northampton	Y	3487	28.4%	42
Abington	10	Northampton	N	3353	31.4%	38
Semilong	11	Northampton	Y	3307	23.7%	38
Brookside	12	Northampton	Y	3600	29.5%	37
Central	13	Corby	Y	3484	35.6%	37
Kingsley	14	Northampton	N	3073	27.4%	35
Trinity	15	Northampton	N	3674	30.0%	35
Sunnyside	16	Northampton	N	3604	32.6%	26
Headlands	17	Kettering	Y	3073	27.0%	19
Rectory Farm	18	Northampton	Y	3151	26.7%	19
Hill	19	Daventry	Y	2854	30.5%	18
Old Duston	20	Northampton	Y	3470	31.7%	16

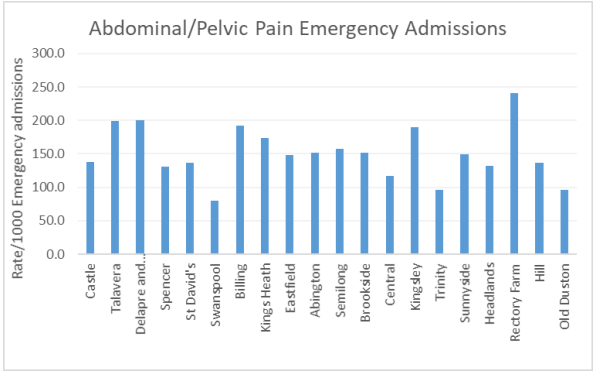
Ambulatory Care Sensitive Conditions (ACSCs): the conditions and variation across wards (Top 20 wards to target)

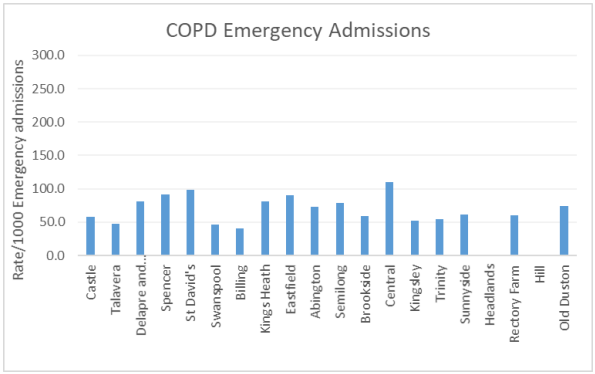
Northamptonshire Health and Care Partnership

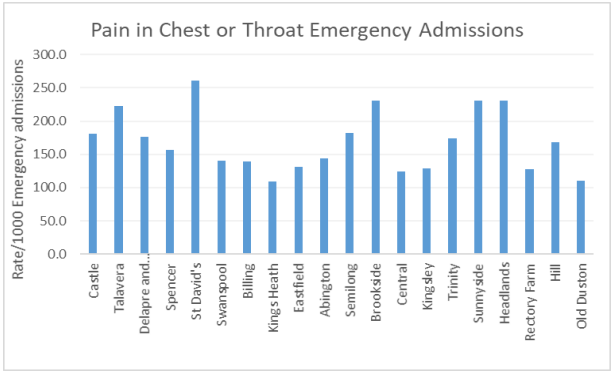
There is variation between wards in both the quantity and type of ACSC emergency admissions. It is not only deprivation that contributes to this picture. Other factors affecting it are age, gender and ethnicity.

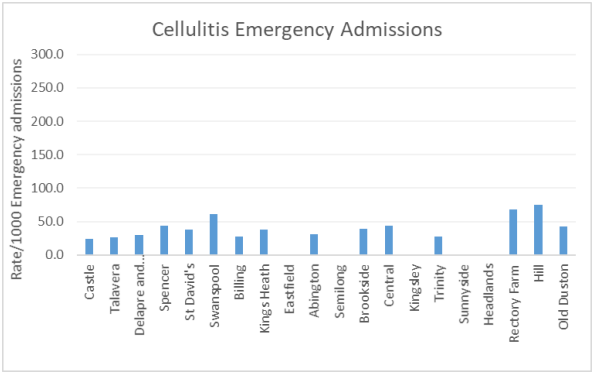










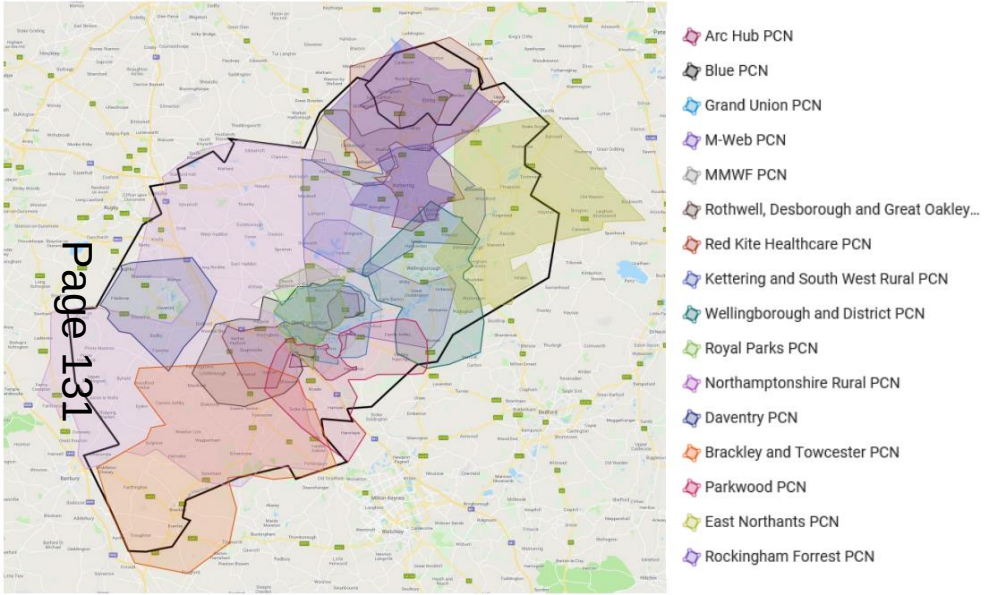


PCN level inequalities

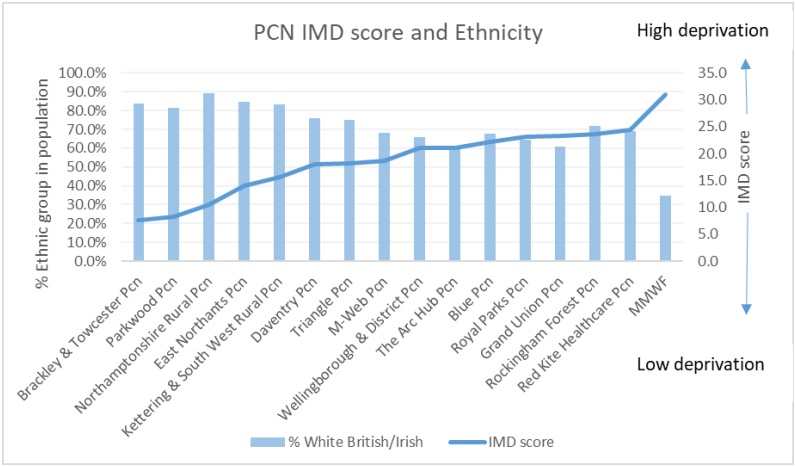
Northamptonshire Health and Care Partnership

The map shows the approximate locations of PCN populations – since PCNs are not geographical areas it is not possible to be very precise. The demographics of main geographical areas covered by PCNs are reflected in each PCN. The example of ethnicity and IMD score is shown below:-

Map of PCNs in Northamptonshire



PCN	White British/Irish	Any other White background	Mixed background	Asian or Asian British	Black or Black British	Other ethnic groups	Unknown
MMWF Pcn	34.8%	28.1%	2.8%	11.0%	10.4%	3.2%	9.8%
Grand Union Pcn	60.9%	16.4%	3.0%	7.2%	5.4%	2.2%	5.0%
The Arc Hub Pcn	61.5%	14.1%	3.0%	5.8%	5.7%	2.0%	7.8%
Royal Parks Pcn	64.4%	12.9%	2.7%	5.7%	4.9%	2.1%	7.4%
Wellingborough & District Pcn	65.9%	15.5%	3.2%	6.2%	5.4%	1.3%	2.4%
Blue Pcn	67.8%	13.0%	2.5%	4.8%	5.0%	1.9%	5.1%
M-Web Pcn	68.4%	10.7%	2.8%	4.2%	4.8%	3.0%	6.2%
Red Kite Healthcare Pcn	69.1%	15.4%	2.2%	4.5%	3.2%	1.6%	3.9%
Rockingham Forest Pcn	71.9%	14.4%	1.6%	1.6%	2.2%	3.2%	5.1%
Triangle Pcn	75.2%	11.9%	1.7%	2.0%	4.3%	1.4%	3.5%
Daventry Pcn	75.8%	12.4%	1.2%	1.8%	1.2%	1.3%	6.4%
Parkwood Pcn	81.4%	6.1%	1.9%	3.4%	1.9%	1.3%	4.1%
Kettering & South West Rural Pcn	83.3%	6.5%	1.5%	2.7%	2.2%	0.7%	3.0%
Brackley & Towcester Pcn	83.7%	8.2%	1.1%	0.9%	0.5%	0.9%	4.7%
East Northants Pcn	84.5%	7.4%	1.4%	1.2%	1.6%	0.8%	3.2%
Northamptonshire Rural Pcn	89.1%	4.4%	1.1%	0.7%	0.5%	0.6%	3.7%



Hidden populations and health inequalities

Northamptonshire Health and Care Partnership

- Some groups in society are particularly disadvantaged: for example people who are homeless, refugees and asylum seekers, including those who receive no financial support and for whom absolute poverty remains a reality.
- The concept of inclusion heath has typically encompassed homeless people; Gypsy, Roma, and traveller communities; vulnerable migrants; and sex workers but other groups can be included. These groups can be socially excluded, which can be defined broadly as processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions.
- Social exclusion is associated with the poorest health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities.
- Inclusion health groups commonly have very high levels of morbidity and mortality, often with multiple and complex needs including overlapping mental and physical ill-health, and substance dependency, creating complex situations that health services are not always equipped to deal with and that traditional population-based approaches generally fail to address.
- The average age at death of people who sleep rough was 44 years for men and 42 years for women
- People living with severe mental illness (SMI) have 15–20 years shorter life expectancy than the general population.
- Gypsy and Traveller women live 12 years less than women in the general population and men 10 years less
- Hepatitis B and C infection among female prisoners are 40 and 28 times higher than in the general population
- Local data on some of these groups is not routinely available and this means that it can be hard to understand the impacts on health and how to support these groups.

Learning Disabilities, Serious Mental Illness, Child & Maternal Health, Respiratory & Air Quality, Hypertension, Cancer & Screening, Immunisations

CORE 20PLUS 5 in Northants

Northamptonshire Health and Care Partnership

Veterans – estimated 3,000 - 4,000 serving or former armed forces personnel (2018)

Care leavers – almost 700 young people left care in 2017/18

Homeless – approx. 6,000 (2018)

Rough sleepers – 91 counted (2018)

6,410 people from BAME groups, 100,125 from white other, 70,170 unknown (2021)

Carers –estimated 75,000+ unpaid carers in Northamptonshire (2019)

3,147 in treatment for substance misuse (2020/21)

Gypsy/Travellers – 527 (2011) Around 250 permanent pitches

123,197 individuals live in top 20% most deprived areas

Maternity continuity of care as of Oct 21 was 5% KGH and 7% NGH. Plans in place to achieve 55% by end of 2022 and 75% by 2023.

In December 2021 38% of people with LD and 25% of people with MH conditions had received an annual health check. Plans are in place to achieve the 60% target for SMI and 75% target for LD.

In Jan 22 49.4% aged 12+ in the top 20% most deprived LSOAs, had received at least 1 dose of Covid-19 vacc. In the other less deprived LSOAs 66.2%.

In 2020/21 Flu vacc was 80.9% in over 65s and 53% for at risk groups.

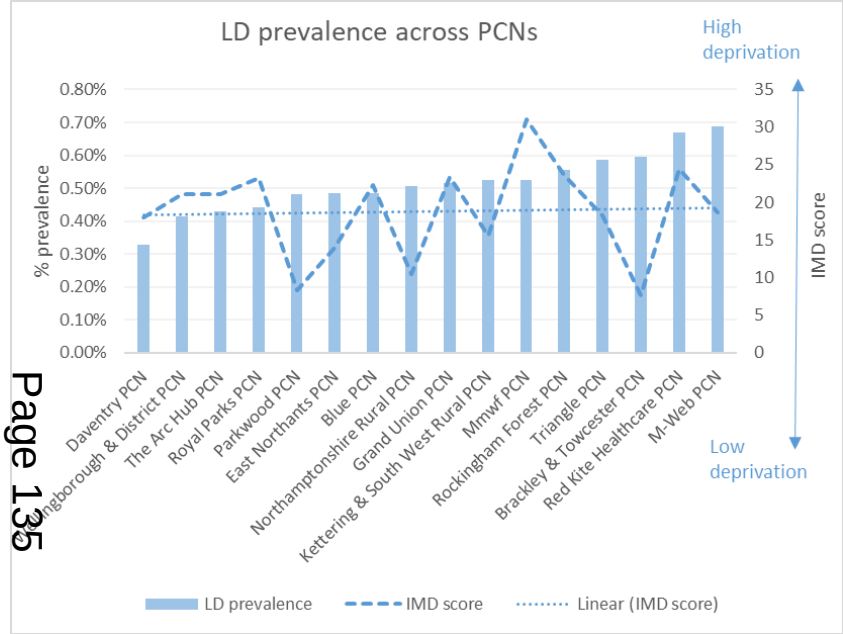
In 2019 early cancer diagnosis rate was 55%.

The proportion of new cancers treated following 2 week wait referral varies across PCNs, from 46% to 67.8%.

In 2021/22 QOF prevalence of hypertension was 14.4%. In 2019-20 QOF identified 32,704 individuals with uncontrolled hypertension – 29% of the total with hypertension.

Learning Disability (LD) health checks: LTP ambition is 75%

Northamptonshire Health and Care Partnership

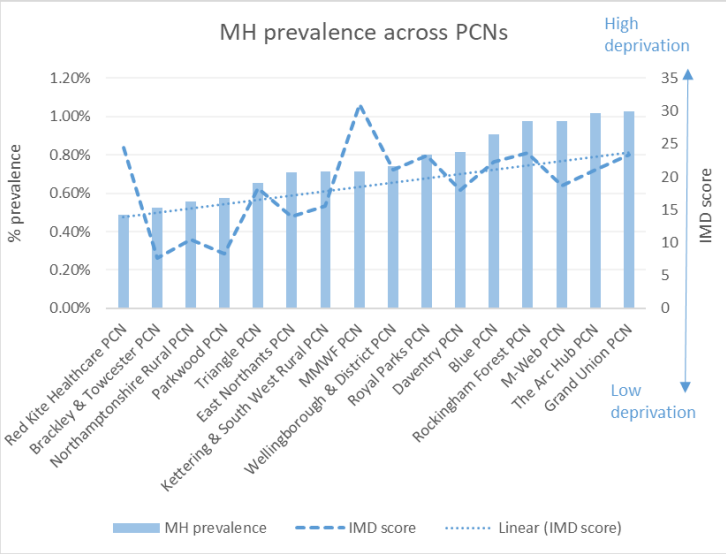


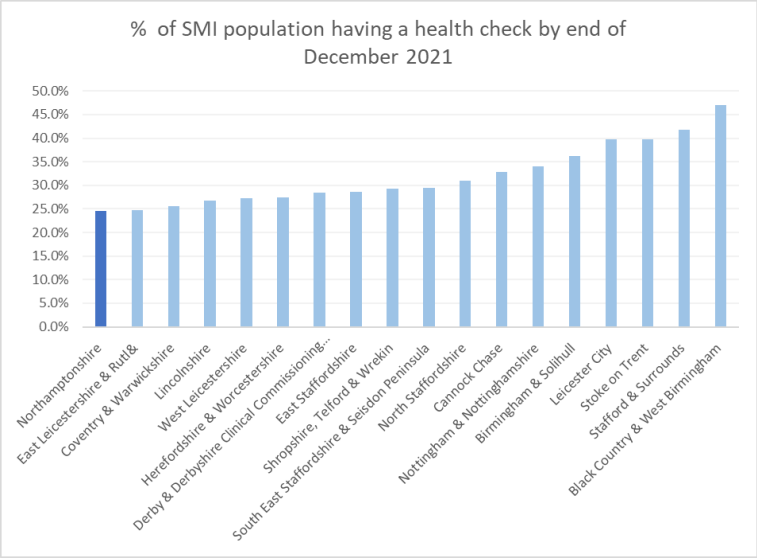
The QOF prevalence for Learning Disabilities is derived at GP practice level. It is important that these are accurate so that people with LD can be contacted and called in for health checks as well as Flu and Covid-19 vaccinations.

Health Checks for people with LD consists of a collaborative review of the physical and mental health of the individual. This includes the review of specific health needs related to particular syndromes, medication checks, communication issues e.g. how the individual can communicate pain or discomfort, family carer reviews, if appropriate, and support for the individual in looking after and making decisions about their own healthcare.

Serious Mental Illness (SMI) health checks: LTP ambition is 75%

Northamptonshire Health and Care Partnership





Serious MH Prevalence

QOF MH prevalence covers: Schizophrenia, Bipolar Disorder and other psychoses. The proportion of people with these disorders varies, with a strong tendency for a greater proportion in more deprived areas due to social drift. This is the tendency for people with long term illnesses, particularly mental illness, to move downwards in terms of social mobility.

SMI Health Checks

People with a serious mental illness suffer from poorer health, a fact reflected in their life expectancy which is 20 years lower than that of the general population. Cardiovascular disease and cancers are two of the main causes of early death.

The physical health complaints of people with SMIs are sometimes mis-diagnosed as manifestations of their mental health. For this reason, health checks include assessment of Alcohol consumption, Weight, Blood Pressure, Cholesterol, Blood Glucose and Cytology. Physical health checks can take place in either primary or secondary care.

Maternity: LTP ambition 75% of women from BAME and deprived areas have continuity of care

Northamptonshire Health and Care Partnership

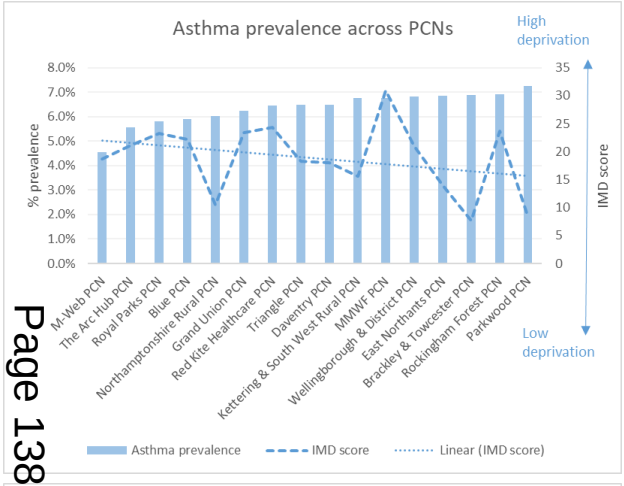
Maternity continuity of care as of Oct 21 was 5% KGH and 7% NGH. Plans in place to achieve 55% by end of 2022 and 75% by 2023.

Indicator	Period	N Northamptonshire			Region England	England		England		W Northamptonshire			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest	Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of deliveries to mothers from Black and Minority Ethnic (BME) groups	2019/20	–	-	-	14.3%	20.5%	1.7%		62.2%	–	-	-	14.3%	20.5%	1.7%		62.2%
General fertility rate	2019	–	-	-	55.8	57.7	34.8		77.5	–	-	-	55.8	57.7	34.8		77.5
Under 18s conception rate / 1,000	2019	↓	81	13.8	15.4	15.7	37.1		3.9	↓	90	13.4	15.4	15.7	37.1		3.9
Under 18s conceptions leading to abortion (%)	2019	→	46	58.0%	49.9%	54.7%	32.5%		91.3%	→	52	57.8%	49.9%	54.7%	32.5%		91.3%
Folic acid supplements before pregnancy	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Early access to maternity care	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Obesity in early pregnancy	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Drinking in early pregnancy	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Drug misuse in early pregnancy New data	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Smoking in early pregnancy	2018/19	–	-	-	-	-	-	-	-	–	-	-	-	-	-	-	-
Smoking status at time of delivery	2020/21	–	418	12.2%	12.6%	9.6%	21.4%		1.8%	–	489	12.3%	12.6%	9.6%	21.4%		1.8%
Teenage mothers	2019/20	–	-	-	0.7%	0.7%	2.3%		0.2%	–	-	-	0.7%	0.7%	2.3%		0.2%
Caesarean section %	2019/20	–	-	-	30.2%	30.1%	37.8%		22.2%	–	-	-	30.2%	30.1%	37.8%		22.2%
Multiple births	2018	–	-	-	14.6	15.4	9.0		25.2	–	-	-	14.6	15.4	9.0		25.2
Low birth weight of term babies New data	2020	–	84	2.50%	2.62%	2.86%	4.85%		1.35%	–	83	2.04%	2.62%	2.86%	4.85%		1.35%
Low birth weight of all babies	2018	–	-	-	7.2%	7.4%	11.1%		4.7%	–	-	-	7.2%	7.4%	11.1%		4.7%
Very low birth weight of all babies	2018	–	-	-	1.08%	1.16%	2.15%		0.24%	–	-	-	1.08%	1.16%	2.15%		0.24%
Premature births (less than 37 weeks gestation)	2016 - 18	–	-	-	83.8	81.2	112.2		61.9	–	-	-	83.8	81.2	112.2		61.9
Stillbirth rate	2017 - 19	–	-	-	3.5	4.0	6.6		2.0	–	-	-	3.5	4.0	6.6		2.0
Neonatal mortality and stillbirth rate	2019	–	20	5.0	6.6	6.6	11.4		1.8	–	37	8.0	6.6	6.6	11.4		1.8
Admissions of babies under 14 days	2019/20	–	-	-	86.6	78.1	220.7		23.0	–	-	-	86.6	78.1	220.7		23.0
Baby's first feed breastmilk	2018/19	–	-	-	64.7%	67.4%	43.6%		98.7%	–	-	-	64.7%	67.4%	43.6%		98.7%
Breastfeeding prevalence at 6-8 weeks after birth - current method	2020/21	–	-	-	*	47.6%*	-	*Insufficient number of values for a spine chart*	-	–	-	-	*	47.6%*	-	*Insufficient number of values for a spine chart*	-
Healthy life expectancy at birth (Male)	2017 - 19	–	-	-	62.2	63.2	53.7		71.5	–	-	-	62.2	63.2	53.7		71.5
Healthy life expectancy at birth (Female)	2017 - 19	–	-	-	61.9	63.5	55.3		71.4	–	-	-	61.9	63.5	55.3		71.4
Life expectancy at birth (Male) New data	2018 - 20	–	-	79.2	79.2	79.4	74.1		84.7	–	-	79.8	79.2	79.4	74.1		84.7
Life expectancy at birth (Female) New data	2018 - 20	–	-	82.4	82.7	83.1	79.0		87.9	–	-	82.8	82.7	83.1	79.0		87.9
Infectious Diseases in Pregnancy Screening - HIV Coverage	2017/18	–	-	-	99.4%*	99.6%*	-	*Insufficient number of values for a spine chart*	-	–	-	-	99.4%*	99.6%*	-	*Insufficient number of values for a spine chart*	-
Sickle Cell and Thalassaemia Screening - Coverage	2016/17	–	-	-	99.3%	99.3%	-	*Insufficient number of values for a spine chart*	-	–	-	-	99.3%	99.3%	-	*Insufficient number of values for a spine chart*	-

Data source: PHOF

Respiratory Disease

Northamptonshire Health and Care Partnership



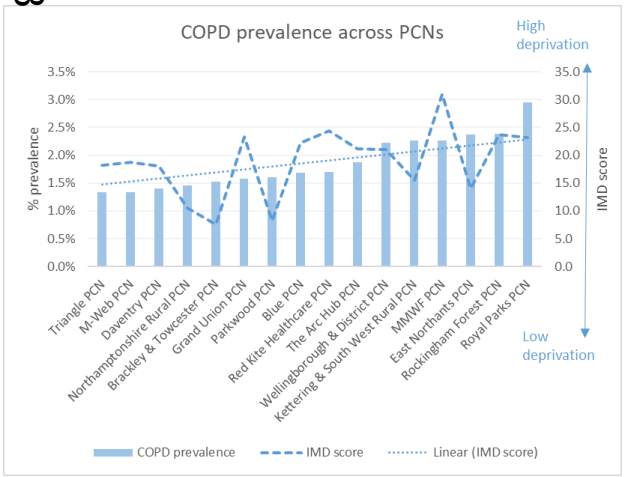
While Asthma prevalence is similar in North and West Northamptonshire (around6%) , COPD is more prevalent in the north of the county. North Northants has a prevalence of 2.4%, while West Northants is at 1.6%.

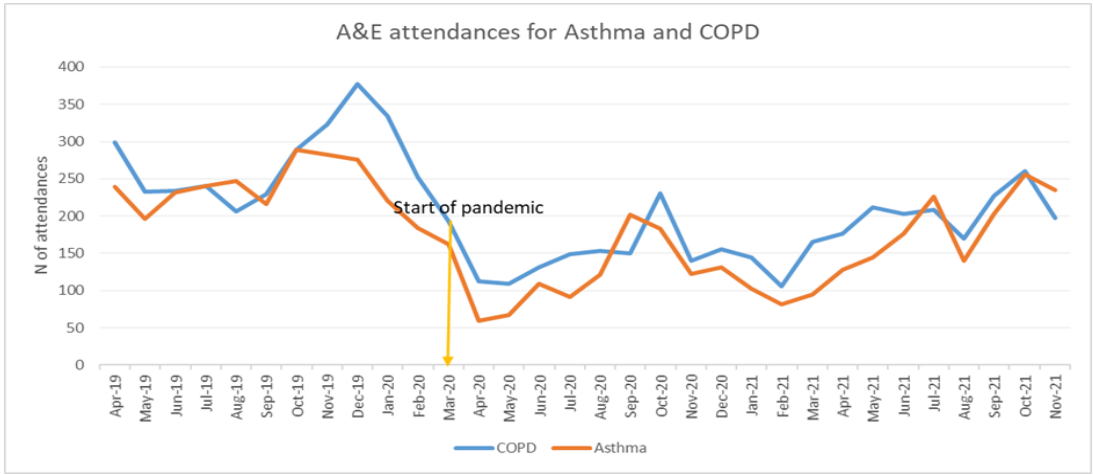
In Corby, COPD prevalence at Dr Kumar's practice is 4% - the highest in the county and there 3 other practices where prevalence exceeds 3%.

In East Northamptonshire PCN, one practice has an Asthma prevalence of 11.6%, the highest in the county. In 3 other practices (two in North and one in West Northamptonshire), Asthma prevalence is higher than 7.5%.

A&E attendances for Asthma and COPD decreased during the Covid-19 pandemic. Attendances usually increase in the winter months when the diseases become complicated by respiratory infections.

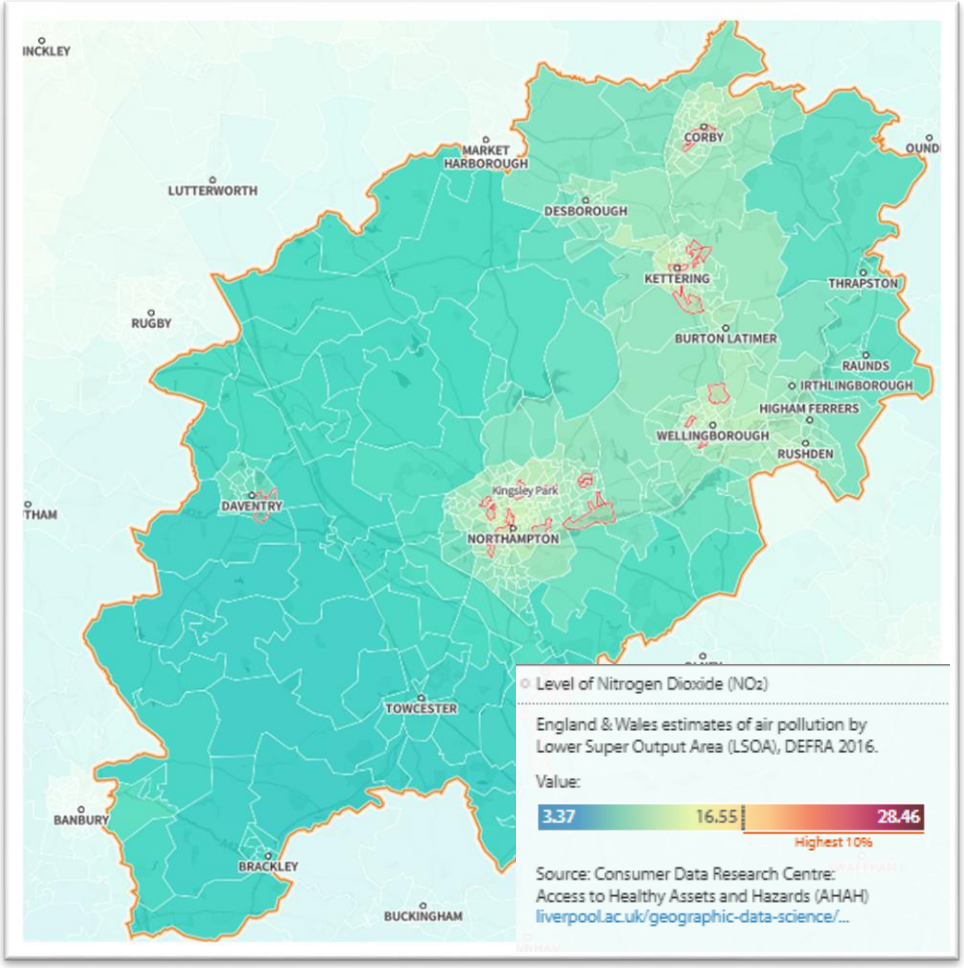
Rockingham Forest and Red Kite PCN have the highest A&E attendance rates for both Asthma and COPD.





Air Quality and deprivation – Nitrous Oxide

Northamptonshire Health and Care Partnership



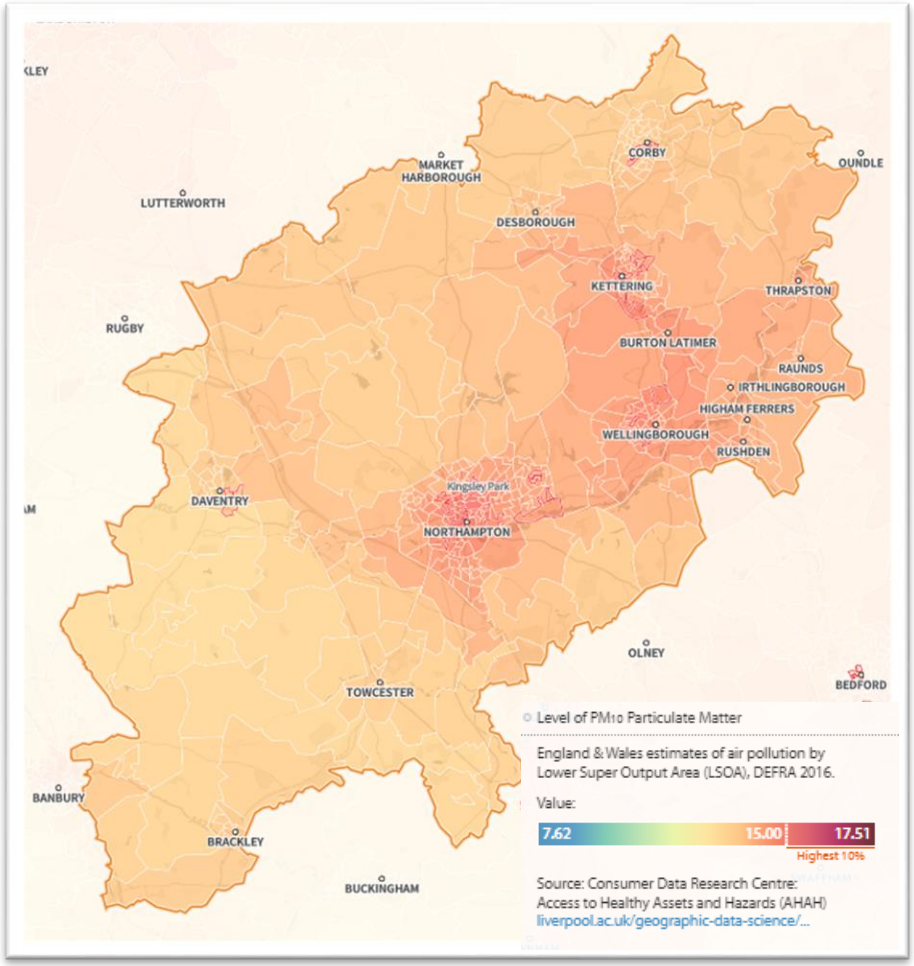
Nitrous Oxide – largely derives from motor vehicle exhaust and industry. It has various effects depending on concentration in the air and duration of exposure:

- Short term high levels – aggravate existing respiratory diseases and are linked with increased A&E attendances and admissions.
- Longer term exposure – linked to development of asthma and susceptibility to respiratory infections.

LSOA's that are in the top 10% most deprived nationally are highlighted in red

Since LSOA areas of increased deprivation in Northants tend to be within urban areas, the air quality may cause and/or exacerbate exiting respiratory disorders. A similar picture is seen for particulate matter in the next slide.

Air Quality and deprivation

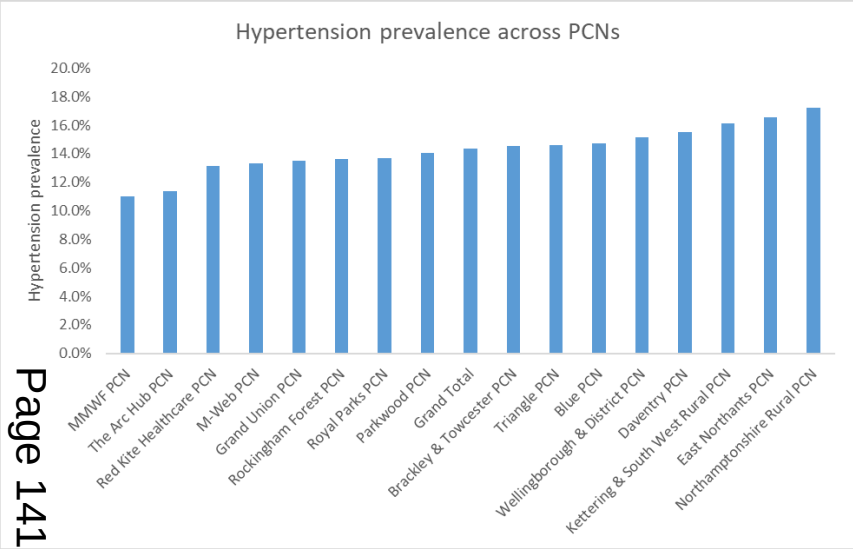


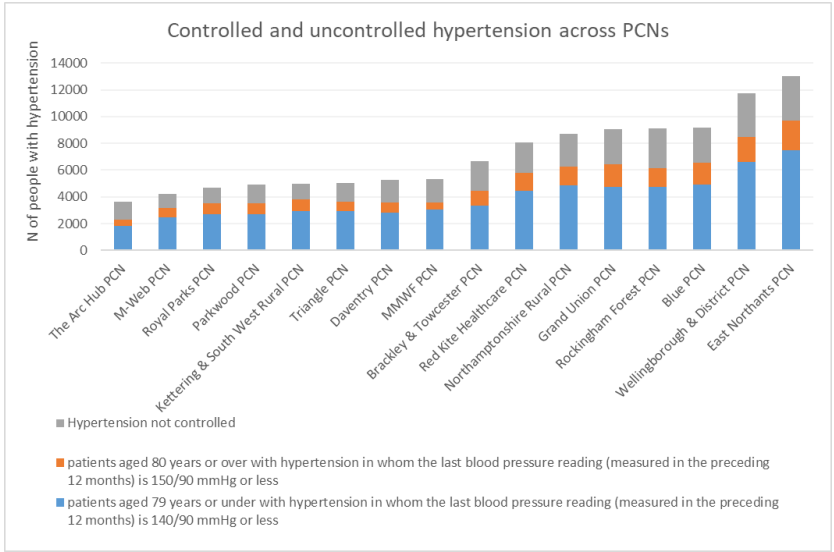
Particulate matter – fine particles are of most concern but map shows PM10 – larger particles.

- The lungs of people with existing cardiac or lung diseases, including asthma and COPD, are irritated by the particles
- Longer term exposure is associated with reduced lung function, development of Chronic Bronchitis and premature death
- Short term exposure to high levels aggravates existing lung disease, causes asthma attacks and acute bronchitis and susceptibility to lung infections

Hypertension

Northamptonshire Health and Care Partnership





There are many population factors that can be involved in a higher prevalence of hypertension: age, gender, ethnicity, genetics, being over weight or obese, smoking, physical inactivity, having other diseases such as chronic kidney disease and diet.

Some of these factors are modifiable and it is important that populations are supported in doing this, to prevent the development of serious cardiovascular disease.

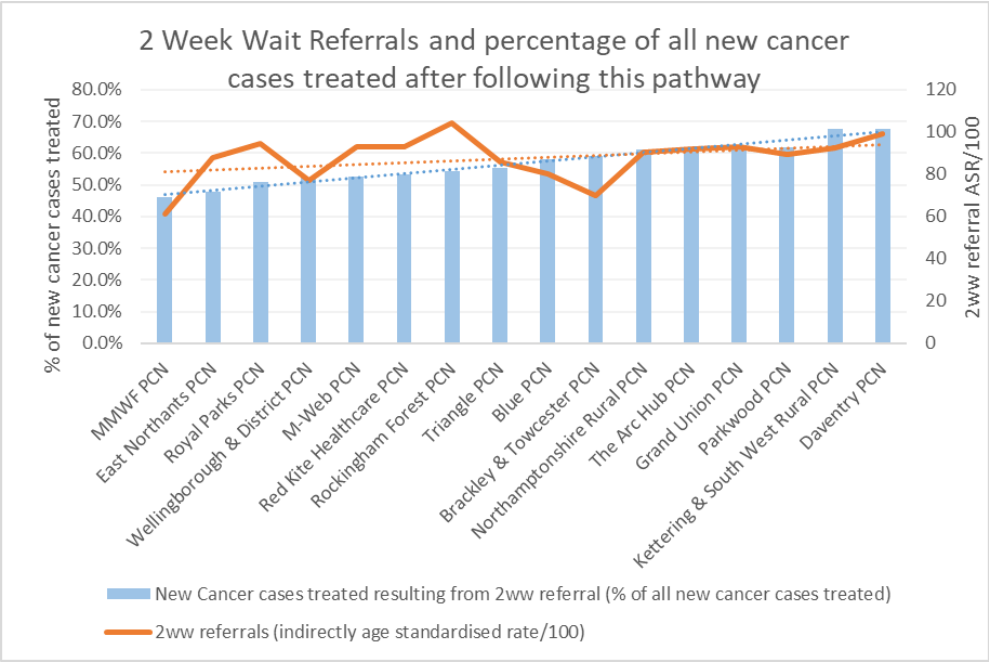
In 2021/22 QOF prevalence of hypertension was 14.4%.

In Northamptonshire, the 2019-20 QOF identified 32,704 individuals with uncontrolled hypertension – 29% of the total with hypertension.

Many of the risk factors for developing hypertension are also those associated with poor control, particularly older age, male gender, higher alcohol use, black ethnicity and obesity. Lower socio-economic status is also associated with poorer control.

Early Cancer Diagnosis

Northamptonshire Health and Care Partnership



In 2019 early cancer diagnosis rate was 55%.

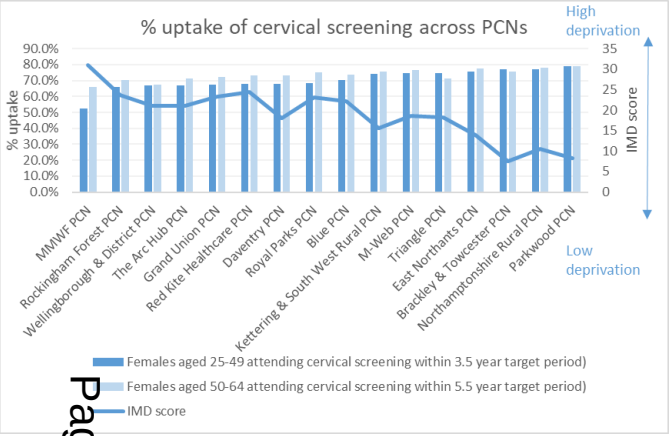
The proportion of new cancers treated following 2 week wait referral varies across PCNs, from 46% to 67.8%.

There is some relationship with the rate of 2 week wait referrals but this is not the only factor affecting the proportion of new cancers treated after following this pathway.

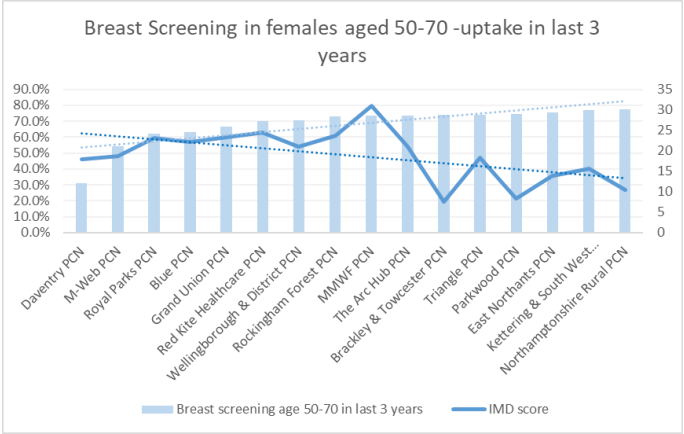
In the following graphs, the uptake of various types of cancer screening is shown for PCNs in Northamptonshire and for all, it is seen that the uptake is lower in the presence of greater deprivation.

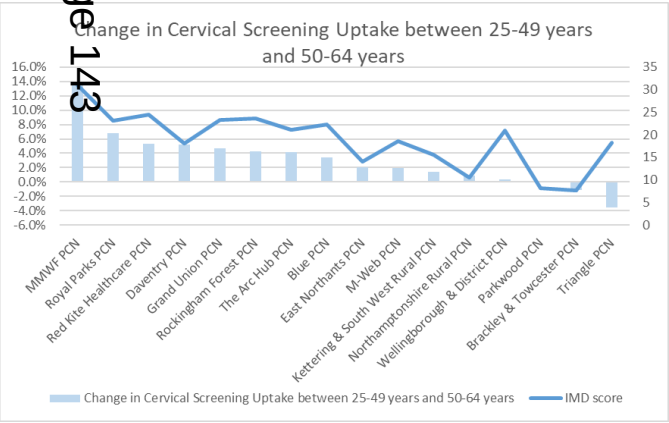
Uptake of screening across PCNs

Northamptonshire Health and Care Partnership

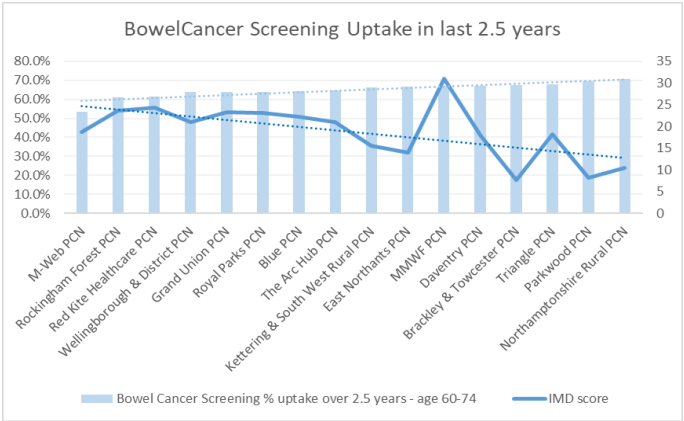


There is some inequality in uptake of cervical screening across PCNs. Uptake generally reflects deprivation levels, with lower uptake occurring in PCNs with higher deprivation.





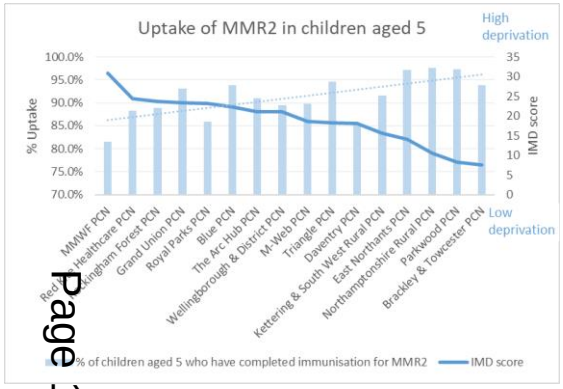
In PCNs with higher deprivation levels, the gap between uptake in younger and older age bands is greater.

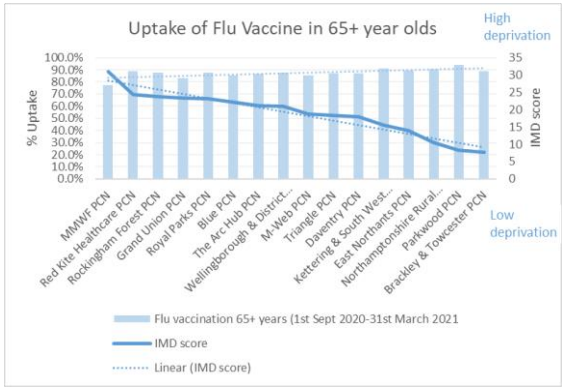


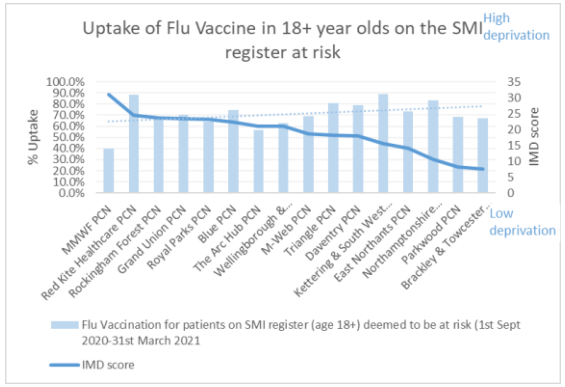
For bowel and breast screening a similar relationship between uptake and deprivation level is seen.

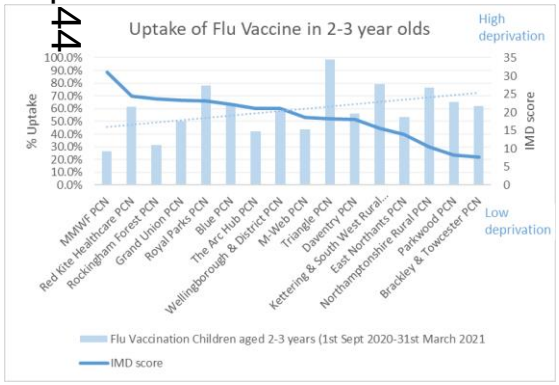
Other Prevention uptake - immunisations

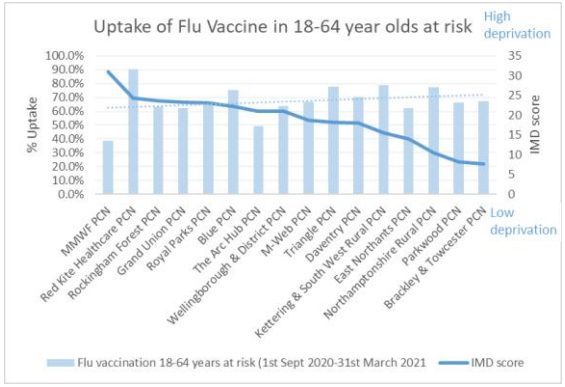
Northamptonshire Health and Care Partnership

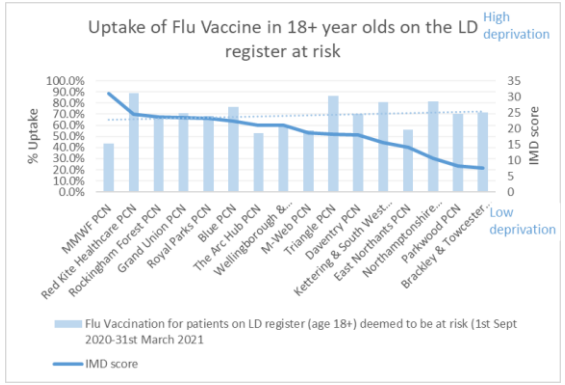








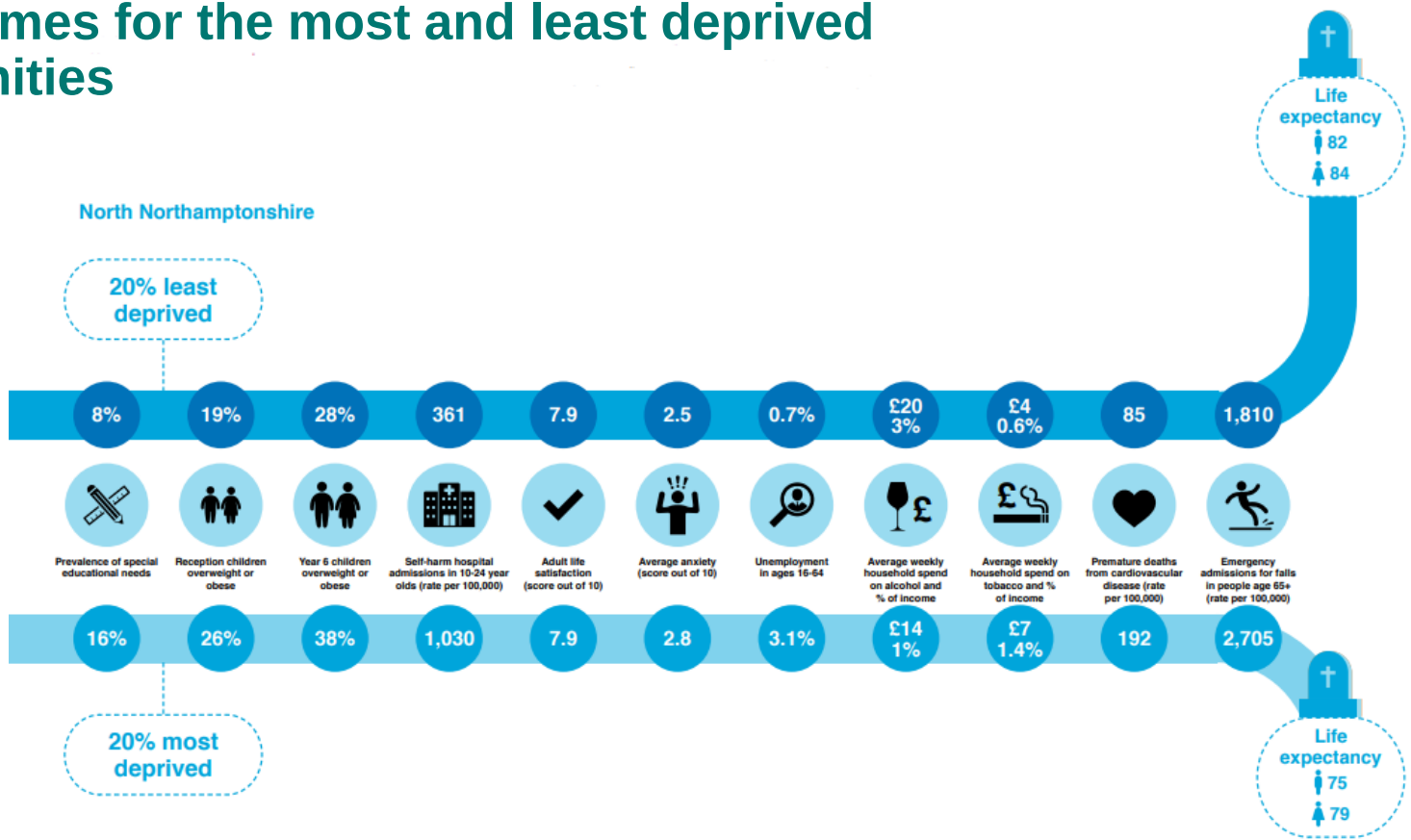




The uptake gradients against deprivation are steepest for vaccinations in children, for the vaccinations covered here.

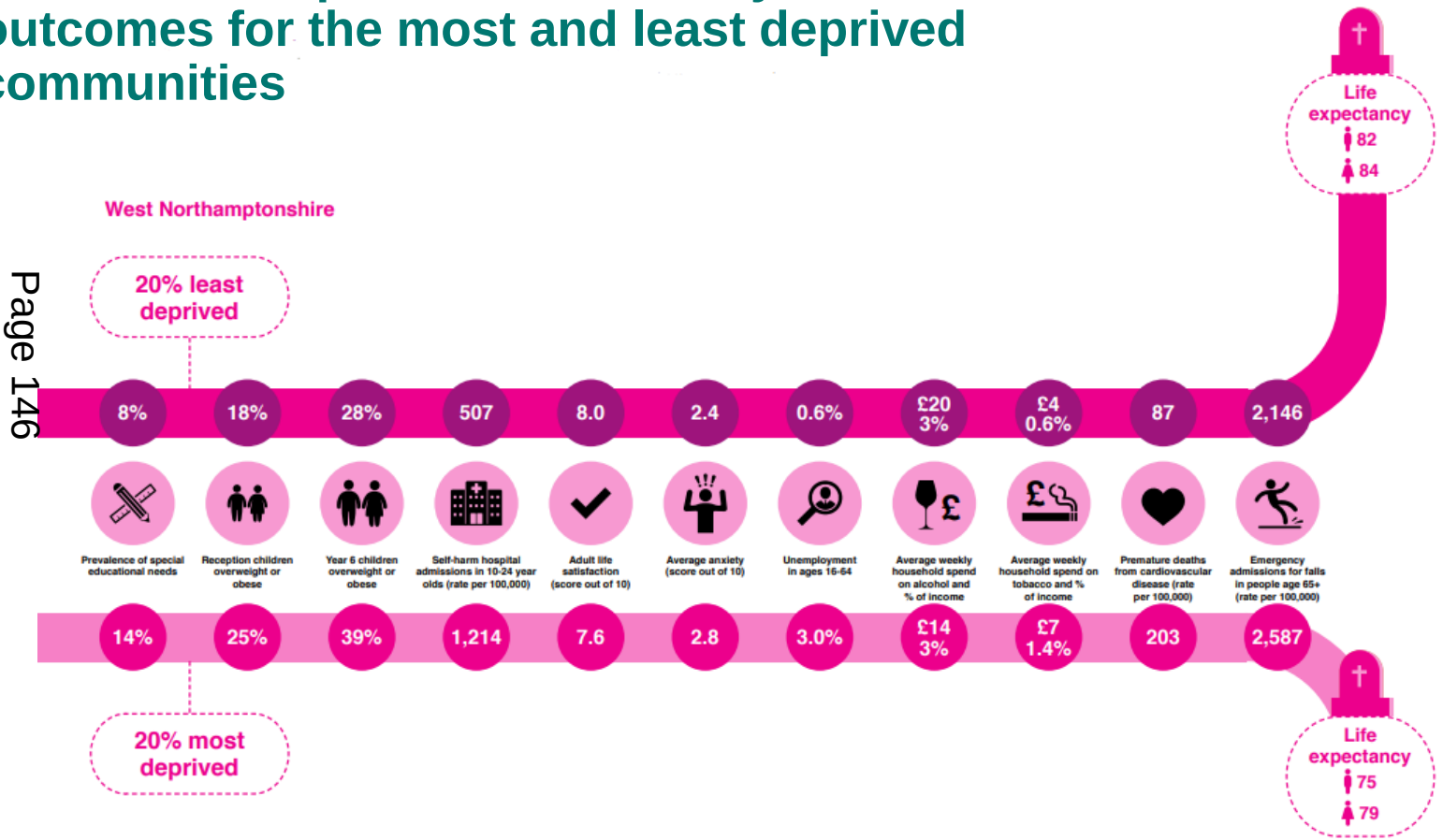
North Northamptonshire summary of the differences in outcomes for the most and least deprived communities

Northamptonshire Health and Care Partnership



Northamptonshire
Health and Care Partnership

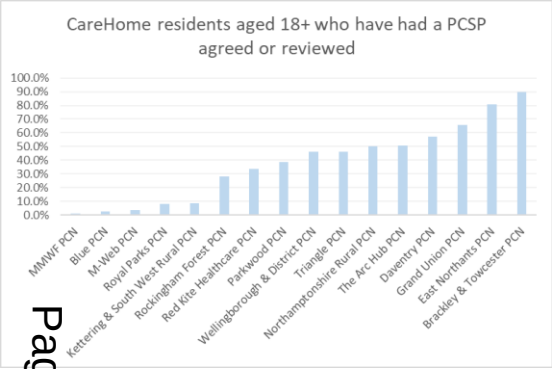
West Northamptonshire summary of the differences in outcomes for the most and least deprived communities



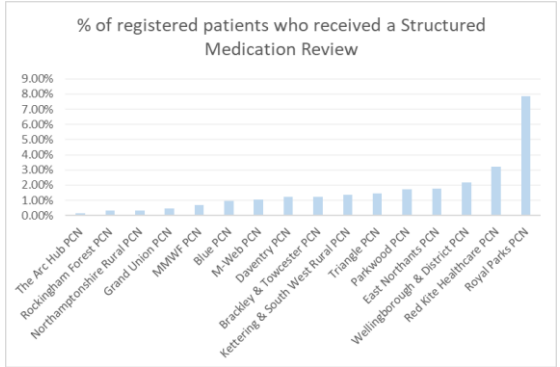
Other

Personalised Care Plans, Medication Reviews, Workforce, Digital exclusion

Variation in services



A PCSP is a 'Personalised Care Support Plan'. This is a collaborative approach to the care of people with Long Term Conditions, which involves the individual, carers and health professionals. It is a holistic approach which is based on what is important to the individual at present but also looks at preparing for deterioration or emergencies and for future care needs.



Structured Medication Reviews (SMRs) are a clinical intervention designed to help patients with long term conditions involving complex polypharmacy. They result in better physical and personal outcomes for patients who receive them.

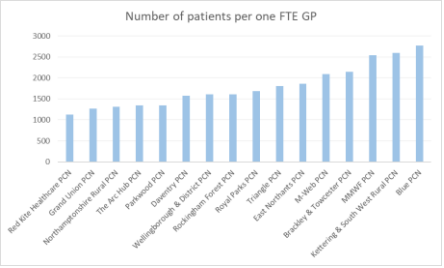
PCSPs and SMRs

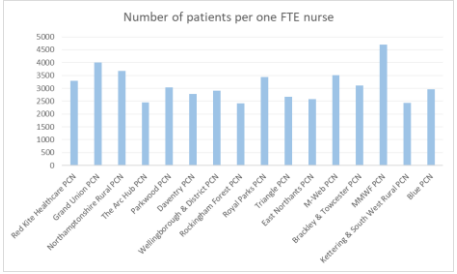
Personalised Care Support Plans and Structured Medication Reviews are two approaches which aim to improve the quality of care provided to individuals.

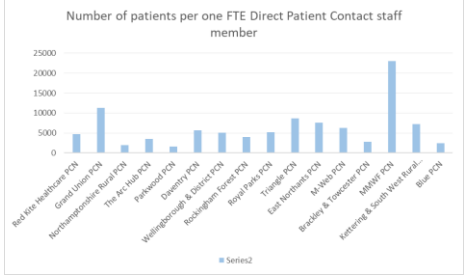
The level of need for these approaches will vary across PCNs. These level of provision will be influenced by the number and availability of staff in the Primary Care Workforce, to provide these services.

The graphs below illustrate the level of variation across PCNs in terms of GPs, nursing staff and other patient facing roles.

Primary Care Workforce across PCNs



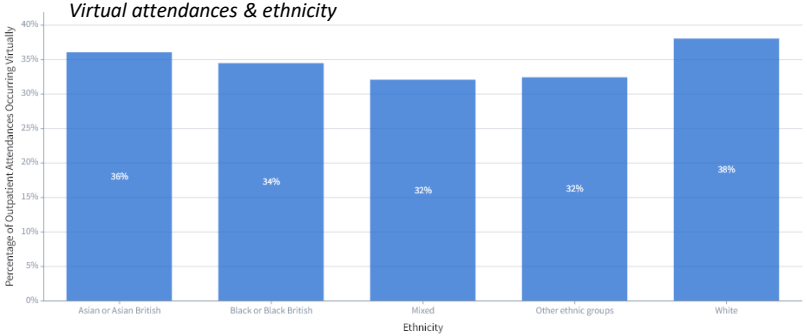




Digital Exclusion – Virtual Follow Up Outpatient Attendances

Northamptonshire Health and Care Partnership

Virtual attendances & ethnicity

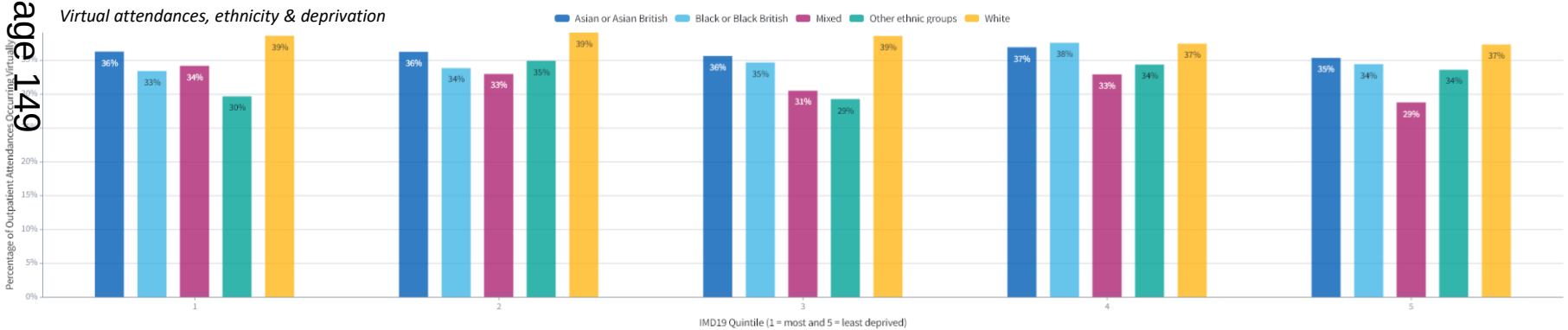


Where an increasing number of consultations are being carried out remotely, it is possible for some people to be disadvantaged by this. The graph on the left shows the percentage of outpatient attendances that have taken place remotely since March 2020, for broad ethnic groups.

The graph below shows the same data split by deprivation quintile. White groups in any deprivation quintile are more likely to have virtual consultations in outpatients.

For all ethnicities and levels of deprivation, the proportion of Outpatient Attendances taking place virtually, declines with age.

Virtual attendances, ethnicity & deprivation



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North Northamptonshire Council

Item no: 8

North Northamptonshire Health and Wellbeing Board

5th July 2022

Report Title	**Northamptonshire Integrated Care System (ICS)** **Further development of the architecture and function of the Integrated Care Partnership (ICP), Places, Communities and Local Area Partnerships**
Report Author	**David Watts Executive Director Adult Social Care, Communities and Wellbeing** **Ali Gilbert ICS Place Director North Northamptonshire Council**

List of Appendices

Appendix A Draft HWB terms of reference (in accordance with the Health and Care Act 2022)
Appendix B Draft Integrated Care Partnership (ICP) terms of reference
Appendix C North Place Development - the way forward

1. Purpose of Report

1.1.1 To describe the draft Health and Wellbeing Board Terms of Reference revised in line with the health and Care Act 2022 for the Integrated Care System (ICS) from the 1st July 2022.

1.1.2 To provide an update on the progression of the Northamptonshire Integrated Care System development of 'place' which was supported by the Northamptonshire shadow Integrated Care Partnership on 31st May 2022

1.1.3 To describe the proposed establishment of the North Northamptonshire Place Delivery Board to progress the mobilisation of the proposed North Place developments

2. Executive Summary

2.1 **Integrated Care System**

The Health and Care Act 2022 (the Act) sets out plans for the future of health and care, including the statutory creation of Integrated Care Systems. The Act also sets out Government plans to improve collaborative working, empower local leaders, address health inequalities, and focus on population health management.

The Act has now received Royal Assent and the new requirements arrangements will come into force on 1st July 2022. For North Northamptonshire, the Integrated Care System will exist at county (Northamptonshire) level. Reforms will mean changes to governance and decision making through the Integrated Care Board and Integrated Care Partnership both at county and place (North Northants) level; to locality leadership and to mechanisms to support enhanced provider collaboration.

This report updates on the preparatory work across Northamptonshire, and specifically on the detailed proposals emerging in North Northants. It sets out the decisions that will need to be taken by the full Council and the Health and Wellbeing Board, to ensure arrangements are fully reflected in the Council's Constitution.

3. Recommendations

3.1 It is recommended that the Board:

a) Review the North Health and Wellbeing Board Terms of Reference for the Integrated Care System from the 1st July 2022. These will then be put forward for consideration to the Democracy and Standards Committee on 11th July 2022 and then to full council for approval on 28th July 2022.

b) Note the progress of the Integrated Care Partnership North Place development since the North Place presentation to the HWB on 10th March 2022. This was endorsed at the Integrated Care Partnership Shadow Board on the 31st May 2022.

c) Support the proposed establishment of the North Northamptonshire Place Delivery Board to progress the mobilisation of the North place development.

3.2 Reason for Recommendations

The Act sets out new statutory responsibilities for the Health and Wellbeing Board and as the board is a statutory function of the local authority these changes need to be approved by full council as per North Northamptonshire's Council Constitution.

This provides an opportunity for the North Health and Wellbeing Board to review its membership in line with local North Northamptonshire requirements.

North Northamptonshire Council has a significant role in the development and delivery of the Integrated Care Partnership and this paper sets out the areas where the council has shaped key proposals in line with the legislation and guidance.

4. Report Background

4.1 Integrated Care System

In November 2020 NHS England and NHS Improvement published ***Integrating care: Next steps to building strong and effective integrated care systems across England***.

It described the core purpose of an **integrated care system (ICS)** being to:

- 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

Further National guidance published has established that the ICS development should be rooted in underlying principles of subsidiarity and collaboration. It described common features that every system is expected to have and develop, as the foundations for integrating care, with local flexibility in how best to design these to achieve consistent national standards and reduce inequalities, as:

- **decisions taken closer to, and in consultation with, the communities they affect are likely to lead to better outcomes**
- collaboration between partners**, both within a place and at scale,** is essential to address health inequalities, sustain joined-up, efficient and effective services and enhance productivity
- **local flexibility**, enabled by common digital capabilities and coordinated flows of data, will allow systems to identify the best way to improve the health and wellbeing of their populations.

The introduction of the Integrated Care System in Northamptonshire offers us an opportunity to work more closely with local areas and people to tackle wider determinant of health and health inequalities.

This will be done by working collaboratively in **local area partnerships** with all stakeholders that will focus on key priorities in local areas. This will reflect the ambitions that we have for people living in North Northamptonshire.

4.2 Health and Wellbeing Boards

Health and wellbeing boards are a formal committee of the local authority charged with promoting greater integration and partnership between bodies from the NHS, public health, and local government. They have a statutory duty, with clinical commissioning groups (CCGs), to produce a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

The boards currently have very limited formal powers. They are constituted as a partnership forum rather than an executive decision-making body.

Under the Act , the Health and Wellbeing Board has some additional responsibilities and duties which are as follows: -

- To review the Integrated Care Board (ICB) 5 Year Plan to ensure it takes proper account of the Joint Health and Wellbeing Strategy.
- To review the ICB Joint Capital Resource Plan
- To consult with the ICB for the ICB Annual Report on performance of any steps taken by the ICB to implement the Joint Health and Wellbeing Strategy.

The ICB and ICP will also have to work closely with local Health and Wellbeing Boards (HWBs) as they have the experience as 'place-based' planners, and the ICB will be required to have regard to the Joint Strategic Needs Assessments and Joint Local Health and Wellbeing Strategies (JHWS) produced by HWBs.

Appendix A reflects the proposed changes to the Terms of Reference for the North Northamptonshire Health and Wellbeing Board which have been made in accordance with the Act. These will then be put forward for consideration to the Democracy and Standards Committee on 11th July 2022 and then to full council for approval on 28th July 2022.

4.3 Integrated Care Partnership (ICP)

Integrated Care Partnerships' (ICP) central role is in the planning and improvement of health and care. They support placed based partnerships and coalitions with community partners which are well situated to act on the wider determinants of health in local areas. ICP's should bring the statutory and non-statutory interests of places together.

Integrated Care Partnerships are responsible for: -

- Developing an **integrated care strategy** to address the broad health and social care needs of the population within the ICP area, including determinants of health such as employment, environment, and housing issues. ICB's and local authorities will be required by law to have regard to the ICP's strategy when making decisions, commissioning services and delivery
- Highlighting where coordination is needed on health and care issues and challenge partners to deliver the action required
  These include as examples: -

  - Taking a holistic view of people's interactions with services across the system and the different pathways in it
  - Helping people live more independent, healthier lives for longer
  - addressing inequalities in health and wellbeing outcomes, experiences, and access to services
  - improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
  - improving the life chances and health outcomes of babies, children, and young people
  - improving people's overall wellbeing and preventing ill health.

The Integrated Care Partnership will be made up from the membership of the two Northamptonshire Health and Wellbeing Boards (North and West) and the ICB Board. The Board will meet twice per year, to consider progress against Northamptonshire's Outcomes Framework over the past year, and (ii) agree a systemwide health and care strategy (or an update to the existing strategy, as appropriate) to improve population outcomes. This then forms the key mandate for the ICB, our Places and our Collaboratives.

After consultation with key system leads it has been agreed that there will be a tripartite chairing arrangement. The chairs of the Integrated Care Partnership will be:

- The Chair of the ICB
- The Chair of the West Health and Wellbeing Board
- Executive member for Adults, Health and Wellbeing for North Northamptonshire Council

A plan for the development of the Integrated Care Strategy has been developed with support. This work will ensure that the board owns and develops a Health and Wellbeing Strategy for North Northants that will underpin the Integrated Care Strategy, focused on its inequalities, health challenges and solutions and that drives local service design. This is a key requirement of the ICP and will influence the ICB's 5-year commissioning plan.

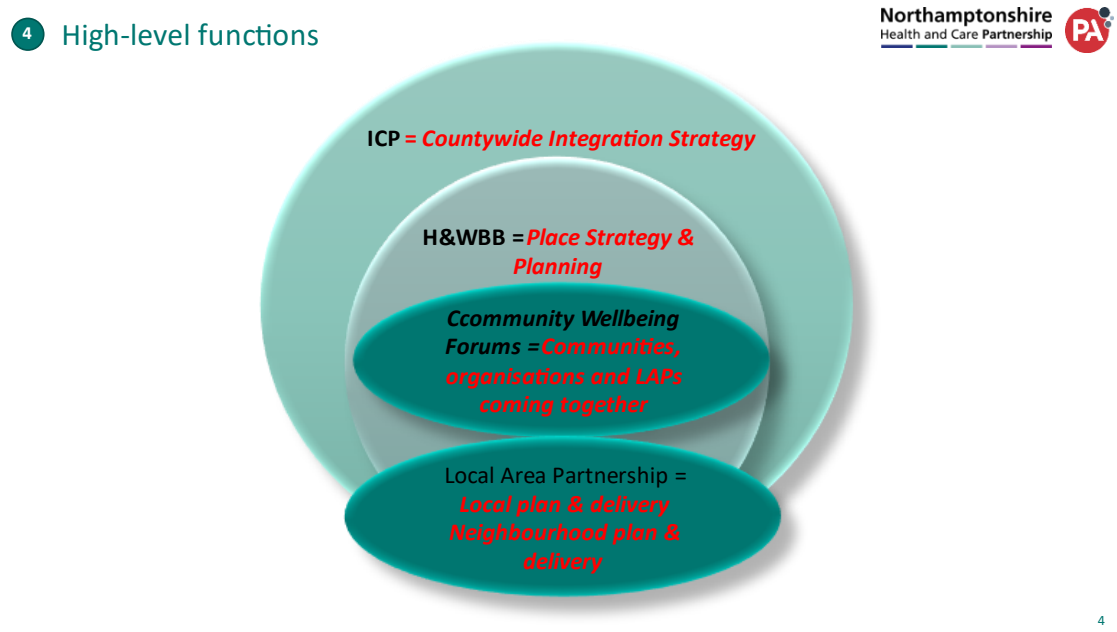
Appendix B reflects the ICP draft terms of reference for comment and finalisation as agreed in the shadow ICP on May 31st, 2022.

4.4 North Place development

Appendix C outlines the North and West Place development proposal supported by the shadow ICP on May 31st, 2022.

As a system we are also undertaking the **Place Development Programme** funded by NHSE which is supporting with the development of the ICP and the North and West Place visions, governance, and population health management approaches.

The following diagram reflects the high-level functional responsibilities of the emerging North place development.



For the North place this shows the forums that align with the North Health and Wellbeing Board and Integrated Care Partnership including **4 Community Wellbeing Forums** which will oversee **8 local area partnerships (LAPS)**.

The 4 community wellbeing forums mirror the existing health and wellbeing forum footprints across Corby, Kettering, Wellingborough, and East Northants and will be responsible for:

- bringing together the people of the communities, organisations, and LAPs together
- providing partnership action to unblock challenges that the LAP's identify that they are unable to tackle
- ensuring that the LAP plans deliver against key priorities determined by local insight data and broader intelligence from the communities.
- where appropriate identify and ensure that "at scale" solutions may be more appropriate across LAP's
- form links and partnerships with other local forums to enable an efficient and effective approach to cross-boundary issues

The terms of reference, functions and membership of the Community Wellbeing Forums and LAPs are currently being developed as part of wider stakeholder engagement.

The North Northamptonshire General Practices locality boards have already agreed to change from 2 localities to 4 localities to mirror the emerging 4 community wellbeing forums.

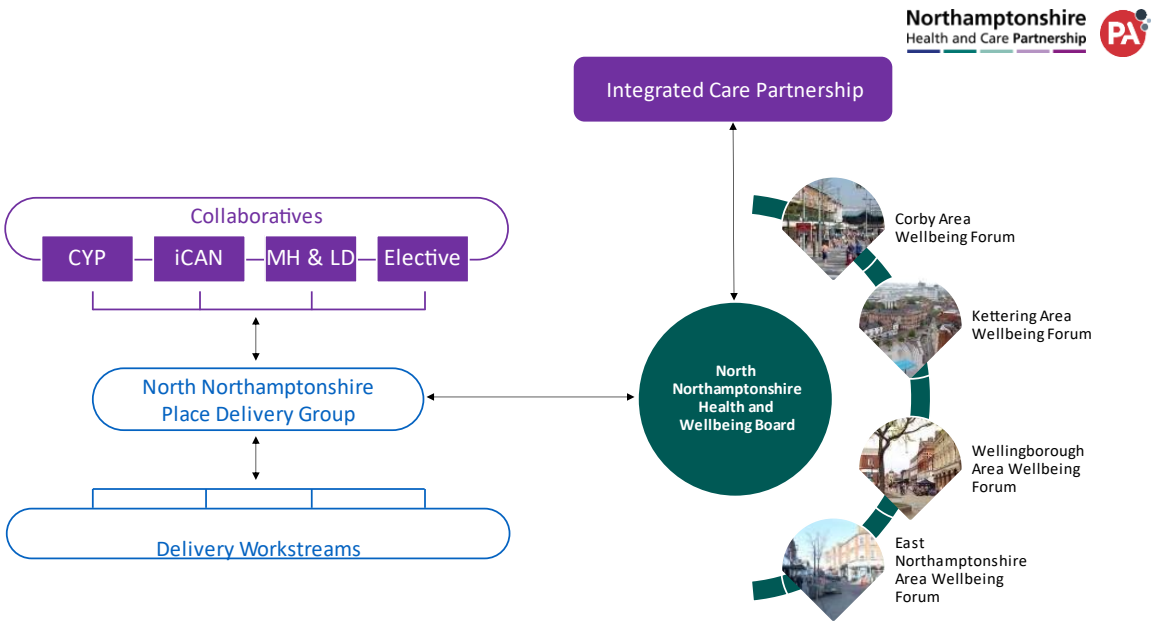
North Place Delivery Board

To progress and implement the North Place development as outlined, it is proposed that a transitional North Place Delivery Board is established, chaired by the ICS Place Director for North Northamptonshire Council. This will oversee the development of the delivery plan and mobilisation of the plan over the next 6 months. This will then be reviewed in line with the progress made at that point.

The board membership will reflect the organisational and community representation of the North HWB ensuring that the membership will include leaders with delegated decision-making authority and have an operational and delivery expertise and responsibility. Additional local place experts will be included where appropriate.

The function of the North Place Delivery Board proposed includes:

- further refinement of the North place shared vision, ambitions, and objectives based on the output of the National place development programme underway
- development of the North place delivery plan
- mobilisation of the North place delivery plan
- further development of the engagement, coproduction with partners and our community activation
- agreeing the population groups and development of the appropriate functions of the community wellbeing forums and LAP's
- supporting the response of the PCN's to the Fuller report and their alignment with the LAPs
- implementation of the insight data tool presented to the ICP on May 31st 2022
- development of data intelligence infrastructure to support prioritisation and decision making
- exploration of North Place transformational commissioning development opportunities e.g. IBCF
- supporting the delivery of the ICS collaboratives where appropriate at place
- utilising of estate enablers to support the developments
- ensuring that the governance framework is simple, functional and enables the development and functioning of the LAP's
- oversees the emergent voluntary sector infrastructure proposals



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5. Issues and Choices

5.1 The ICS and its requirements are requirements under the legislation laid out in the Act and therefore health and social care bodies are required to have in place the specified governance arrangements for 1st July 2022.

5.2 The structure of the North place has been developed in consultation with a wide variety of stakeholders and we have taken these views into consideration as part of the final proposal.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 There are currently no identified financial implications.

6.1.2 Staffing resources to facilitate the development of North Place is being managed through existing resources

6.2 Legal

To give effect to the requirements of the Act a number of changes will need to be made to the Council's existing governance arrangements, some of these are a necessary consequence of statute and can be made immediately under the Monitoring Officers powers to amend the Constitution to give effect to changes in the law. Any changes to the Constitution will be reported to the next meeting of Council after the change is made.

6.3 Risk

There are no formal identified risks currently.

6.4 Consultation

Consultation in accordance with the developing ICB communication framework will continue as the ICS and its structures develop. To date we have consulted with all key stakeholders. These include: -

- Elected members
- GPs
- Health Partners
- VCSE

- Police
- Northamptonshire Children's Trusts
- Health and Wellbeing forums

Communications will play a key role in informing and engaging the public around the creation of the new ICS and explaining the objectives, priorities to our local communities and how these will translate into future improved outcomes to meet their health and care needs. NNC is working closely with its partners on developing the communications framework for these future activities.

6.5 Consideration by Scrutiny

The North place development has been considered, progress noted and supported by the North Scrutiny Commission on 17th May 2022.

6.6 Climate Impact

There is currently no identified climate or environmental implications.

6.7 Community Impact

The ICS will create positive impacts on communities, wellbeing and on our ability to collectively support better outcomes for residents. Key priorities at a local level underpinned by insight data and led by Local Area Partnerships will drive the delivery of services that meet the wider determinants of health supporting people to live their best life in North Northamptonshire.

7. Background Papers

None

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North Northamptonshire Council

Item no: 9

NORTH NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

5th July 2022

Report Title	**Northamptonshire Joint Health Protection Plan 2022 - 24**
Report Author	**Chloe Gay, Public Health Principle – Health Improvement**

Contributors/Checkers/Approvers		
Other Director/SME	John Ashton, Director of Public Health, North Northants	25/5/22

List of Appendices

Appendix A – Northamptonshire Joint Health Protection Plan 2022 - 2024

1. Purpose of Report

1.1. To NOTE the Northamptonshire Joint Health Protection Plan 2022 – 2024

2. Executive Summary

This report provides a summary of the health protection annual report and the strategic priorities as set out in the Northamptonshire Joint Health Protection Plan 2022 - 24

3. Recommendations

To NOTE the Northamptonshire Joint Health Protection Plan 2022 – 2024

4. Report Background

4.1 Health protection involves planning, surveillance and response to outbreaks and incidents; it prevents and reduces the harm caused by communicable diseases and mitigates the impact on health from environmental hazards such as chemicals and radiation. Health protection also involves the delivery of major programmes such as national immunisation programmes and the provision of health services to diagnose and treat infectious diseases.

4.2 The local authority should have effective health protection arrangements with local organisations; this includes producing plans to prevent infectious diseases, as well as joint

approaches for responding to incidents and outbreaks, agreed locally with partners (including PHE and NHS England). Local arrangements should be revised and updated for the new system, as per regulation 8(7) of section 6C

4.3 The Joint Health Protection Plan 2019-21 set out the health protection strategic priorities for Northamptonshire alongside an action plan. It also set out the roles and responsibilities of local organisations to support achievement of these.

4.4 The annual health protection report looked at progress against those priorities and recommended the priorities for 2022 – 24, which have been developed into the Joint Health Protection Plan 2022-24. This was ratified by the Health Protection Committee on 19 May 2022.

5. Issues and Choices

5.1 The health protection annual report looks at progress and challenges for each of the strategic priorities.

5.2 The time-period covered is two years, 1 April 2019 to 31 March 2021, as an annual report was not completed in 2020 due to COVID-19. Below is a summary of the achievements and challenges and recommendations.

5.3 COVID-19 was a significant health protection issue that impacted on other priority areas. The COVID-19 response is covered in the Director of Public Health Annual Report, so is not covered in depth here.

5.4 Achievements:

Immunisations:

Coverage of some childhood vaccinations increased including flu vaccination in school age children. Coverage of adult vaccinations including pneumococcal and flu in people with long term conditions and in people ages 65 and above, also exceeded the target of 75%.

Screening:

Cancer screening uptake for bowel and breast cancers show improvement and were above the national average in 2020. Non-Cancer screening, including AAA, showed improvement with coverage above regional and national averages in 2019/20. Antenatal and Newborn screening were also reported to be higher than the national average in 2020/21.

Infectious Disease:

Tuberculosis (TB):

TB incidence rate was lower than regional and national averages in 2018/20

Blood borne viruses (BBV):

There is an improvement in new HIV diagnosis rate, our testing coverage was above regional and national averages in 2020. Hepatitis C detection rate was lower compared to national average in 2017 and our percentage uptake of Hepatitis C testing in persons in drug misuse treatment who inject drugs is above national averages.

Healthcare Acquired Infections (HCAI)
Infection rates for HCAI including Methicillin Sensitive Staphylococcus Aureus (MSSA), Methicillin Resistant Staphylococcus Aureus (MRSA) Clostridium Deficile (C. Dif) and E. coli have decreased in comparison to previous year for both NGH and KGH and are below the national average.

Other Infectious diseases:
Measles, Campylobacter and Shigella infections were also reported to be lower than the national average.

Environmental Health:
Fuel poverty was below regional and national averages in 2018

5.5 Challenges

Immunisations:
In children, coverage of preschool vaccination, flu in 2- and 3-year-olds and Human Papilloma Virus (HPV) vaccination in 12–13 year-olds have decreased and are below national average. Flu vaccination in pregnant women was lower than national average and did not meet its target.

Screening:
Cervical cancer screening coverage in women aged 20-49 and 50-64 did not meet the target in 2020/21. In non-cancer screening, coverage of infectious disease screen, Sickle cell and Thalassaemia screen and blood spot screen have decreased. Uptake of Diabetic Eye screening was also lower than the national average.

Tuberculosis (TB):
The proportion of TB cases starting treatment within four months of symptom onset was lower than national average in 2019, as well as the proportion of TB cases offered a HIV test was lower than England average in 2019.

Blood borne viruses (BBV):
Percentage of HIV late diagnosis was higher compared to national average.

Other Infectious Disease
Non-typhoidal Salmonella as well as Typhoid & Paratyphoid incidence rates including Giardia and Cryptosporidium incidence rates were above national average.

Environmental Health:
The fraction of mortality attributable to particulate air pollution was above regional and national averages in 2019.

5.6 As we recover from COVID-19 in Northamptonshire the recovery transition project will ensure that we build a health protection team fit for the future to become more proactive and ensure that we have a strong health protection function across Northamptonshire. The priorities will be to address some of the challenges that resulted directly and indirectly from COVID-19, building back the health protection programmes.

5.7 Based on the findings of the annual report, the strategic health protection priorities for the Health Protection Committee area (Northamptonshire) for the period 1 April 2022 until 31 March 2024 are outlined as follows:

5.7.1 Strategic Priority 1: Immunisation
Ensure the delivery of childhood and adult immunisation programmes in accordance with national and local targets.

5.7.2 Strategic Priority 2: Screening
Ensure the delivery of cancer and non-cancer screenings in accordance with national and local targets.

5.7.3 Strategic Priority 3: Infection Prevention and Control
Ensure infection prevention and control arrangements within organisations delivering health and social care services, and other high-risk settings, to support a reduction in the number of healthcare acquired infections and other Notifiable infections, including COVID-19.

5.7.4 Strategic Priority 4: Tuberculosis
Ensure the local implementation of the recommendations of the national TB Strategy and NICE 2016.

5.7.5 Strategic Priority 5: Blood Borne Virus
Ensure that local service provision is in line with the national strategies for HIV, Hepatitis B and Hepatitis C.

5.7.6 Strategic Priority 6: Outbreak Management
Ensure effective outbreak planning and response arrangements are in place within NHS and non-NHS partner organisations including Environmental Health teams. To ensure the coordinated delivery of the COVID-19 outbreak plan and pandemic response and recovery phase.

5.7.7 Strategic Priority 7: Environmental Health
Ensure measures are in place to identify, manage and mitigate environmental health hazards including elevated levels of air pollution and environmental noise.

5.7.8 Strategic Priority 8: Training and Campaigns
Ensure appropriate training and learning opportunities are available to educate professionals and the public in relation to health protection priorities.

5.7.9 Strategic Priority 9: Addressing Health Inequalities
Ensure that in each of the Health Protection priorities health inequalities and inequities are understood and plans are developed to address them, engaging with communities to understand their needs and coproduce solutions.

6. Implications (including financial implications)

6.1 **Resources and Financial**

There are no resources or financial implications arising from the proposals.

6.2 **Legal**

There are no legal implications arising from the proposals.

6.3 **Risk**

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

6.4 **Consultation**

6.4.1 The Members of the Health Protection Committee have been engaged with to inform the annual report and agree the Joint Health Protection Plan 2022 – 24.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 Not applicable

6.6 **Climate Impact**

6.6.1 Not applicable

6.7 **Community Impact**

6.7.1 Not applicable

7. Background Papers

Appendix A – Northamptonshire Joint Health Protection Plan 2022 - 2024

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Joint Health Protection Plan

Northamptonshire

2022 - 2024

Author: Chloe Gay

On behalf of the Public Health Team

Contribution from	Dr Annapurna Sen Environmental Health CGL, Drug and Alcohol service provider NHS Northamptonshire
In consultation with	Regional Partnership Teams (RPTs) led by UKHSA Office for Health Improvement and Disparities (OHID), DHSC Northampton and Kettering Hospital NHS Trusts Northamptonshire Community NHS Trusts NHS England (Midland and East) Environmental Health North and West Northamptonshire Councils Northamptonshire Health Resilience partnership Northamptonshire Local Resilience Forum

1. Glossary

Vaccines	Diseases protected against
DTaP/IPV/Hib/HepB	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B
MenB	Meningococcal group B (MenB)
Rotavirus Rotarix	Rotavirus gastroenteritis
PCV	Pneumococcal (13 serotypes)
Hib/MenC	Hib and Meningitis C
MMR	Measles, mumps and rubella (German measles)
dTaP/IPV	Diphtheria, tetanus, pertussis and polio
HPV	Cancers and genital warts caused by specific human papillomavirus
Td/IPV	Tetanus, diphtheria and polio
MenACWY	Meningococcal groups A, C, W and Y
PPV	Pneumococcal (23 serotypes)

2. Introduction

2.1 Background

Health protection involves planning, surveillance and response to outbreaks and incidents; it prevents and reduces the harm caused by communicable diseases and mitigates the impact on health from environmental hazards such as chemicals and radiation. Health protection also involves the delivery of major programmes such as national immunisation programmes and the provision of health services to diagnose and treat infectious diseases.

The Local Authorities Regulations (2013) states that the Director of Public Health (DPH) is responsible for the local authority's contribution to health protection matters, including its role in planning for, and responding to, incidents that present a threat to the health of the public. UK Health Security Agency (UKHSA) has the responsibility to deliver a specialist health protection response, including the response to incidents and outbreaks. These roles are complementary and both are required to ensure an effective response. In practice, local authorities and UKHSA will work closely together as a single public health system through joint working, with clarity on roles and responsibilities, which is crucial for the safe delivery of health protection. The DsPH will work with local partners to ensure that threats to health are understood and appropriately addressed.

The NHS will continue to be an important partner in planning and securing the health services required to protect health, and in mobilising NHS resources needed in the response to incidents and outbreaks. NHS England (NHSE) and the Clinical Commissioning Group (CCG) (which will be replaced by then Integrated Care Board from 1 July 2022) have a duty to cooperate with local authorities under the NHS Act (2006). Effective planning is essential in order to limit the impact on health when hazards cannot be prevented (NHS Act 2006), and the DsPH, on behalf of the local authorities, should be assured that the arrangements to

protect the health of the community it serves are robust and implemented appropriately so as to meet local needs. The DsPH also have the opportunity to escalate concerns, as necessary, and should expect a highly responsive service from UKHSA, NHS England and other partners in this respect.

The local authority has a local leadership function and relies on the skills of the DsPH and the Public Health teams working across Northamptonshire. The local leadership of the DsPH is critical in ensuring that the local authorities and their partners are implementing preventative strategies to tackle the key threats identified locally. To deliver effective planning and response arrangements at the local level, there needs to be constructive and collaborative working relationships between the partner agencies. There should also be a shared understanding regarding communications about health protection concerns. UKHSA will keep the DsPH informed about health protection issues and the actions being taken to resolve them; it will provide local authorities with information, evidence and examples of best practice via the DsPH, who should have a clear plan of engagement at the local level.

The local authorities should have effective health protection arrangements with local organisations; this includes producing plans to prevent infectious diseases, as well as joint approaches for responding to incidents and outbreaks, agreed locally with partners (including UKHSA and NHS England). Local arrangements should be revised and updated for the new system, as per regulation 8(7) of section 6C, which has been set out to include:

- Clearly defined roles and responsibilities of partners, including operational arrangements for releasing clinical resources, with contact details of a responsible officer and deputy for each organisation
- Local agreement on arrangements for a 24/7 on-call rota of qualified personnel to discharge the functions of each organisation
- Clear responsibilities in an outbreak or incident
- Information sharing arrangements to ensure that the DPH, PHE and the NHS emergency leads are informed of all outbreaks and incidents
- Arrangements for managing cross-border outbreaks and incidents
- Arrangements for exercising, testing and peer review
- Arrangements for the stockpiling of essential medicines and supplies, as appropriate
- Escalation procedures and arrangements for setting up an Outbreak Control Team (OCT)
- Schedules for the regular (annual/biennial) review of arrangements

2.2 Purpose

This document has been produced for Northamptonshire in collaboration with local health organisations and the North and West Northamptonshire Councils.

It has been written with the aim of supporting the new arrangements for an integrated system that delivers effective protection for the population based on:

- A clear line of sight from the top to the frontline
- Clear accountabilities
- Collaboration and coordination at every level of the system
- Robust, locally sensitive arrangements for planning and response

Please note that this document is not intended as an exhaustive guide to infectious diseases and emergency preparedness and response and should be read in conjunction with the relevant plans and procedures.

2.3 Document Maintenance

This document will be reviewed annually and refreshed every two years by the Public Health Teams in Northamptonshire, in consultation with regional and local partner organisations.

3 Health Protection Strategic Priorities

3.1 Strategic Priorities 2022-24

The strategic health protection priorities for the Health Protection Committee area (Northamptonshire) for the period 1 April 2022 until 31 March 2024 are outlined as follows:

- **Strategic Priority 1: Immunisation**
  Ensure the delivery of childhood and adult immunisation programmes in accordance with national and local targets.

- **Strategic Priority 2: Screening**
  Ensure the delivery of cancer and non-cancer screenings in accordance with national and local targets.

- **Strategic Priority 3: Infection Prevention and Control**
  Ensure infection prevention and control arrangements within organisations delivering health and social care services, and other high-risk settings, to support a reduction in the number of healthcare acquired infections and other Notifiable infections, including COVID-19.

- **Strategic Priority 4: Tuberculosis**
  Ensure the local implementation of the recommendations of the national TB Strategy and NICE 2016.

- **Strategic Priority 5: Blood Borne Virus**
  Ensure that local service provision is in line with the national strategies for HIV, Hepatitis B and Hepatitis C.

- **Strategic Priority 6: Outbreak Management**
  Ensure effective outbreak planning and response arrangements are in place within NHS and non-NHS partner organisations including Environmental Health teams.
  To ensure the coordinated delivery of the COVID-19 outbreak plan and pandemic response and recovery phase.

- **Strategic Priority 7: Environmental Health**
  Ensure measures are in place to identify, manage and mitigate environmental health hazards including elevated levels of air pollution and environmental noise.

- **Strategic Priority 8: Training and Campaigns**
  Ensure appropriate training and learning opportunities are available to educate professionals and the public in relation to health protection priorities.

- **Strategic Priority 9: Addressing Health Inequalities**
  Ensure that in each of the Health Protection priorities health inequalities and inequities are understood and plans are developed to address them, engaging with communities to understand their needs and coproduce solutions.

3.2 Work Delivery

The strategic priorities for health protection will be delivered by the relevant organisations (as outlined in Table 1 below), and assurance will be sought by the Health Protection Committee that appropriate arrangements are in place to protect population health.

For further information on the Health Protection Committee, see the Terms of Reference in Appendix 1.

Table 1: Health Protection Work Delivery Programme (2022-24)

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 1 – Immunisation			
SP1 (1)	Provision of support to organisations to ensure uptake of all childhood immunisations is maintained	National aspiration/targets are met/improvement in uptake achieved	NHSE NHFT child Health service provider Northamptonshire CCG
SP1 (2)	Improve uptake of MMR vaccinations Provision of support to implement UK Measles and Rubella elimination strategy 2019	Improved uptake MMR to reach the national aspirational target of 95%	NHSE NHFT School Health service provider Primary care
SP1 (3)	Improve seasonal flu vaccination uptake in: • At Risk people aged below 65 • Improve uptake in carers • Pregnant women	Improved flu vaccination uptake to meet national target of 75% Improved flu vaccination uptake to meet national target of 75%	NHS England Primary Care NNC and WNC Adult Social Care
SP1 (4)	Maintain adolescence vaccine uptake, which includes HPV and MenACWY	Adolescence vaccine uptake is maintained as per the national aspiration	NHS England NHFT School Health service provider
SP1 (5)	Increase uptake of the flu vaccination in preschool and school aged children (2 – 11-year-olds) and continuing to raise awareness of the flu vaccine to parents of children	Achieve expected target, as specified in the national flu plan	NHS England NHFT School Health service provider
SP (6)	Improve adult pneumococcal vaccination uptake specially in 65 and above	Achieve maximum expected average of 75% (Range 65-75%)	Northamptonshire CCG and Primary Care Providers
SP (7)	Improve Shingles vaccination in cohort of age 70 years	Achieve minimum expected average of 50% (national aspiration -50%-60%)	Northamptonshire CCG Primary Care Providers NHS England

SP (8)	Improve update of preschool boosters and address inequalities in uptake	Achieve expected target	NHSE NHFT child Health service provider Northamptonshire CCG Primary Care
SP (9)	Improve the uptake of the COVID vaccination programme across all groups	Achieve maximum expected targets for all groups	Northamptonshire CCG Primary Care Providers Pharmacy Providers Public Health Teams
SP (10)	Ensure that inequities in vaccination uptake is investigated and actions put in place to address these	Reduce inequities in uptake of vaccinations	Northamptonshire CCG Primary Care Providers Pharmacy Providers NHFT school service NHSE NHFT child Health service provider Public Health Teams

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 2 – Screening			
SP2 (1)	Maintain coverage of Ante natal and new-born screening programme	Both hospital providers and both CCGs to ensure that coverage meets national target in all screening indicators	NHS England Local Screening Programme Board Primary Care NGH and KGH maternity and Hepatology, child health and audiometry services
SP2 (2)	Increase cervical cancer screening uptake for those aged 25-49 and 50-64 years old	Increased cervical cancer screening uptake to meet the national target of 80%	NHS England Local Screening Programme Board

			Primary Care
SP2 (3)	Maintain coverage of bowel cancer screening	Consistent bowel cancer screening uptake to meet the target of 52% in all GP Practices	NHS England Local Screening Programme Board Primary Care
SP2 (4)	Address breast cancer screening coverage in order to meet the national aspirational target of 70% in all GP Practices	All GP Practices to meet the national aspirational 70%target	NHS England Local Screening Programme Board
SP2 (5)	Increase annual abdominal aortic aneurysm (AAA) screening coverage	Increase AAA screening coverage to meet the target of 100%	NHS England Local Screening Programme Board
SP2 (5)	Increase Diabetic Eye screening coverage and address practice variation in uptake	Increase consistent DES screening coverage to meet the target of 70%	NHS England Local Screening Programme Board
SP2 (6)	Supporting the health system to reduce inequalities in screening and implement PHE Screening inequalities strategy	Maintain consistent uptake of screenings in all quintiles of deprivation	NHS England Northamptonshire Health Inequalities Group Northamptonshire CCG Public Health Teams

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 3 - Infection Prevention and Control			
SP3 (1)	Local health and social care providers (NHS and non-NHS organisations) to ensure that appropriate action is taken to maintain the given trajectory ceilings for C.Dif.	Given trajectory ceilings for C.Dif maintained by providers	Northamptonshire Whole Health Economy Group NGH and KGH Acute Trusts Northamptonshire CCG WNC and NNC Adult Social Care Community Service Providers
SP3 (2)	Maintain MRSA zero tolerance in health and social care settings	Zero tolerance and reduced infection rates of MRSA in health and social care settings	Northamptonshire Whole Health Economy Group Northamptonshire CCG NGH and KGH Acute Trusts WNC and NNC Adult Social Care Community Service Providers
SP3 (3)	Ensure processes are in place to reduce MSSA and E.coli in health and social care settings	Reduced number of MSSA and E.coli in health and social care settings than in previous years	Northamptonshire Whole Health Economy Group Northamptonshire CCG CCG Medicine Management Teams NGH and KGH Acute Trusts NNC and WNC Adult Social Care Community Service Providers
SP3 (4)	Antimicrobial resistance and antibiotic prescribing	i) Reduce number of antibiotic prescription in primary care ii) Reduce proportion of e coli samples resistant to various antibiotics (AMR local indicators antimicrobial resistance)	Northamptonshire Whole Health Economy Group Primary Care CCG Medicines Management

		iii) Improve number of antimicrobial guardians	
SP3 (5)	Local health and social care providers (NHS and non-NHS organisations) to ensure that appropriate action is taken to manage and reduce COVID-19 infections	Reduction in COVID-19 infections.	Northamptonshire Whole Health Economy Group NGH and KGH Acute Trusts Northamptonshire CCG NNC and WNC Adult Social Care Community Service Providers
SP3 (6)	Proactive work with food businesses to reduce risk of infection through good food hygiene practice and effective investigation of any outbreaks that occur	To reduce cases of foodborne infection	Environmental Health teams

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 4 – Tuberculosis			
SP4 (1)	Appraise options of delivery of Latent TB infection screening programme through alternate model of delivery	Implementation of Latent TB screening programme (retrospective) through two hubs across the county	UKSHA EM Northamptonshire CCG Northamptonshire TB Services (NHFT) NGH and KGH
SP4 (2)	Review of local TB service provision and Contractual arrangements with CCG to ensure the implementation of the recommendations from the national TB Strategy 2021	Local implementation of the recommendations from the national TB Strategy updated in 2021	UKSHA (East Midland Centre) Northamptonshire CCG Northamptonshire TB Services (NHFT)

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 5 - Blood Borne Virus (BBV)			
SP5 (1)	Ensure local service provisions of Hepatitis B and C have more coordinated pathways of care from initial diagnosis to specialist care and treatment, and maintain coordinated pathway of care of HIV for high-risk homeless population	A coordinated pathway of care for people with Hepatitis B and C resulting in better management of complications and a gradual reduction in the number of new cases in Homeless population	NHS Hepatitis C ODN Sexual Health Services CGL Drug and Alcohol Service NGH/KGH Hepatology Public Health Teams UKHSA
SP5 (2)	Implement BBV screening in new registrants in Northamptonshire in high-risk population aimed at reducing incidences of Hepatitis C	Provision of routine BBV testing for new registrants in Northamptonshire	Hepatitis C ODN CGL Drug and Alcohol Service Sexual Health Services Hepatology services-NGH/KGH Public Health Teams
SP5 (3)	Develop a strategy to address the late diagnosis for HIV rate, including increasing access to HIV testing.	Improved care pathway with early diagnosis and treatment	Sexual Health Services CGL Drug and Alcohol Services Acutes Primary Care Public Health Teams
SP5 (4)	Ensure adequate training for healthcare workers and other key workers, and the development of a robust data system to improve the quality of services	Provision of training to healthcare workers and other key workers to ensure core competencies in relation to blood borne viruses, and the implementation of a robust data system to improve the quality of services	Hepatitis C ODN UKHSA

SP5 (5)	Ensure that health inequalities are understood and plans are developed address any inequities in access or outcomes.	Reduced inequalities in access, uptake and outcomes.	Sexual Health Services CGL Drug and Alcohol Services Acutes Primary Care Public Health Teams

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 6 - Outbreak Management			
SP6 (1)	Deliver outbreak management roles and responsibilities formalised in a MoU and agreed by all organisations with a role in outbreak management	Delivery of Outbreak Management MoU to ensure a clear and coordinated multi-agency approach to outbreak management within Northamptonshire	UKHSA Public Health Teams Emergency Planning LHRP Environmental Health Teams
SP6 (2)	Ensure effective plans, procedures and policies in relation to outbreak management are in place and maintained	Effective and efficient response to an outbreak by individual organisations with a role in outbreak management	All HPC members All LHRP partners
SP6 (3)	Implementation of learnings from lessons or issues identified from any simulated or actual outbreak or health incident	Continued improvement to outbreak response	All HPC members Head of Emergency Planning and Resilience CCG on behalf of LHRP members
SP6(4)	Ensure effective plans, procedures and policies in relation to managing emergencies impacting health are in place and maintained	Effective and efficient response to an emergency by individual organisations through their role in emergency and resilience forum membership	All members of LHRP Head of Emergency Planning and Resilience LRF (if involved)

SP6 (5)	Delivery of COVID-19 outbreak management and recovery plan • Outbreak response and incident management: Preparedness for a surge response with testing/tracing/IPC and vaccination • Local surveillance of infection rate/vaccination/testing/hospital admission and mortality • Infection prevention and control measures at health & social care and other settings including educational and businesses • Delivery of spring and autumn Covid vaccination programme- addressing inequality in vaccine uptake • Carry out Covid impact Assessment to inform recovery plan. • Communication and Engagement- to educate and promote benefits of infection prevention measures and Covid vaccination	Effective and efficient response to COVID-19 by individual organisations through their role in emergency and resilience forum membership Health protection team providing specialist advice on IPC to all settings and deliver IPC training. Monitor local Covid status and seek assurance from partners Evaluate vaccination uptake and recommend actions to improve uptake Working with community leaders and engage with communities and vulnerable groups with high risk of infection and low vaccination uptake	Public Health Northamptonshire All members of LHRP LA Emergency and Resilience LRF partners UKHSA EMand NHSEI midland
SP6 (6)	Ensure that the public are supported to build resilience and develop plans so that communities are able to respond to a local incidents	Effective and efficient response to an emergency by individuals and communities	All members of LHRP Head of Emergency Planning and Resilience LRF (if involved)

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 7 - Environmental Health			
SP7 (1)	Ensure measures are in place to manage and mitigate environmental health hazards due to poor air quality	Effective management of Air quality of Northamptonshire and reduced health impact Reduction in mortality attributable to air pollution	WNC and NNC Environmental Health Teams WNC and NNC Planning Teams Highways/ Highways England DEFRA Public Health Teams
SP7 (2)	Ensure issues are raised and addressed in relation to known or emerging environmental health hazards (food/land/water/contamination)	Effective management of environmental health hazards	WNC and NNC Environmental Health Teams WNC and NNC Planning Teams Public Health Teams DEFRA Environment Agency Food Standards Agency Trading Standards
SP7 (3)	Ensure that health inequalities in the impacts of environmental health issues, including air quality, are understood and action plans developed to address any inequalities	Reduction in inequalities in outcomes	WNC and NNC Environmental Health Teams WNC and NNC Planning Teams Highways/ Highways England DEFRA Public Health Teams
SP7 (4)	Establish more representative datasets to Environmental Health –	Improved understanding of environmental health	WNC and NNC Environmental Health Teams

Strategic Priority	Activity	Outcome	Lead Organisation(s)
Strategic Priority 8 - Training and Campaigns			
SP8 (1)	Deliver Infection Prevention and Control training to frontline health and social care professionals as per community infection prevention and control responsibilities (Green Book) and professional codes of conduct (GMC and LMC and HSC ACT)	Delivery of Infection Prevention and Control training to frontline health and social care workforce to maintain competencies	Northamptonshire CCG Public Health Teams NGH and KGH Acute Trusts NHFT CGL Drug and Alcohol Service North and West Northants Adults Services Children's Trust
SP8 (2)	Deliver Immunisation/Anaphylaxis training to frontline healthcare professionals as per the mandatory requirement	Delivery of Immunisation/Anaphylaxis training to frontline healthcare professionals to ensure competencies are maintained	Northamptonshire CCG NGH and KGH Acute Trusts NHFT CGL Drug and Alcohol Service WNC and NNC Adults and Children Services
SP8 (3)	Delivery of professional updates to clinicians and healthcare professionals: • TB update • BBV update • Immunisation programme update • Winter preparedness and outbreak management update	Delivery of professional updates to maintain the competencies of clinicians and healthcare professionals	Northamptonshire CCG NGH and KGH Acute Trusts NHFT CGL Drug and Alcohol Service

SP8 (4)	Deliver planned health protection campaigns for 2022/23, suggested campaigns could include: • Seasonal flu • Focus on immunisation (Childhood Immunisation) • Breast cancer awareness month • Bowel cancer awareness month • Cervical cancer prevention • World TB Day • HIV week and world AIDS day • World Hepatitis Day	Timely delivery of planned health protection campaigns contributing to increased awareness of health protection priorities and supporting the prevention and detection of diseases	Public Health Teams UKHSA Local programme boards and providers
SP8 (5)	Ensure that campaigns are targeted to key groups and coproduced and delivered with the community where possible to ensure that they reach all target audiences.	Increased reach and awareness of health protection campaigns	Public Health Teams UKHSA Local programme boards and providers

4. Outbreak and Incident Management

4.1 Emergency Preparedness, Resilience and Response (EPRR)

Under the Health and Social Care Act (2012), and its associated changes to other legislation, Public Health and the local healthcare system must provide a coordinated and effective response to incidents, including but not restricted to, natural hazards, accidents, pandemics and acts of terrorism. This is achieved through a robust and integrated system which allows health organisations to work collaboratively with each other, and the wider resilience community, to ensure that arrangements are in place to provide a coordinated multi-agency response, with the aim of protecting the health and wellbeing of the local population.

In respect to multi-agency health emergency preparedness, within Northamptonshire this is undertaken through the existing local resilience forum (LRF) structure, with strategic (Local Health Resilience Partnership (LHRP)) and operational (LHRP Support Group) health resilience groups having been established and added to the LRF.

As the Co-Chairs of the LHRP, the Directors of Public Health and NHS England determine and lead the strategic agenda for local health emergency planning. The LHRP Support Group, led by NHS Northamptonshire CCG, and with representation from local health organisations (including public health), is responsible for ensuring the timely delivery of the strategic priorities of the LHRP.

The response to an incident will be managed in accordance with the Northamptonshire LRF command and control structure (for further information, refer to the NLRF Command and Control Plan).

In order to ensure a coordinated health response to an incident, a Health Economy Tactical Coordination Group (HETCG) may be convened (dependent on the incident) to manage and coordinate the NHS and public health response. Health representation will also be sought for the Tactical Coordinating Group (TCG) and Strategic Coordinating Group (SCG), in situations where the scale of the incident is such that these groups are activated.

In the event of a chemical, biological, radiological or nuclear (CBRN) incident, a Scientific and Technical Advice Cell (STAC) may be convened to provide scientific and technical advice to the SCG. UKHSA will provide the STAC resource, at the request of the SCG, and will require representation from public health and environmental health to provide expert advice on their respective areas.

4.2 Outbreak Management

An outbreak of infectious disease is not a rare event and can regularly occur in the community in care homes and schools, and in closed settings such as prisons and detention centres. The response to outbreaks often requires the deployment of significant NHS resources in order to deliver the investigations and interventions necessary to control them. As such, it is imperative that local health and social care organisations have an agreed

approach to outbreak management, ensuring a collaborative approach and clear accountabilities of all organisations involved.

Locally, UKHSA will lead the response to an outbreak of infectious disease affecting Northamptonshire, with support from local health organisations to bring the outbreak to an end.

The responsibilities and key contact arrangements for the response to, and management of, common outbreak situations can be found in the Northamptonshire Infection, Prevention and Control Handbook.

Where an outbreak, such as that of Covid-19 or influenza, escalates to pandemic level, the response to this will be managed by a Strategic Co-ordinating Group, convened through the Local Resilience Forum in accordance with the command-and-control structure and the NLRF Pandemic Plan.

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North Northamptonshire Council

Item no: 11

North Northamptonshire Health and Wellbeing Board
5th July 2021

Report Title	**Better Care Fund End of Year Performance Report.**	
Report Author	**Samantha Fitzgerald – Assistant Director Adult Services** **Samantha.fitzgerald@northnorthants.gov.uk**	
Contributors/Checkers/Approvers		
Other Director/SME	David Watts Executive Director for Adult, Communities, Wellbeing	28th June 2022

List of Appendices

Appendix 1: BCF Performance template 2021/22 for North Northamptonshire
Appendix 2: BCF Narrative Plan 2021/22

1. Purpose of Report

1.1. To provide the Health and Wellbeing Board with the 21 / 22 Better Care Fund End of year performance Report, against the (BCF) policy statement for 2021 to 2022 published on 19 August 2021, and the metrics in the Better Care Fund plan for 2021 to 2022.

1.2. To request the Health and Wellbeing Board to sign off the Better Care Fund (BCF) 2021/2022 performance template submitted to NHSE.

1.3. To note Better Care fund 2022 / 2023 proposed timelines.

2. Executive Summary

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

2.2 The Health and Wellbeing Board has a duty to monitor the performance against the Better Care Fund plan

2.3 The Health and Wellbeing Board are required to approve the 2021/22 performance template submitted to NHSE.

3. Recommendations

a) The Health and Wellbeing Board approve the Better Care Fund (BCF) 2021/2022 performance template submitted to NHSE.

b) To note Better Care fund 2022 / 2023 proposed timelines.

4. Report Background

4.1 The Better Care Fund

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

4.3 Better Care Fund plan for 2021 to 2022 sets out the ambitions on how the spending will improve performance against the following BCF 2021 to 2022 metrics:

- Avoidable admissions to hospital
- Length of stay
- People discharged to their usual place of residence
- Admissions to residential and care homes
- Effectiveness of reablement

The approach to delivering these locally is set out in BCF Narrative plan for 2021/22 and attached as **Appendix 2**.

4.4 BCF National conditions and metrics for 2021/22

The national conditions for the BCF in 2021/22 were:

1. A jointly agreed plan between local health and social care commissioners, signed off by the HWB.
2. NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.
3. Invest in NHS-commissioned out-of-hospital services.

4. A plan for improving outcomes for people being discharged from hospital.

4.5 **Metrics**

North Northamptonshire Performance against the defined metrics for 2021/22 is attached as **Appendix 1.**

4.6 Avoidable Admissions

Admission Avoidance	21 – 22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Unfortunately, the national metric is not available for inclusion

4.7 Length of Stay

Percentage of inpatients, resident in the HWB, who have been an inpatient in an acute hospital for:

Length of Stay	Plan	June Average	Monthly average
14 days or more*	14.0%	12.4%	14.2%
21 days or more*	7.0%	6.6%	8.3%

* As a percentage of all inpatients

Metric Not on Track to meet the planned target at 14 days and 21 days (or longer) % proportion showing as slightly higher than planned with highest rates towards the last quarter of the financial year.

4.8 People 65+ Discharged to their usual place of residence

People 65+ discharged to their usual place of residence	Plan 21 – 22	Actuals
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	95.1%	95.3%

Metric is on Track to meet the planned target. This metric has remained consistently high. Monthly average for the year is 95.3%. Last month of the financial year shows the highest result of 96.3%

4.9 Admission to Residential and Care Homes

Admissions to residential and care homes	21-22 Plan	Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	604	Q1- 175.87 Q2- 324.66 Q3- 489.28 Q4- 624.93

Not on track to meet the planned target. This metric has been something of a curiosity for NNC as it is high, especially when compared to the figure for all of Northamptonshire published last year; the performance of last year however was skewed by the Covid pandemic. Following the split into two unitary authorities the data is also still showing us how the degree of need is split across the two areas. Furthermore, because the population is lower, a small number of people requiring admission has a greater effect on the overall indicator.

4.10 Effectiveness of Reablement

Effectiveness of Reablement	21-22 plan	Q2
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	79.2%	North final month improved to show 72.0%. Monthly average 57.78%

Not on Track to meet the planned target, the final months position improved to show 72.0% against a target of 79.2%. Our assumption is that with a focus on Pathway 1 home reablement service have taken those with a higher level of acuity and this has impacted on this metric.

4.11 **Better Care fund planning 2022/23**

The 2022/23 plan will be developed locally by North Northamptonshire Council and the Integrated Care Board / Integrated Care Partnership. We are expecting further guidance from NHSE during July 22, and it is anticipated that a report will be submitted to the Health and Wellbeing Board in September 2022.

5 Issues and Choices

None

6 Implications (including financial implications)

6.1 Resources and Financial

Please see Appendix 1 for financial details

7 Legal

None

8 Risk

None

9 Consultation

No consultation was required

10 Consideration by Scrutiny

This report has not been considered by scrutiny.

11 Climate Impact

There are no known direct impacts on the climate because of the matters referenced in this report.

12 Community Impact

There are no distinct populations that are affected because of the matters discussed in this report, however those that access care and health services more frequently than the general population will be impacted more by any improvements associated with activity undertaken

13 Background Papers

None

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Appendix

Item no: 11

North Northamptonshire Council

North Northamptonshire Health and Wellbeing Board
Appendix 1 – BCF 2021-2022 Year End

Contents

Better Care Fund 2021-22 Year-end Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2021-22, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:

1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) To confirm actual income and expenditure in BCF plans at the end of the financial year
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the BCF Team will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCEx) prior to publication.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:
england.bettercaresupport@nhs.net
(please also copy in your respective Better Care Manager)
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2021-22 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

https://www.england.nhs.uk/publication/better-care-fund-planning-requirements-2021-22/

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: NHS contribution to adult social care is maintained in line with the uplift to CCG Minimum Contribution

National condition 3: Agreement to invest in NHS commissioned out-of-hospital services

National condition 4: Plan for improving outcomes for people being discharged from hospital

4. Metrics

The BCF plan includes the following metrics: Unplanned hospitalisation for chronic ambulatory care sensitive conditions, Proportion of hospital stays that are 14 days or over, Proportion of hospital stays that are 14 days or over, Proportion of discharges to a person's usual place of residence, Residential Admissions and Reablement. Plans for these metrics were agreed as part of the BCF planning process.

This section captures a confidence assessment on achieving the plans for each of the BCF metrics.

A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes that have been achieved.

The BCF Team publish data from the Secondary Uses Service (SUS) dataset for Long length of stay (14 and 21 days) and Discharge to usual place of residence at a local authority level to assist systems in understanding performance at local authority level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric plans and the related narrative information and it is advised that:

- In making the confidence assessment on progress, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.

- In providing the narrative on Challenges and Support needs, and Achievements, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

5. Income and Expenditure

The Better Care Fund 2021-22 pool constitutes mandatory funding sources and any voluntary additional pooling from LAs (Local Authorities) and CCGs. The mandatory funding sources are the DFG (Disabled Facilities Grant), the improved Better Care Fund (iBCF) grant, and the minimum CCG contribution. A large proportion of areas also planned to pool additional contributions from LA and CCGs.

Income section:

- Please confirm the total HWB level actual BCF pooled income for 2021-22 by reporting any changes to the planned additional contributions by LAs and CCGs as was reported on the BCF planning template.

- The template will automatically prepopulate the planned expenditure in 2021-22 from BCF plans, including additional contributions.

- If the amount of additional pooled funding placed into the area's section 75 agreement is different to the amount in the plan, you should select 'Yes'. You will then be able to enter a revised figure. Please enter the **actual income** from additional CCG or LA contributions in 2021-22 in the yellow boxes provided, **NOT** the difference between the planned and actual income.

- Please provide any comments that may be useful for local context for the reported actual income in 20121-22.

Expenditure section:

- Please select from the drop-down box to indicate whether the actual expenditure in you BCF section 75 is different to the planned amount.

- If you select 'Yes', the boxes to record actual spend, and explanatory comments will unlock.

- You can then enter the total, HWB level, actual BCF expenditure for 2021-22 in the yellow box provided and also enter a short commentary on the reasons for the change.

- Please provide any comments that may be useful for local context for the reported actual expenditure in 2019/20.

6. Year End Feedback

This section provides an opportunity to provide feedback on delivering the BCF in 2021-22 through a set of survey questions
These questions are kept consistent from year to year to provide a time series.
The purpose of this survey is to provide an opportunity for local areas to consider the impact of BCF and to provide the BCF national partners a view on the impact across the country. There are a total of 9 questions. These are set out below.

Part 1 - Delivery of the Better Care Fund

There are a total of 3 questions in this section. Each is set out as a statement, for which you are asked to select one of the following responses:

- Strongly Agree
- Agree
- Neither Agree Nor Disagree
- Disagree
- Strongly Disagree

The questions are:

1. The overall delivery of the BCF has improved joint working between health and social care in our locality
2. Our BCF schemes were implemented as planned in 2021-22
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality

Part 2 - Successes and Challenges

This part of the survey utilises the SCIE (Social Care Institute for Excellence) Integration Logic Model published on this link below to capture two key challenges and successes against the 'Enablers for integration' expressed in the Logic Model.

Please highlight:

8. Two key successes observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-22.
9. Two key challenges observed toward driving the enablers for integration (expressed in SCIE's logic model) in 2021-22?

For each success and challenge, please select the most relevant enabler from the SCIE logic model and provide a narrative describing the issues, and how you have made progress locally.

SCIE - Integrated care Logic Model

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset-based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

7. ASC fee rates

This section collects data on average fees paid by the local authority for social care.

Specific guidance on individual questions can be found on the relevant tab.

Better Care Fund 2021-22 Year-end Template

2. Cover

Version 2.0

Please Note:

- The BCF end of year reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. Narrative sections of the reports will not be published. However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information, including that provided on local authority fee rates, will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	North Northamptonshire
	Complete:
Completed by:	Samantha Fitzgerald
E-mail:	samantha.fitzgerald@northnorthants.gov.uk
Contact number:	7912892140
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No, subject to sign-off
If no, please indicate when the report is expected to be signed off:	Tue 05/07/2022

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Executive Director of Adult Communities and wellbeing
Name:	David Watts

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income and Expenditure actual	Yes
6. Year-End Feedback	Yes
7. ASC fee rates	Yes

[<< Link to the Guidance sheet]

Better Care Fund 2021-22 Year-end Template

3. National Conditions

Selected Health and Wellbeing Board:	North Northamptonshire

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in 2021-22:**
1) A Plan has been agreed for the Health and Wellbeing Board area that includes all mandatory funding and this is included in a pooled fund governed under section 75 of the NHS Act 2006? (This should include engagement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the BCF policy?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	

4) Plan for improving outcomes for people being discharged from hospital	Yes	

Better Care Fund 2021-22 Year-end Template

4. Metrics

Selected Health and Wellbeing Board: North Northamptonshire

National data may likely be unavailable at the time of reporting. As such, please utilise data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed, or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2021-22 planning				Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs	Achievements
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)				197.0	Data not available to assess progress	Data is not available via NHS Digital to the council therefore the BI team West Northants are unable to calculate this indicator as other councils. See email attachments BCF exchange.	NA
Length of Stay	Proportion of inpatients resident for: i) 14 days or	**14 days or**	**14 days or mor**	**21 days or**	**21 days or**	Not on track to meet target	14 days and 21 days (or longer) % proportion	14+ (12.4%) June 21 21+ (6.6%) June 21

	more ii) 21 days or more	**more (Q3)** 14.1%	**e (Q4)** 14.0 %	**e (Q3)** 7.9 %	**e (Q4)** 7.0 %		showing as slightly higher than planned with highest rates towards the last quarter of the financial year.	14 Days monthly average - 14.2% 21+ Days monthly average - 8.3%
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence				95.1%	On track to meet target	Monthly average for the year is 95.3%. Last month of the financial year shows the highest result of 96.3%	March 22 (96.3%)
Res Admissions *	Rate of permanent admissions to residential care per 100,000 population (65+)				1,308	Not on track to meet target	Q1- 175.87 Q2- 324.66 Q3- 489.28 Q4- 624.93	This metric has been something of a curiosity for NNC as it is high, especially when compared to the figure for all of Northamptonshire published last year; the performance of last year however was skewed by the Covid pandemic. Following the split into two unitary authorities the data is also still showing us how the degree of need is split across the two areas. Furthermore, because the population is lower, a small number of people requiring admission has a greater effect on the overall indicator.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	79.2%	Not on track to meet target	North final month improved to show 72.0%. Monthly average 57.78%	Q4 66.7% July 22 (72.1%)

* In the absense of 2021-22 population estimates (due to the devolution of North Northamptonshire and West Northamptonshire), the denominator for the Residential Admissions metric is based on 2020-21 estimates

Better Care Fund 2021-22 Year-end Template

5. Income and Expenditure actual

Selected Health and Wellbeing Board: North Northamptonshire

Income

	2021-22				
Disabled Facilities Grant	£2,561,759				
Improved Better Care Fund	£11,184,632				
CCG Minimum Fund	£23,877,791				
Minimum Sub Total		£37,624,182			
	Planned		Actual		
CCG Additional Funding	£2,601,472		Do you wish to change your additional actual CCG funding?	No	
LA Additional Funding	£630,447		Do you wish to change your additional actual LA funding?	No	
Additional Sub Total		£3,231,919			£3,231,919

	Planned 21-22	Actual 21-22
Total BCF Pooled Fund	£40,856,101	£40,856,101

Please provide any comments that may be useful for local context where there is a difference between planned and actual income for 2021-22	

Expenditure

	2021-22
Plan	£40,856,101

Do you wish to change your actual BCF expenditure?	No

Actual	

Please provide any comments that may be useful for local context where there is a difference between the planned and actual expenditure for 2021-22	

Better Care Fund 2021-22 Year-end Template

6. Year-End Feedback

The purpose of this survey is to provide an opportunity for local areas to consider and give feedback on the impact of the BCF. Covid-19 had a significant impact on services and schemes delivered on the ground which may have changed the context. However, national BCF partners would value and appreciate local area feedback to understand views and reflections of the progress and challenges faced during 2021-22
There is a total of 5 questions. These are set out below.

Selected Health and Wellbeing Board: North Northamptonshire

Part 1: Delivery of the Better Care Fund

Please use the below form to indicate to what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	Agree this has given us a shared and collectively agreed vision for NNC
2. Our BCF schemes were implemented as planned in 2021-22	Agree	Our schemes under the BCF and ICAN support the workstreams of improvement in relation too, Avoidable admissions to hospital, Length of stay reduction, volumes of People discharged to their usual place of residence and a focus on reducing Admissions to

		residential and care homes as well as the Effectiveness of reablement
3. The delivery of our BCF plan in 2021-22 had a positive impact on the integration of health and social care in our locality	Agree	The work undertaken has strengthened system partnership and collaboration

Part 2: Successes and Challenges
Please select two Enablers from the SCIE Logic model which you have observed demonstrable success in progressing and two Enablers which you have experienced a relatively greater degree of challenge in progressing. Please provide a brief description alongside.

4. Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest successes
Success 1	2. Strong, system-wide governance and systems leadership	The 21/22 BCF plan is linked to the Integrated Care Across Northamptonshire (ICAN) services and schemes. this has formed the basis of our system collaboration and integrated service delivery. There are 3 core components (or "pillars") within the BCF/ ICAN transformation programme all designed to increase prevention, improve outcomes, and shift activity from acute hospitals to our community
Success 2	5. Integrated workforce: joint approach to training and upskilling of workforce	Community resilience workstream delivered through ICAN – supporting people to age well with planned support at home, as they become frailer, and care from the right team in the right setting in a crisis This is underpinned by care plans for all social prescribing, education, information, and urgent community care wrapped around the

		patient and has been delivered

5. Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2021-22	SCIE Logic Model Enablers, Response category:	Response - Please detail your greatest challenges
Challenge 1	6. Good quality and sustainable provider market that can meet demand	Social Care recruitment crisis Care workers – Care workers generally are paid national minimum wage whilst other sectors re opened following lockdown have expanded and increased rates of pay resulting in an inability for providers to recruit and take on new packages resulting in discharge delays and waits for home care
Challenge 2	3. Integrated electronic records and sharing across the system with service users	Data and Insight – Lack of consistent and holistic system data to inform both operational and strategic decision making, although this work is in train this has proved a challenge in 21/22

Footnotes:

Question 4 and 5 are should be assigned to one of the following categories:

1. Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)
2. Strong, system-wide governance and systems leadership
3. Integrated electronic records and sharing across the system with service users
4. Empowering users to have choice and control through an asset based approach, shared decision making and co-production
5. Integrated workforce: joint approach to training and upskilling of workforce
6. Good quality and sustainable provider market that can meet demand
7. Joined-up regulatory approach
8. Pooled or aligned resources
9. Joint commissioning of health and social care

Other

7. ASC fee rates

Selected Health and Wellbeing Board:	North Northamptonshire

The iBCF fee rate collection gives us better and more timely insight into the fee rates paid to external care providers, which is a key part of social care reform.
Given the introduction of the Market Sustainability and Fair Cost of Care Fund in 2022-23, we are exploring where best to collect this data in future but have chosen to collect 2021-22 data through the iBCF for consistency with previous years.

These questions cover average fees paid by your local authority (gross of client contributions/user charges) to external care providers for your local authority's eligible clients. The averages will likely need to be calculated from records of payments paid to social care providers and the number of client weeks they relate to, unless you already have suitable management information.

We are interested ONLY in the average fees actually received by external care providers for your local authority's eligible supported clients (gross of client contributions/user charges), reflecting what your local authority is able to afford.

In 2020-21, areas were asked to provide actual average rates (excluding whole market support such as the Infection Control Fund but otherwise, including additional funding to cover cost pressures related to management of the COVID-19 pandemic), as well as a 'counterfactual' rate that would have been paid had the pandemic not occurred. This counterfactual calculation was intended to provide data on the long term costs of providing care to inform policymaking. In 2021-22, areas are only asked to provide the actual rate paid to providers (not the counterfactual), subject to than the exclusions set out below.

Specifically the averages SHOULD therefore:

- EXCLUDE/BE NET OF any amounts that you usually include in reported fee rates but are not paid to care providers e.g. your local authority's own staff costs in managing the commissioning of places.
- EXCLUDE/BE NET OF any amounts that are paid from sources other than eligible local authority funding and client contributions/user charges, i.e. you should EXCLUDE third party top-ups, NHS Funded Nursing Care and full cost paying clients.
- EXCLUDE/BE NET OF whole-market COVID-19 support such as Infection Control Fund payments.
- INCLUDE/BE GROSS OF client contributions /user charges.
- INCLUDE fees paid under spot and block contracts, fees paid under a dynamic purchasing system, payments for travel time in home care, any allowances for external provider staff training, fees directly commissioned by your local authority and fees commissioned by your local authority as part of a Managed Personal Budget.
- EXCLUDE care packages which are part funded by Continuing Health Care funding.

If you only have average fees at a more detailed breakdown level than the three service types of home care, 65+ residential and 65+ nursing requested below (e.g. you have the more detailed categories of 65+ residential without dementia, 65+ residential with dementia) **please calculate for each of the three service types an average weighted by the proportion of clients that receive each detailed category:** 1. Take the number of clients receiving the service for each detailed category.

2. Divide the number of clients receiving the service for each detailed category (e.g. age 65+ residential without dementia, age 65+ residential with dementia) by the total number of clients receiving the relevant service (e.g. age 65+ residential).

3. Multiply the resultant proportions from Step 2 by the corresponding fee paid for each detailed category.

4. For each service type, sum the resultant detailed category figures from Step 3.

Please leave any missing data cells as blank e.g. do not attempt to enter '0' or 'N/A'.

	For information - your 2020-21 fee as reported in 2020-21 end of year reporting *	Average 2020/21 fee. If you have newer/better data than End of year 2020/21, enter it below and explain why it differs in the comments. Otherwise enter the end of year 2020-21 value	What was your actual average fee rate per actual user for 2021/22?	Implied Uplift: Actual 2021/22 rates compared to 2020/21 rates
1. Please provide the average amount that you paid to external providers for home care, calculated on a consistent basis. (£ per contact hour, following the exclusions as in the instructions above)	£17.25	£17.25	£19.57	13.4%
2. Please provide the average amount that you paid for external provider care homes without nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions as in the instructions above)	£695.06	£695.06	£724.12	4.2%
3. Please provide the average amount that you paid for external provider care homes with nursing for clients aged 65+, calculated on a consistent basis. (£ per client per week, following the exclusions in the instructions above)	£698.65	£698.65	£710.26	1.7%
4. Please provide additional commentary if your 2020-21 fee is different from that reported in your 2020-21 end of year report. Please do not use more than 250 characters.				

Footnotes:

* ".." in the column C lookup means that no 2020-21 fee was reported by your council in the 2020-21 EoY report

** For column F, please calculate your fee rate as the expenditure during the year divided by the number of actual client weeks during the year. This will pick up any support that you have provided in terms of occupancy guarantees.
(Occupancy guarantees should result in a higher rate per actual user.)

*** Both North Northamptonshire & West Northamptonshire will pull the same last year figures as reported by the former Northamptonshire County Council.

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Item no: 12

North Northamptonshire Council

NORTH NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

5th July 2022

Report Title	**University Hospitals of Northamptonshire Clinical Strategy**
Report Author	**Polly Grimmett, Group Director of Strategy and Strategic Estates**

List of Appendices

Appendix A – University Hospitals of Northamptonshire Group Clinical Strategy
Appendix B – Clinical Strategy Engagement Report

1. Purpose of Report

1.1. This report introduces the University Hospitals of Northamptonshire Group Clinical Strategy 2022 to 2027 and seeks the support of the Health and Wellbeing Board and any recommendations on how we further engage partners and the public in developing hospital services.

2. Executive Summary

1.2. The Clinical Strategy has been developed by hospital clinicians with the aim of tackling rising demand for hospital services, in the most effective way and within the available workforce and financial resources.

1.3. It sets out how the Northampton General and Kettering General Hospitals will collaboratively work together with partners in primary care and the community to provide excellent clinical care for the people of Northamptonshire with four key strands:

- Work with our partners to prevent ill-health and reduce hospitalisation, changing the way care is provided along the care pathway.
- Develop two centres of excellence in the county, building on our established strengths in each hospital, with cardiology being led by Kettering General Hospital and cancer led by Northampton General Hospital, with consistent access to these services by all patients in the county.
- Protect elective beds to reduce cancelled operations, reduce long waiting times and increase efficiency.
- Build on our University Hospital status, to become a hub for innovation, training and research, attracting high calibre talent and growing the number of clinical trials our patients can access.

3. Recommendations

It is recommended that the North Northamptonshire Health and Wellbeing Board:

a. Note the significant engagement that has taken place with staff, patients, the public and local stakeholders in developing this Group Clinical Strategy.
b. Approve the document as a strategic direction of travel for acute hospital care in the county.

4. Report Background

Northampton Hospital Trust and Kettering Hospital Foundation Trust came together as 'a group' with a shared leadership and management structure in 2020, in order to improve services for all patients in the county and improve recruitment and retention of key staff. In November 2021 the two public Boards discussed a Group Clinical Ambition paper which set out some further detail as to how our staff felt they would best deliver these ambitions, and we committed to engaging more widely with our patients and local partners to understand what they thought of our ideas. This has taken place over 2022 and has culminated in this Group Clinical Strategy, which has previously been discussed at Northamptonshire shadow ICS Board.

5. Issues and Choices

5.1 The issues and choices for the strategy are included in the main strategy document, and members are invited to focus on the Executive summary on slides 4-17.

6. Implications (including financial implications)

6.1 Resources and Financial

It is expected that implementing the strategy will bring financial efficiencies in the future by lowering a reliance on temporary staff, reducing future demand on healthcare by keeping patients well in their homes and communities, and through improving operational efficiency.

6.2 Legal

6.2.1 There may be a legal requirement to engage the public in the future if we consider changes in the way services are delivered to improve care for our patients. We will share the high level strategy with the Health and Wellbeing Boards in Northamptonshire and respond to any specific requests they may have for further engagement with them and the public.

6.3 Risk

6.3.1 Having a clear direction for clinical services is fundamental to meeting the needs of our local population and delivering the care that they need now and in the future. Agreeing a strategy will bring opportunities to communicate to our staff and partners in the Integrated Care System, region and nationally how we intend to provide acute care in Northamptonshire in the coming 5-7 years.

6.3.2 The engagement process has been wide, although it is recognised that not all members of the public or service users would have been able to contribute. As a high level document, we will continue to engage with specific patient groups and service users as we develop individual service strategies in more detail.

6.4 **Consultation**

6.4.1 The Medical Directors from both Trusts have led this engagement over many months, which has included sharing the document widely within and outside the two Trusts through:

- Face to face sessions
- Online surveys and dedicated email address to send comments
- University Hospitals of Northamptonshire website with details of the clinical ambition and ways to feedback
- Attendance at partner meetings
- Public sessions

6.4.2 Integrated Care System partners have been included in the engagement and feedback. The ambition and opportunities to comment on it have been shared widely on social and printed media. The wider public were given the opportunity to meet face to face with the Group CEO and Medical Directors at four open sessions.

6.4.3 Detailed feedback has been collated in Appendix 2 and used to inform the Strategy. This feedback has been shared with the Group Clinical Senate who recommended approval of the Clinical Strategy to the Boards of both hospitals.

6.5 **Consideration by Overview and Scrutiny**

6.5.1 The HWB are invited to advise on whether the strategy should be referred to the Overview and Scrutiny Committee.

6.6 **Climate Impact**

6.6.1 The clinical strategy includes a section on how clinical services will be delivered in an environmentally sustainable way as part of the hospital's Green plan on slide 70.

6.7 **Community Impact**

6.7.1 The strategy describes how clinical service configuration will be used to reduce health inequalities by providing equitable access to services and address areas of greatest need by taking a population health approach.

7. Background Papers

7.1 Reference is made in the strategy to the Integrated Care System plans and builds the role of the acute hospitals as described in the plans. The first area of focus in the strategy is how the

hospitals will work together with health and system partners in the prevention of ill health and reducing the time patients spend in hospital.

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

NHS
University Hospitals of Northamptonshire
NHS Group

Group Clinical Strategy

Appendix

May 2022

Dedicated to excellence

Services provided by Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Foreword

University Hospitals of Northamptonshire NHS Group

Our two organisations – Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust – are committed to providing safe, compassionate and clinically-excellent care for local people in Northamptonshire. For our workforce, we strive to offer a supportive culture that empowers teams to learn, develop and innovate in partnership with the wider system.

We face, however, a range of challenges in delivering this commitment, from difficulties in recruiting some specialist staff, to a population growing and ageing above the national average. We recognise that in order to deliver our strategy and respond to the challenges we have, we need close collaboration between our two organisations. Working as a Group, we have far better opportunities to realise benefits for our patients and staff than we could as separate hospital Trusts. By integrating our clinical services to share staff, skills and resources we are well placed to respond to ever increasing service demand. We believe that collaboration, between us and our other local healthcare partners will be an opportunity to improve the quality of our services and reduce variation across our hospitals, whilst finding sustainable ways to manage and tackle staffing shortages. This will mean we can provide local people with the rapid access to the high quality, specialist care that they require, and that our staff are proud to deliver.

This document develops the clinical ambition agreed in November 2021, and builds on our existing collaborations to establish clinical centres of excellence for Northamptonshire, protecting elective capacity so our patients do not experience cancelled operations and longer waiting times, and progresses us towards becoming a hub for research, education and innovation. All our clinical services across the two organisations will work together to share expertise and best practice. They will continue the journey towards single team working, for many of our services across both hospital sites. We will of course continue to deliver local services such as the Emergency Departments and consultant-led maternity services on both hospital sites. Where clinically appropriate, some of our services will be delivered in community settings away from the main hospitals, taking care closer to home and integrating with relevant community and primary care services. For some highly specialist care, where it delivers proven better outcomes for patients, such as heart attacks and specialist cancer surgery, we propose delivering these services on just one of our hospital sites but with equitable access for all patients in the county.

Our strategy has been finalised following engagement with a wide range of staff, patients, health and care partners and our local communities, gathering feedback on our November clinical ambition proposals to strengthen our plans. We look forward to the future as we develop excellent hospital services for the people of Northamptonshire.

Mr Matthew Metcalfe, Medical Director, Northampton General Hospital NHS Trust
Dr Rabia Imtiaz, Acting Medical Director, Kettering General Hospital NHS Foundation Trust

Dedicated to excellence

Contents

Dedicated to excellence

NHS
University Hospitals of Northamptonshire
NHS Group

Executive summary

Services provided by Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Our group and our case for change

University Hospitals of Northamptonshire NHS Group

Our Group

Our Group is made up of two hospital Trusts in Kettering and Northampton. We provide acute services principally for the population of Northamptonshire, and some specialist services for a wider population. We are part of the Northamptonshire Integrated Care System (ICS) where we collaborate with health and care partners to prevent ill-health and deliver more integrated services for patients.

We are already successfully collaborating across our hospital sites in many clinical areas and are proud of our successes in how this has improved clinical quality and patient care. We have also recently become an academic university hospital group and want to build our academic and research reputation, whilst taking the opportunity to re-build our hospitals to support the delivery of high-quality services as part of the National Hospital Programme.

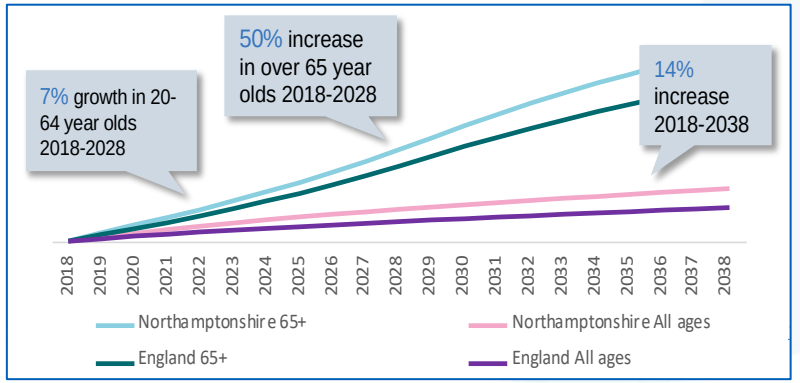
Engagement

We have engaged extensively in developing this strategy with clinicians, patients, the public and partners. We have incorporated this feedback into the strategy including key themes of access, engagement, clinical quality, estates, digital and prevention

Our case for change

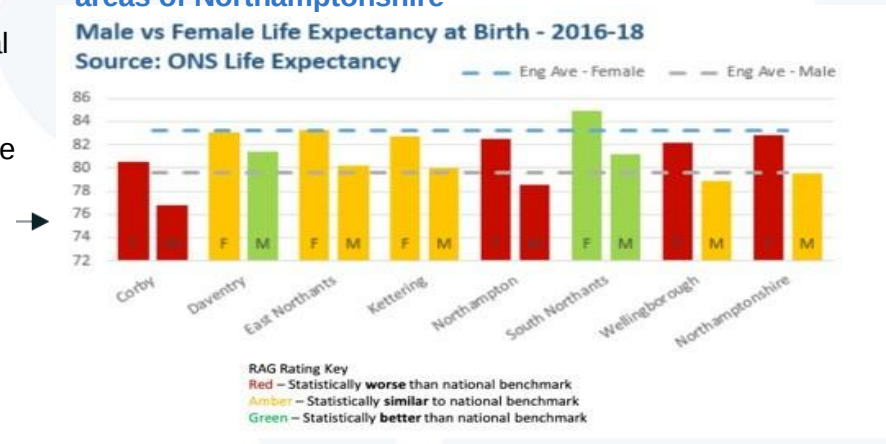
Our local population is older than, and growing faster than, the national average so the demand for good quality care and support will increase over the coming years. Some of our local populations have significantly poorer health outcomes and life expectancy than the national average, and many of these people do not get the access to the care they need in a timely way. In some instances, and with some conditions, people are being admitted to hospital when, with the right services, these patients could be managed in their homes and communities without the need for a hospital stay. Some patients are also staying longer in hospital than is medically necessary. It is essential that in all clinical specialties we work well with our health and care partners and our local communities, to address these issues and tackle health inequalities, ensuring everyone has the same level of access to facilities and are supported to live well. Where patients do require hospital care then the pathways and communication between system partners should be seamless and transparent for those patients.

Our population is growing and ageing faster than the national average



Our local area

Life expectancy is lower than the national average in most areas of Northamptonshire



Dedicated to excellence

Our case for change (continued)

University Hospitals of Northamptonshire NHS Group

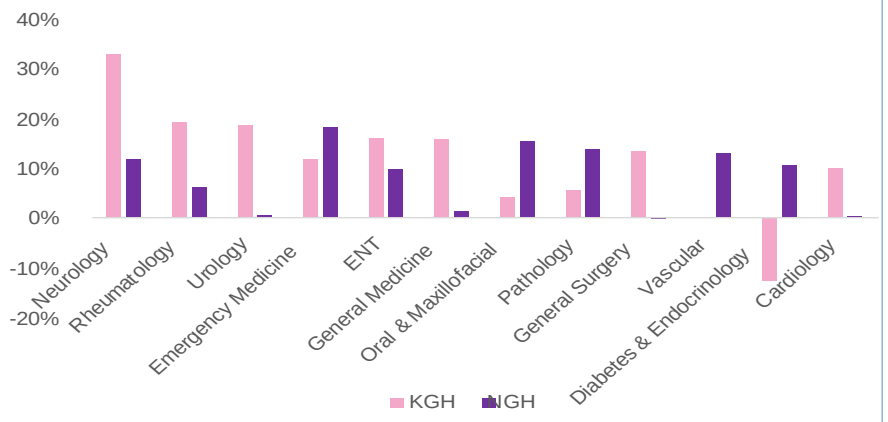
Our case for change

We have more to do across our Group to consistently deliver clinical best practice and meet national quality guidelines, with some of our services “requiring improvement” or in lower quartile performance when compared to national benchmarks. There is also inequity in access to services and quality between our two hospitals, with patients in some areas for example able to easily access advanced epilepsy or sleep study services, and others don't have the same ease of access purely due to where they live.

In line with other NHS Trusts, we find it difficult to retain and recruit clinical staff to some specialties and there is a national shortage of staff in some areas. Workforce shortages drive a reliance on bank/agency staff which impacts on the quality and cost of our services. Some of our services are fragile, with few consultants and low volumes in some specialties, which leads to unsustainable service delivery for our patients.

Our organisations are struggling to attract and retain clinical staff with significant vacancy rates

Vacancy Rates by specialty for March 2021
KGH & NGH Human Resources (Mar 2021)



Dedicated to excellence

We know that we need to change the way we deliver services to improve quality and efficiency. Our financial position, and that of the wider NHS, is under pressure but we know we also need to invest in transformation of services to meet the needs of the future. We also need to tackle pressures on elective waiting lists across the local area, driven by the COVID pandemic.

Both our organisations are rated by the CQC as ‘requires improvement’

CQC Ratings
KGH 2020, NGH 2019

	KGH	NGH
Overall	**Requires Improvement**	**Requires Improvement**
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good
Caring	Good	Good
Responsive	Requires Improvement	Good
Well-led	Good	Requires Improvement

As a significant producer of greenhouse gases and consumer of single use plastic items, one of the significant ways we can contribute to the health of future generations is to deliver our clinical services in ways which cause less harm to the environment, for example by reducing the use of older anaesthetic gases, single use plastic devices and using energy efficient equipment. Increasing the use of digital records and appointments will also reduce reliance on paper and travel to and from hospitals, whilst also improving continuity of care and convenience for patients and their families.

Our proposals for transformation

University Hospitals of Northamptonshire NHS Group

Our proposals for transformation

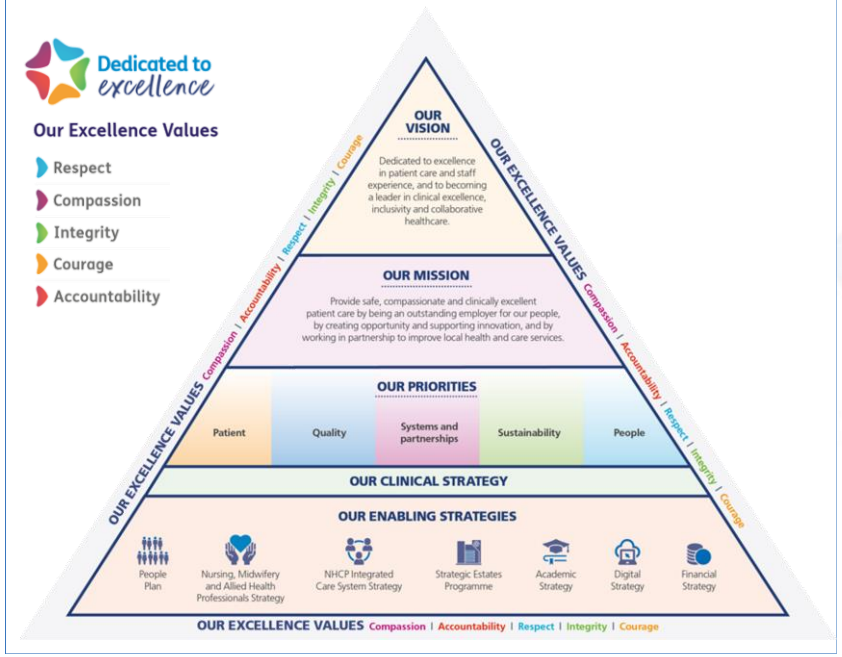
In 2021, we developed an overall Group strategy which has guided the development of '*Our clinical ambitions' ,* which we consulted widely on to develop this final *Group Clinical Strategy*. Developing this document involved over 600 of our staff in face to face discussion, meetings with our key stakeholders, and four widely publicised public sessions. Our staff, partners and public have been involved in individual discussions, surveys and in open meetings throughout the winter of 2021/22. Our proposals for transforming care set out in detail the feedback we have received on *Our Clinical Ambition* on what we need to do to tackle the challenges we have set out in the 'case for change', and to provide outstanding care for our patients. In all cases this involves improved collaboration across the two hospitals and with our community partners to strengthen services, improve care for patients and improve opportunities for staff. We recognise that we can only deliver this strategy by working closely with patients, carers and our local partners.

We recognise that we are on a journey to excellence. This document sets out our initial priority areas to strengthen and improve, and the key areas where our local population will require care and treatment over the coming years.

Clinical collaboration across the Group and the system however will continue wider than just these areas, and we will engage with partners and wider stakeholders to continually develop and improve services for patients and our staff in all areas.

Our Group strategy

Our group *dedicated to excellence strategy* sets out our values, vision, mission and group priorities – this identified a group clinical strategy as a key strategic initiative



What the Group vision means for the clinical strategy

- The Group will be **known for safe, compassionate and clinically excellent care**: working in partnership as a **system leader** of integrated acute care and a **hub for innovation and research.**
- Integrated services will deliver **consistently exemplar outcomes** for our patients across Northamptonshire, providing timely, seamless care, **minimising disruption to our patients' lives**. Patients will only come in when they need specialist acute services.
- Our staff across the Group will work collaboratively together, and with system partners, to deliver **cutting edge treatments** and produce **high quality research** - enabling the Group to become an outstanding employer able attract and retain leading experts.
- Patients and staff across the county are **proud of their local NHS.**

Dedicated to excellence

Our proposals for transformation (continued)

We have identified four core ambitions where we will initially focus. For these four areas we have developed a more detailed clinical strategy to address the specific challenges each area poses, to transform and improve care for patients and provide attractive places for staff to come and work.

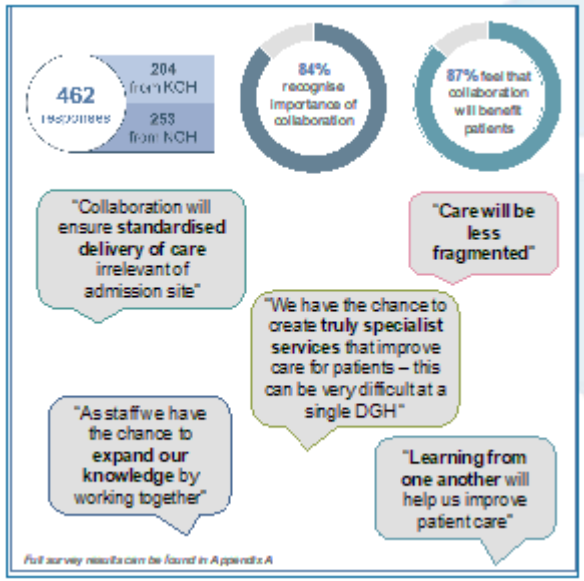
The four core ambitions are:

1. Work with our partners to **prevent ill-health and reduce hospitalisation**, changing the way care is provided along the care pathway
2. Develop **two centres of excellence** in the county, building on our established strengths in each hospital, with cardiology being led by Kettering General Hospital and cancer led by Northampton General Hospital, with consistent access to these services by all patients in the county.
3. **Protect elective beds** to reduce cancelled operations, reduce long waiting times and increase efficiency.
4. **Build on our University Hospital status**, to become a hub for innovation and research, attracting high calibre talent and growing the number of clinical trials our patients can access.

To deliver our ambitions, we will also explore options for the specialties that are currently **unsustainable and fragile** at one or both of our hospitals, to develop more robust services that we can reliably offer patients.

We know we cannot make all of these changes as individual hospitals and will work together and with our system partners to agree and implement our strategy. This will be the beginning of our journey to clinical excellence.

Staff survey results (2021) demonstrate support for collaboration



Our clinical strategy

Our Group vision

Work with health and care partners to prevent ill-health and reduce hospitalisation

Develop Centres of Excellence across all services, starting with cardiology and cancer

Ring-fence elective capacity to reduce waiting lists and variation between sites, and increase efficiency

Build on our University Hospital status to become a hub for training, research and innovation

To deliver our ambitions, we will work together more collaboratively, starting with our most fragile services

We are working with health and care partners to change the way care is delivered along the care pathway

University Hospitals of Northamptonshire NHS Group

Transformation of services across Northamptonshire

Our clinical services are delivered as part of a much bigger picture across Northamptonshire.

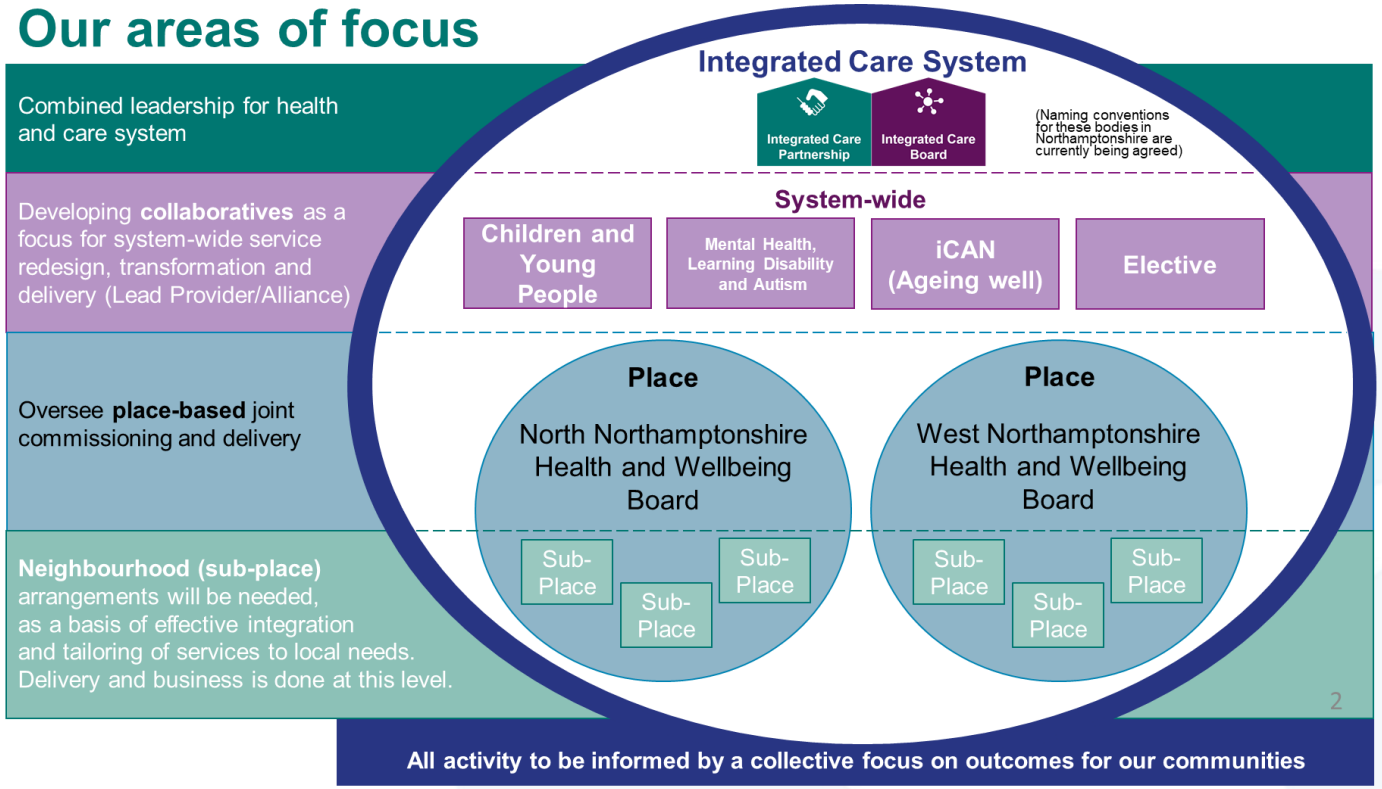
Health and care partners are transforming the way services are delivered in a newly formed Integrated Care System (ICS) called Northamptonshire Health and Care Partnership.

The ICS four priorities are being developed through collaboratives for:

1. Children and young people
2. Mental health
3. Integrated Care Across Northamptonshire (iCAN, ageing well), and
4. Elective care

We will come together at system (ICS) level with local organisations and providers to join up and redesign services to improve outcomes.

There are two 'Places' within the ICS, based on the geography of the two Unitary Authorities. It is at this level that we will deliver integrated care locally by connecting the hospitals with primary care, other health and care services and the voluntary sector. The aim is to deliver more care out of hospital.



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Our system ambitions will be delivered through collaborative working

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Collaboratives are the preferred delivery approach to realise our ambition for outcomes-based services to meet the health and care needs of our population

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Elective collaborative

We will work collaboratively with system partners to develop integrated pathways that support the transformation and delivery of more out of hospital care. Patients will access the right clinician in the right place, for example, in community integrated diagnostic hubs, transformed outpatient services supported by a systemwide patient waiting list to support equitable access.

Mental health, learning disability and autism

The Mental Health, Learning Disability and Autism Collaborative ('MHLDA') goal is to reduce health inequality, improve social impacts and enable this population to embrace their chosen life in the community, as an equal contributor to our county.

Across the Group, we will work with partners to support the development of integrated seamless pathways so that people who attend acute hospitals and emergency departments with mental health, learning disability or autism are treated rapidly and receive the aftercare required. In partnership with our mental health colleagues, we will also improve mental health support for inpatients with physical health conditions.

Children and young people

We will develop our out of hospital integrated children's service to support our children, young people and their families to provide the best quality service that wsill be integrated, holistic, offer choice and enable shared decision-making.

iCAN

The focus will be on improving outcomes for older people in Northamptonshire, through creating alternatives to an Emergency Department in the community, and by reducing admissions and length of stay in hospital. We will do this by working with local communities to help people remain well for longer and provide better self-care support.

In the Group, we will develop our frailty units to provide seamless pathways with community hubs to provide frailty assessment units, prevent hospital admissions and facilitate discharges.

Our Group clinical strategy includes engaging our clinicians in the development and implementation of these redesigned services

We aim to establish a cancer Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

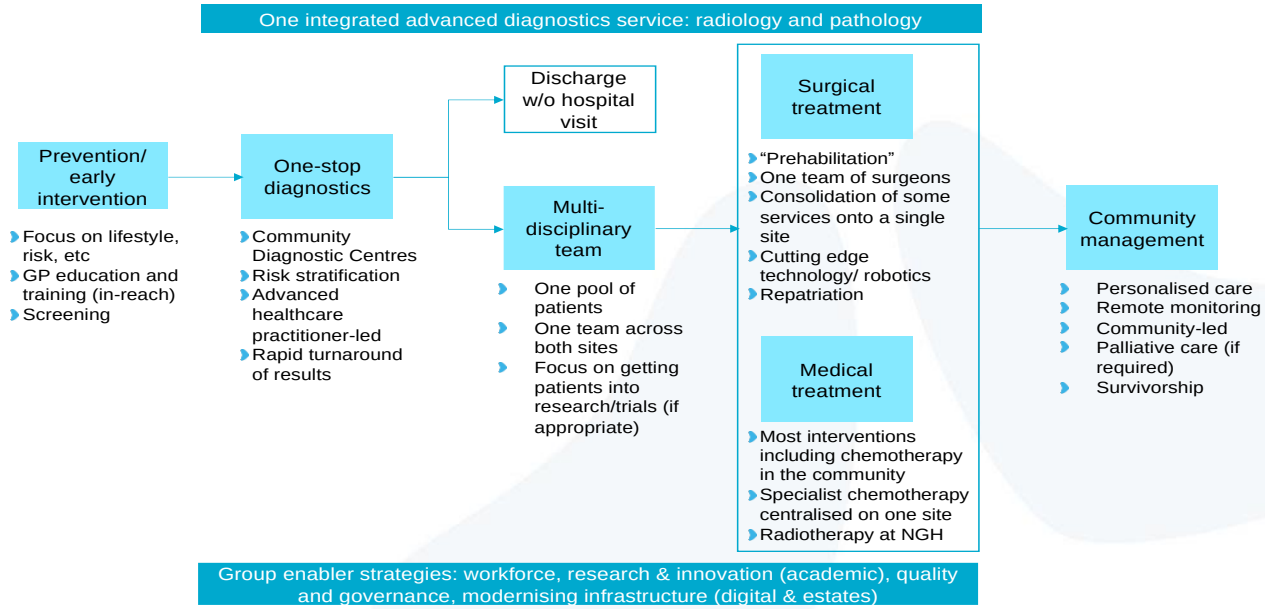
Our cancer Centre of Excellence

The cancer UHN Centre of Excellence will be an **integrated service** that the Group is known for nationally, owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output**.

The Centre of Excellence will **attract and retain leading experts**, offering **outstanding career and development opportunities** and providing a sustainable service that supports growth and innovation.

The Group will collaborate with system partners to explore new ways of working to increase the **accessibility and early diagnosis of cancer care**

Our proposed acute cancer pathway



As a Cancer Centre of Excellence, we commit to…

- ✓ A single cancer team driving the integration of pathways across the acute hospitals and in the community
- ✓ Equal access to excellent screening programmes across Northamptonshire
- ✓ Being in the top 10% nationally for a number of patient experience and outcome metrics, including cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

Dedicated to excellence

We aim to establish a cardiology Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

Our cardiology Centre of Excellence

The cardiology Centre of Excellence will be an integrated service across the Group which will be known nationally for **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload.**

The cardiology service will be known for its **extensive research capability, scholarship and academia, attracting and retaining leading experts** in the field.

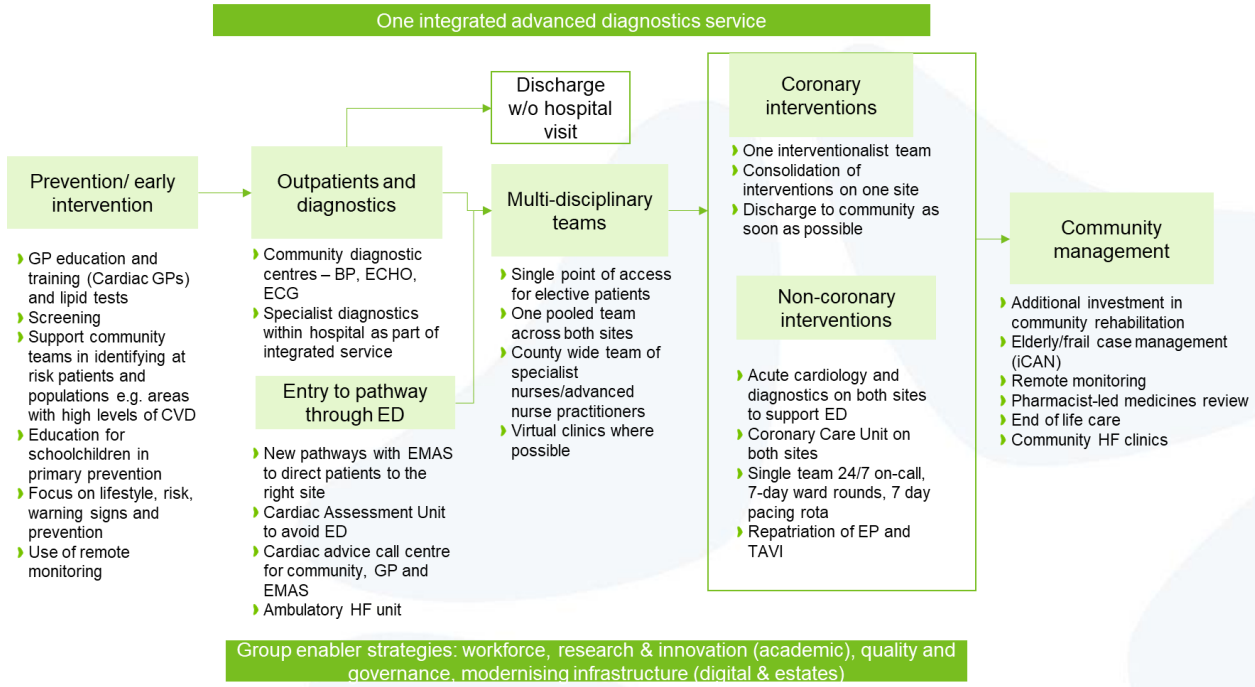
The cardiology service will work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

As a Cardiology Centre of Excellence, we will commit to…

- ✓ Delivering national quality standards for PCI and pacing as set out by Getting it Right First Time (GIRFT) BCIS (British Cardiovascular Intervention Society) and the National Institute for Cardiovascular Outcomes Research (NICOR)
- ✓ No duplication of complex procedures across sites, to improve quality and performance
- ✓ Focus on prevention in schools and with families of cardiac patients
- ✓ Work with GPs to treat patients in the community
- ✓ Virtual ward and remote monitoring to bring care closer to home
- ✓ Single cross site studies which will allow for greater population recruitment
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose
- ✓ Work in partnership with neighbouring Trusts to improve access to specialist cardiac services to all our PPCI catchment area

Dedicated to excellence

Our proposed cardiology pathway



We will ensure elective patients consistently get timely, equitable access to high quality care and experience

University Hospitals of Northamptonshire NHS Group

Our elective care strategy

In partnership with the Independent Sector, the Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committing to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation,** and maximise **day surgery** and **one stop pathways.**

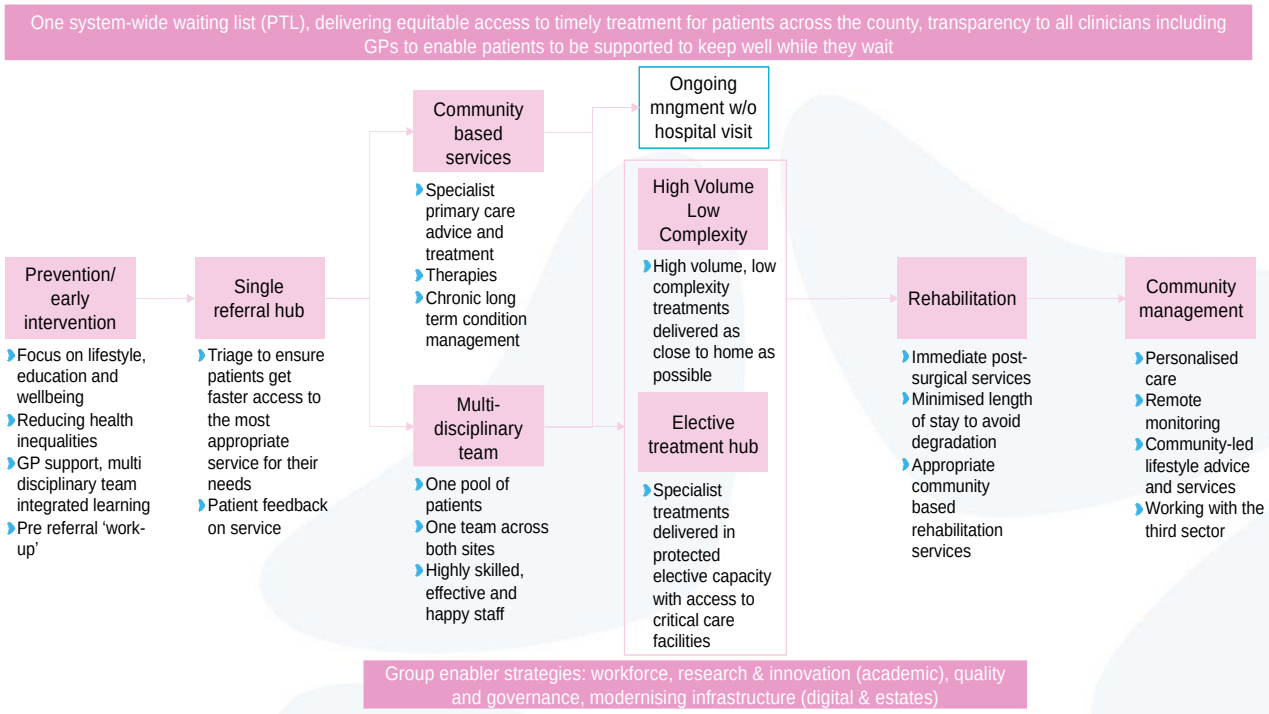
The Group is committed to delivering more care on a **day surgery** pathway at dedicated facilities developed in partnership with the Independent Sector and in Community Diagnostic Centres, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team will work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities.**

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.

Dedicated to excellence

Our proposed elective care pathway



As a lead provider for the elective care collaborative in Northamptonshire, we commit to…

- ✓ Single point of access across the ICS to elective care
- ✓ Working to deliver top decile performance in GIRFT and model health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnosis
- ✓ Delivering the same service and experience in the county regardless of provider

We will deliver emergency and integrated care as part of an emergency pathway, with partners

University Hospitals of Northamptonshire NHS Group

Our strategy for emergency and integrated care services

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

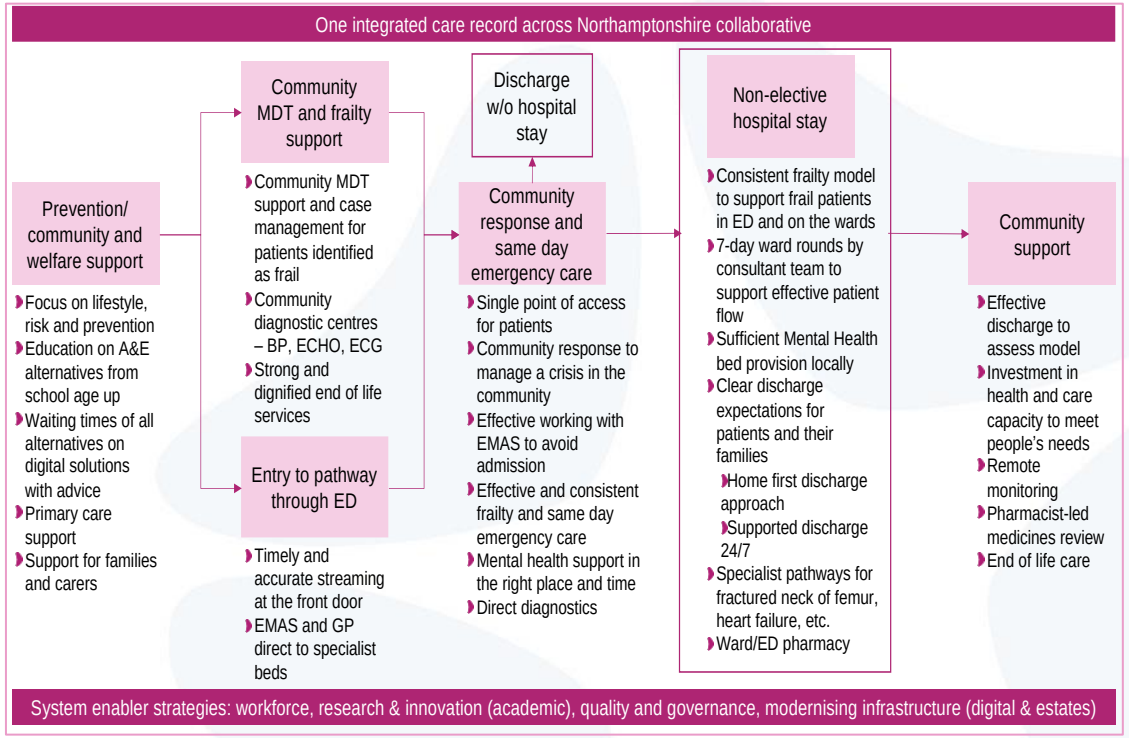
Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

As an emergency and integrated care service, we commit to…

- ✓ Develop pathways in partnership with the GP out of hours service, community teams and NHS 111 to direct patients who need emergency care to the right team, first time
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Supporting the expansion of Urgent Treatment Centres for minor injuries and illnesses,
- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county

Dedicated to excellence

Our proposed emergency pathway



Implementing our proposals will address the issues in our case for change

Case for change	*How our plans will address the case for change*
1. Meeting the needs of a growing and aging population	✓ Working closely with system partners to deliver seamless care particularly for patients with complex conditions ✓ Closer collaboration for frailty and older people's services
2. Strengthening fragile services	✓ Clinical integration will allow best practice to be shared across the Group ✓ Moving to single teams and/or single site working will allow us to use our staff and equipment as efficiently and effectively as possible ✓ Collaboration will combine the depth and breadth of our collective expertise allowing us to increase specialist service provision
3. Retaining and recruiting talent	✓ Establish the Group as an attractive place to work offering a broad career portfolio to our staff with increased clinical research opportunities and complex service provision ✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing ✓ By working together, we will have the scale to explore and pilot new roles and workforce models
4. Implementing clinical best practice	✓ Develop Centres of Excellence across all our services over time, building on the excellence that already exists, developing our services to become nationally known for excellent outcomes and patient experience. ✓ Increased provision of ringfenced beds on both sites and, in the longer term, aim to establish a dedicated elective unit(s) separate from emergency care
5. Reducing avoidable admissions and length of stay	✓ Working closely with our health and care partners through iCAN, which is focused on improving outcomes for older people in Northamptonshire, will reduce admissions and length of stay in hospital.
6. Reducing elective waiting lists	✓ Improving the quality of our services and increasing provision of specialist care will reduce patients being transferred out of area with corresponding length waiting times ✓ The Group will work to establish community diagnostic hubs which will reduce waiting times for diagnostics ✓ We will work collaboratively to protect our elective capacity, providing timely care, minimising infection rates and reducing length of stay in hospital
7. Improving our financial position	✓ Reducing vacancy rates and staff to reduce expenditure on expensive agency staff ✓ Consolidation and single- team working will allow us to use our resources efficiently ✓ Implementing clinical best practice will reduce duplication and avoid waste

There are several enablers that will need to be in place to deliver this clinical strategy

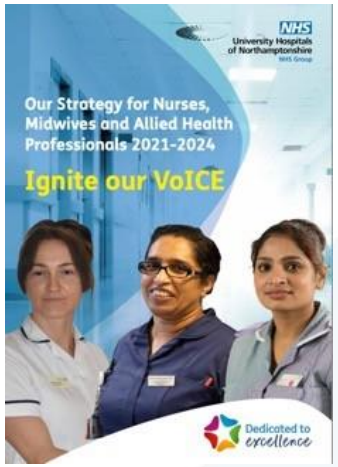
University Hospitals of Northamptonshire NHS Group

Enablers

We know there are several enablers that will be critical to delivery of the clinical strategy. Our clinical strategy will be supported by our Group enabler strategies:

- We have a robust digital plan in place that we will accelerate where possible.
- We have plans in place to recruit and retain a high quality and motivated workforce. Staff also highlight culture and communication as important if we are to achieve collaboration at pace.
- We will be supported by our academic strategy.
- We will have new estate at Kettering and Northampton from which to deliver our services.

Our enablers will be underpinned by a programme of transformation and quality improvement



Top three priority enablers as voted for by clinicians (workshops 2021)

Enablers	Diagnostics	Cancer	Women & Children's	Elective	Emergency
Capital investment in the right facilities	3		3	2	
Digital	1	2	2	1	1
Organisational Development and communications	2	3	2	2	2
Integrated workforce		1	1	1	2
Support structures			3		3
Reporting					

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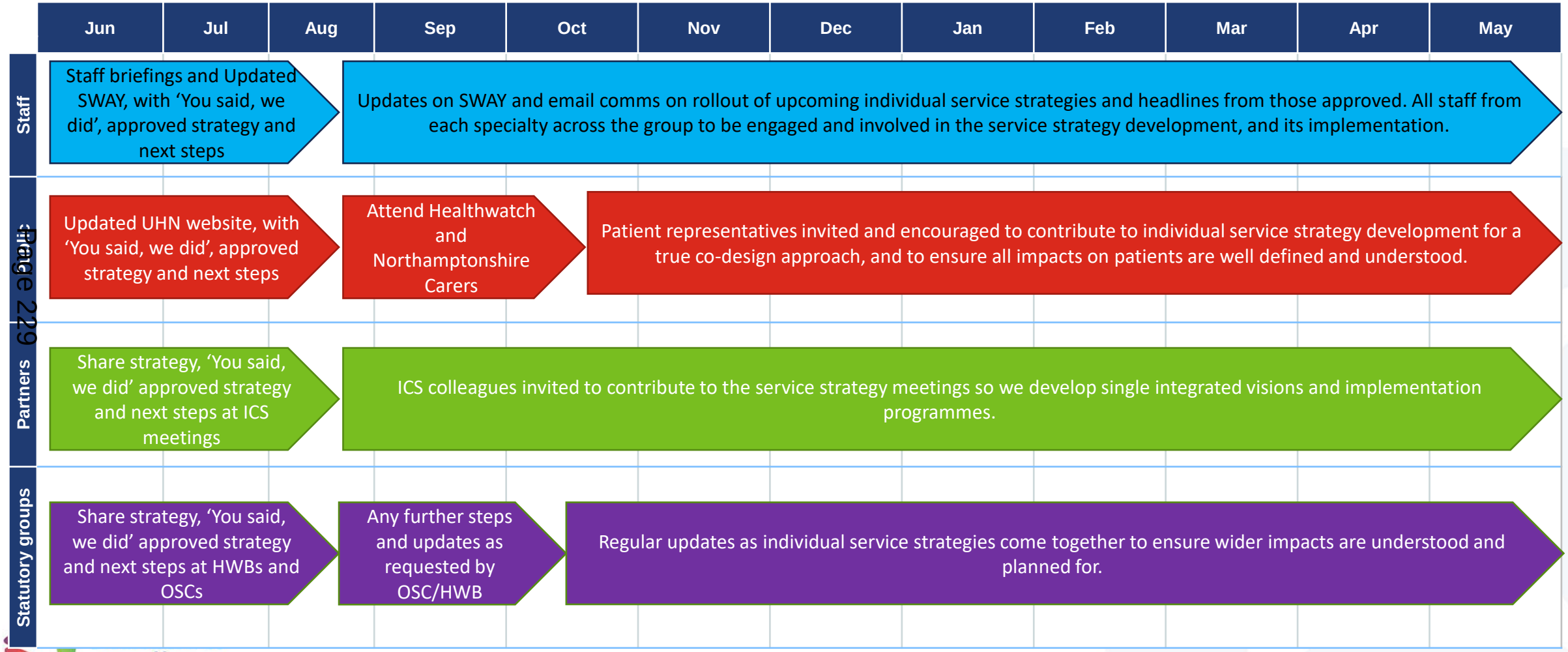
Engagement next steps

As we move forward in further developing the detail around the priority ambitions we have set out in this document, and in working with wider specialties in developing their future operating models, we remain committed to continuing the strong engagement and co-design that has been at the centre of the development of this document and our journey so far.



University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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Engagement in developing our strategy

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Our clinical strategy was developed with staff, patients and senior clinicians

University Hospitals of Northamptonshire NHS Group

Development → Listening → Learning

- Our clinical ambition has been developed together with our staff, patients, and in particular our senior clinicians.
  - Development of the clinical ambition in 2021 involved senior clinicians from across the Group in workshops and discussions involving over 200 clinicians.

All-staff survey

Through the all-staff survey and discussions with patient engagement leads, an initial set of hypotheses was developed.

These hypotheses were further developed through established clinical forums and extensively tested through 20+ pillar workshops with clinical and non clinical teams

Hypotheses were tested and developed with:

- ✓ **Clinical Reference Group**
- ✓ **NGH Clinical Leads Group**
- ✓ **KGH Clinical Leads Group**
- ✓ **Strategic Collaboration Group**
- ✓ **Joint pillar & specialty discussions**
- ✓ **UHN Group Clinical Senates**

Initial thinking and hypotheses were also tested with a Clinical Panel.

- A Clinical Senate was formed to consider in detail each element of the ambition with member clinicians reflecting the views of themselves and their colleagues. Over 200 attendances at both conferences combined. These have continued on a monthly basis to oversee the development of this document and to listen to all the feedback from the wide engagement, considering what else needed to be added and strengthen in our plans. Moving forward this senate will oversee implementation of the new ways of working.
- East and West Midlands Clinical Senate brought a wider breadth of clinical engagement and views.

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We engaged extensively through several different channels

University Hospitals of Northamptonshire NHS Group

Development | Listening | Learning

- We have spoken to:

600+ internal staff:
- 114 consultants
- 102 nurses
- 84 clinical support
- 300 other

ICS Partners, including:
- Northants CCG
- NHFT
- NNLA
- 360 Care Partnership

Distribution:
- 232 senior roles
- 52 middle grade/management
- 62 junior
- 77 other

Members of the public
- Website
- Survey
- Social media
- Public sessions

A number of groups, including:
- Primary care
- Governors

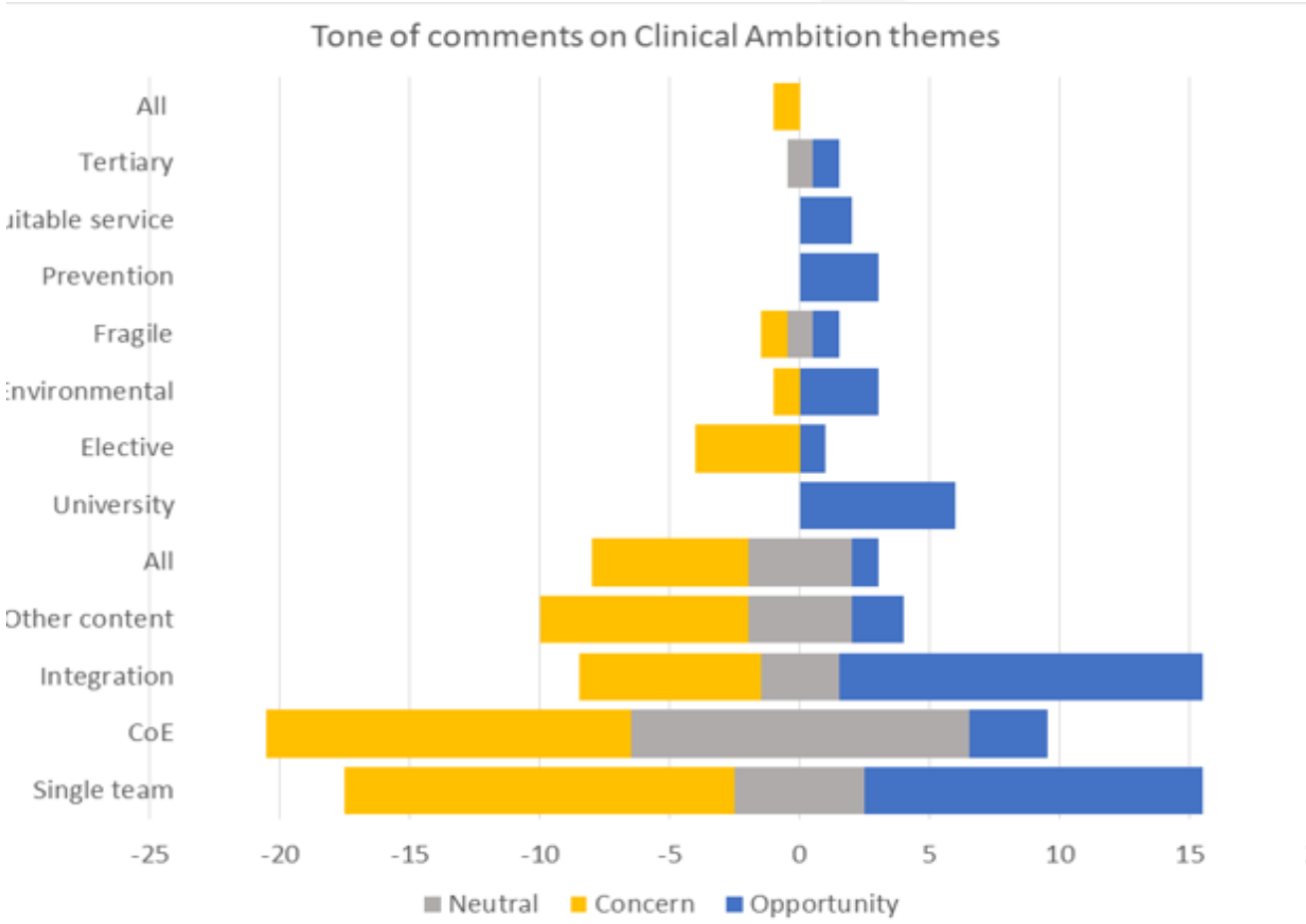
Dedicated to excellence

Feedback on the Clinical Ambition has shaped this Group clinical strategy

University Hospitals of Northamptonshire NHS Group

Development | Listening | Learning

- Feedback on the Clinical Ambition has shaped the Group Clinical Strategy.
- The conversation centred on how the two hospitals will work together as single teams, including how Centres of Excellence will provide better care for patients while maintaining excellent services on each site and avoiding unnecessary travel for patients.
- The case for change for integrating teams is strongest for specialties facing difficulties in recruitment, and patients will benefit in other specialties where there are opportunities to sub-specialise and bring services into the county which are not feasible with smaller teams.
- The clinical ambition reflects this feedback with an emphasis on centralisation of services only where this brings better outcomes for patients, with the emphasis on keeping services such as outpatient appointments either local or virtual wherever possible to reduce travel time for patients.



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Feedback on the clinical ambition has informed the strategy

University Hospitals of Northamptonshire NHS Group

Development → Listening → Learning

The issues raised most frequently during engagement are shown below. A full list is in the separate 'Clinical strategy engagement' report

You said…	Our response…
Will patients and staff have to travel further to access services at the Centres of Excellence?	We plan to keep the majority of routine appointments and treatments close to home. If we co-locate specialist services at the Centres of Excellence, patients will have greater access to services which were previously only available outside Northamptonshire e.g. robotic surgery. Where there is additional travel we will consider different options to ensure that staff and patients are not adversely impacted and can equitably access the services they need.
What will happen to services not at the hub of the Centre of Excellence?	The Centres of Excellence are a Group approach to benefit all patients and staff in the county. Cardiology and cancer services will have focussed development to meet the needs of the population that may be site specific if specialist care, but in general services will be delivered from both sites as part of the same Centre of Excellence.
Won't recruiting and retaining staff on the spoke sites be more challenging?	All staff will benefit from the CoEs if they choose, they can rotate between sites to update skills. Investment in the CoEs will provide new local development opportunities e.g. electrophysiology in cardiology to attract more staff into the county.
The buildings on both sites don't always reflect a CoE	The KGH HIP programme and site development plan for NGH will include development of Centres of Excellence
How will governance work for single teams but in two Trusts?	The strategy describes how Group Clinical Leadership will work including a site taking the lead responsibility for developing and implementing collaborative working and improved care for patients
There is a high dependency on IT for shared records and systems to deliver the strategy	The Group digital strategy describes how electronic records are being expanded on a Group-wide basis to ensure patients can be cared for between the sites, and with GPs and the community
Does past competition between care providers pose challenges to delivering truly collaborative working?	Healthcare staff want what is best for patients including joining up care between providers. Teams implementing the strategy will be supported where required by Organisational Development expertise
We need to look after the mental as well as physical health needs of our patients	The strategy now refers to how we will work jointly with colleagues in mental health, aligning the Group clinical strategy with the system mental health strategy
There is a lack of focus on delivering environmentally sustainable clinical services	There is a new section in the strategy focused on improving the environment for our local residents and the wider population

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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Our Group

Dedicated to excellence

Our Group is made up of two hospital Trusts in Kettering and Northampton

NHS
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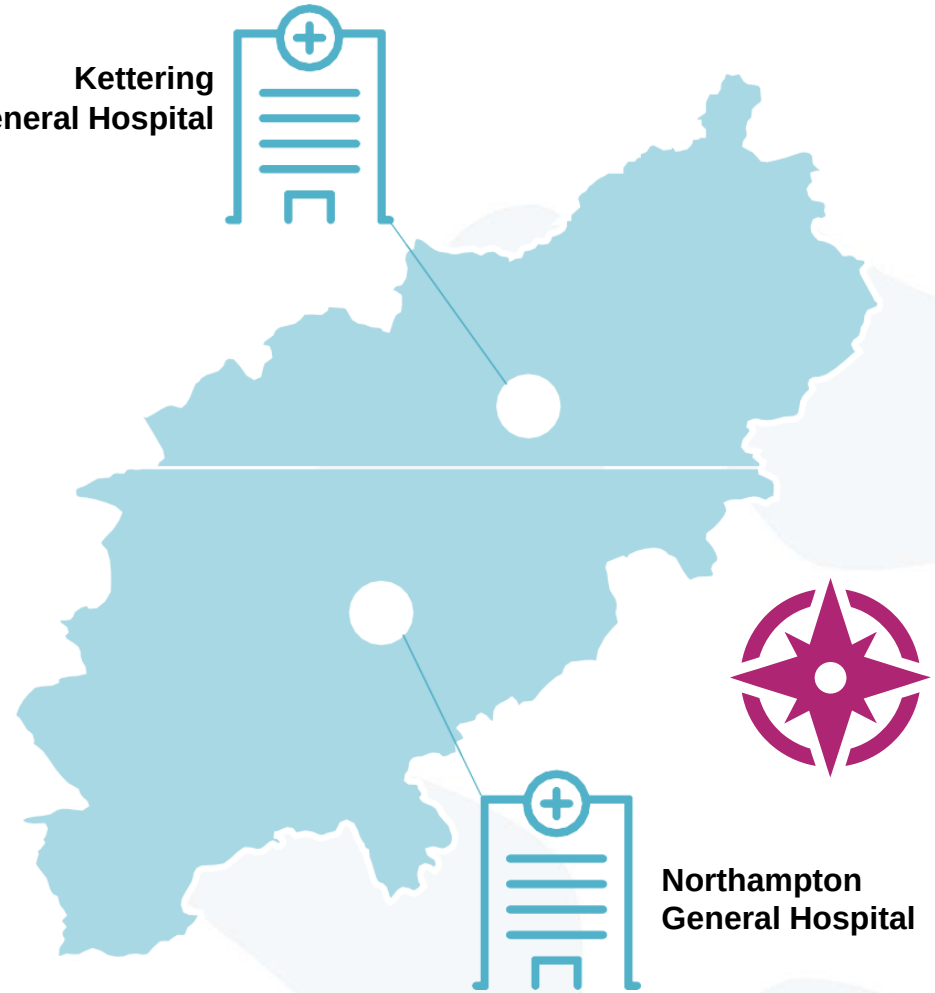
NHS Group

Our group is made up of Kettering General Hospital (KGH) NHS Foundation Trust and Northampton General Hospital (NGH) NHS Trust, and was formed in 2020.

We deliver acute services from two main sites: Kettering General Hospital and Northampton General Hospital. We also provide care at a number of satellite locations including in Corby, Wellingborough, Irthlingborough, Daventry and GP facilities.

Both our hospitals are acute hospitals providing 24-hour emergency care. We offer a full range of district general hospital care as well as some specialist services: KGH provides emergency cardiac care for the county and NGH provides stroke and some specialist cancer and care for the county. In total we have approximately 1,400 beds with over 600 at KGH and nearly 800 at NGH.

We serve a population of approximately 900,000 people across the county and employ over 9,000 staff, making us one of the largest employers in Northamptonshire.



Dedicated to excellence

We are part of the Northamptonshire Integrated Care System (ICS) where we collaborate with partners

University Hospitals of Northamptonshire NHS Group

Integrating care is a strategic priority at both a regional and national level given the recognised benefits to quality of care and patient experience.

NHS Long Term Plan and move to ICSs

The NHS Long Term Plan (LTP) sets out how integration of care across organisational boundaries is critical to overcoming the challenges health and care systems are facing.

With the move to ICSs, system partners will be required to work together to deliver 'triple integration' of primary and specialist care, physical and mental health services and health with social care. There will be increased support for integration between trusts to embed cultures of compassion, inclusion and collaboration across the NHS.

The *Integration and Innovation* white paper released in February 2021 accelerates the shift to ICSs by setting out the government's legislative proposals. These proposals intend to remove the barriers to integration including transactional bureaucracy, and ensure systems are more accountable and responsive to their populations.

Northamptonshire Health and Care Partnership

The Northamptonshire Health and Care Partnership (NHCP) is clear that working together and differently will help 'empower people to choose well, stay well and live well' .

As we move to establish our ICS NHS Body and ICS Health and Care Partnership in July 2022, system partners continue to develop plans for greater collaboration and integration across Northamptonshire in line with the White Paper: *Integration and Innovation; working together to improve health and social care for all*.

As part of our leadership within the ICS system, we will ensure we:

- Have a purpose and ambition that is closely aligned to the purpose and ambition of the ICS
- Enable clinical collaboration both across the Group and with services locally, integrating services at place level
- Are a strong leader in the system, providing collective leadership in all discussions and decisions regarding local clinical collaboration across the ICS
- Build relationships with wider providers across and outside our own ICS
- In line with the national and regional strategic direction, we recognise the importance of collaboration both within the group and with the wider system in order to deliver outstanding patient care.

There is an opportunity for our Group to be a key system leader, leading and delivering integrated services in the ICS, taking an active role to work with our system partners in both preventative and proactive care.

Dedicated to excellence

Our two Trusts are already collaborating in many clinical areas and are proud of our recent successes

University Hospitals of Northamptonshire NHS Group

We are already implementing Group-enabling strategies, and many of our clinical teams are already collaborating - but given the fragility of some of our services and the scale of the challenges we face - we know we need to go further, faster.

Many of our clinical teams are already collaborating, which we know is delivering benefits for our patients and our staff

Specialties which already collaborate include:

- Cancer
- Maternity & neonates
- Pathology
- Imaging
- Cardiology
- Head & neck
- Stroke
- Renal
- Nuclear medicine

Collaboration in head and neck services and cardiology has dramatically improved the patient experience

Patients on a ward at KGH on a Friday, transferred via ambulance to NGH and back on a Monday. No sharing of care records and disjointed care.

→

Single team working across both sites delivering seamless care and equitable access for patients.

Dedicated to excellence

Collaboration in cardiology has allowed the establishment of a heart attack centre for the county

Patients can access:

- 24/7 cardiac outreach nurse service
- 7 day a week PCI service for patients with minor heart attacks
- 7 day a week Consultant led service
- Specialist service for complex pacing devices and cardiac imaging

As a result, patients no longer have to travel to other specialist centres for life-saving treatment. This service means that patients have a reduced length of stay in hospital and improved rates of recovery from a heart attack.

Respondents to the all-staff survey (2021) spoke with pride about current clinical collaboration

'We already work together to share care of our patients, a **group clinical strategy** will ensure we are even more joined up and able to deliver even better care'

'The collaboration we're doing on **head & neck services** is something to be proud of. The drive for our Head & Neck clinical lead to develop an integrated service is something we need to replicate'

'Our county wide **stroke service** I feel has been hugely successful – this should be mirrored in other departments'

Full survey results can be found in Appendix A

We have recently become an academic university hospital and want to build our academic and research reputation

University Hospitals of Northamptonshire NHS Group

Our ambition to achieve international recognition as an academic centre that promotes and delivers better health service, provision and health outcomes to our patients

The Academic Strategy sets out how we will:

- Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer
- Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services
- Establish robust estates and digital infrastructure to support innovative clinical education and research
- Foster a culture of inclusivity and learning, with strong leadership championing the strategy
- Increase the number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources

Dedicated to excellence

Our vision for the Academic Strategy is to **improve patient care through excellence in education and research.** We will achieve our vision by delivering the following eight objectives:

- Partnering with University of Leicester to become a University Teaching Hospital Group
- Foster a culture of learning, research and innovation with strong leadership championing the strategy
- Provide a multi-professional clinical academic programme and improved training and development offer for staff
- Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice
- Increase the number of research posts in the Group including Associate Professorships, research clinicians and nurses
- Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio
- Increase success of research funding from research networks, grant giving bodies and commercial sources, and support sponsorship of those wanting to undertake their own research where this supports the clinical strategy
- Develop closer alignment with all our University partners
- Develop and promote the academic brand

We also have an opportunity to re-build our hospitals to support the delivery of high-quality services

University Hospitals of Northamptonshire NHS Group

Our current estate

Both hospitals have an aging estate that does not provide the experience we would like for our patients or for our staff. Our clinical services are not able to always be co-located next to each other meaning staff and patients sometimes have to travel across our hospital sites. In some cases patients are cared for in cramped environments with limited natural light or privacy and dignity. For our staff, they often have to work in less efficient ways to treat patients effectively and keep patients safe.

Our Estates Strategy

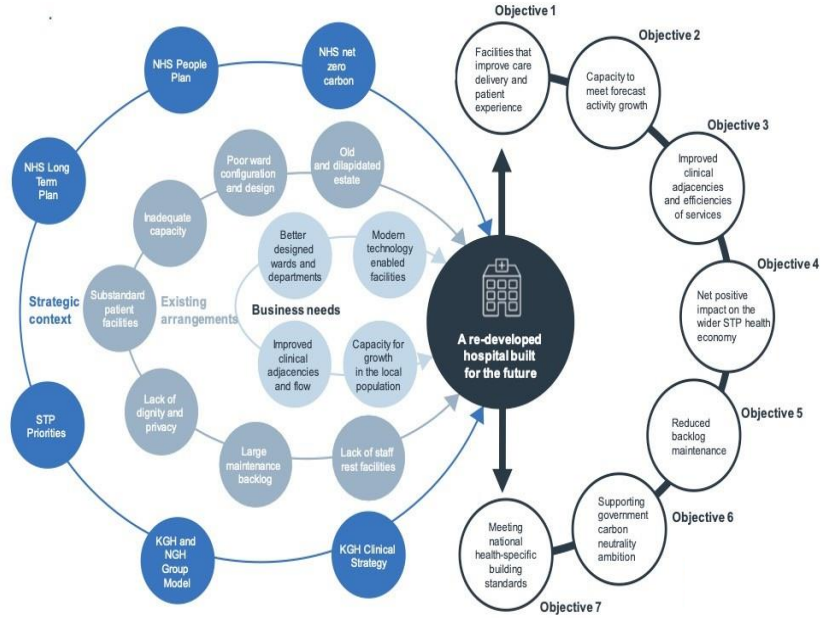
We will need to find ways to improve the current estate we have, and a Group Estate Strategy will follow to deliver the Group clinical strategy:

- **Kettering Hospital** submitted a Strategic Outline Case in January 2021 for a large re-build of the hospital incorporating a new ED and new wards, theatres, critical care and day services. This scheme is part of the national New Hospitals Programme and is on track to deliver by 2030.

- **Northampton General Hospital will** open a new state-of-the-art critical care unit by summer 2022 following earlier developments of a designated children's emergency department and new main entrance in 2021. We are preparing a full site development plan which will be informed by the clinical strategy and which will set the blueprint for future bids for funding on the site.

Dedicated to excellence

Our plans for KGH



Our new main entrance at Northampton Hospital

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

NHS
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NHS Group

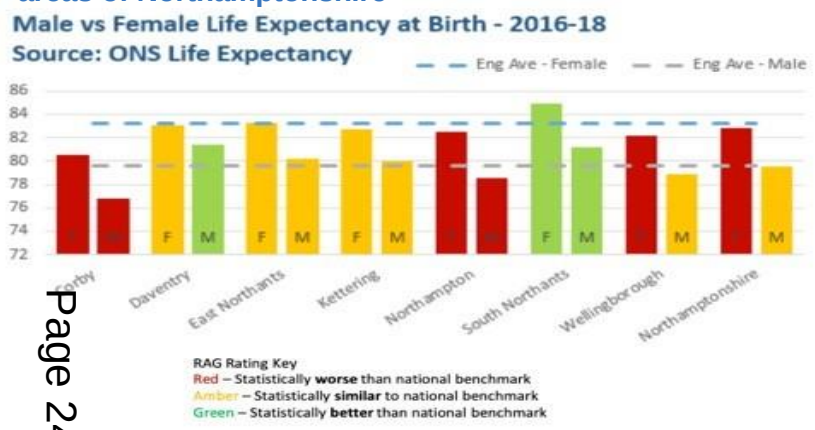
Our case for change

Dedicated to excellence

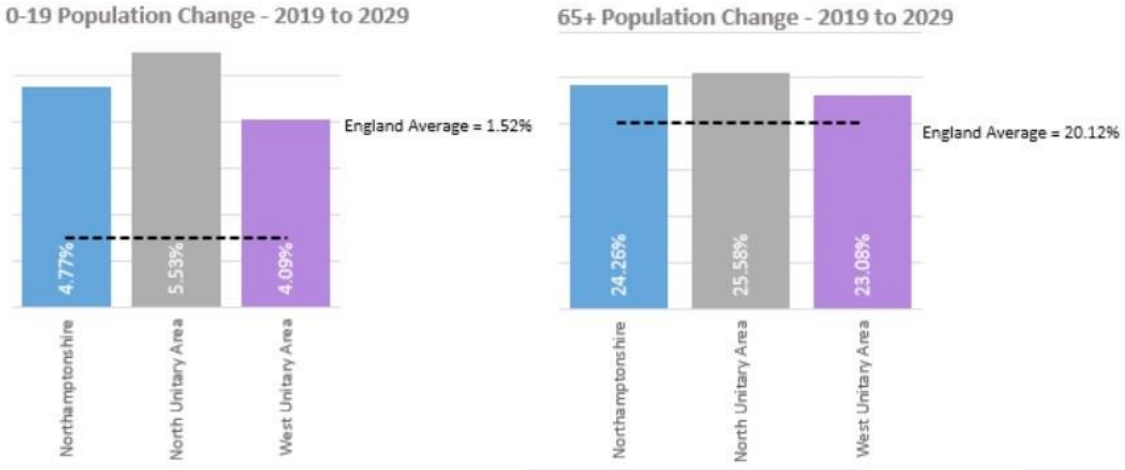
Our local population is older than the national average with poor outcomes in some areas

University Hospitals of Northamptonshire NHS Group

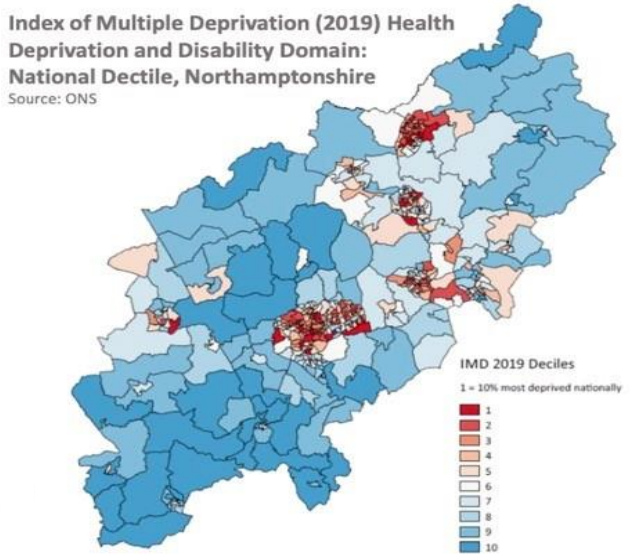
Life expectancy is lower than the national average in most areas of Northamptonshire



The old and young population are increasing faster than the national average



There are some areas of deprivation in Northamptonshire



There are poor outcomes in some areas. Across Northamptonshire, 90% of adult disease can be attributed to just 10 risk factors

Health & Wellbeing in Northamptonshire *JSNA Feb 2020*		
	59 deaths from COPD per 100,000	Worse than England avg.
	10% - adults with long-term mental health problems	Worse than England avg.
	68% adults overweight or obese	Worse than England avg.
	46 deaths from cardiovascular disease considered preventable per 100,000	Similar to England avg.
	80 deaths from cancer considered preventable per 100,000	Similar to England avg.

The local population is growing and aging and will need more care; we also need to address health inequalities

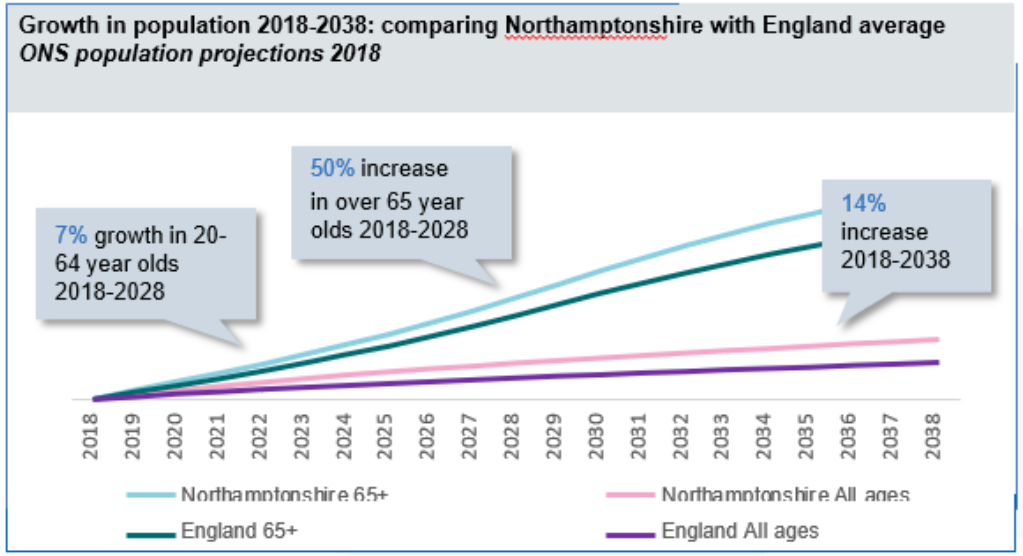
University Hospitals of Northamptonshire NHS Group

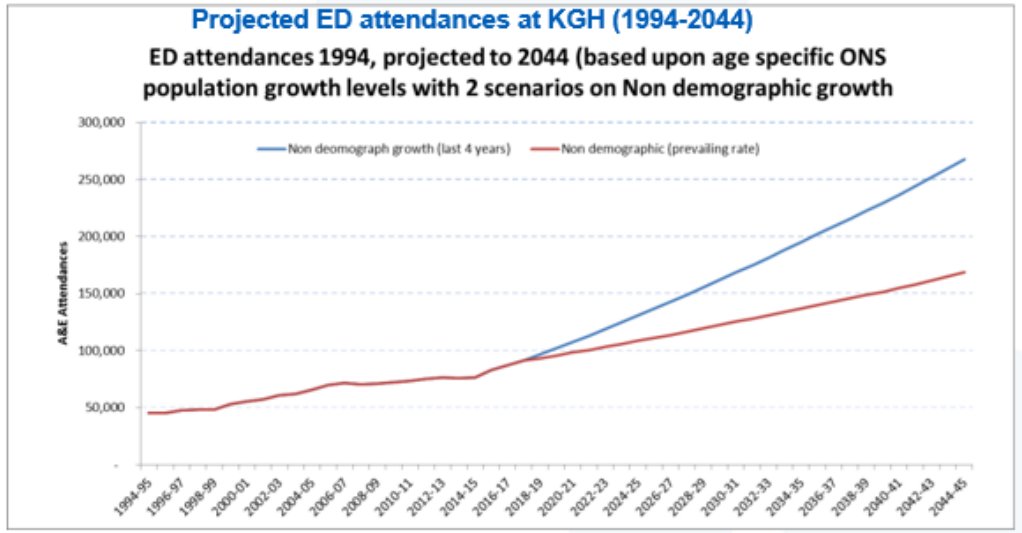
Our population is growing and ageing faster than the national average, increasing the demands on our clinical teams. The Northamptonshire population is projected to increase by 14% between 2018 and 2038. This includes a 50% increase in people aged over 65 (and we already have the highest percentage of over 65s in the country). An ageing population will increase the proportion of our patients with frailty and complex comorbidities.

In North Northamptonshire, a government-backed plan could also see 33,000 new homes built, primarily likely to be for young families, increasing demand for maternity and paediatric services.

The Northamptonshire Health Care Partnership (NHCP) has identified the growing population and increasing disease prevalence linked to unhealthy lifestyles as key drivers for change across the system.

We will work with our system partners to ensure our healthcare services are ready to meet the future needs of our population.





Dedicated to excellence

People are being admitted to hospital when it could be avoided and are staying longer in hospital than they should

NHS
University Hospitals of Northamptonshire
NHS Group

Our 2018 CQC local system review found patient experience for people aged 65+ was varied and sometimes unsatisfactory.

Compared to our peers, in Northamptonshire we:

- admit almost 9% more people aged 65+ a day to hospital (8 out of 90 daily admissions)
- have 12% more stranded patients:113 out of 900 on average, one in three patients in acute beds and one in two in community beds no longer need to be there
- are twice as likely to admit patients from the community and three times as likely from care homes.

Someone who needs care for a variety of conditions could be receiving services from five or six different organisations with very little coordination between them, which is confusing, wastes resources, and leaves no one taking overall responsibility for the individual's care. It also puts them at higher risk of an emergency department attendance or admission when things go wrong.

This is not what people want. It does not achieve the best outcomes for them. It is not the quality of care our organisations want for our residents. And with rising demand for health and care services in Northamptonshire and the Group had an an underlying deficit of £87m in 2020/21 which directly impacts on our ability to invest in staff and resources to drive up outcomes, and in our ability to transform pathways for patients.

Indeed, if we do not act now, in four years financial demand will have increased so much that we will not be able to support our population.

Dedicated to excellence

We have more to do to implement clinical best practice as many of our services "require improvement"

University Hospitals of Northamptonshire NHS Group

Overall, we have been rated as "Requires Improvement" by the CQC and our clinical strategy underpins our efforts to improve this rating.

Specific areas that have been highlighted for improvement include urgent and emergency care, surgery and services for children and young people at KGH, maternity services at NGH, and medical care (including older peoples care) at both KGH and NGH.

Workforce challenges are one of the key issues raised by CQC.

The national cancer patient survey highlighted timeliness of diagnostic tests and access to clinical networks as issues.

Dedicated to excellence

Both our organisations are rated by the CQC as 'requires improvement'

CQC Ratings
KGH 2021 NGH 2019

	KGH	NGH
Overall	**Requires Improvement**	**Requires Improvement**
Safe	Requires Improvement	Requires Improvement
Effective	Requires Improvement	Good
Caring	Good	Good Good
Responsive	Requires Improvement	
Well-led	Good	Requires Improvement

We are below national median in our friends and family scores

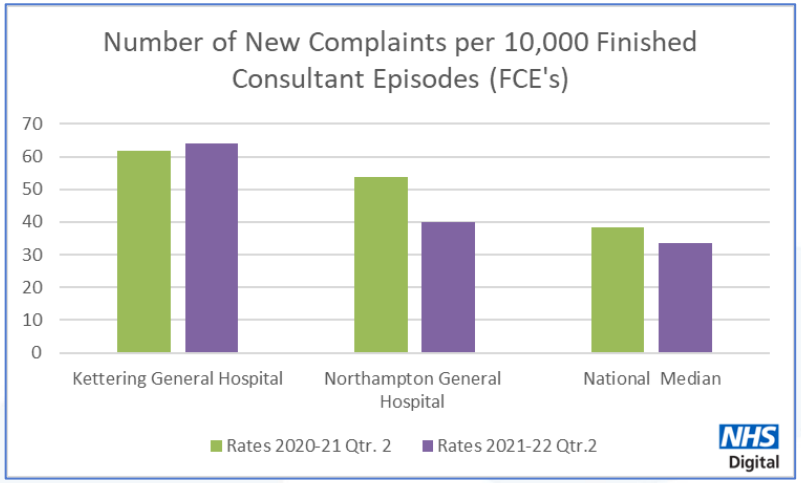
Friends & Family Test Scores
NHS England (For February 2022)

Friends & Family Test (FFT) Scores
KGH & NGH Inpatient Services are below the national median

For Feb 2022	KGH	NGH	National Median
A & E	77%	74%	77%
Inpatient	88%	92%	94%
Outpatients	92%	93%	93%

Sources: KGH & NGH Annual Patient Experience and Complaints Report 20120-21. Friends and Family Test Scores for the Month of February 2022, NHS England. NHS Digital Table 9c. East Midlands Cancer Alliance Patient Survey Question 61 in 2019 & 2020

Complaints remain high for NGH ED and at KGH for ophthalmology, urology and paediatrics



In 2020, Northampton General Hospital were the best in the East Midlands Cancer Alliance peers patient survey question "Overall how would you rate your care?", Kettering General Hospitals were rated lowest

We also need to follow the national direction of travel and national quality guidelines

University Hospitals of Northamptonshire NHS Group

We have identified a number of key national strategies and guidelines that have been considered in developing our clinical ambitions

Diagnostics: Recovery and Renewal 2020

- Split of emergency and elective
- Community diagnostic hubs to provide highly productive elective diagnostic centres
- Increase in advanced practitioner radiographer and assistant practitioner roles to address staff shortages.

Royal College of Physicians: Outpatients the Future

- Move to flexible, one-stop-shops, see-and-treat clinics and patient-initiated-follow-ups.
- Services should optimise the staff skill mix rather than always relying on consultant-led care

Royal College of Surgeons: Future of Surgery

- Increase in preventative surgery
- Increase in day-case surgery with focus on preoperative and follow up care undertaken using telemedicine and digital platforms.

GIRFT Recommendations

Including but not limited to:

- **GIRFT elective recovery programme:** standardised pathways at system level and establishing fast track surgical hubs while 85% of all elective surgery should be on a day surgery pathway**.**
- **GIRFT radiology 2020:** hot/ cold splits of activity, staff working at the top of their license, robust clinical pathways supported by clinical decision making tools.
- **GIRFT cardiology 2021;** introducing 7-day on-call, 7-day pacing services and extended access to diagnostics

NHS Long Term Plan recommendations

- **Cancer:** by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients.
- **W&C:** Children's mental health services are expected to grow to deliver integrated mental and physical health care. Where possible care will be delivered closer to home for children and their families.
- **Elective:** supports separation of urgent from planned services. Sets the ambition for the NHS to avoid up to a third of outpatient appointments.
- **Emergency:** every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care 12 hrs a day, 7 days a week. Need for appropriate triage and location for urgent mental health services.
- **Diagnostics:** networks to improve access to more complex tests and enable rapid transfer of clinical images
- **Discharge to assess** for all patients all of the time.

Dedicated to excellence

There is inequity in access and quality between our two hospitals

University Hospitals of Northamptonshire NHS Group

There is variation in the quality of access and quality between our hospitals. For some specialties there are significant differences in the time it takes for patients to receive treatment following a referral; for other specialties there is a variation in how long patients on average spend in hospital once they're admitted; and some specialist treatments are simply not accessible to some patients.

The pandemic nationally has exacerbated health inequalities in populations, with many patients with underlying or deteriorating health even less likely to access the care they need in the right way. We will implement tools to analyse how effective our services are at reaching those of greatest need, and make changes to ensure we eliminate health inequality of access to our services.

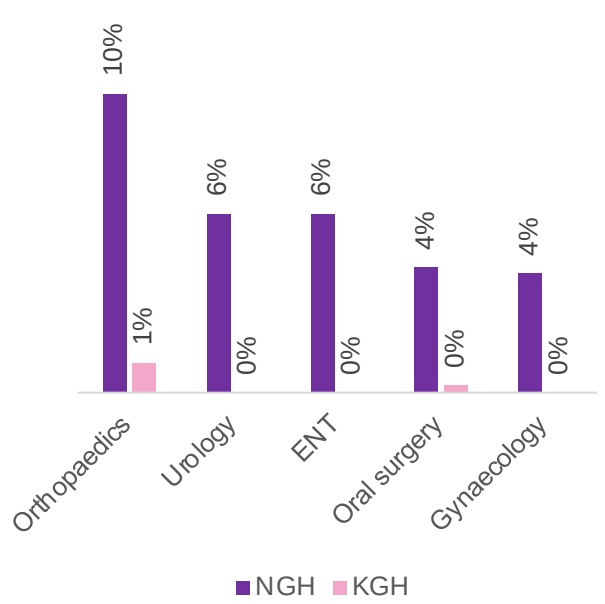
The Northamptonshire Health Care Partnership has set an ambition to ensure everyone has access to the best care wherever they live in the county. We are committed to delivering against this.

Our survey of staff identified reducing variation in quality variation across our hospitals as a top priority.

Dedicated to excellence

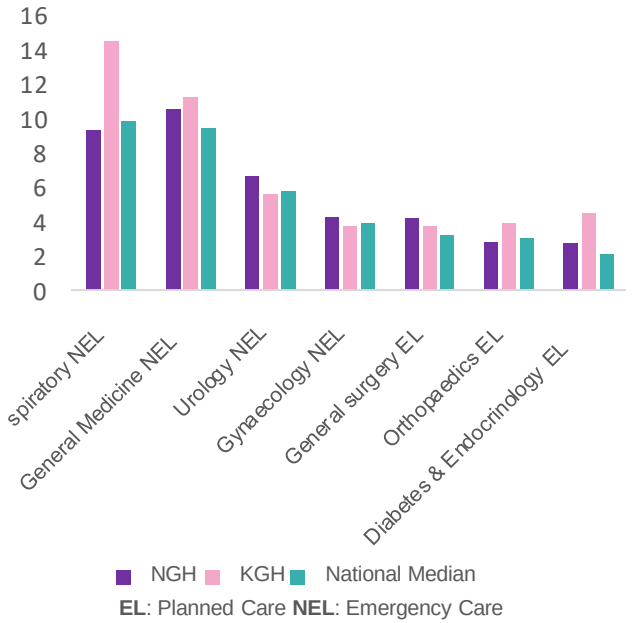
For some specialties there are significant differences in % of patients waiting over 52 weeks for planned care

RTT 52 week wait against national target of 0% for specialties with > 4%point difference
NHS England, RTT Waiting Times (Mar 2021)



…and in others the length of stay varies by over half a day between the trusts

Average rolling length of stay (2019/20) for specialties with a 0.5 day difference
NHS Digital, Hospital Episode Statistics



Survey respondents identified that one of the biggest opportunities for collaboration was to begin to reduce the **clinical quality variation** across sites.

We find it difficult to retain and recruit to some specialties with a national shortage of staff in some areas

University Hospitals of Northamptonshire NHS Group

There is a national picture of staff shortages and healthcare providers are increasingly collaborating to address this. The Health Foundation predicts that by 2031 there will be a 375,000 FTE gap between staff in post and future demand. This modelling has not taken account of the pandemic impact which may worsen staffing shortages. The Kings Fund acknowledge that staffing shortages were already widespread before the pandemic hit leading to excessive workload and high levels of stress for staff in post.

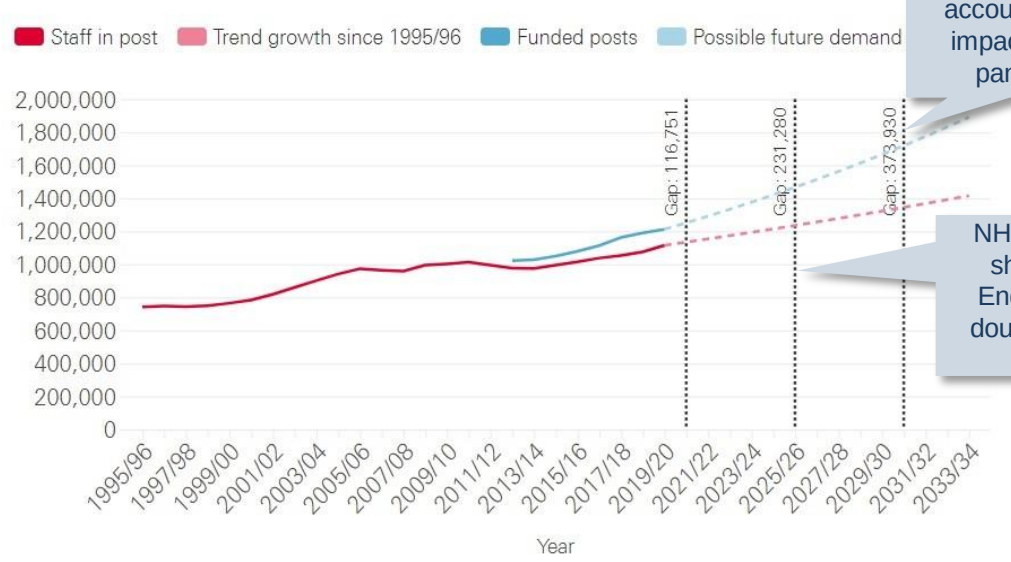
We have identified areas where national workforce shortages particularly impact on our services:

- Interventional and breast radiology
- Emergency care; all medical grades
- Microbiology and blood sciences
- Specialist cardiology nurses
- Physiotherapists and occupational therapists
- Cardiologists
- Respiratory consultants
- Theatre staffing
- Cancer nursing specialists
- Fetal medicine (at KGH)

The close location of tertiary centres also mean that staff have other attractive employment options.

The Health Foundation (2020) 'Going into COVID-19, the health and social care workforce faced concerning shortages'

Potential future shortfall in workforce supply in the NHS in England



Potential gap of 374,000 FTE staff by 2031-32, which does not account for any impacts of the pandemic

NHS workforce shortages in England set to double in next 5 yrs

"Before the pandemic, **staffing shortages were endemic**, chronic excessive workloads commonplace and levels of stress, absenteeism and turnover worryingly high"
Kings Fund (2021) A plan for the NHS and Social Care

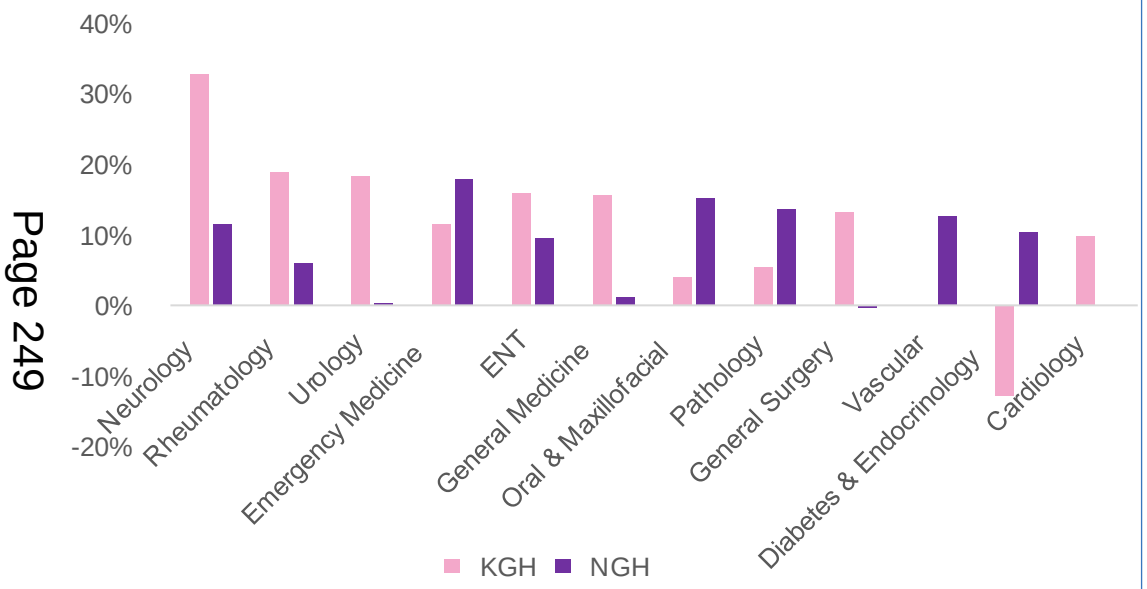
Dedicated to excellence

Workforce shortages drive a reliance on bank/agency staff which impacts on quality (and cost) of services

University Hospitals of Northamptonshire NHS Group

In common with the wider NHS, our organisations are struggling to attract and retain clinical staff with significant vacancy rates

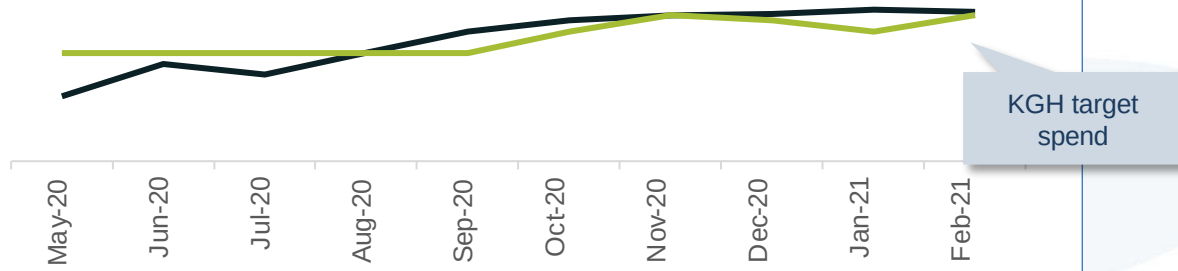
Vacancy Rates by specialty for March 2021
KGH & NGH Human Resources (Mar 2021)



The model hospital data places NGH approximately **10% below** their peer median in terms of overall substantive WTE medical staff. KGH is **12% below** their peer median by this measure.

There is a heavy reliance on agency and substantive staff overtime which creates a significant financial pressure.

Agency spend in £m – (Dec-20 is equivalent to 7% of pay expenditure)
KGH Board Report March 2021



"Temporary staff require a level of orientation and supervision that substantive staff – already under pressure – may find difficult to provide. When the proportion of temporary staff becomes too great, this **impacts the quality of care** provided"

Royal College of Nursing (2017) Safe and Effective Staffing

"Staff shortages identified as the most important factor in determining chronic excessive workload – **a key contributor to staff burn out"**
Health and Social Care Committee (2021) Workforce Burnout

Dedicated to excellence

Existing structures are potential barriers to effective collaborative work

- While there are already examples of good collaboration between the two Trusts there is background of competition rather than collaboration in the NHS which has led to culturally different approaches
- We are working towards making it easier for teams to work across sites, for example we now have an MoU in place to allow staff to work across sites should they choose to
- We have in place a programme of HR policy harmonisation so that we have one set of HR policies, and will be looking at our mandatory training alignment in 2022/23
- However, there are still significant examples of separate arrangements for some of the fundamentally important aspects of joint working. We will address some practical arrangements, examples being; different work patterns and a different to approach to on call arrangements

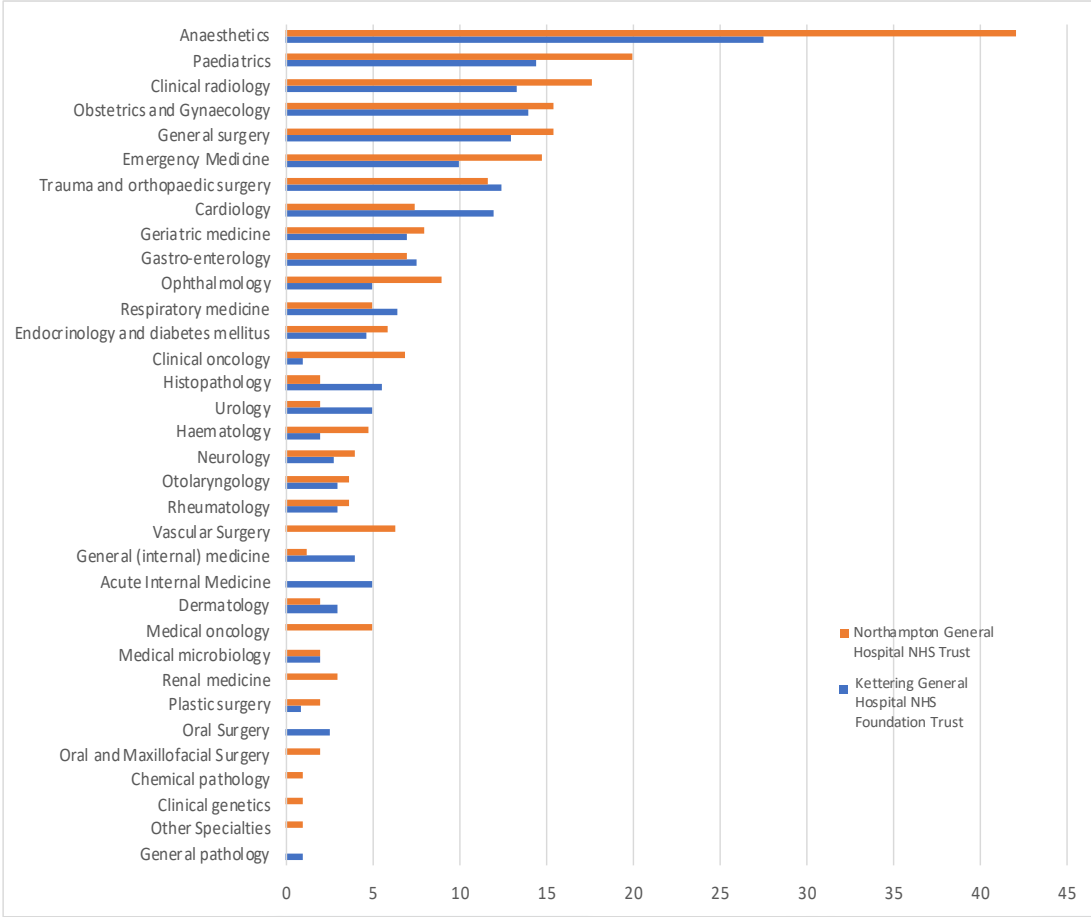
Some of our services are fragile with few consultants in some specialties, and/or small volumes of patients

We have few consultants in some specialties and there are insufficient levels of activity:

- **Neurology**: significant pathway improvement opportunities at both sites (driven by workforce challenges)
- **Geriatric medicine:** the volume of work in this specialty is one that is not only likely to continue to grow significantly, but will also increasingly require specialist skills that interconnect with all other specialisms of care. Nationally there are not enough geriatricians to support this service in the future which results in general adult physicians needing to cover.
- **Surgery**: concerns about workforce sustainability of smaller specialist services including plastics, head and neck, hand surgery and spine surgery
- **Plastics:** fragile service with inpatients already seen at University Hospitals Leicester
- **Gastroenterology:** activity at NGH is in smallest quartile nationally with high costs and poor waiting list performance
- **Microbiology:** workforce shortages at NGH leading to unsustainability
- **Renal:** workforce shortages at KGH requiring a Group approach
- **Haematology:** workforce shortages for a high demand service

These services are not currently resilient or able to adapt to changing conditions. There are challenges to delivering high quality services efficiently and effectively, and our ability to attract staff in these areas

Number of WTE consultants, by specialty, by site



Source: NHS Workforce statistics, May 2021 (excludes Associate Specialists and Staff Grades)

We need to change the way we deliver services to improve quality and efficiency against a difficult financial position

University Hospitals of Northamptonshire NHS Group

Although the Northamptonshire Health System broke even in 2021/22, this was in part due to one off funding e.g. to fund recovery of the waiting list and manage Covid. In 2020/21 there was an underlying deficit of £87m across the Group, and the financial position in 2022/23 across the group and the System remains very challenging. This directly impacts on our ability to invest in staff and resources to drive up outcomes, and in our ability to transform pathways for patients.

Many services, often those with low clinical output and workforce challenges, are comparatively expensive to run when compared to other Trusts.

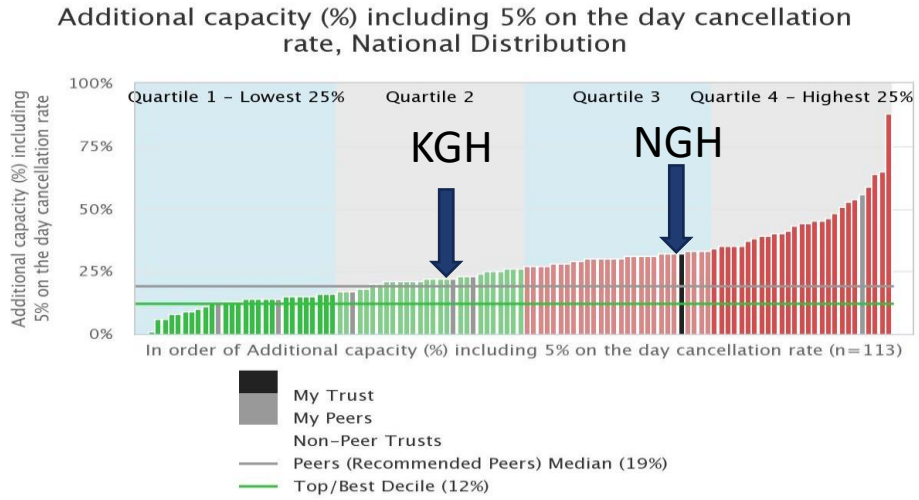
Opportunities have been identified through the Getting it Right First Time (GIRFT) programme:

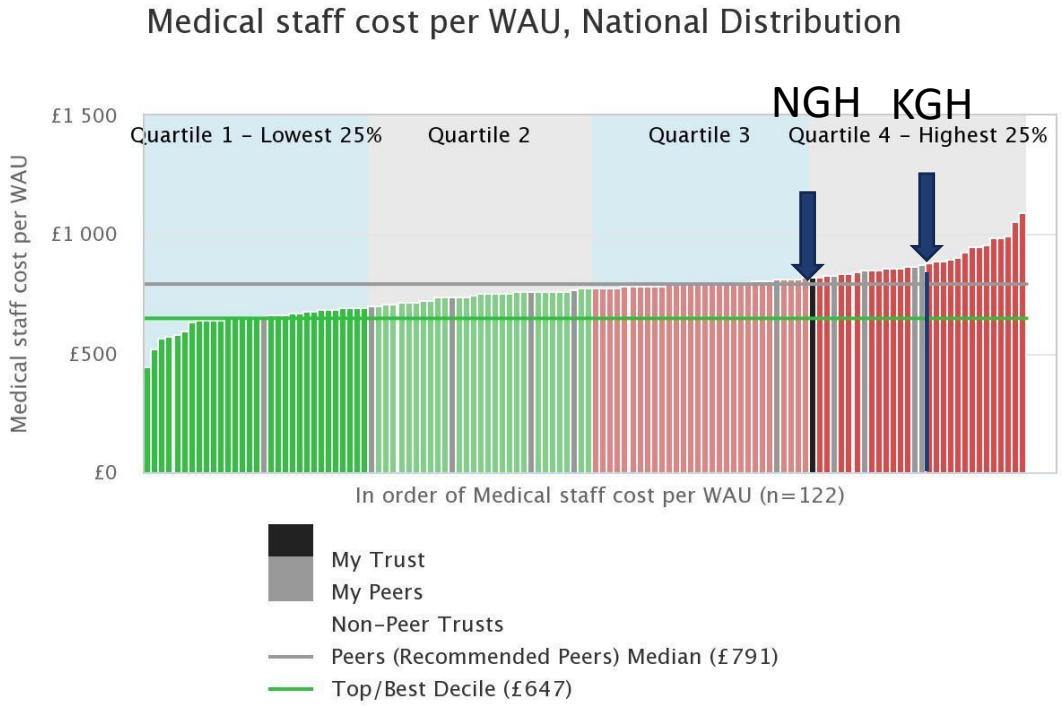
- re-admission rates are high in many specialties
- there are opportunities to improve daycase rates
- there are high lengths of stay for general surgery and orthopaedics
- GIRFT have identified opportunities for efficiencies in orthopaedics, ENT and breast surgery

GIRFT also recommended th

Model hospital data (2020) shows that, compared to peers:

- Kettering General Hospital has comparably high medical staff costs
- Kettering General Hospital has higher nursing staff costs
- Northampton General Hospital has comparably high medical staff costs
- Northampton General Hospital has similar to average nursing staff costs





Dedicated to excellence

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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Our proposals for transformation

Dedicated to excellence

We have developed a Group strategy which is guiding the development of our clinical strategy

University Hospitals of Northamptonshire NHS Group

In January 2021, Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust boards approved our Group strategy. This sets out our shared vision, mission and values, all 'dedicated to excellence'.

The Group strategy also outlines the Group priorities and programmes of work required to deliver against these.

One of these programmes of work or 'strategic initiatives' was to **develop a Group clinical strategy and clinical collaboration**.

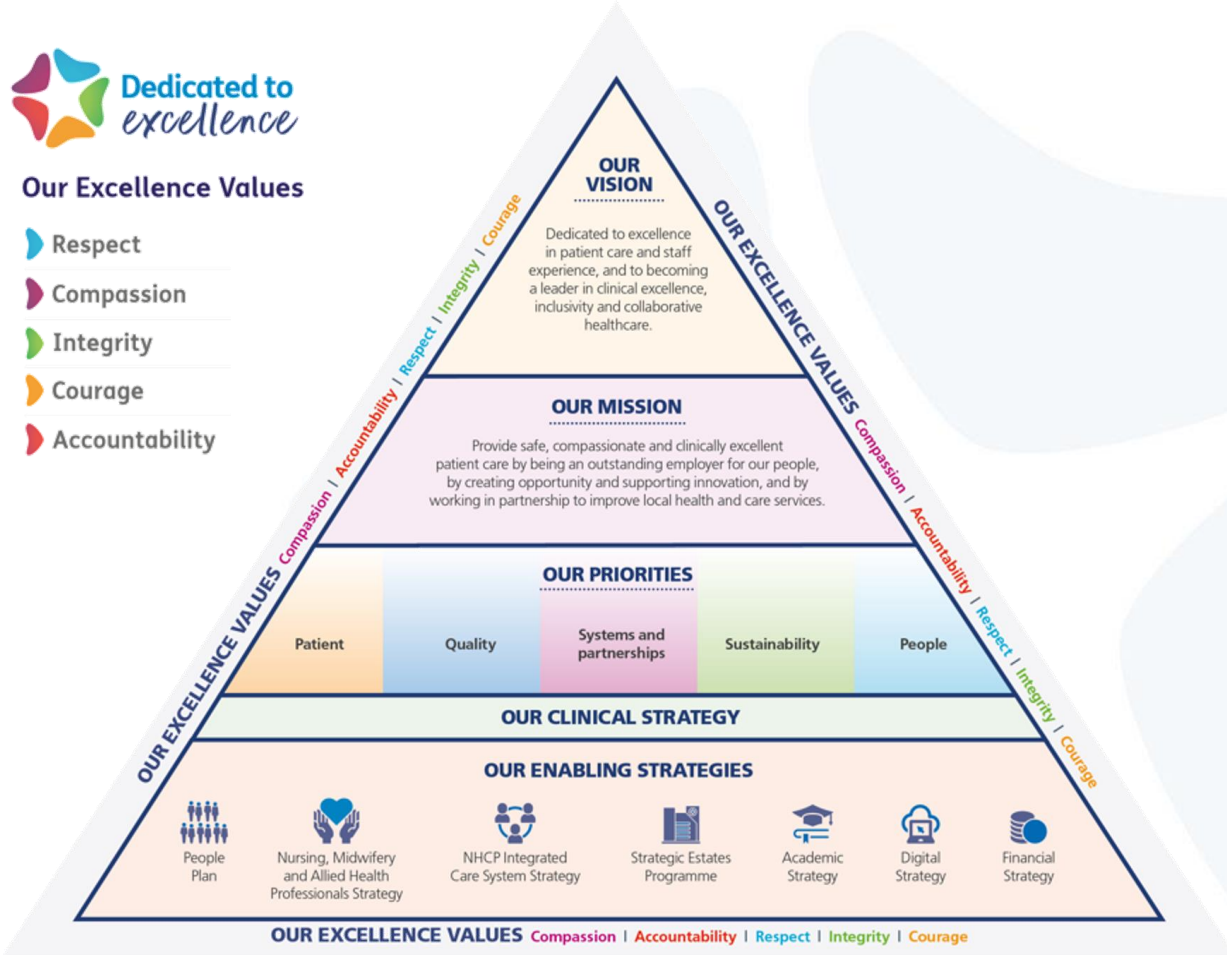
Dedicated to excellence

Our Group *dedicated to excellence strategy* sets out our values, vision, mission and group priorities – this identified a Group clinical strategy as a key strategic initiative

Dedicated to excellence

Our Excellence Values

- Respect
- Compassion
- Integrity
- Courage
- Accountability



We have explored what our Group vision means for the clinical strategy

University Hospitals of Northamptonshire NHS Group

OUR GROUP VISION STATEMENT

Dedicated to outstanding patient care and staff experience by becoming a university hospital group and a leader in clinical excellence, inclusivity and collaborative healthcare.

OUR GROUP MISSION STATEMENT

Provide safe, compassionate and clinically excellent patient care by being an outstanding employer for our people, creating opportunity and supporting innovation and working in partnership to improve local health and care services.

What the Group vision means for the clinical strategy

- The Group will be **known for safe, compassionate and clinically excellent care**: working in partnership as a **system leader** of integrated acute care and a **hub for innovation and research.**
- Integrated services will deliver **consistently exemplar outcomes** for our patients across Northamptonshire, providing timely, seamless care, **minimising disruption to our patients' lives**. Patients will only come in when they need specialist acute services.
- Our staff across the Group will work collaboratively, and with system partners, to deliver **cutting edge treatments** and produce **high quality research,** enabling the Group to become an outstanding employer able attract and retain leading experts.
- Patients and staff across the county are **proud of their local NHS.**

Dedicated to excellence

We have developed clinical ambitions and proposals that will transform care for patients

University Hospitals of Northamptonshire NHS Group

To achieve our Group vision, we propose that our clinical collaboration focus on four core ambitions:

1. Work with our partners to **prevent ill-health and reduce hospitalisation**, changing the way care is provided along the care pathway.
2. Develop **two centres of excellence** in the county, building on our established strengths in each hospital. Each centre of excellence will be across both hospitals and patients will have the same, high quality care wherever they access services. Our centres of excellence will be for everyone in Northamptonshire, and cardiology will be led by Kettering General Hospital with cancer led by Northampton General Hospital.
3. **Protect elective beds** to reduce cancelled operations, reduce long waiting times and increase efficiency.
4. **Build on our University Hospital status**, to become a hub for innovation, training and research, attracting high calibre talent and growing the number of clinical trials our patients can access.

To deliver our ambitions, we propose solutions for the specialties that are currently **unsustainable and fragile** at one or both of our hospitals, to develop more robust services that we can reliably offer patients. We know we cannot make these all of changes as individual hospitals, and we will work together and with our system partners to agree and implement our strategies.

Our clinical ambitions

Our Group vision

Work with health and care partners to prevent ill-health and reduce hospitalisation

Develop Centres of Excellence across all services, starting with cardiology and cancer

Ring-fence elective capacity to reduce waiting lists and variation between sites, and increase efficiency

Build on our University Hospital status to become a hub for training, research and innovation

To deliver our ambitions, we will work together more collaboratively, starting with our most fragile services

Dedicated to excellence

We are working with health and care partners to change the way care is delivered along the care pathway

University Hospitals of Northamptonshire NHS Group

Transformation of services across Northamptonshire

Our clinical services are delivered as part of a much bigger picture across Northamptonshire.

Health and care partners are transforming the way services are delivered in a newly formed Integrated Care System (ICS) called Northamptonshire Health and Care Partnership.

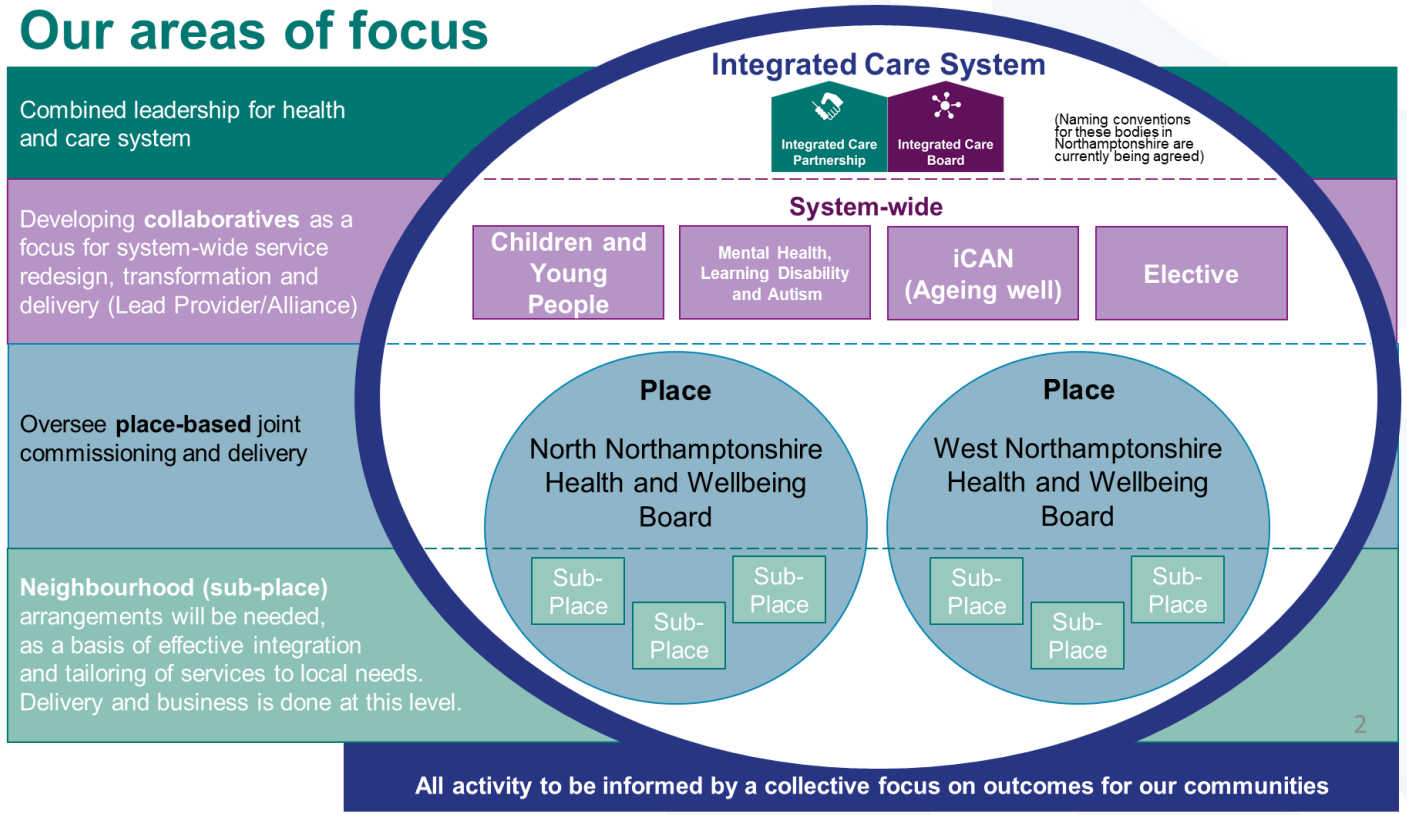
The ICS four priorities are being developed through collaboratives for:

1. Children and young people
2. Mental health
3. Integrated Care Across Northamptonshire (iCAN, ageing well), and
4. Elective care

We will come together at system (ICS) level with local organisations and providers to join up and redesign services to improve outcomes.

There are two 'Places' within the ICS, based on the geography of the two Unitary Authorities. It is at this level that we will deliver integrated care locally by connecting the hospitals with primary care, other health and care services and the voluntary sector. The aim is to deliver more care out of hospital.

In the Group, we will develop our frailty units to provide seamless pathways across the community to prevent hospital admissions and facilitate early discharge.



Dedicated to excellence

Our system ambitions will be delivered through collaborative working

Collaboratives are the preferred delivery approach to realise our ambition for outcomes-based services to meet the health and care needs of our population

Dedicated to excellence

Elective collaborative

We will work collaboratively with system partners to develop integrated pathways that support the transformation and delivery of more out of hospital care. Patients will access the right clinician in the right place, for example, in community integrated diagnostic hubs, transformed outpatient services and a system patient list to provide equitable access

Mental health, learning disability and autism

The Mental Health, Learning Disability and Autism Collaborative ('MHLDA') goal is to reduce health inequality, improve social impacts and enable this population to embrace their chosen life in the community, as an equal contributor to our county.
Across the Group, we will work with partners to support the development of integrated seamless pathways so that people who attend acute hospitals and emergency departments with mental health, learning disability or autism are treated rapidly and receive the aftercare required. In partnership with our mental health colleagues, we will also improve mental health support for inpatients with physical health conditions.

Children and young people

We will develop our out of hospital integrated children's service to support our children, young people and their families to provide the best quality service that will be integrated, holistic, offer choice and enable shared decision-making.

iCAN

The focus will be on improving outcomes for older people in Northamptonshire through alternatives in the community to the Emergency Department and by reducing admissions and length of stay in hospital. We will do this by working with local communities to help people remain well for longer and provide better self-care support.

In the Group, we will develop our frailty units to provide seamless pathways with community hubs to provide frailty assessment units, prevent hospital admissions and facilitate discharges.

Our Group clinical strategy is to engage our clinicians in the development and implementation of these redesigned services for the benefit of patients

We will develop centres of excellence, starting with cardiology and cancer

University Hospitals of Northamptonshire NHS Group

We will develop Centres of Excellence across all our services over time, building on the excellence that already exists with the first Centres of Excellence in cancer and cardiology. This is an opportunity to expand and develop our services to become nationally known for excellent outcomes and patient experience.

Our **Cancer Centre of Excellence will** provide a fully integrated system wide service ensuring equity of care across Northamptonshire. Our cancer centre of excellence will be across both hospitals and patients will have the same, high quality care wherever they access services. Our cancer centre of excellence will be for everyone in Northamptonshire and we propose consolidating some specialist cancer surgery at Northampton General Hospital, to improve outcomes and quality. We will broaden the complexity of our case load to offer patients highly specialised treatments including precision medicine, the next generation of robotic surgery and artificial intelligence assisted diagnostics.

We will offer a single point of access for patients from anywhere in Northamptonshire and work closely with health and care partners to prevent cancer and identify cancer earlier, including the development of one-stop diagnostics centres.

Our **cardiology Centre of Excellence will** be across both hospitals and patients will have the same, high quality care wherever they access services . It will focus the delivery of some of our more specialist services at Kettering General Hospital with a single team (with a single clinical leadership) providing high quality care across both sites. We will build and grow specialist services such as electrophysiology provision, offering exemplary outcomes to everyone in Northamptonshire.

We will consolidate catheter labs on one site, with pathways for acute coronary syndrome integrated with our partners in the East Midlands Ambulance Service (EMAS) and primary care to ensure patients receive the right treatment at the right time in the right location, with a treat and return model. There will be greater emphasis on prevention by working with patients and their families to make lifestyle adjustments to reduce the risk of coronary heart disease and heart attack. Fundamental to this will be shared care records which will facilitate seamless care between sites.

Dedicated to excellence

Our clinical ambitions

Our Group vision

- Work with health and care partners to prevent ill-health and reduce hospitalisation
- Develop Centres of Excellence across all services, starting with cardiology and cancer
- Ring-fence elective capacity to reduce waiting lists and variation between sites, and increase efficiency
- Build on our University Hospital status to become a hub for training, research and innovation

To deliver our ambitions, we will work together more collaboratively, starting with our most fragile services

Our Centres for Excellence will deliver our key principles for excellent care

University Hospitals of Northamptonshire NHS Group

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

Dedicated to excellence

We aim to establish a cancer Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

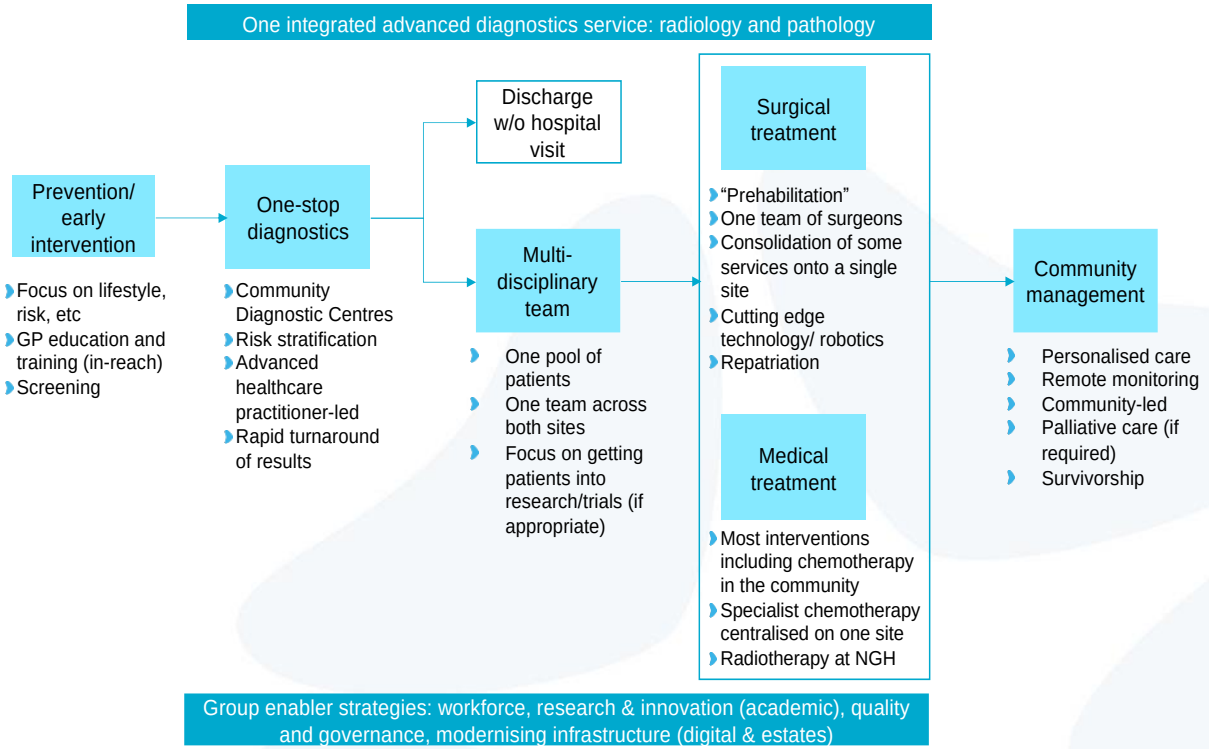
Our cancer Centre of Excellence

The cancer UHN Centre of Excellence will be an **integrated service** that the Group is known for nationally, owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output**.

The Centre of Excellence will **attract and retain leading experts**, offering **outstanding career and development opportunities** and provide a sustainable service that supports growth and innovation.

The Group will collaborate with system partners to explore new ways of working to increase the **accessibility and early diagnosis of cancer care**

Our proposed acute cancer pathway



As a Cancer Centre of Excellence, we commit to…

- ✓ A single cancer team driving the integration of pathways across the acute hospitals and in the community
- ✓ Equal access to screening programmes across Northamptonshire
- ✓ top 10% nationally for a number of patient experience and outcome metrics, including cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

excellence

We aim to establish a cardiology Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

Our cardiology Centre of Excellence

The cardiology Centre of Excellence will be an integrated service across the Group which will be known nationally for **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload.**

The cardiology service will be known for its **extensive research capability, scholarship and academia, attracting and retaining leading experts** in the field.

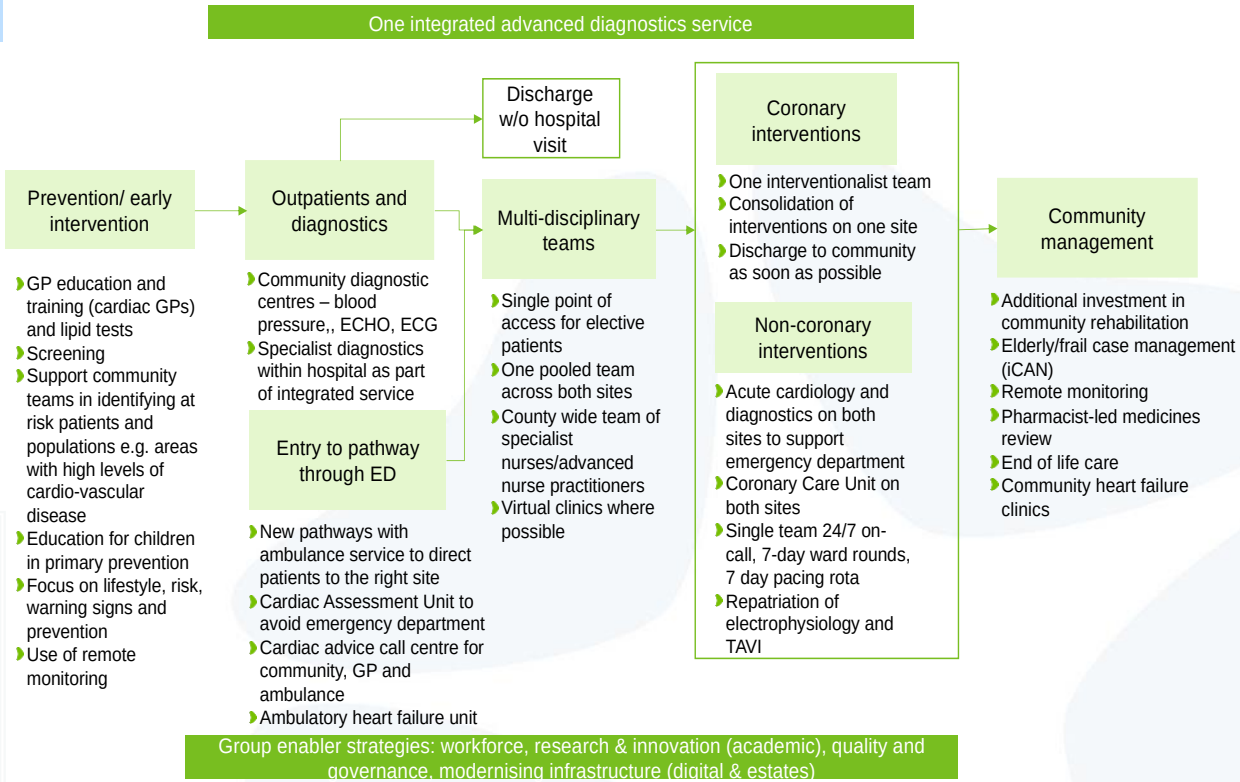
The cardiology service will work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

As a Cardiology Centre of Excellence, we will commit to…

- ✓ Delivering national quality standards for PCI and pacing as set out by Getting it Right First Time (GIRFT) BCIS (British Cardiovascular Intervention Society) and the National Institute for Cardiovascular Outcomes Research (NICOR)
- ✓ No duplication of complex procedures across sites, to improve quality and performance
- ✓ Focus on prevention in schools and with families of cardiac patients
- ✓ Work with GPs to treat patients in the community
- ✓ Virtual ward and remote monitoring to bring care closer to home
- ✓ Single cross site studies which will allow for greater population recruitment
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose
- ✓ Work in partnership with neighbouring Trusts to improve access to specialist cardiac services to all our PPCI catchment area

Dedicated to excellence

Our proposed cardiology pathway



Our ambition is to ensure elective patients consistently get timely equitable access to high quality care and experience

University Hospitals of Northamptonshire NHS Group

Our elective care strategy

In partnership with the Independent Sector, the Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committed to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation,** and maximise **day surgery** and **one stop pathways.**

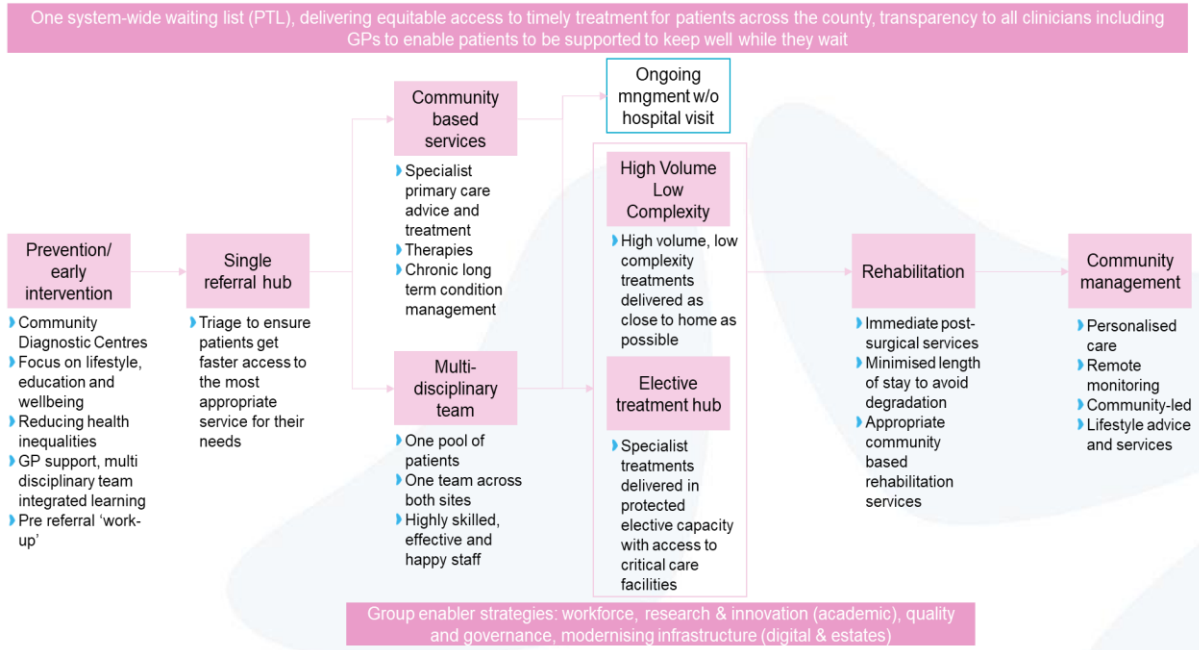
The Group is committed to delivering more care on a **day surgery** pathway at dedicated facilities developed in partnership with the Independent Sector and in Community Diagnostic Centres, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team will work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities.**

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.

Dedicated to excellence

Our proposed elective care pathway



As a lead provider for the Elective Care Collaborative in Northamptonshire, we commit to…

- ✓ Single point of access across the ICS to elective care
- ✓ Working to deliver top decile performance in GIRFT and model health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnosis
- ✓ Delivering the same service and experience in the county regardless of provider

Our strategy to improve integrated care pathways over the next few years

University Hospitals of Northamptonshire NHS Group

Our strategy for emergency and integrated care services

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

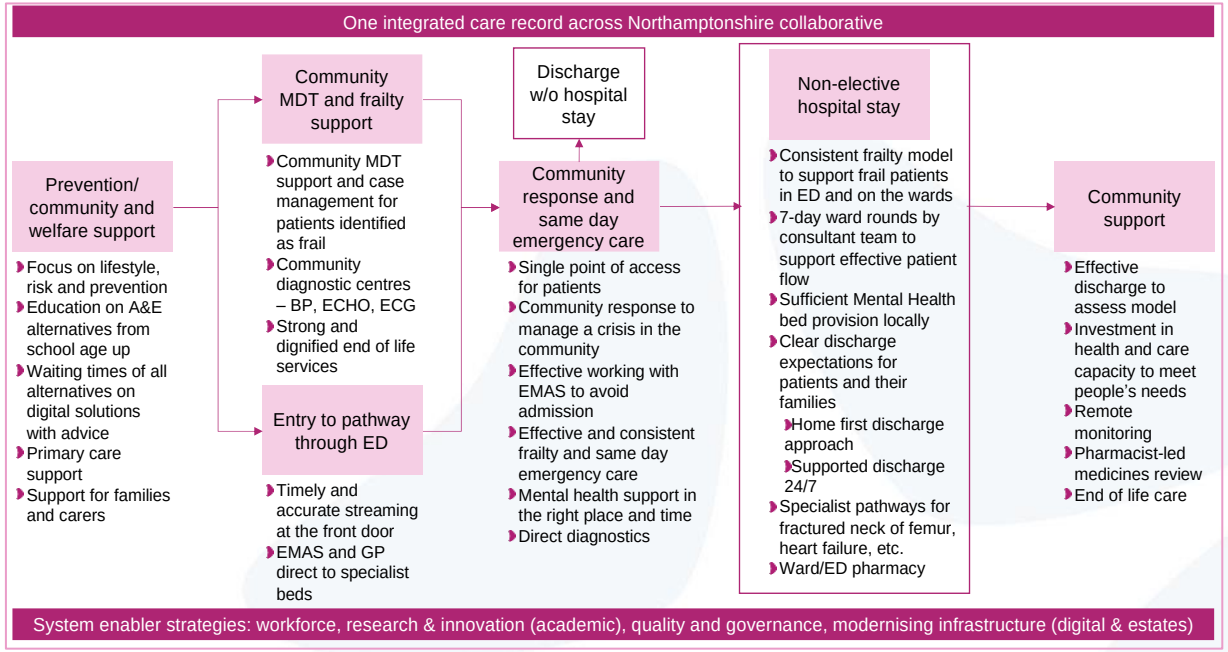
As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

As an emergency and integrated care service, we commit to…

- ✓ Develop pathways in partnership with the GP out of hours service, community teams and NHS 111 to direct patients who need emergency care to the right team, first time
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Expansion of Urgent Treatment Centres for minor injuries and illnesses,
- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county

Our proposed emergency pathway



We will build on our University Hospital status, becoming a hub for innovation and research, attracting high calibre talent

University Hospitals of Northamptonshire NHS Group

Our ambition is to build on our University Hospital status and create a culture of innovation across our Group. Our teams will be supported to expand clinical research so that we can offer our patients access to cutting edge treatments.

As set out in our *Group Academic Strategy*, we are committed to learning and developing our services so we can provide the best possible care for our patients.

We will be ambitious in our plans in order to attract and retain high calibre, motivated and innovative staff who are best placed to deliver excellent patient outcomes.

Whilst all our services will be supported to increase their research activity, we will strive to **significantly expand research in our two centres of excellence: cancer and cardiology**

We will ensure that staff who are involved in the Centres of Excellence have equal access to training and education, so that all patients and staff benefit from these centres. This for example will include staff in training rotating between the sites so that they have access to both general and specialist training opportunities.

Dedicated to excellence

Our clinical ambitions

Our Group vision

Work with health and care partners to prevent ill-health and reduce hospitalisation	Develop Centres of Excellence across all services, starting with cardiology and cancer
Ring-fence elective capacity to reduce waiting lists and variation between sites, and increase efficiency	Build on our University Hospital status to become a hub for training, research and innovation

To deliver our ambitions, we will work together more collaboratively, starting with our most fragile services

To deliver these ambitions, we will increasingly collaborate across the hospitals, starting with our most fragile services

University Hospitals of Northamptonshire NHS Group

We will strengthen our collaboration with wider partners

Due to national policy, some specialties already work in wider clinical networks on a regional basis. Pathology and radiology are examples. We will initially strengthen collaboration across the Group which will then lead to a stronger position within Regional networks and enable greater investment and opportunity from the networks into the county.

Many of our patients need to travel to Leicester, Coventry or other specialist centres for specialist treatments, but these vary depending on which hospital the consultant works at. We will work consistently as a Group to establish single pathways to these centres and improve the seamless journeys of our patients into these tertiary centres.

In some specialties, we will immediately go further and establish single teams, some of whom we propose will operate from a single site.

We will move faster to single leadership and teams in some services

This is because of a number of reasons including:

1. It is a fragile specialty which due to workforce constraints or low activity volume, is unsustainable in its current form
2. There is significant variation in quality across sites with opportunity to collectively improve care through working collaboratively
3. There is existing collaboration with proven benefits to patients which clinical teams wish to strengthen

Where in the best clinical interests of patients, services may be consolidated on a single site, and where clinically safe, they will be delivered as close to patient's homes as possible and away from acute hospital sites

There are different models of collaboration

Single team service
A single team operating across both sites

Networked service
Services on both sites adopting a single way of working and model of care

Single site service
A single team operating predominantly from one site

Over time, all services will move to single team

Dedicated to excellence

We know we could not make these changes as individual hospitals

University Hospitals of Northamptonshire NHS Group

We believe that working together will help us better overcome the challenges we face and unlock greater opportunities for improving patient care and staff experience.

We have the opportunity to **combine our expertise and experience to provide outstanding patient care** at the right place and in the right time.

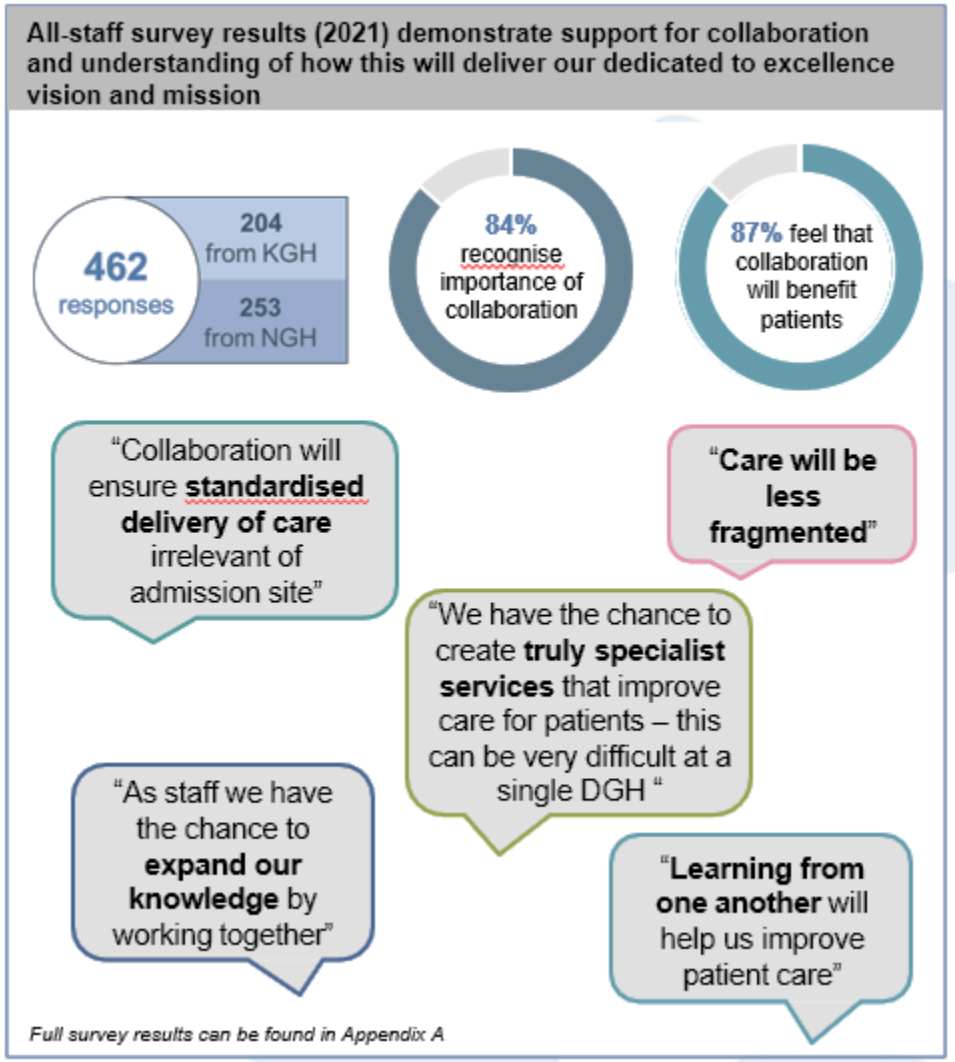
We are already a University Hospital Group and have the ambition to attract high calibre clinicians to join our teams delivering cutting edge clinical research and treatment for our patients. This will improve access to best practice care in Northamptonshire, and mean more patients can receive treatment in county, nearer to their homes.

Collaboration will reduce the current inequity in care and access to hospital services across Northamptonshire

We are committed to **working with our system partners** to transform care across our county with a focus on prevention and proactive services.

When people become ill we will ensure they can quickly access the care and support they need in **the right place at the right time**.

We will harness the **latest digital technologies** to deliver care in the most appropriate and convenient location for our patients.



Dedicated to excellence

We will ensure that people will be able to access services, with many services provided closer to home

University Hospitals of Northamptonshire NHS Group

We will provide services as close to home as possible. We will work with our partners to promote good health and to reduce the need for people to attend hospital. Where people do need health care, we will work to provide as many of our services as possible closer to home. For example, we already have plans to deliver virtual outpatient appointments and chemotherapy at home and diagnostics in community diagnostic hubs. Most people who do need to visit hospital will continue to access services where they are currently.

We may propose moving or consolidating some services where there are strong clinical quality reasons for doing so. There are some part of this clinical strategy which propose moving or consolidating some more specialised services. These proposals for consolidation has been made by clinicians because of the evidence that this improves quality and outcomes for patients. This includes the proposals for the development of an elective care hub and proposals to consolidate cardiac surgery at a single site. Changes to the location of services will only be considered where**:**

- there is **a scare resource at one site** or another that leads to unreliable service provision for patients now or in the future
- there is **clinical evidence** that co-locating clinicians and services drives up patient care and outcomes
- co-locating services brings **significantly greater operational and financial efficiency** to be re-directed into improving services for patients

We have already committed to maintaining **full emergency departments and maternity services at both Kettering and Northampto**n hospitals, and the associated services required to deliver these effectively.

We will thoroughly assess the potential impact of any changes on access and travel, including any potential impact on inequalities and staff. Any possible impact on patients of moving services will be assessed by how the change:

- **improves care outcomes**, and service reliability for them
- **reduces health inequalities** and disease prevalence across Northamptonshire
- **affects travel times** as related to convenience and in ensuring **equitable access** to excellent services to all patients

Before moving any services, we will commission analysis to understand the potential impact of any changes on access to services, for example, for people (including staff) travelling by car or public transport or requirements for parking spaces. As part of this we will also look at the potential impact on deprived communities and people with protected characteristics such as the Black, Asian and Minority Ethnic (BAME) population and disabled people. People from inequality groups will benefit from the improvements in quality from consolidating services but we will make sure we understand any potential negative impacts such as on the cost of travelling by public transport or increased travel times. We will make sure that we engage with communities to fully understand any issues and develop a mitigation plan before we make changes.

Dedicated to excellence

Implementing our proposals will address the issues in our case for change

Case for change	*How our proposals address the case for change*
1. Meeting the needs of a growing and aging population	✓ Working closely with system partners to deliver seamless care particularly for patients with complex conditions ✓ Closer collaboration for frailty and older people's services
2. Strengthening fragile services	✓ Clinical integration will allow best practice to be shared across the Group ✓ Moving to single teams and/or single site working will allow us to use our staff and equipment as efficiently and effectively as possible ✓ Collaboration will combine the depth and breadth of our collective expertise allowing us to increase specialist service provision
3. Retaining and recruiting talent	✓ Establish the Group as an attractive place to work offering a broad career portfolio to our staff with increased clinical research opportunities and complex service provision ✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing ✓ By working together, we will have the scale to explore and pilot new roles and workforce models
4. Implementing clinical best practice	✓ Develop Centres of Excellence across all our services over time, building on the excellence that already exists, developing our services to become nationally known for excellent outcomes and patient experience. ✓ Increase provision of ringfenced beds on both sites and, in the longer term, aim to establish a dedicated elective unit(s) separate from emergency care
5. Reducing avoidable admissions and length of stay	✓ Work closely with our health and care partners through iCAN, which is focused on improving outcomes for older people in Northamptonshire and reducing admissions and length of stay in hospital.
6. Reducing elective waiting lists	✓ Improving the quality of our services and increasing provision of specialist care will reduce patients being transferred out of area with corresponding length waiting times ✓ The Group will work to establish a community diagnostic hub which should reduce waiting times for diagnostics ✓ We will work collaboratively to protect our elective capacity, providing timely care, minimising infection rates and reducing length of stay in hospital
7. Improving our financial position	✓ Reducing vacancy rates and staff turnover will reduce expenditure on expensive agency staff ✓ Consolidation and single- team working will allow us to use our resources efficiently ✓ Implementing clinical best practice will reduce duplication and avoid waste

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

NHS
University Hospitals of Northamptonshire
NHS Group

Enablers

Dedicated to excellence

We know there are a number of enablers which are critical to delivery of the clinical strategy

Clinicians were asked to select the top three enablers that would be crucial for them to deliver the clinical ambitions. These discussions, in addition to the all-staff survey results, were used to create a heat map.

Whilst all six of the enablers were deemed critical, it was felt that organisational development and communication, digital and integrated workforce were the three highest priority ones.

All-staff survey results 2021
The top 3 themes from the qualitative feedback (in order of prevalence) were:

1. **Culture** – need to remove the 'us vs them' mentality
2. **Communication about the change** – need regular honest communications to overcome fear of change
3. **Digital** – need shared systems to allow easy communication and seamless patient care

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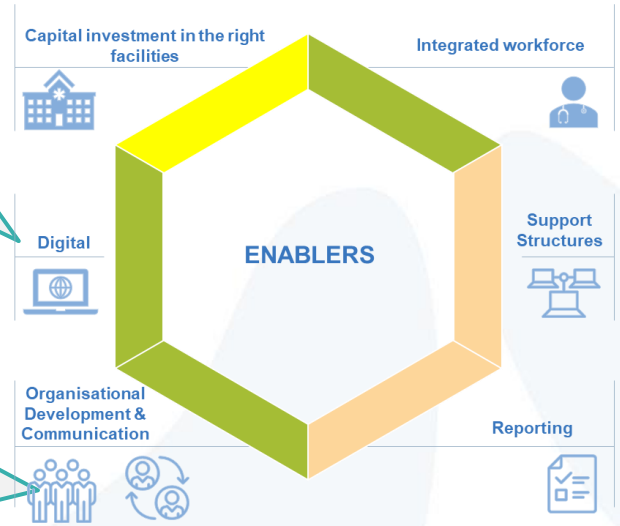
We have done an initial assessment of the potential financial impact of our proposals, which is shown in Appendix A

Integrated digital systems were consistently seen as a key enabler by clinicians along with the structures to allow integrated teams across sites

Culture and communication were perceived by survey respondents as the biggest barriers to collaboration



Top three priority enablers as voted for by clinicians (workshops 2021)

Enablers	Diagnostics	Cancer	Women & Children's	Elective	Emergency
Capital investment in the right facilities	3		3	2	
Digital	1	2	2	1	1
Organisational Development and communications	2	3	2	2	2
Integrated workforce		1	1	1	2
Support structures			3		3
Reporting					

Our clinical strategy will be supported by changes in digital, workforce, research and education and estates

University Hospitals of Northamptonshire NHS Group

Capital investment in the right facilities

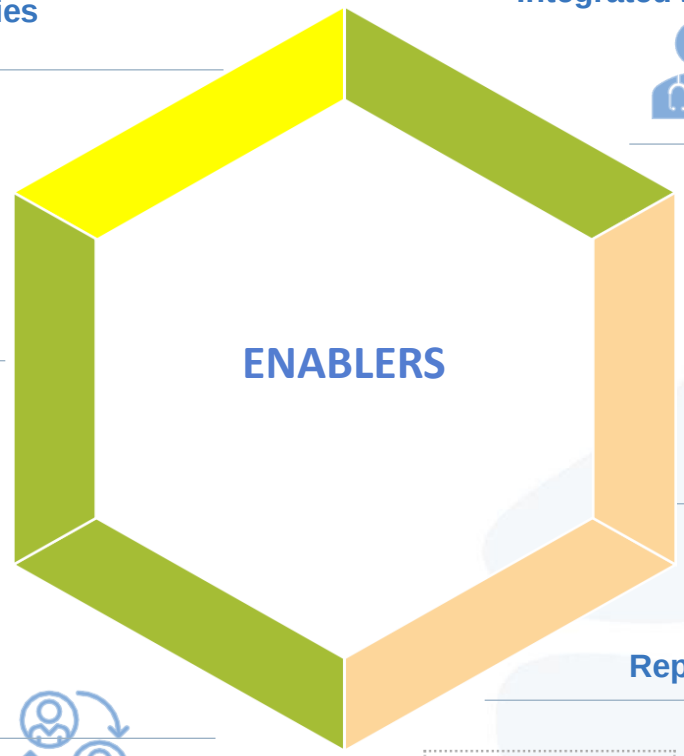
- We need the right facilities to accommodate **consolidation of services** (clinical and back office)
- We need to address our **critical infrastructure risks** to provide a fit-for-purpose care setting
- We need to expand our **community facilities** to deliver care outside the acute setting, where appropriate

Digital

- We need robust **data sharing** to allow easy comparison of care across the system
- At a system level we need a **shared care record** and **integrated care systems** so our staff and patients can move seamlessly between sites
- We need integrated digital systems to enable collaboration e.g. joint MS Teams, joint address books
- We need to ensure we have a system- wide **culture of clinical collaboration**

Organisational Development & Communication

- We need to provide **change management support** to our teams
- We need to continue **engaging with our staff and patients** throughout implementation of the strategy
- We need comprehensive leadership development programme to grow a pipeline of group and system leaders
- We need to market our Group to raise our organisational profile



Integrated workforce

- We need **structures and policies** in place that enable cross-site working
- We need to deliver **shared training** and development opportunities, bringing in system partners where appropriate
- We need to begin **shared workforce planning** to ensure we have the capacity to deliver our group ambitions
- We need to carry out a Group **skill-mix review** –esp. opportunities for new Group roles or system-wide roles

Support Structures

- We need shared **clinical governance** to oversee implementation of clinical integration
- Over time we need to **integrate our back office** structures and systems (HR, IT, Finance)

Reporting

- We need a shared **reporting process and metrics** to allow like for like comparison and to highlight future collaboration opportunities
- We need to establish a **shared quality improvement process** to tackle unwarranted variation

Heat Map Key
High priority
Medium priority
Lower priority

Dedicated to excellence

We have a robust digital plan in place that we will accelerate where possible

We aspire to be the most Digital Hospital Group in England by July 2023. Of particular relevance to the Clinical Strategy are our commitments to:

- Have a **Group Electronic Patient Record** so that our two hospitals can share the same record, viewable from any location on any device
- Implement **single sign-on** across all sites for our staff
- **Implement the Northamptonshire Care Record** (NCR), fully supporting the digital strategy for the Northamptonshire Integrated Care System (ICS)
- Work together and with partners to **enable digital care for patients** across the Northamptonshire Health Economy in a joined-up and integrated care system
- **Hold virtual appointments** for our patients where safe and appropriate.
- **Virtually monitor our patients' condition**
- **Join our records up** so our patients have access to their records across the health system
- Develop **dashboards that are intuitive and staff can use** to revolutionise decision- making
- Develop **universal NHS.net and Office 365 accounts** across all sites for our staff

We have a robust Group People Plan in place to support the development of our workforce

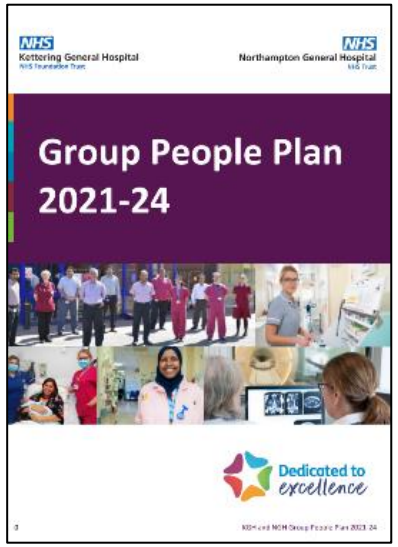
A focus on people as a core priority across the Group will ensure that we feel empowered and supported working within both Trusts. This will allow us to not only continue to provide excellent patient care, but also to ensure that we can provide an excellent experience for ourselves and our colleagues as an outstanding employer and create an inclusive place to work.

We will continue to improve our support for colleague health and wellbeing and ensure that people working within the Group feel supported and valued regardless of their background or circumstances.

We aim to empower people to voice suggestions and make improvements in how we deliver care together, ensuring our patients and service users receive the care they would wish to receive.

We will build compassionate leadership at all levels and ensure that leaders and managers are supported to lead, engage and develop their teams, in line with the staff survey feedback we have received.

Collaborative working will require courage from all our staff including leaders, to bring together services in ways which will benefit our patients, This will require new Group roles, starting with Clinical Directors, who will be supported in developing joint ways of working across our sites.



Our People pledges

Health & Wellbeing	We will provide bespoke health and wellbeing spaces and access to health assessment and psychological support for all our people
People Planning	We will support people plans for our patient services with effective attraction and retention plans that support new roles, new ways of working and career pathways.
People Partnering	To consider how we work with one another, reflecting, learning and ensuring feedback is heard and actioned, leading to a reduction in formal employee relations management
People Development	We will support colleagues to build a career providing opportunity for people joining us from any level and background to progress
People Processes	Colleagues will be able to access systems to enhance their work experience and flexibility, with training on either site recognised across the Group
Organisational Development & Inclusion	To bring our dedicated to excellence values to life, improving the way we work with each other, particularly focusing on empowerment and inclusion
Volunteering	We aspire to have the largest volunteer base within the Group across the NHS with volunteers that are representative of the population of Northamptonshire providing opportunities for our community.

We already have plans in place to recruit and retain a high quality and motivated workforce

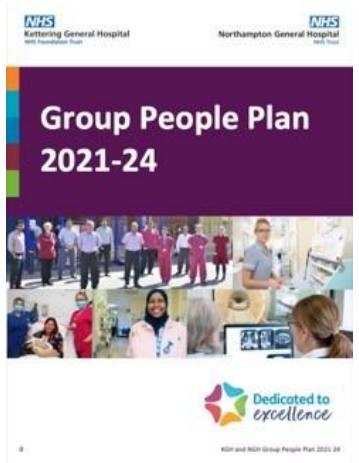
University Hospitals of Northamptonshire NHS Group

Our Group strategic priority

An inclusive place to work where people are empowered to make a difference

Our ambition

Seeing an improvement in the feedback we receive from our colleagues, leading to being in the top 20% of acute Trusts with the national NHS staff survey



Commitments

- Dedicated car parking and travel plan reviews across both sites
- Access to psychological support internally and within the county
- Physical places on site to work out, rest and relax, with refreshments
- Staff inclusion networks, leading to change and support increasing diversity in senior roles and development opportunities
- Increased International Recruitment to support current vacancies
- Development programmes which are consistent and enhance your career
- A resolution of a contractual query within 48 hours
- Having the largest number of volunteers in the NHS supporting across varied roles
- A shared temporary staffing service with access to additional experiences
- Consistent policies across both Trusts

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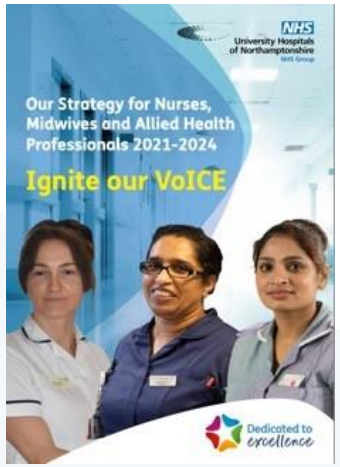
Dedicated to excellence

Ignite our Voice strategy



- Enhance staff development, diversity and inclusivity through our innovative Leadership programmes and fellowships
- Nurses, Midwives and AHPs will be supported to lead on research in clinical academic pathways
- Nurses, Midwives and AHPs have received training, coaching and support to lead Quality Improvement focussed on reducing harm and enhancing patient experience
- We will ensure all clinical areas will have progressed towards achieving the highest level of attainment in our respective accreditation programmes and develop a multi-professional approach

Staff also highlight culture and communication as important if we are to achieve collaboration at pace

University Hospitals of Northamptonshire NHS Group

Addressing our culture and ensuring we communicate regularly with our teams came out as key priorities to address from our all-staff survey

Key themes

- **Culture:** needing to remove the 'us vs them' mentality
- **Communication:** need for regular open communication with staff and patients

…we need to address the concerns of our staff through a comprehensive communications and change management process

All-staff survey results (2021) – culture and communication identified as the key barriers to collaboration currently

'An **us and them** culture'

'There's a **competitive edge** to collaboration'

'Staff working on the shop floor not being consulted – **we need to be part of the development**'

'Need to understand if this will lead to **job losses**'

'**Culture** – one hospital told it is not good enough, the other perceived as snooty and superior'

'We need to remove the '**we are better than you**' attitude'

'Need an **open dialogue**'

'This vision can only work with the **staff on board**'

'Staff are anxious about **travel times and job losses** – need more listening to Trust employees'

'**History of competition** between the two trusts – this is a chance to develop a partnership and feeling of togetherness'

"We currently have two separate identities – **needs to be one identity**"

Dedicated to excellence

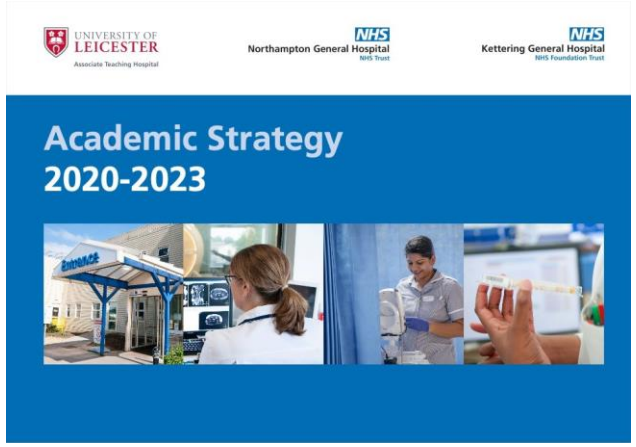
We have recently become an academic university hospital and want to build our academic and research reputation

University Hospitals of Northamptonshire NHS Group

Our ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

The Academic Strategy sets out how we will:

- Attract, retain and develop the country's top talent. Putting our staff and patients at the heart of its development by improving the training and development we offer
- Enable us to work more effectively with our health and care partners to collectively improve access, quality and consistency across local patient pathways and services
- Establish robust estates and digital infrastructure to support innovative clinical education and research
- Foster a culture of inclusivity and learning, with strong leadership championing the strategy
- Increase the number of patients included in clinical trials and success of funding from research networks, grant giving bodies and commercial sources



We are already creating new academic posts, including Associate Professorships and plan to develop more. Our vision for the Academic Strategy is to **improve patient care through excellence in education and research.** We will achieve our vision by delivering the following eight objectives:

- Partnering with University of Leicester to become a University Teaching Hospital Group
- Foster a culture of learning, research and innovation with strong leadership championing the strategy
- Provide a multi-professional clinical academic programme and improved training and development offer for staff
- Increase opportunities and resources for innovation and research to be incorporated at the core of our work and clinical practice
- Build academic, research and digital infrastructure to support and grow innovative clinical education and an increased research portfolio
- Increase success of research funding from research networks, grant giving bodies and commercial sources
- Develop closer alignment with all our University partners
- Develop and promote the academic brand

Dedicated to excellence

We also have an opportunity to re-build our hospitals to support the delivery of high-quality services

University Hospitals of Northamptonshire
NHS Group

Our current estate

Both hospitals have an aging estate that does not provide the experience we would like for our patients or for our staff. Our clinical services are not able to always be co-located next to each other meaning staff and patients sometimes have to travel across our hospital sites. In some cases patients are cared for in cramped environments with limited natural light or privacy and dignity. For our staff, they often have to work in less efficient ways to treat patients effectively and keep patients safe.

Our Estates Strategy

We will need to find ways to improve the current estate we have, and a Group Estate Strategy will follow to deliver the Group clinical strategy:

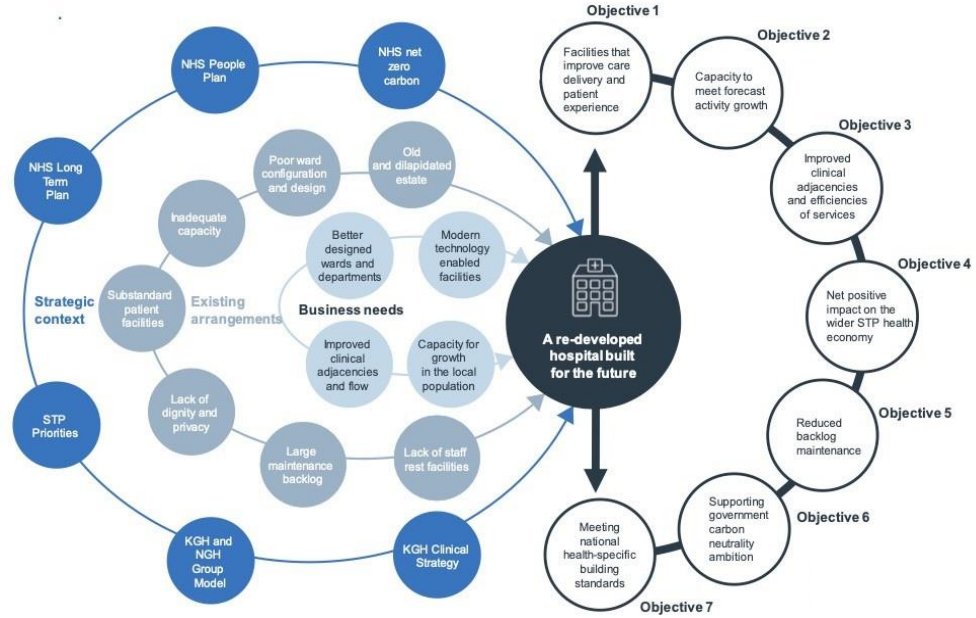
- **Kettering Hospital** submitted a Strategic Outline Case in January 2021 for a large re-build of the hospital incorporating a new ED and new wards, theatres, critical care and day services. This scheme is part of the national New Hospitals Programme and is on track to deliver by 2030.

- **Northampton General Hospital will** open a new state-of-the-art critical care unit by summer 2022 following earlier developments of a designated children's emergency department and new main entrance in 2021. We are preparing a full site development plan which will be informed by the clinical strategy and which will set the blueprint for future bids for funding on the site.

During 2022/23, we will set out the estate implications of this clinical strategy and develop a Group Estate Strategy to support delivery.

Dedicated to excellence

Our plans for KGH



Our new main entrance at Northampton Hospital

Bed and theatre capacity and demand

University Hospitals of Northamptonshire NHS Group

Bed capacity and demand

Independent modelling of capacity and demand demonstrated that the existing provision of adult inpatient beds on each site (488 KGH, 600 NGH) is less than the modelled baseline requirement (497 KGH, 615 NGH) to achieve a 92% occupancy rate, meaning there is a current shortfall of 10-15 beds on each site.

Demographic pressure of around 2% per year is forecast based on population projections, equivalent to 10-15 adult inpatient beds per hospital per year or 400 beds by 2037/38.

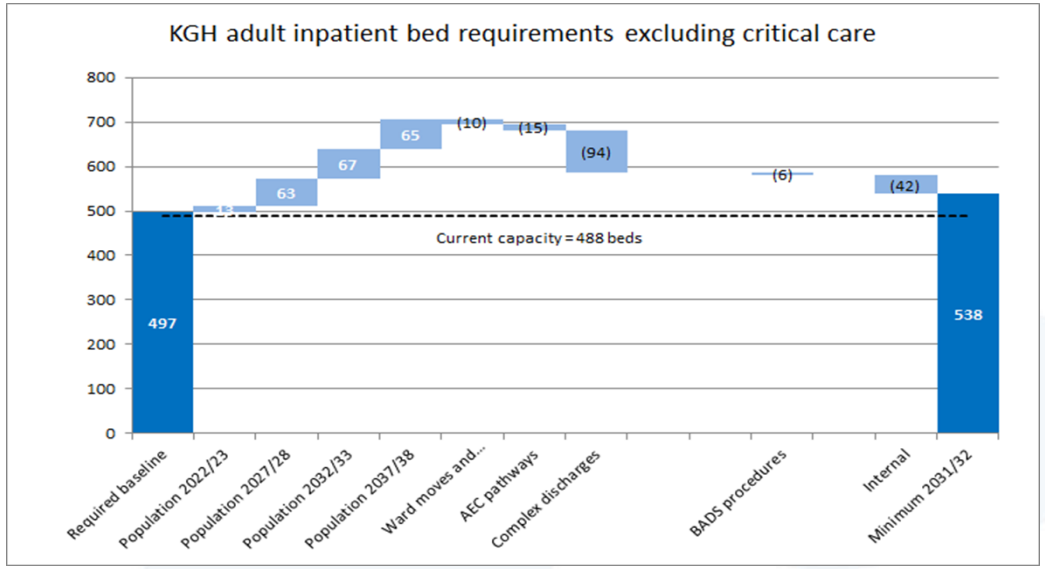
We will address through hospital and system wide opportunities to reduce the time our patients spend in hospital.

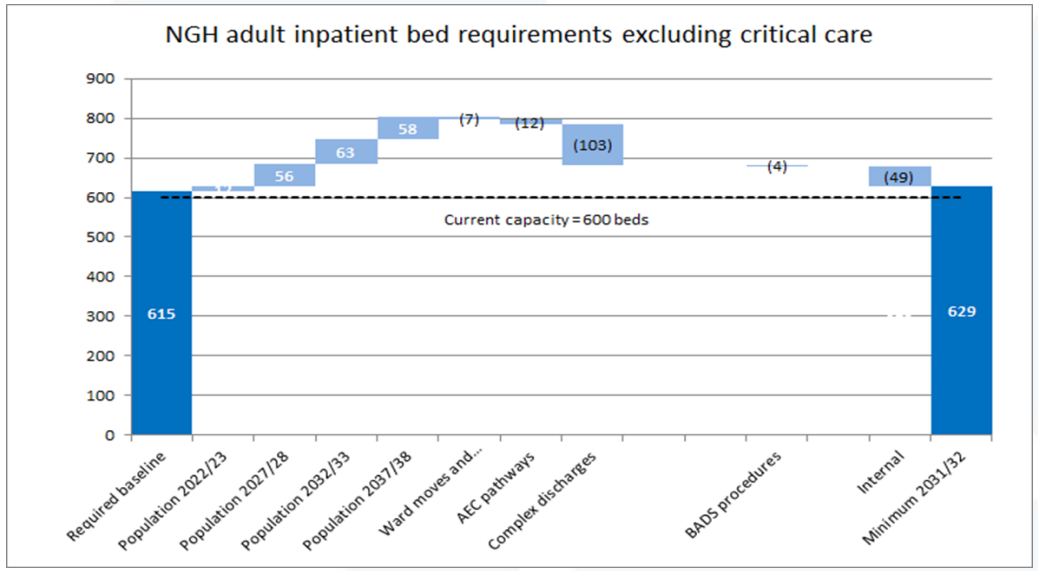
In hospital opportunities include:

- 27 beds relating to ambulatory emergency care pathways
- 10 beds relating to elective surgery
- 12 beds as a result of reconfiguring the existing acute bed base
- Benchmarking Length of Stay between NGH and KGH (meet the best of either site) would release 150 beds

System wide opportunities include:

- 45 beds relating to mental health needs
- 12 beds relating to end of life care needs
- 22 beds relating to delayed care home transfer
- 54 beds relating to other frail/elderly need





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Bed and theatre capacity and demand

University Hospitals of Northamptonshire NHS Group

Theatre capacity and demand

There are currently 14 operating theatres at KGH and 16 at NGH, including emergency and trauma, excluding obstetrics.

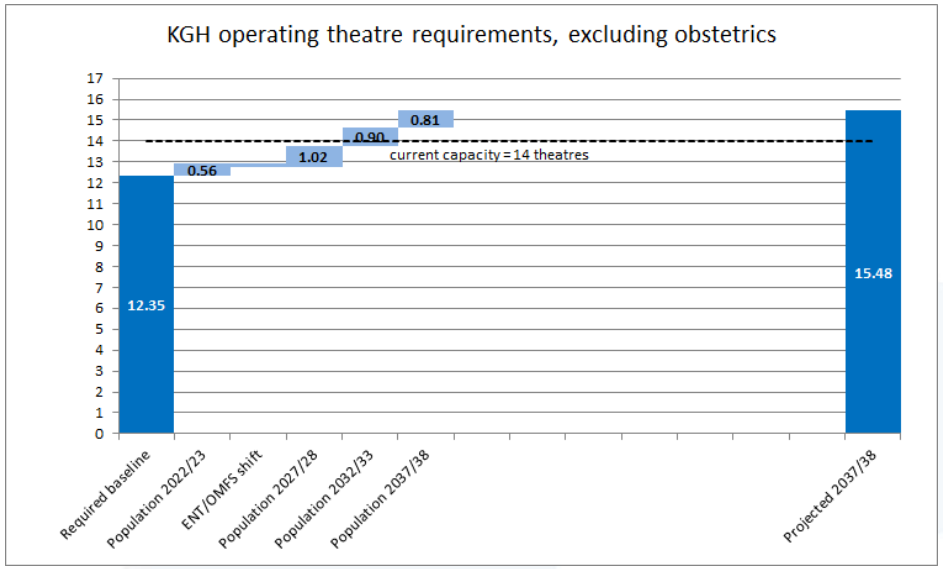
The modelled requirement to accommodate 2022/23 recurrent demand is 12.74 theatres at KGH and 14.41 at NGH.

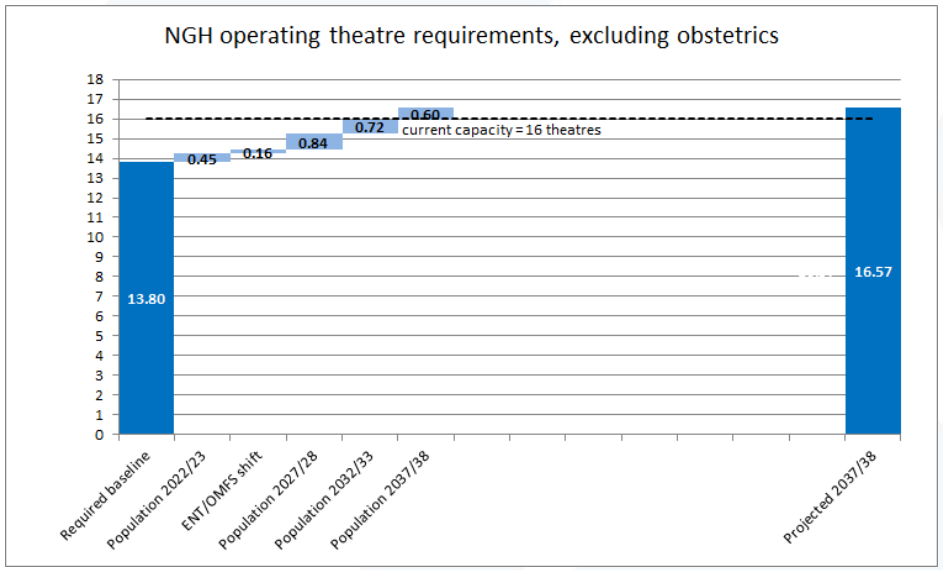
Over the 15-year planning horizon there is a modelled requirement for 2 emergency theatres and 1.5 trauma theatres on each site. The requirement for planned surgery is:

- 119 half-day sessions per week at KGH
- 133 half-day sessions per week at NGH

which assuming 5 days x 2 sessions for planned surgery would require 16 theatres in total at KGH and 17 at NGH.

Extended operating days and/or core weekend sessions would reduce the theatre requirement.





Dedicated to excellence

The Group Transformation and Quality Improvement team will drive forward these strategic priorities

University Hospitals of Northamptonshire NHS Group

Executive leadership of Group priorities and Strategic Initiatives
- Large strategic programmes aligned to Group vision, mission, values and priorities
- Executive-led change and championing transformation and quality and service improvement

Transformation delivery
- Identification of root causes and design of programmes
- Supporting delivery of change, transformation and quality improvements
- Delivery of Group priority programmes
- Delivery of Strategic Initiatives (where identified by execs)
- Supporting divisions to deliver quality and service improvement

Centre Dedicated to Excellence
- Empowering, supporting, and building capability and confidence for front-line staff to deliver continuous and quality improvement

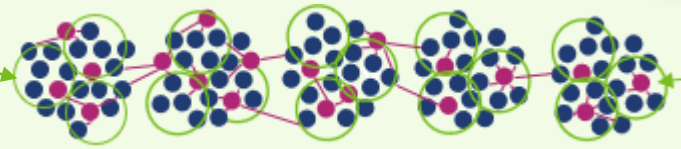
Key annual improvement priorities identified through Integrated Business planning, supporting quality and service improvement

3-4 large-scale change programmes running simultaneously, focused on the Group priorities

Divisional Transformation business partners supporting the delivery of quality and service improvement

Larger projects identified by front-line staff supported by transformation delivery

Excellence coaches supporting 4-5 teams



Change networks facilitating shared learning and spreading innovation

All staffed trained in improvement and change techniques

Centre Dedicated to Excellence training academy

Strategic Portfolio Office
- Tracking overall delivery of the portfolio and the impact on key metrics, including quality metrics
- Managing the Group portfolio aligned to the Group strategy and the Group priorities, with flexibility to change as necessary
- Ensuring programmes strive to improve quality and experience of care
- Providing expertise and targeted support to programmes where needed, accelerating delivery
- Managing the impact of change and celebrating successes

Dedicated to excellence

Our clinical strategy aligns and supports our environmental and sustainability ambitions

University Hospitals of Northamptonshire NHS Group

The Lancet[1] reported that climate change was the biggest threat and the biggest opportunity for human health of the 21st century – threatening to undo 50 years of positive public health achievements. Our clinical strategy aims to deliver safe care now and for the future by taking an environmentally responsible approach to the delivery of patient care. As a Group, we will achieve net zero carbon by 2040. Whilst there are general measures we will take across the Group to tackle the climate crisis, there are some specific actions related to direct patient care we will take as part of this strategy:

- Reduce the impact of patient and staff travel to sites through increased use of one stop clinics and virtual (video) appointments and “my Pre-Op” before elective procedures
- Provide environmental information to clinicians who prescribe inhalers and Entonox
- Adopt a net zero approach to any development of new or major refurbishment of buildings
- Reduce reliance on single use plastic, nitrous oxide and desflurane
- Reduce waste of high environmental impact medicines
- Expand digital record keeping to reduce paper use and travel, while improving continuity of care for our patients
- As part of our university hospital status, act as a test bed for sustainable care solutions from Academic Health Science Networks (AHSNs) and the universities

Source: Lancet countdown report, October 2021

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University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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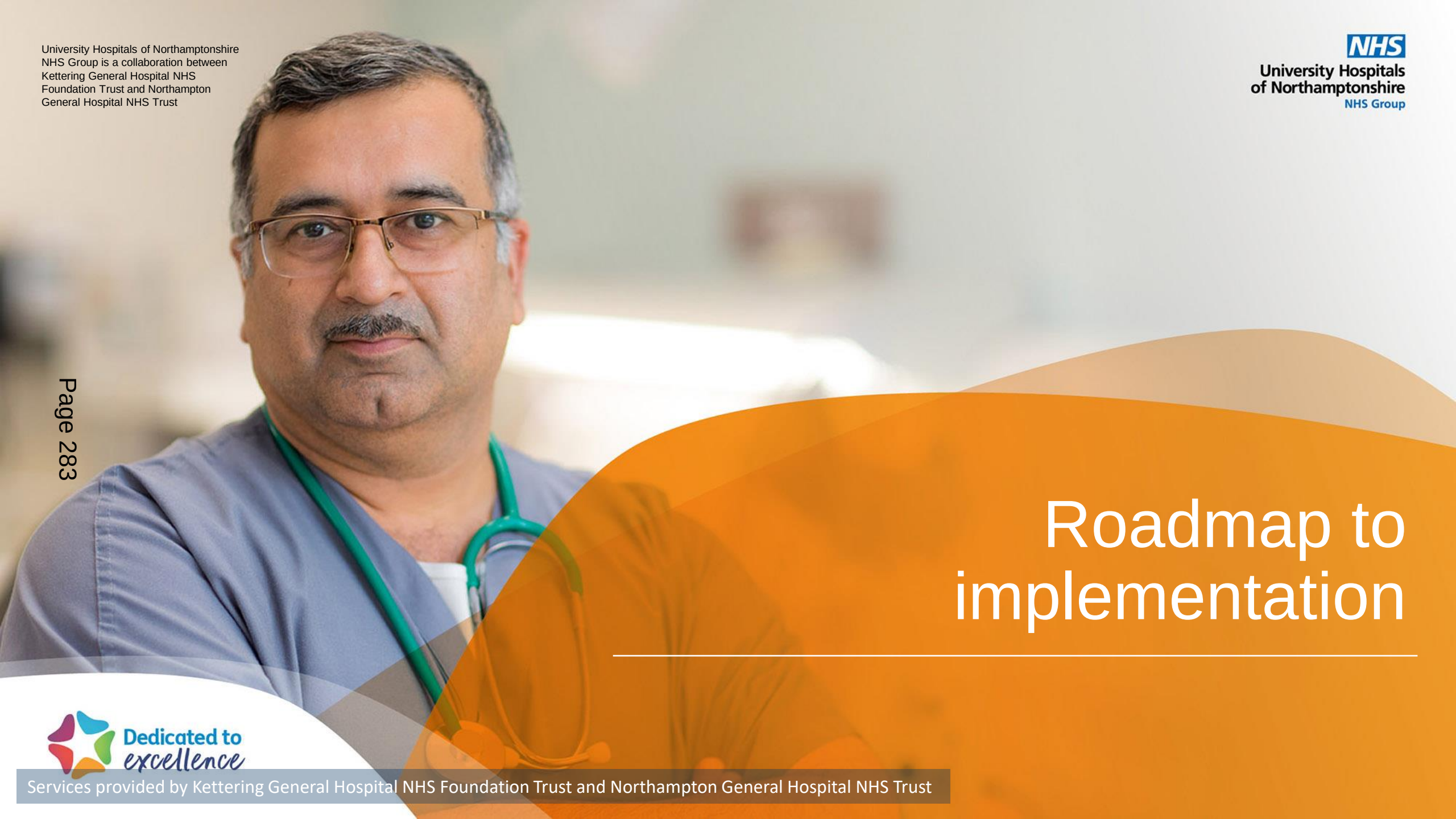


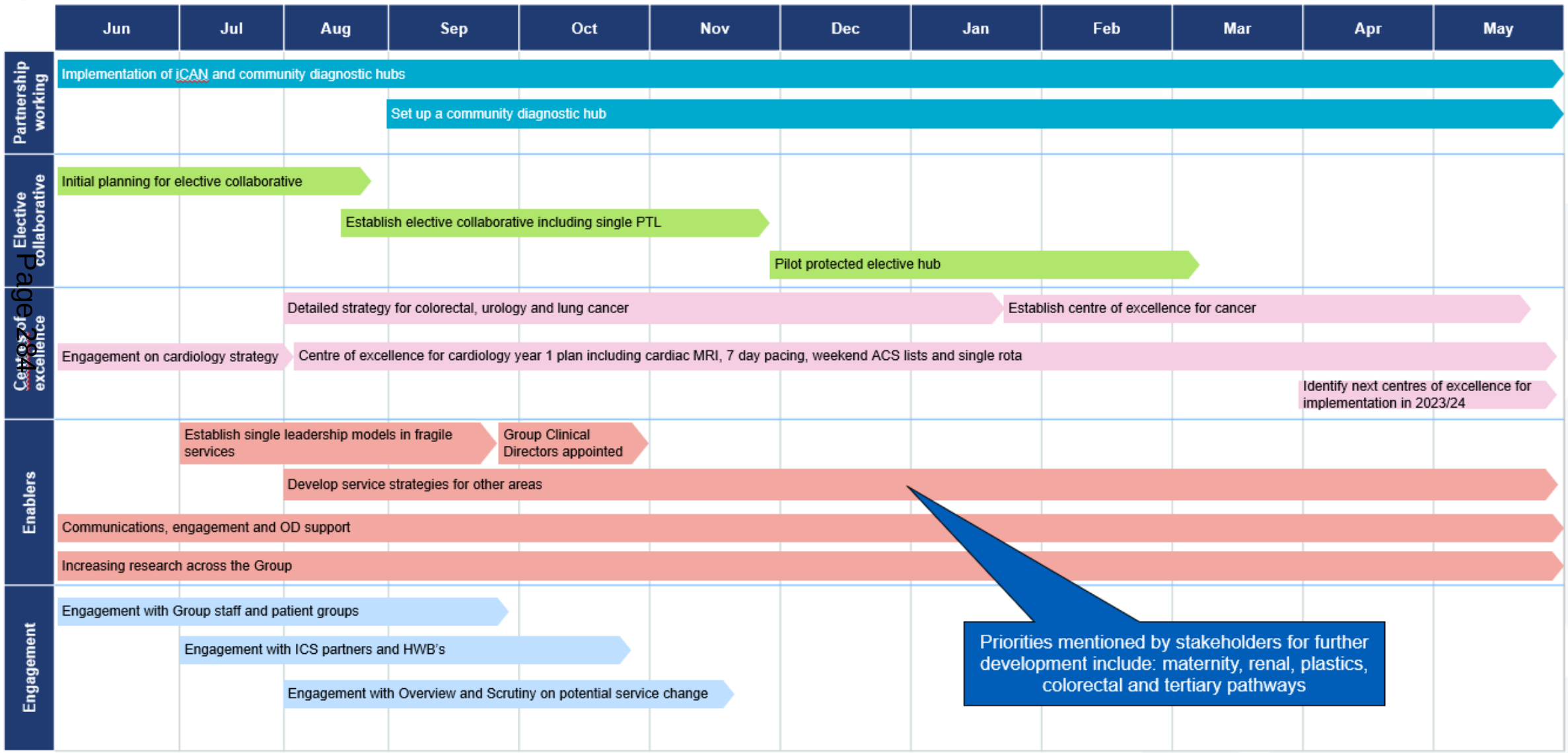
Roadmap to implementation

Dedicated to excellence

Services provided by Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Over the coming year, we will focus on developing clinical service strategies and start to implement changes

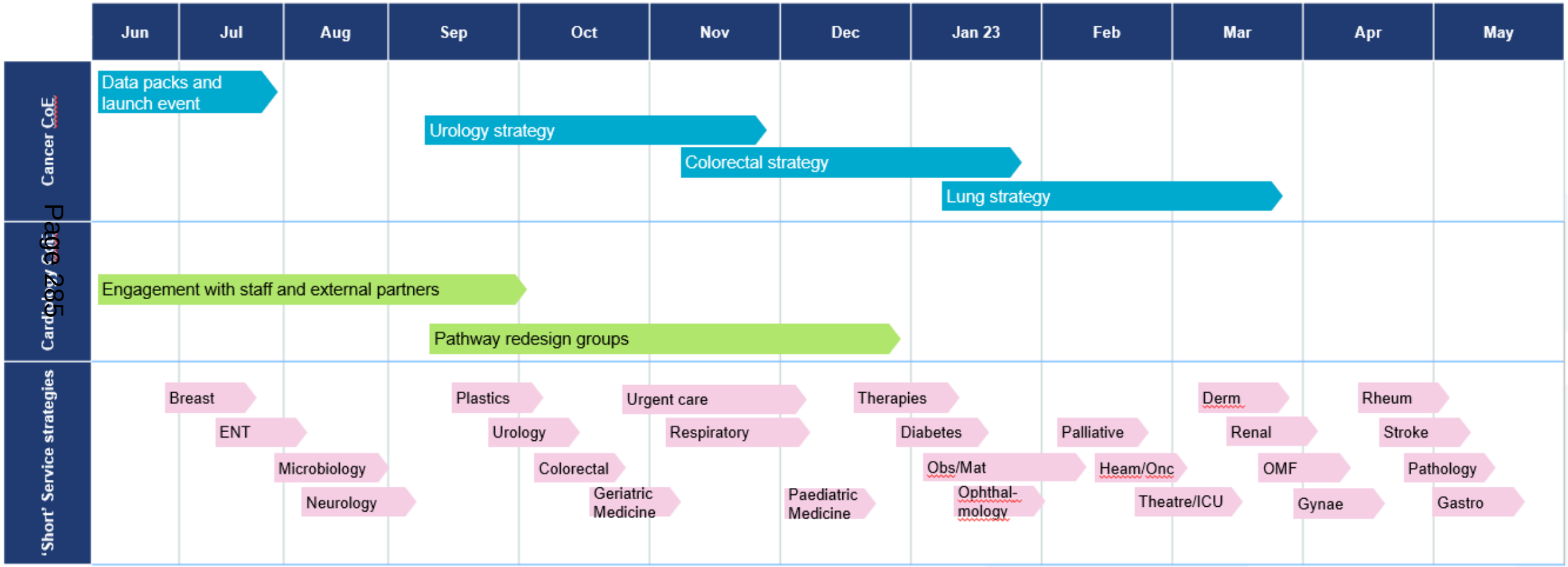
University Hospitals of Northamptonshire NHS Group



A priority is to develop supporting clinical service strategies

University Hospitals of Northamptonshire NHS Group

Throughout 22/23, as we work with staff and patients to develop the next level of detail on our Centres of Excellence and Fragile Services, and we roll-out high level service strategies for all our services, we will develop a detailed roadmap of the work required over the next 3-5years. This will ensure we can align the strategies with the enabling works in particular of what the estate plans need to look like to support implementation.



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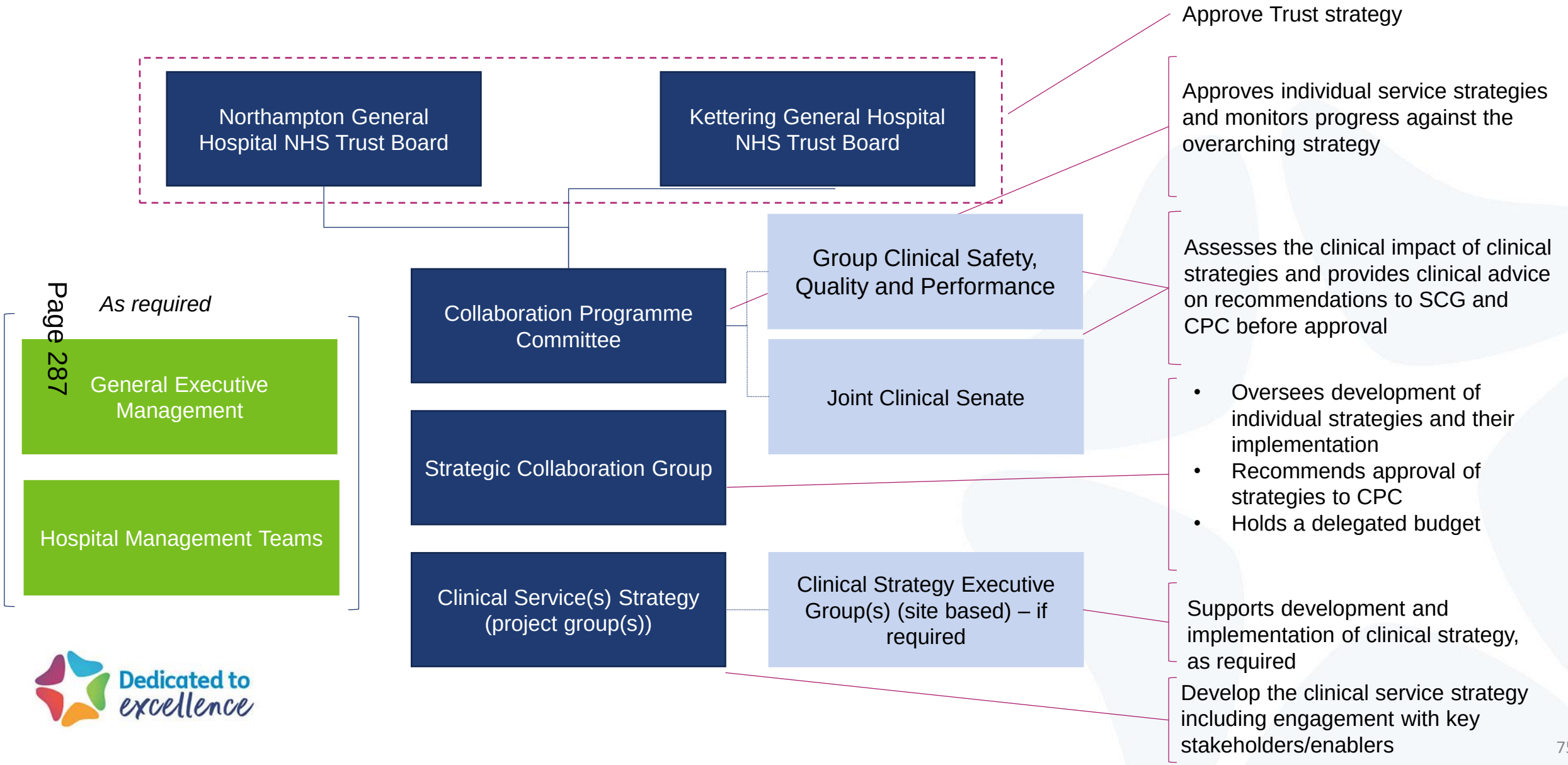
Over the next few months, we will develop a more detailed service strategy for each clinical service

Section:	Content:
SWOT analysis	• A few key bullet points of the strengths, weaknesses, opportunities, and threats to the service
Vision	• High level statement stating the aims of the service with supporting Target Operating Model
Aims	• Point by point statement of the outcomes required to deliver the vision
Objectives	• Year by year objectives to deliver the strategic aims • Key measurables for each stage • Enablers to deliver the strategy
Interdependencies	• Support required from other services including clinical and non-clinical e.g. digital, workforce, OD, transformation

We have developed a robust governance structure to support delivery of the strategy

University Hospitals of Northamptonshire NHS Group



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Dedicated to excellence

We have identified resources to support delivery of the clinical strategy

University Hospitals of Northamptonshire NHS Group

- Collaboration strategy development and implementation requires support to the clinicians and operational teams.
- The early adopters highlighted the need for organisational development, transformation, strategy, finance, workforce and project management alongside communications, patient engagement and analytical support
- Collaboration cannot be an add on to current operational and clinical roles.
- No additional resources are required within people, finance and digital as they have recently been restructured to support delivery of their strategies. Operational teams will be involved in the development of the strategies and responsible for implementation.
- Around 25-30% of teams will require support to fully develop their strategies which equates to 2 WTE organisational development (OD) leads dedicated to the process in 2022/23.
- We have already started delivering a specific training programme for our clinical leads, as they will require additional and specific leadership skills to bring teams together, agree and develop strategies and implement change. Clinical teams will also need project support and protected clinical time to develop the service strategies.
- We have also agreed to invest in the following implementation 0.5 WTE project resource for each service in 2022/23 to support development of the service strategies.

Dedicated to excellence

We have identified priority programme risks and mitigations in delivering this clinical strategy

Type	Risk	Mitigation
Strategic	Delays to strategy development and implementation due to requirements for additional OD	OD and training plan in place. On-going support to GCDs as required
Strategic	Capital funding to support proposals not available/unaffordable	Initial financial review undertaken. More detailed finance modelling in 2022/23
Strategic	Delays in implementing other Group strategies (e.g. People Plan, Digital Strategy) impact on dependencies in the clinical strategy	Dependencies have been mapped. On-going liaison to understand impact of any delays
Operational	Patient confusion around location of services during implementation of strategy	Communications and engagement plan developed
Operational	Difficulties in recruiting and retaining staff whilst strategy is being developed and implemented	On-going staff engagement. Move to Group contracts
Programme	Operational pressures mean that clinical staff are unable to engage in the programme	Additional resources identified and protected clinical time
Programme	Requirements for consultation result in implementation delays	Early engagement with Health Overview and Scrutiny
Programme	Lack of resources to support service delivery and/or implementation	Additional resources agreed

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

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Next Steps

Dedicated to excellence

Services provided by Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Our plans for communicating and implementing the strategy

University Hospitals of Northamptonshire NHS Group

Strategy approval
May 2022

- Clinical strategy developed
- Detailed implementation planning and prioritisation
- Clinical strategy and implementation plan published in May 2022

Engagement and communication
May 2022 – Jul 2022

Key audiences for communication:

- Staff
- Patients, carers and public
- Northamptonshire Health and Care Partners
- Health overview and scrutiny committees
- Politicians (local and national)

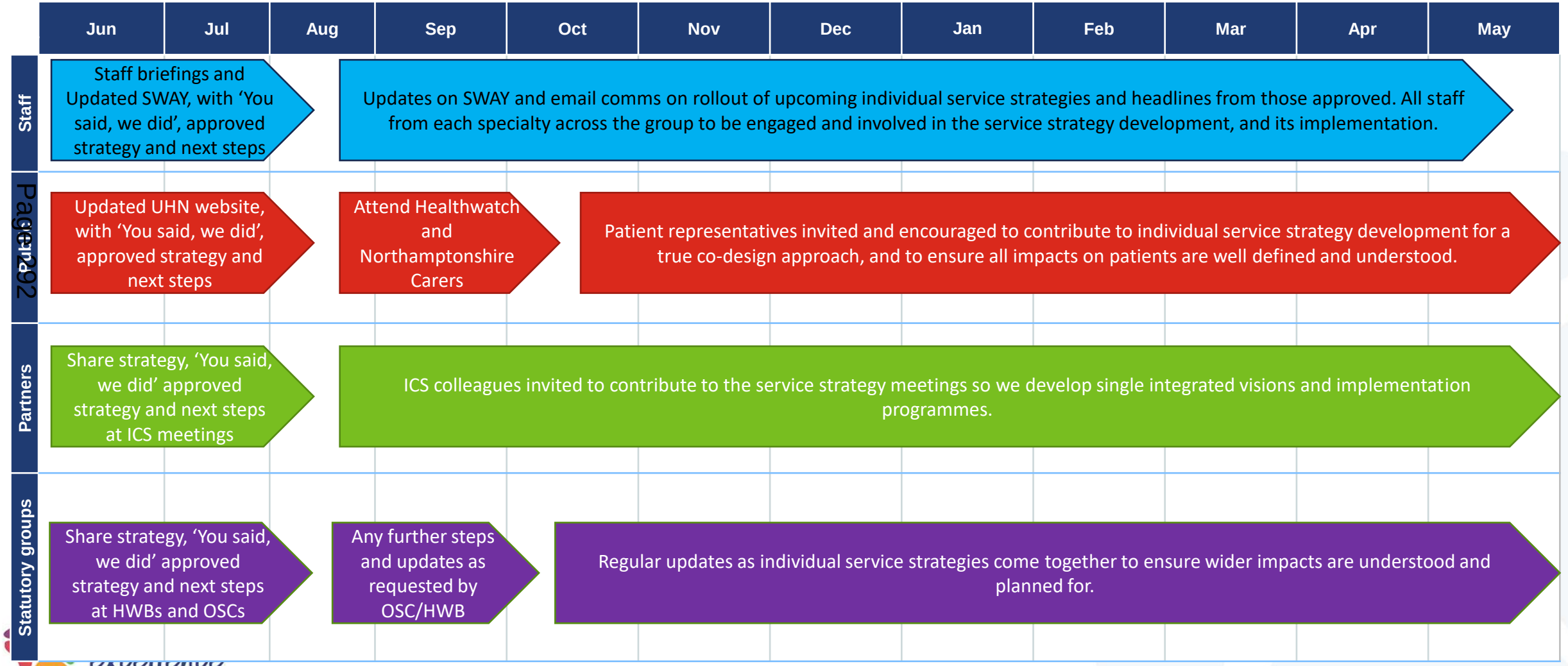
Implementation
Jun 2022 – Feb 2023

- Detailed supporting service strategies developed
- Implementation of the strategy overseen by the Strategic Collaboration Group
- Group Clinical Directors appointed
- Collaboration programme with transformation, OD and programme support

Dedicated to excellence

Engagement Next steps

As we move forward in further developing the detail around the priority ambitions we have set out in this document, and in working with wider specialties in developing their future operating models, we remain committed to continuing the strong engagement and co-design that has been at the centre of the development of this document and our journey so far.



Centre of Excellence: Cancer

Dedicated to excellence

Cancer services are currently provided on both sites, with several specialist services provided outside of county

University Hospitals of Northamptonshire NHS Group

Cancer care is currently provided at both hospital sites, with some specialist services on a single site

Cancer Services @ KGH

- Diagnostics
- Oncology (medical)
- Haematology (malignant and non-malignant)
- Chemotherapy (NGH-based oncologists)
- Immunotherapy
- Systemic Anti Cancer Treatments (SACT)
- Supportive treatment e.g. blood transfusions
- Breast screening
- Surgical cancer treatment
- Total Lung Health checks
- Bowel cancer screening unit

KGH currently provide the Bowel Cancer Screening Service for Leicestershire, Northamptonshire and Rutland area

Cancer Services @ NGH

- Diagnostics
- Oncology (medical)
- Haematology (malignant and non-malignant)
- Chemotherapy
- Immunotherapy
- Systemic Anti Cancer Treatments (SACT)
- Supportive treatment e.g. blood transfusions
- Breast screening
- Surgical cancer treatment (inc. all head and neck)
- Direct emergency admissions for patients undergoing chemo treatment

NGH provides radiotherapy, chemotherapy and brachytherapy for KGH, NGH and MKUH

- Northamptonshire Breast Service working across KGH and NGH with a single rota and pooled clinical capacity to deliver one stop clinics
- Surgery is provided by two completely separate teams, chemotherapy is a single team working across two sites
- Some specialist services provided at Leicester (pelvic, lung, upper GI), Oxford (brain), Nottingham (sarcoma)

Dedicated to excellence

Local and national strategies set the strategic context for our proposals for cancer services

University Hospitals of Northamptonshire NHS Group

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

NATIONAL

- **NHS Long Term Plan:** sets the ambition that by 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise from around 50% to 75% of cancer patients. The NHS will also continue pioneering precision medicine such as CAR-T cancer therapies.
- **Health and Care white paper:** supports greater integration across local health and care organisations through the establishment of integrated care systems
- **Diagnostics: Recovery and Renewal 2020:** recommends implementation of rapid diagnostic centres (RDCs) to offer a single point of access to a diagnostic pathway for all patients with symptoms that could indicate cancer.

GROUP/ REGIONAL

- **East Midlands Cancer Alliance:** evidence suggests access to and provision of robotic surgery provides a number of benefits and can offer safer surgical procedure and smooth recovery for patients. Supporting partners to scope demand and benefits for robotic surgery across the region.
- **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24**: ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- **Group Digital Strategy**: ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

LOCAL

- **The KGH Clinical Strategy 2020**: against a background of great performance historically, KGH are delivering against more stringent cancer targets. Strategy to address these includes a delivery plan for radiology services and overall increase in hospital capacity.
- **The NGH Strategy 2019-24**: acknowledges the challenges with meeting national cancer targets and sets the ambition to deliver high quality and timely cancer pathways. NGH want to deliver cutting edge cancer care by introducing robotic surgical techniques for cancer surgery and improving patient experience with the build of Maggie's centre.

Dedicated to excellence

Our case for change shows that there are several issues that we must address

University Hospitals of Northamptonshire NHS Group

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for cancer services.

There is growing demand for services

- Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 year olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1].

Patients are not always satisfied with our service

- National Cancer Survey 2020 – '*Overall how would you rate your care?' KGH was below the national average whereas NGH was average*.
- Patients are moved between teams and information is transferred, meaning care is not seamless

We can become a centre for academic excellence

- According to the National Cancer Survey 2018 – only 16% of patients at KGH and 20% of patients at NGH were invited to participate in cancer research following their diagnosis (national average is 30%)
- Increasing research trials across the group will help us to attract and retain staff.

Dedicated to excellence

We need to invest in new technology and ways of working

- Opportunity for the Group to improve care and patient outcomes by focusing on specialist areas e.g. robotic surgery
- Opportunity to improve patient experience by sharing best practice and adopting new models such as PIFU

Further integration with community partners should improve outcomes

- Need to provide timely accessible care for patients across the county (at home/ in community) which requires greater integration with system partners
- Integration could improve front of pathway e.g. diagnostics in community and back of pathway e.g. supported discharge and community monitoring

Delivery of emergency care has a continuing impact on planned care

- Need to consider the delivery of hot and cold sites, to ensure planned care can continue despite pressures on emergency care
- Operating as two teams restricts our opportunity to move patients between sites

We have difficulty recruiting and retaining staff

- High staffing vacancies for oncology and haematology & poor retention of staff
- Recruitment challenges for medical staff leading to poor levels of timely access to advice and treatment at KGH
- Challenge recruiting cancer nurse specialists [3]
- Challenges in junior doctor satisfaction and support and training

We have insufficient volume of activity in some services

- As individual hospitals, we have insufficient activity to deliver the most specialist services
- Lower throughput can have an impact on outcomes and staff retention

Sources: [1] ONS Population Projections 2018-2028 [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20 [4] National Cancer Survey Results by Trust

We have an ambition to develop a cancer Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

Our ambition for a cancer Centre of Excellence

The cancer Centre of Excellence will be an **integrated service** that the Group is known for nationally owing to **excellent outcomes and patient experience, complexity of caseload and extensive research output**.

The Centre of Excellence will **attract and retain leading experts**, offering **outstanding career and development opportunities** and providing a sustainable service that supports growth and innovation.

The Group will collaborate with system partners to explore new ways of working to increase the **accessibility of cancer care**

Dedicated to excellence

As a Cancer Centre of Excellence, we commit to…

- ✓ Achieving top 10%* nationally for a number of patient experience and outcome metrics, including Cancer patient experience survey results
- ✓ Ensuring every cancer patient has the opportunity to participate in a clinical trial where available and clinically appropriate
- ✓ Offering more Northamptonshire patients the chance to be seen and treated by our team if that is what they choose [repatriating some of the activity that is currently sent out of area]
- ✓ Delivery of constitutional standards: 28 day diagnostic standard, maximum 62 day wait to first treatment from urgent GP referral, maximum one-month wait from decision to treat to treatment.

The cancer Centre for Excellence will deliver our key principles for excellent care

University Hospitals of Northamptonshire NHS Group

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

Dedicated to excellence

To deliver the cancer Centre of Excellence, we will pursue four themes, underpinned by three enablers

University Hospitals of Northamptonshire NHS Group

Themes

Research and innovation	Treatment and care	Modernising infrastructure	Sustainability
◗ Access to clinical trials ◗ Preventing cancers ◗ Detecting cancers ◗ Pathways ◗ Digital	◗ Integrated care models ◗ Risk stratified pathways ◗ Collective expertise ◗ Repatriation of activity ◗ Use of genomics to improve diagnostics and treatment plans	◗ Redevelopment ◗ Co-location ◗ Investing in clinical capacity/ green sites ◗ Diagnostics ◗ Genomic medicine ◗ Information ◗ Digital technology	◗ Operational flexibility ◗ Stage migration ◗ Prevention/ screening/ cessation

Enablers

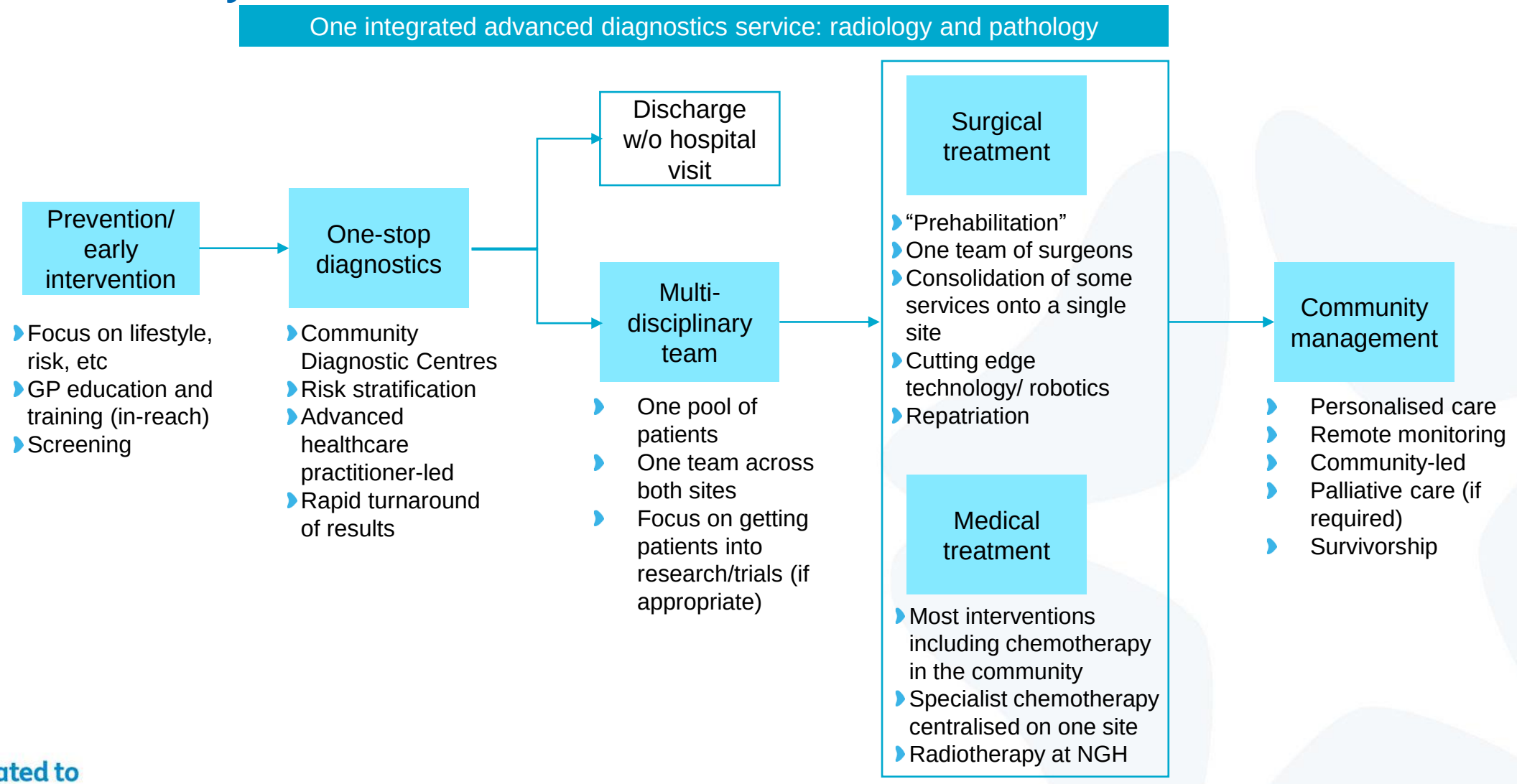
Workforce: education and training, expert workforce for future, new roles and technology, recruitment

Quality and governance: patient safety and experience, regulation, safety innovation, system leadership

Efficiency and transformation: early risk assessment, enhance referral communication, enhance triage

Dedicated to excellence

These themes will improve care along the whole cancer pathway over the next 3-5 years



Dedicated to excellence

There are key enablers required to support the successful implementation of the cancer proposals over 3-5 years

University Hospitals of Northamptonshire NHS Group

Workforce

- Skills mix review
- Organisational/team development
- Single teams working together to deliver equitable access, reduce clinical variation and drive improved patient outcomes

Research and innovation (academic)

- New academic post in cancer
- Successful delivery of our new NIHR Biomedical Research Centre
- Establishing Cancer research board to develop academic, research and commercial collaborations.

Quality and governance

- Single system leadership
- Synchronised governance
- Agreed common pathways

Modernising infrastructure (estates & digital)

- Investment in technology/robotics
- Development of community diagnostic hubs
- Single patient record

Dedicated to excellence

Our proposals mean some changes to how and where we provide cancer services

University Hospitals of Northamptonshire NHS Group

Our proposals mean some changes to how and where we provide cancer services for local people in Northamptonshire over the next five years with the aim of improving clinical outcomes of treatment

Cancer Services @ KGH

- Diagnostics
- Oncology (medical)
- Haematology (malignant and non-malignant)
- Chemotherapy (NGH-based oncologists)
- Immunotherapy
- Systemic Anti Cancer Treatments (SACT)
- Supportive treatment e.g. blood transfusions
- Breast screening
- Total Lung Health checks
- Bowel cancer screening unit

KGH currently provide the Bowel Cancer Screening Service for Leicestershire, Northamptonshire, and Rutland area

Cancer Services @ NGH

- Diagnostics
- Oncology (medical)
- Haematology (malignant and non-malignant)
- Chemotherapy
- Immunotherapy
- Systemic Anti Cancer Treatments (SACT)
- Supportive treatment e.g. blood transfusions
- Breast screening
- Robotic cancer treatment
- Specialised cancer services
- Direct emergency admissions for patients undergoing chemo treatment

NGH provides radiotherapy, chemotherapy and brachytherapy for KGH, NGH and MKUH

- Single point of access for patients
- One clinical team for Northamptonshire operating across all sites.
- Outpatients, Diagnostics, Surgical operations and other treatments available on both sites and in communities where possible, with some consolidation of specialist surgical care on the NGH site where this improves patient care.
- Single integrated clinical leadership and management structure with one governance route with ability to make decisions on behalf of both organisations

Dedicated to excellence

Our proposals mean some changes to how and where we provide cancer services

University Hospitals of Northamptonshire NHS Group

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Dedicated to excellence

Clinical Strategy: Investment in a surgical robot

- We have introduced a minimally invasive Robotic Assisted Surgical (RAS) service for patients with cancer - the first RAS in the county
- Our patients were limited to open or laparoscopic surgery within their local area or travel outside the county, with longer waiting times
- This new treatment benefits hundreds of local patients and supports our ambition to be a centre of excellence for patients with cancer
- RAS benefits patients and the hospitals as it reduces length of stay, increases surgical dexterity and improves outcomes
- Access to these treatments locally enables equity of access for patients across Northamptonshire

In the first year, we will take some initial steps to deliver our proposals (1/3)

University Hospitals of Northamptonshire NHS Group

Area	Changes	How we will know we succeeded	Benefit
Focused development	◗ Focus on three priority tumour sites: ◗ Urology ◗ Lung ◗ Colorectal	◗ Cancer service strategies for these three tumour sites	◗ Faster access to diagnostics resulting in better outcomes for patients
Multi-disciplinary teams	◗ Joint clinics (pool of patients) for all pathways	◗ Single PTL ◗ Merged operations team ◗ Similar waiting times for both sites	◗ Equity of access for patients ◗ More efficient use of resources
Treatment (surgical):	◗ Consolidate breast surgery on one site ◗ Consolidate head & neck surgery on one site ◗ Commence mastalgia pathway to reduce pressure on breast cancer pathway	◗ All breast surgery coded to single site ◗ All head and neck surgery coded to single site	◗ Improved outcomes as teams undertake a greater volume of procedures and more attractive to recruit
Treatment (medical):	◗ MDT delivery of chemotherapy (single team) ◗ Pilot a community chemotherapy clinic	◗ Proportion of chemotherapy delivered outside of hospital in “green” site	◗ Sick patients do not have to travel to hospital for treatment ◗ Reduced risk of infection

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Dedicated to excellence

In the first year, we will take some initial steps to deliver our proposals (2/3)

Area	Changes	How we will know we succeeded	Benefit
Prevention/ early intervention	◗ Expansion of Total Lung Checks to whole county and therefore equal access	◗ Total Lung Checks rolled out across county	◗ Prevention of lung cancer
One-stop diagnostics	◗ One-stop diagnostic operational at one community diagnostic centre (CDC)	◗ Consistently meet faster diagnosis standards for all patients	◗ Faster access to diagnostics resulting in better outcomes for patients
Multi-disciplinary teams	◗ Joint clinics (pool of patients) for all pathways	◗ Single PTL ◗ Merged operations team ◗ Similar waiting times for both sites	◗ Equity of access for patients ◗ More efficient use of resources
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Treatment (medical):	◗ MDT delivery of chemotherapy (single team) ◗ Pilot a community chemotherapy clinic	◗ Proportion of chemotherapy delivered outside of hospital in “green” site	◗ Sick patients do not have to travel to hospital for treatment ◗ Reduced risk of infection

In the first year, we will take some initial steps to deliver our proposals (3/3)

Area	Changes	How we will know we succeeded	Benefit
Workforce	◗ Undertake skills mix/roles review	◗ New roles for nurses/AHPs in place at both sites	◗ More attractive place for staff to work and therefore improved recruitment and retention
Research and innovation (academic)	◗ Cancer academic post in place ◗ Single research team and academic appointments for cancer	◗ At least 22% of patients at both sites to be invited to take part in cancer research	◗ More attractive place to work – improve recruitment and retention ◗ Support the development of new treatment and technologies ◗ Improve access to new treatment and technologies for patients
Quality and governance	◗ Align governance across both sites ◗ Develop an end of life strategy with system partners	◗ Merged overarching cancer board ◗ Joint harm reviews (with CCG) ◗ Single MDT leadership for an additional tumour site (gynae)	◗ Safer services from joint learning ◗ More joined up care for patients
Modernising infrastructure (estates and digital)	• Extend use of Robot Assisted Surgery (RAS)	• Robotic platform at NGH fully established with Group surgeons trained	◗ Robotic surgery available for local people in Northamptonshire

Centre of Excellence: Cardiology

Dedicated to excellence

Cardiology services are currently provided on both sites, with PPCI and a coronary care unit at KGH

University Hospitals of Northamptonshire NHS Group

High quality cardiology services will be provided for everyone in Northamptonshire. Some services will be provided at both hospital sites, with some specialist services at Kettering General Hospital

Cardiology services @ KGH

- Acute cardiology
- Rapid access chest pain unit
- Cardiac rehabilitation services
- Coronary care unit
- Cardio-respiratory diagnostics
- Cardiovascular MRI
- Adult congenital heart disease (ACHD) clinics
- Kettering Cardiac Centre
  - Pre-assessment clinics
  - Outpatients and diagnostics
  - Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM)
  - 24 hour Primary Percutaneous Coronary Intervention (PPCI) emergency service (Northamptonshire and surrounding areas)

Services requiring co-location with acute cardiology

- *Emergency Department – mostly unselective*

Cardiology services @ NGH

- Acute cardiology
- Rapid access chest pain clinic
- Cardiac rehabilitation services
- Myocardial perfusion scintigraphy (MPS)
- Adult congenital heart disease (ACHD) clinics
- Northampton Heart Centre
  - Pre-assessment clinics
  - Outpatients and diagnostics
  - Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM)
- Cardiothoracic surgical clinic (visiting surgeons from Oxford)

Services requiring co-location with acute cardiology

- *Emergency Department – mostly unselective*
- *Vascular surgery*

Dedicated to excellence

Local and national strategies set the strategic context for our proposals for Group cardiology

University Hospitals of Northamptonshire NHS Group

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

NATIONAL

- **NHS Long Term Plan:** identifies cardiovascular disease (CVD) as the single biggest area where the NHS can save lives over the next decade. CVD is largely preventable through lifestyle changes and there is a need to increase early detection and treatment of CVD. People with heart failure and heart valve disease will be better supported by multi-disciplinary teams within primary care networks.
- **Getting it right first time (GIRFT) Cardiology report (2021):** clinical cardiology networks should be established shaped by function and need rather than geography and all hospitals should be able to provide extended access to diagnostics, 24/7 on-call rotas for consultant cardiologists with 7-day ward rounds are recommended for acute medical admissions and a 7-day pacing (cardiac rhythm management (CRM)) service, there should be an emphasis on multidisciplinary teams within hospitals and across cardiology networks and digital transformation will be key to transform outpatient care and improve communication..
- **The Future of Cardiology, British Cardiovascular Society (2020):** cardiology services should be delivered on the basis of networks or systems of care that are fully and seamlessly integrated from community to tertiary care. As default, diagnostics should be delivered in an integrated community diagnostic hub run by secondary care in partnership with primary care. Virtual consultation should become the norm in both primary and secondary care.

GROUP

- **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24**: ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- **Group Digital Strategy**: ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

LOCAL

- **The KGH Clinical Strategy 2020:** **a**mbition to create a single cardiology service to improve care and outcomes for patients across Northamptonshire. Focus on raising clinical standards to a consistently high level across the county and expand the service to treat more patients. Integrate service with system partners to deliver proactive and preventative care.
- **The NGH Clinical Service Reviews:** Ambition to create and deliver a single countywide integrated cardiology service agreed by clinical and operational stakeholders. The service will consistently deliver excellence in quality of care and patient experience. Pooled resources will improve waiting times and reduce readmission rates and bed days for heart failure patients through enhanced discharge to community services.

Cardiology: The case for change

- Ischaemic heart disease accounts for the largest number of observed deaths in Northamptonshire
- CHD prevalence in Northants will gradually rise over the next ten years
- North Northamptonshire has the three practices with the highest CHD prevalence in Northamptonshire, significantly higher than the England average
- Prevalence in the county is highest in White and Asian populations
- Three-quarters of the practices with the highest heart failure prevalence rates are in the north of the county
- Spend on overnight NEL admission for CHD is higher than the national average and higher elective bed day use and spend

Cardiology: The case for change

University Hospitals of Northamptonshire NHS Group

GIRFT requires:

- 24/7 on call cardiologist for each site receiving acute medical admissions
- 24/7 emergency temporary pacing and 7/7 permanent pacing
- All PPCI have 24/7 PCI operators
- Urgent coronary angiography +/- PCI should be provided within 72hrs of admission with ACS
- All PCI centres should have 24/7 cath lab oncall to enable immediate return to lab onsite out of hours
- Coronary angiography should only be performed in PCI centres, by PCI capable operators
- Rehab for all HF patients
- 24/7 emergency echo

Cardiology GIRFT report

Dedicated to excellence

We have developed a vision for a cardiology Centre of Excellence for Northamptonshire

University Hospitals of Northamptonshire NHS Group

The cardiology Centre of Excellence will be an integrated service with the Group known nationally for **exemplary outcomes, excellent patient and staff experience**, and **complexity of caseload.**

The cardiology service will be known for its **extensive research capability**, **scholarship and academia, attracting and retaining leading experts** in the field.

The cardiology service will work **closely and integrate with colleagues in the community** to improve cardiovascular health and disease prevention for our local population.

As a Cardiology Centre of Excellence, we will…

Provide safe, effective cardiology care for everyone in Northamptonshire across both KGH and NGH sites through:

1. Continuity of care and communication between teams using a single patient record between KGH and NGH, and then with all county health providers
2. Consolidation of interventional procedures and pacing on one site with a resilient transport system to deliver national quality standards for PCI and pacing for every patient in Northamptonshire
3. Acute cardiac admissions unit and Ambulatory Heart Unit and Heart Failure Unit to stream patients to the most appropriate place for their care
4. New services in the county to bring care closer to home including electrophysiology and Transcatheter Aortic Valve Insertion
5. An integrated advanced diagnostic team to support early intervention to improve quality and performance
6. Care closer to home with integrated with community nursing, with remote monitoring of patients and treatment in ‘virtual wards’
7. Single cross site studies which will allow for greater population recruitment into clinical research
8. Work in partnership with neighbouring Trusts to improve access to specialist cardiac services to all our PPCI catchment area

Dedicated to excellence

The cardiology Centre for Excellence will deliver our key principles for excellent care

University Hospitals of Northamptonshire NHS Group

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't come into hospital in the first place, and when they do, they are discharged safely as early as possible
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** by working with voluntary and charitable groups to educate people so they don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients with consistent terms and conditions across the Group
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

Dedicated to excellence

Improve care along the cardiology pathways over the next 3-5 years

University Hospitals of Northamptonshire NHS Group

One integrated advanced diagnostics service

Prevention/ early intervention

- GP education and training (Cardiac GPs) and lipid tests
- Screening
- Support community teams in identifying at risk patients and populations e.g. areas with high levels of CVD
- Education for schoolchildren in primary prevention
- Focus on lifestyle, risk, warning signs and prevention
- Use of remote monitoring

Outpatients and diagnostics

- Community diagnostic centres – BP, ECHO, ECG
- Specialist diagnostics within hospital as part of integrated service

Entry to pathway through ED

- New pathways with EMAS to direct patients to the right site
- Cardiac Assessment Unit to avoid ED
- Cardiac advice call centre for community, GP and EMAS
- Ambulatory HF unit

Discharge w/o hospital visit

Multi-disciplinary teams

- Single point of access for elective patients
- One pooled team across both sites
- County wide team of specialist nurses/advanced nurse practitioners
- Virtual clinics where possible

Coronary interventions

- One interventionalist team
- Consolidation of interventions on one site
- Discharge to community as soon as possible

Non-coronary interventions

- Acute cardiology and diagnostics on both sites to support ED
- Coronary Care Unit on both sites
- Single team 24/7 on-call, 7-day ward rounds, 7 day pacing rota
- Repatriation of EP and TAVI

Community management

- Additional investment in community rehabilitation
- Elderly/frail case management (iCAN)
- Remote monitoring
- Pharmacist-led medicines review
- End of life care
- Community HF clinics

Group enabler strategies: workforce, research & innovation (academic), quality and governance, modernising infrastructure (digital & estates)

Dedicated to excellence

Our proposals mean some changes to how and where we provide cardiac services

University Hospitals of Northamptonshire NHS Group

- Single point of access for patients
- One site service with outreach provided on the second site. Single team operating across both sites providing the same high quality care to all patients.
- Single integrated clinical leadership and management structure with one governance route with ability to make decisions on behalf of both organisations.

Potential cardiology services @ KGH

- 24/7 general acute cardiology
- Rapid access chest pain unit
- Cardiac rehabilitation services
- Coronary care unit (with cardiovascular admissions unit)
- Cardio-respiratory diagnostics (including cardiac-MRI)
- Cardiac Centre (for Northamptonshire)
  - Pre-assessment clinics
  - Outpatients and diagnostics
  - Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM) inc. cath labs
  - 24 hour Primary Percutaneous Coronary Intervention (PPCI) emergency service (Northamptonshire and surrounding areas)

Specialist services

- Chronic Total Occlusion (CTO)
- Electro physiology spoke repatriate from UHL initially provided at NGH pending estates development at KGH

Services requiring co-location with acute cardiology

- *Emergency Department – mostly unselective*

Potential cardiology services @ NGH

- 24/7 general acute cardiology
- Rapid access chest pain clinic
- Cardiac rehabilitation services
- Coronary care unit
- Cardiac outreach from KGH
  - Pre-assessment clinics
  - Outpatients and diagnostics (inc. ECHO*)
  - PCI – eventually all move to KGH
- Cardiothoracic surgical clinic (visiting surgeons from Oxford)
- Electro physiology and TAVI proposal to develop new County service

Services requiring co-location with acute cardiology

- *Emergency Department – mostly unselective*
- *Vascular surgery and interventional renal – Ideally co-located along with interventional radiology for TAVI*

Community diagnostic hubs – (blood pressure, ECHO, ECG)

Integration with system partners to deliver community heart failure pathways and cardiac rehab

- One site – to be decided. Planned procedures including percutaneous coronary intervention (PCI), implantable cardioverter-defibrillator (ICD) and permanent pacemakers (PPM) inc. cath labs

There are key enablers required to support the successful implementation of the proposals over 3-5 years

University Hospitals of Northamptonshire NHS Group

Workforce

- Organisational/team development
- New appointments to work across both organisations automatically to facilitate cross-site working
- Alignment of workforce conditions, including parity of pay between sites, ensuring we are able to retain staff
- Establish team of county wide specialist nurses/advanced nurse practitioners therefore upskill to deliver cardiac assessments
- Training rotations across the sites
- Provide career path and progression for all advanced healthcare practitioners (AHPs)
- Further develop international recruitment programme for middle grade and hospital specialists in cardiology

Research and innovation (academic)

- Expand patients involved with trials (e.g. C-MRI)
- In-house training of staff with University (e.g. physiologists) – cardiac physiology school

Quality and governance

- Establish safe and effective way of transferring patients between sites
- Establish joint multidisciplinary team, morbidity and mortality conferences (M&Ms) and joint quality committees
- New EMAS pathways and interhospital transport
- Establish cardiology network
- Single team/governance, Joined MDT and M&Ms
- More patient information leaflets/links

Modernising infrastructure (digital & estates)

- Inpatients being given FU appt on discharge (if required)
- Intra-hospital transport
- Cardiovascular assessment space and wards co-located with CCU and cath labs
- Protected five cath labs with foundations for a sixth
- Diagnostic images available between sites
- Single patient record between sites and primary care
- Patient centric wards – phone charger, food and drink for families

Dedicated to excellence

In the first two years, we will take some initial steps to deliver our proposals (1/2)

University Hospitals of Northamptonshire NHS Group

Area	Changes	How we will know we succeeded	Benefit
Prevention/ early intervention	◗ Sign off vision and work programme ◗ Appoint dedicated consultant to lead	◗ Work programme being successfully implemented	◗ Prevention of cardio-vascular disease ◗ Equity of access to services for patients across Northamptonshire
Community monitoring	◗ Fund, recruit and train community heart failure nurses	◗ Heart failure team established	◗ Convenience for patients ◗ Earlier identification of issues
Outpatients and diagnostics	◗ Site specific pool of patients/single point of access for each site ◗ Identify pathways and workforce for community diagnostics centre	◗ Merged operational diagnostic team ◗ Equitable waiting times for both sites	◗ Faster access to diagnostics resulting in better outcomes for patients ◗ Equity of access for patients
Multi-disciplinary teams	◗ Cross site MDTs ◗ Extended advanced healthcare practitioner (AHP) roles defined	◗ Established MDTs ◗ Procedures to be undertaken by AHPs identified	◗ More efficient use of resources ◗ Improved recruitment and retention – reduced vacancy levels and bank and agency spend
Coronary interventions	◗ Describe proposals to consolidate PCI on a single site ◗ Establish joint on call rota for PPCI ◗ Deliver a seven day cardiac pacing service ◗ Deliver 5-day TOE cover across sites ◗ Appoint Group electrophysiologist to support repatriation of electrophysiology in year 2 ◗ Weekend ACS lists	◗ Clinicians on-call from both sites for PPCI ◗ Electrophysiologist appointed	◗ Meet the NSTEMI 72-hour target to improve patient outcomes ◗ Reduced intensity of workload for consultants ◗ Deliver consistent service for all local people ◗ Provide more services closer to local communities
Non-coronary interventions	◗ Develop medical physics specialty technical support	◗ Technical support outsourced	◗ Better use of resources

In the first two years, we will take some initial steps to deliver our proposals (2/2)

University Hospitals of Northamptonshire NHS Group

Area	Changes	How we will know we succeeded	Benefit
Workforce	◗ Align working and pay rates between KGH and NGH ◗ Develop cross site working ◗ Resolve cross-contracting between hospitals ◗ Team support to develop future working relationships	◗ Pay rates and working conditions aligned for all staff ◗ Good cross site relationships with joint MDTs	◗ More flexible working, increased rota resilience and greater provision of training and research opportunities ◗ Joint recruitment reduce cost
Education, research & innovation	◗ Plan to establish physiologist academic course ◗ Appoint academic lead	◗ Lead physiologist approved and appointed	◗ Access to highly trained staff and novel equipment/approaches ◗ Improved recruitment and retention, reduced vacancy rates
Quality and governance	◗ Nominate lead clinicians for Midlands cardiology network workstreams ◗ Single team/governance structure	◗ Clinical leads for network workstreams in place ◗ Governance in place ◗ Joint audit	◗ Better outcomes and more joined-up care for patients
Modernising infrastructure (digital & estates)	◗ Develop proposals to establish cath labs at single site ◗ Operationalise dedicated cardiac MRI ◗ Implement system to allow instant viewable access to scans on both sites	◗ Proposals for establishing cath labs at single site agreed ◗ Scans instantly viewable across sites	◗ Quicker access to dedicated diagnostic equipment ◗ Quicker access to scans / no need to re-scan

Dedicated to excellence

Roadmap for cardiology

Fragile services

Our ambition is to make fragile service sustainable for patients in Northants

University Hospitals of Northamptonshire NHS Group

Some of our services are fragile, with few consultants and low volumes in some specialties, which leads to unsustainable service delivery for our patients

- We will develop individual service strategies for all our services, starting with those which are the most fragile.
- The future ways of working will reflect the various options to make the service clinically sustainable and reflect the underlying reasons for them being fragile in the first place.
- We can will match capacity with the needs of our patients without placing unreasonable demands on our staff.

Examples of the approach we will take:

- Microbiology, bringing together the two teams to provide equitable access across the Group
- Neurology, working with tertiary providers to deliver care closer to home and access for all patients across the county
- Plastics, work in partnership with neighbouring Trusts to create a network of clinicians who can support each other and provide a resilient service

Dedicated to excellence

Protecting our elective pathway

Dedicated to excellence

A full range of elective services for adults are currently provided on both sites

The elective pathway provided for each specialty by each site, includes outpatient appointments either face to face or virtually, diagnostic services, pre-operative assessment, outpatient treatments, day case examinations and treatment, surgery and inpatient stays.

Elective Services available @ KGH & NGH

- General surgery
- Head & neck
- ENT
- T&O
- Urology
- Pain services
- Endoscopy
- Audiology
- Gastroenterology
- Ophthalmology
- Breast
- Vascular services
- Plastics
- Colorectal
- Gynaecology

Most inpatient elective services require co-location with critical care facilities

Some sub-speciality procedures are only undertaken on one site or another. For example T&O spinal surgery only takes place at KGH.

Both organisations work closely with the two Independent sector providers in the county, with some NHS services and procedures being undertaken in collaboration between the NHS and the independent sector to maximise the use of available capacity.

NGH

Provide the regional specialist vascular surgery services
Some services are also provided from Danetre Hospital in Daventry

KGH

Provide a range of outpatient and diagnostic tests in satellite locations closer to patients' homes:
- Corby Health complex and GP surgery
- Nene Park in Irthlingborough
- Isebrook Hospital in Wellingborough
- Kettering town centre

Local and national strategies set the strategic context for our proposals for Group elective care

University Hospitals of Northamptonshire NHS Group

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations.

NATIONAL

- **NHS Long Term Plan:** supports separation of urgent from planned services. Sets the ambition that redesigned hospital support should help the NHS avoid up to a third of outpatient appointments, saving patients 30 million trips to hospital.
- **Royal College of Surgeons - Future of Surgery:** anticipates an increase in preventative surgery that will increasingly focus on quality of life. Day-case surgery will continue to increase with more importance placed on preoperative and follow up care which will be undertaken using telemedicine and digital platforms.
- **Royal College of Physicians:** recommend move away from routine first and follow up care to flexible, one-stop-shops, see-and-treat clinics and patient-initiated-follow-ups. Services should optimise the staff skill mix rather than always relying on consultant-led care. The ultimate objective should be reducing the number of steps in a patient's pathway.
- **GIRFT Elective Recovery High Volume Low Complexity (HVLC) Programme:** standardised procedure level pathway at system level and establishing fast track surgical hubs. 85% of all elective surgery should be on a day surgery pathway in dedicated facilities away from unplanned care.
- **Recovering from the pandemic:** Nationally it is reported that there are currently over £5m people waiting for treatment, with approximately 80% of those waiting for a diagnosis, and over 384k waiting over a year. There are an unknown number who have also yet to come forward for treatment. Recovering this position and treating these patients is one of the four key priorities for the NHS in 2021/22, but we must use innovative ways and digital technologies to do this in the most effective ways.

GROUP

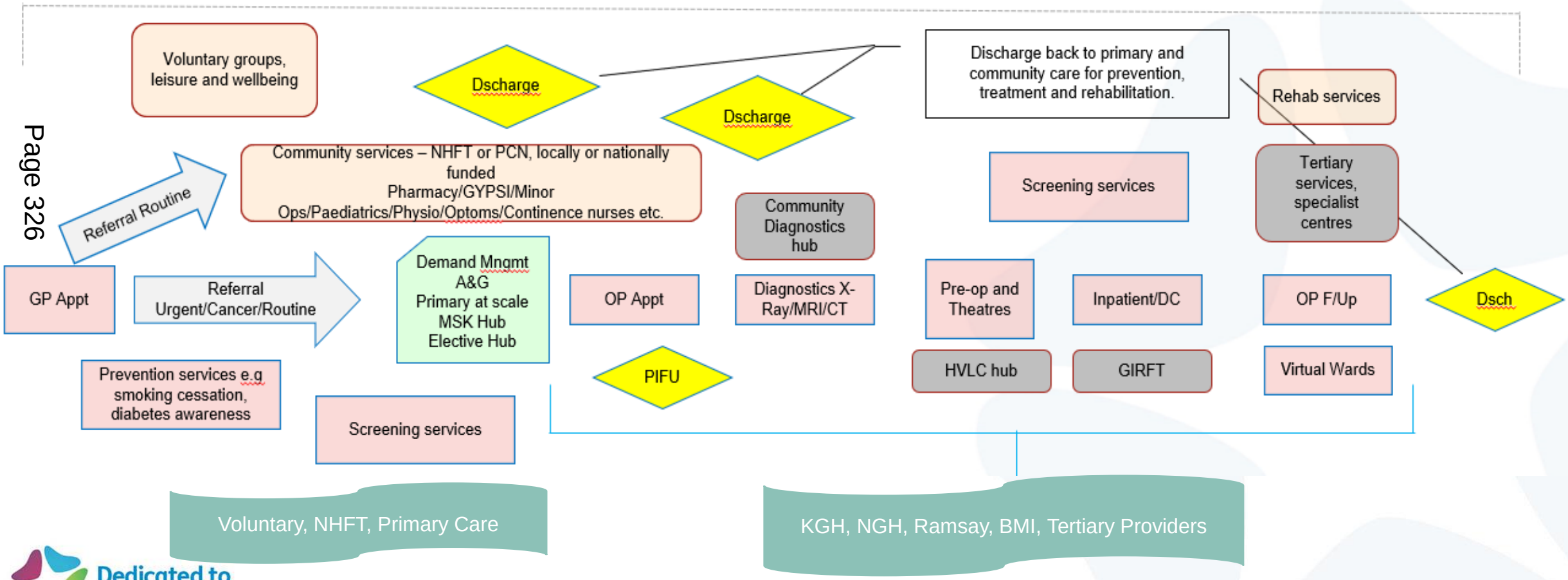
- **NGH/KGH Group Digital Strategy**: ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Nursing, Midwifery, Allied Health Professional Strategy 21-24**: ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish.
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients
- **Northamptonshire Health and Care Partnership:** develop musculoskeletal hub

LOCAL

- **The KGH Clinical Strategy 2020**: ambition to deliver seven day services and opportunity to collaborate with NGH to provide county-wide services and provide access to a larger, more sustainable workforce with greater flexibility. Expected to improve access to a wider range of services for patients.
- **The NGH Strategy 2019-24**: sets an ambition is to build dedicated elective centre with KGH that is easily accessible for all patients.

The elective pathway is not as simple as it seems with many hand-offs and fragmented elements

The elective pathway is not as simple as it seems, there are many hand-offs and fragmented elements of the pathway, which can lead to duplication and delays for patients. There is limited focus on prevention and psychological support for those with long term conditions. Pathways can be different by provider even within specialties. There is not a collective elective service offer for the Northamptonshire population.



Our current waits for treatments are low, but we must act now to ensure we continue to meet the needs of our patients

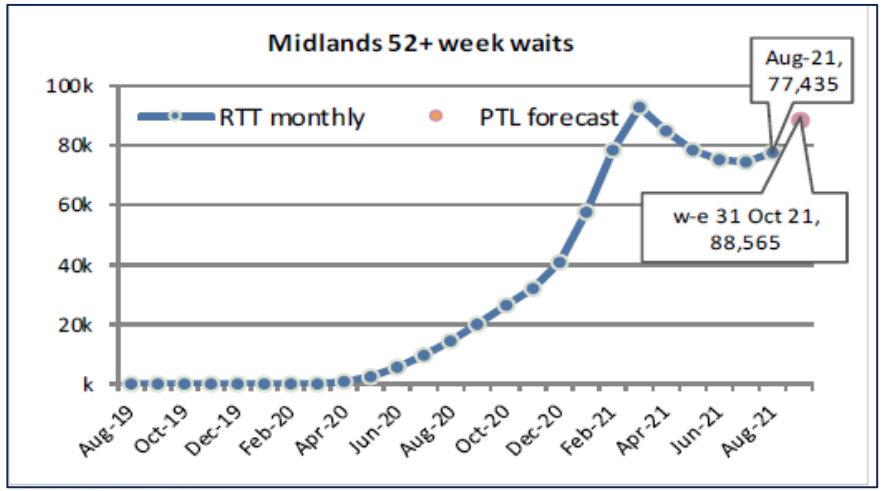
University Hospitals of Northamptonshire NHS Group

Nationally and regionally elective waiting times have grown significantly as a result of the COVID pandemic. This was due to:

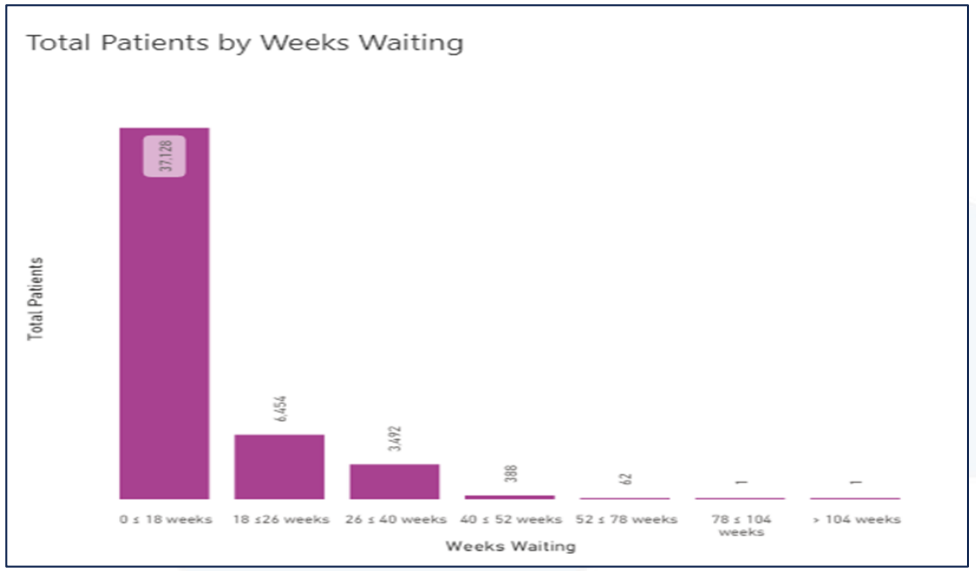
- staff being redeployed to respond to the pandemic
- increased infection control and social distancing standards resulting in a drop in efficiency of those patients who can be treated in the same amount of clinical time
- many patients' clinical priority did not warrant urgent treatment during the pandemic

However demand is significantly increasing and many patients may yet come forward, so we need to work with our primary care colleagues to implement innovative ways of keeping patients well in their communities, managing conditions effectively through joint models of care to ensure those that do need to access acute hospital services and get to the right clinician at the right time with no undue delay.

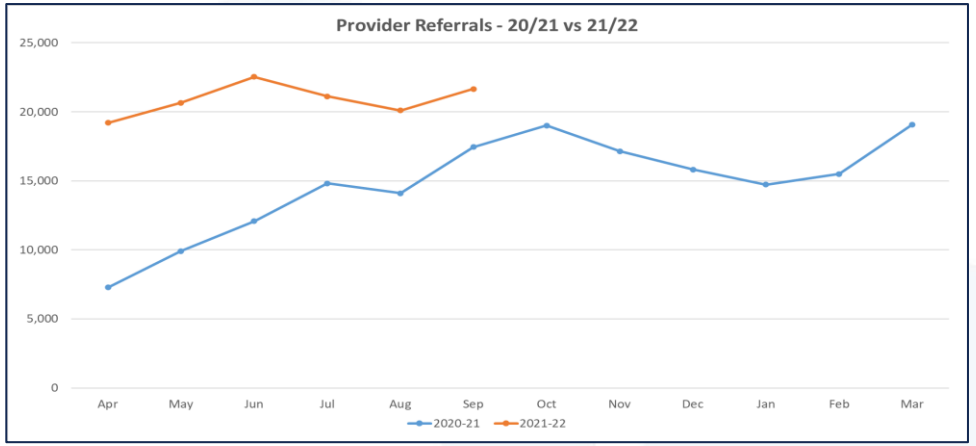
There are significant numbers of people waiting over 52 weeks in the Midlands



Patients waiting for elective treatments in Northamptonshire, currently have some of the lowest waiting times in the UK



Referrals are growing leading to increasing pressures on waiting lists



Dedicated to excellence

Our case for change shows that there are several issues that we must address

University Hospitals of Northamptonshire NHS Group

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for elective services.

There is growing demand for our services

- Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1].
- Referrals for elective treatment have increased since pre-pandemic levels.

There is an opportunity to deliver care differently

- The delivery of many outpatient appointments has been virtual in the past 18 months. Whilst it is clinically appropriate that some of these return to face to face, we should, where possible, embed these new ways of working as more convenient for our patients.
- Innovative use of emerging technology should be capitalised such as remote monitoring or new theatre techniques.
- Care as close to home and 'health on the high street' should be a strategy we follow where possible.

Dedicated to excellence

There is not equitable access to elective surgery across Northamptonshire

- Health inequalities of those accessing our services and getting treating according to underlying health need, is not fully understood but is likely to not be equitable.
- Non-elective activity redirects focus away from elective cases, and disrupts theatre lists.
- Elective activity is cancelled due to bed pressures leading to poorer patient experience and poorer outcomes. Cancellations also impact of the efficiency and productivity of the services.

There are opportunities to streamline pathways

- Opportunity for pathway standardisation to reduce unwarranted clinical variation
- Integrated working with system partners to increase provision of care closer to home
- Streamlined pathways to minimise disruption to patients' lives

We have difficulty recruiting and retaining our staff

- National workforce challenges with theatre staffing are also echoed locally. Both Trusts are unable to fully staff all their theatre capacity.
- Opportunity to adopt new workforce models, in line with the AHP strategy
- Opportunities to improve training and research offerings through collaboration (in line with academic strategy)

We can improve efficiency and quality by implementing GIRFT recommendations

- Opportunities identified in many areas:
  - theatre efficiencies, start times and turnaround times
  - day case rates in ENT, general surgery, breast and orthopaedics
  - Length of stay in general surgery and urology

Sources: [1] ONS Population Projections 2018-2028 [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20, [4] CQC.org.uk [5] NGH Board of Directors report, Jan 2021 [6] KGH Board of Directors report, Jan 2021 [7] Model Hospital

The rationale for changing elective pathways is clear

University Hospitals of Northamptonshire NHS Group

The rationale for changing elective pathways is clear. If we do not change, we will see:

- Further increases in waiting times for elective care with an increased risk of deterioration with emergency attendances and longer recovery
- Pathways that are not joined up and people don't experience the right care, in the right place at the right time
- Growth in primary care will not grow at the same pace of our population needs, and we will lose the opportunity to do things differently through neighbourhoods and integrated community teams

Currently

£196 million combined elective spend across partners

90 over 65s admitted daily - this is **8** more people each day than peers

900 stranded patients - we have an average of **113** stranded patients more than our peers

5% a year plus increase each year in demand for Emergency Department care

£36m shortfall in funding in 2020-21

If we do nothing, in four years time…

A new hospital would be needed to meet expected demand for 25,000 additional elective operations

150 extra GPs to deal with 500,000 more patient contacts

10,000 more admissions a year into hospital

£120k (£90m a year) more a day spent supporting discharge staffing and short term support

2,500 more requests for social care support

Dedicated to excellence

Our ambition is to ensure our elective patients consistently get timely equitable access to high quality care and experience

University Hospitals of Northamptonshire NHS Group

The Group will work collaboratively to provide **dedicated elective capacity** protected from the pressures of emergency services, committed to providing **timely and equitable access to care, minimising infection rates** and **reducing length of stay** in hospital.

Elective care across the Group will offer exemplar **standardised best practice patient pathways** in line with national recommendations which minimise **unwarranted clinical variation,** and maximise **day surgery** and **one stop** pathways.

The Group is committed to delivering more care on a **day surgery** pathway, with more assessment, diagnosis and treatment being offered in a **one-stop** pathway, **in the community or virtually** to minimise disruption to patient's lives.

The elective care team will work as one across the Group, providing a positive and fulfilling working environment that **attracts and retains a range of multi-disciplinary staff**, offering **outstanding careers and development opportunities.**

The Group will collaborate with system partners to set up an **Elective Care Collaborative**, providing seamless pathways for patients, working to keep patients well in their homes and providing advice and care as close to their homes as possible.

As a Lead Provider for the Elective Care Collaborative in Northamptonshire, we commit to…

- ✓ Working to deliver top decile performance in GIRFT and Model Health benchmarked analysis
- ✓ Eliminating any differences in equitable access to care related to health inequalities
- ✓ Delivery of constitutional standards: Zero patients waiting over 52 weeks, 92% of patients waiting less than 18 weeks for treatment and all patients waiting less than 6 weeks for a diagnostics.
- ✓ Delivering the same service and experience in the county regardless of provider.

Dedicated to excellence

*10% is a commitment in the Group's dedicated to excellence strategy; the working group suggested 25% target – the Group to confirm

The Group elective proposals will deliver our key principles for excellent care

- **Integrated, seamless pathways for patients:** so that people get the care they need, when they need it, by professionals working together across primary community and acute settings
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Focus on pre-hospital care:** so that people know how to keep well, and can access advice and services in their communities without needing to wait for a hospital appointment
- **Digital innovation:** so that patients can be treated in any setting with digital care records and test results available, and so patients are able to engage in their own treatment journey through the use of technology
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Fit for purpose estate:** so that services can be delivered as efficiently as possible, with improved quality and experience in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

A single system approach will improve care along the whole elective pathway over the next 3-5 years

University Hospitals of Northamptonshire NHS Group

One system-wide waiting list (PTL), delivering equitable access to timely treatment for patients across the county, transparency to all clinicians including GPs to enable patients to be supported to keep well while they wait

Prevention/ early intervention

- Focus on lifestyle, education and wellbeing
- Reducing health inequalities
- GP support, multi disciplinary team integrated learning
- Pre referral 'work-up'

Single referral hub

- Triage to ensure patients get faster access to the most appropriate service for their needs
- Patient feedback on service

Community based services

- Specialist primary care advice and treatment
- Therapies
- Minor treatments in CDCs
- Chronic long term condition management

Multi-disciplinary team

- One pool of patients
- One team across both sites
- Highly skilled, effective and happy staff

Ongoing mngment w/o hospital visit

High Volume Low Complexity

- High volume, low complexity treatments delivered as close to home as possible

Elective treatment hub

- Specialist treatments delivered in protected elective capacity with access to critical care facilities

Rehabilitation

- Immediate post-surgical services
- Minimised length of stay to avoid degradation
- Appropriate community based rehabilitation services

Community management

- Personalised care
- Remote monitoring
- Community-led lifestyle advice and services
- Working with the third sector

Dedicated to excellence

Group enabler strategies: workforce, research & innovation (academic), quality and governance, modernising infrastructure (digital & estates)

The elective collaborative is a partnership across Northamptonshire

NHS
University Hospitals of Northamptonshire
NHS Group

NHS
University Hospitals of Northamptonshire
NHS Group

NHS
Kettering General Hospital
NHS Foundation Trust

NHS
Northampton General Hospital
NHS Trust

NHS
Northamptonshire Healthcare
NHS Foundation Trust

NHS
Northamptonshire
Clinical Commissioning Group

Northamptonshire
Health and Care Partnership

Northants LMC

Woodland Hospital
Part of Ramsay Health Care

Circle Health Group
Three Shires Hospital

PML

3SIXTY
CARE PARTNERSHIP
BUILDING HEALTHIER FUTURES

Dedicated to excellence

Implementing our proposals will address the issues in our case for change

NHS
University Hospitals of Northamptonshire
NHS Group

Our current priority issues	How working as a collaborative would address these
Increasing elective waiting lists • Each organisation holds different pieces of the elective care jigsaw and multiple waiting lists • There is no single version of the truth • Patients deteriorating during wait	✓ A single PTL resulting in equitable access to care ✓ Standardising protocols, policies and pathways ✓ System wide transformation to improve efficiencies, create capacity and introduce innovations ✓ Delivering consistency in diagnosis, treatment and care; new service and pathway development meaning equal access to high quality services
Understanding our capacity • We plan capacity at organisational level • We don't have the ability to share knowledge at specialty level to ensure space/equipment and staff resource are maximised	✓ Demand and capacity is planned at system level ✓ Knowledge is formally shared to ensure capacity and resources are maximised ✓ Opportunities are maximised to create dedicated elective facilities enabling us to protect our elective capacity, provide timely care, minimising infection rates and reduce length of stay in hospital
Not person centric • Fragmented pathways with multiple handovers • Confusing for patients and heavy communication burden on all partners	✓ Commissioning end to end pathways enabling us to focus on prevention and out of hospital care ✓ More assessments, diagnosis and treatment being offered in a one-stop pathway, in the community or virtually to minimise disruption to patient's lives ✓ Working to engage with patients to design and transform services to deliver improved outcome
Workforce constraints • Each organisation competes for staff with separate skill mix models for the same service • Recruitment and retention managed separately	✓ Integrated teams will increase rota resilience and reduce workloads, reducing reliance on temporary staffing and improving staff wellbeing ✓ By working across the system, we will have the scale to explore and pilot new roles and workforce models
Value for Money is compromised • Pricing and activity is based on organisational activity and not pathways or outcomes • Variation in costs across the System	✓ A lead provider model, offering a single provider lead for administering collaborative planning and delivery ✓ Outcomes based commissioning focused on delivering end to end pathways ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)

Dedicated to excellence

In the first year, we (the Group) will take some initial steps to deliver our proposals

University Hospitals of Northamptonshire NHS Group

Area	Changes	How we will know we succeeded	Benefit
Prevention/ early intervention	Understand the current impact of health inequalities on elective care in the county	Strategy to reduce health inequalities in place	Reduction in health inequalities
Single referral hub	Implement a systemwide waiting list (PTL) to support delivery	Single waiting list (PTL) implemented	Equity of access for patients More efficient use of resources
Community based services	Develop community based pathways such as chronic pain and rheumatology, and set-up some community based services such as pre-op and ophthalmology away from the acute sites	Community based services set-up	Access closer to home for patients More efficient use of estates
Community diagnostic centres	Identify pathways and workforce for community diagnostics centre	Higher conversion rate of referrals to procedures Similar waiting times for both sites	Faster access to diagnostics resulting in better outcomes for patients Equity of access for patients
Elective treatment hub	Pilot a dedicated protected elective hub on one site and engage with patients and stakeholders on the benefits Co-locate low volume sub-specialties where this is in the best interests of patients Develop a strategy for fragile services or subspecialties such as plastics	Single elective hub (pilot) established Low volume specialties co-located	Separation of elective and emergency work means fewer cancelled operations and shorter waiting lists Co-locating specialties improves quality as staff are able to specialise more
Workforce	A joint strategy for the recruitment and retention of theatre staff	Reduction in vacancies and turnover for theatre staff	Attract and retain high quality staff More efficient theatre and equipment use
Quality and governance	Launch the system Lead Provider Collaborative for Elective Care, with an agreed set of system objectives to cover the next 2 years	Lead Provider Collaborative launched	Improved efficiency and reduced waiting times for patients

Emergency and integrated care across Northamptonshire

Dedicated to excellence

University Hospitals of Northamptonshire NHS Group is a collaboration between Kettering General Hospital NHS Foundation Trust and Northampton General Hospital NHS Trust

Emergency care services are currently provided on both sites, and at the urgent care centre in Corby

The hospitals are working with partners to reduce emergency hospital visits through the iCAN programme. An Emergency Department is provided at both sites

Emergency and integrated care services @ KGH

Emergency care services

- Emergency department
- Same day emergency care

Other emergency care services

- *Urgent care centre at Corby*

Integrated care services for frail patients

- Frailty unit
- Community services provided by NHFT
- Primary care services provided by primary care
- Social care services commissioned by North Northamptonshire Council

Emergency and integrated care services @ NGH

Emergency care services

- Emergency department
- Same day emergency care
- Emergency eye department

Integrated care services for frail patients

- Frailty hub
- Community services provided by NHFT
- Primary care services provided by primary care
- Social care services commissioned by West Northamptonshire Council

Local and national strategies set the strategic context for our proposals for emergency and integrated care

University Hospitals of Northamptonshire NHS Group

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

NATIONAL

- **NHS Long Term Plan:** identifies genuinely integrating care in our communities as a priority, including creating true integrated teams of GPs, community health and social care staff, expanding community health teams to keep people at home and increase support to care homes. Emergency care models building on the success of Urgent Treatment Centres and focussing on increasing usage of same day emergency care.
- **NHS Ageing Well programme:** the NHS ageing well programme identifies the development of person-centred services that enable people to age well, supporting people who are identified as frail to manage their health and wellbeing according to their needs
- **Home First policy:** the Home First approach is about supporting patients at home or in an intermediate care service. This is often implemented alongside a Discharge to Assess model, whereby home is the default pathway and the assessment is completed at home, with ongoing support services for up to 6 weeks.

GROUP / SYSTEM

- **Northamptonshire Health and Care Partnership iCAN programme:** the integrated care across Northamptonshire programme outlines our ambition for deliver a refreshed focus and way to improve the quality of care and achieve the best possible health and wellbeing outcomes for older people across our county, supporting them to maintain their independence and resilience for as long as possible. Ensuring to Choose Well which services we use for frail patients, Stay Well and Live Well.
- **Group Digital Strategy**: ambition to implement a shared care record across Northamptonshire, enabling truly integrated care, supporting the delivery of our frailty model.

LOCAL

- **The KGH Clinical Strategy 2020:** ambition to provide acute frailty services 70 hours a week and ensure frailty patients receive a comprehensive geriatric assessment. Focus on same day emergency care model, treating a greater number of patients without an overnight.
- **The NGH Clinical Service Reviews:** Ambition to create and deliver integrated services agreed by clinical and operational stakeholders. The service will consistently deliver excellence in quality of care and patient experience, including enhanced discharge to community services

Dedicated to excellence

Our case for change shows that there are several issues that we must address

University Hospitals of Northamptonshire NHS Group

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for cardiology services.

There is growing demand for our services

- Our population is growing, with a 14% increase over the next 20 years
- There is expected to be a 50% increase in the 65yrs+ population in Northamptonshire between 2018 and 2038 [3].

There is an opportunity to look after people at home rather than in hospital

- Patients across NGH and KGH do not have equal access to integrated multi-disciplinary care that supports frail patients.
- Case reviews have identified that we could better support people in the community to avoid their health reaching a crisis point.
- When people do reach a crisis point, better availability of services in the community should prevent an emergency department admission.
- For those who do come to ED, we can reduce the chance of being admitted to hospital by ensuring the right services are in place and known about

Our patients could be supported to be discharged home quicker

- Across KGH and NGH, a high proportion of our beds are occupied by patients who have been in hospital for more than 14 and more than 21 days.
- Around 35% of our patients have no clinical reason to reside in a hospital bed and are waiting for either KGH and NGH or system partners to support them to be discharged.

Dedicated to excellence

We have difficulty recruiting and retaining our staff

- There is a national shortage of emergency care staff to support our patients in ED.
- Recruitment is challenged by the geography of KGH/ NGH, located close to leading teaching hospitals
- Retention is challenged by high workload and National shortage
- Terms and conditions are different between the two sites
- A national shortage of care staff reduces capacity to support our patients in the community, meaning we need to best support our patients to be independent.

We need to do more multidisciplinary and network working to improve outcomes and patient experience

- We currently have two separate teams on our two sites
- There could be greater integrated working with our health and social care partners operating in a multi-disciplinary manner to care for our most frail patients
- The NHS long term plan emphasises the need for enhanced care for people living with frailty and prioritises more effectively integrated services

We have developed a vision for emergency and integrated care in Northamptonshire

University Hospitals of Northamptonshire NHS Group

Emergency and integrated care services will provide an integrated service that the Northamptonshire system will be known for nationally for delivering the **best outcomes for patients, organisations and our staff – putting patients at the centre of all we do.**

As we develop further models of integrated care across Northamptonshire with our system partners, we will **support people to choose well**, ensuring no one is in hospital without a need to be there, **ensure people can stay well**, and **ensure people can live well**, by staying at home if that is right for them.

Our emergency departments will be the **departments of choice** for staff across the East Midlands. We will embed **continuous development and learning** for staff, with **a diversity of skilled roles** all working together in a **single team**. Our vacancy rates will be low and we will excel in our staff and GMC surveys.

As an emergency and integrated care service, we commit to…

- ✓ No avoidable harm in emergency care, and no site specific variation in emergency care.
- ✓ Outstanding CQC rating at both departments
- ✓ No patients waiting over 12 hours in our emergency departments
- ✓ Work in partnership with our Northamptonshire Health and Care Partnership colleagues to provide seamless care for our most frail patients
- ✓ Embed the Home First principles and Discharge to Assess within the county
- ✓ Supporting people to access the right care in the right place, first time
- ✓ A single model for frailty across the county

Dedicated to excellence

Emergency and integrated care services will deliver our key principles for excellent care

University Hospitals of Northamptonshire NHS Group

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **Keeping people at home where possible:** so that people don't get admitted to hospital or for onward care when not necessary, keeping people independent and resilient
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality, integrated services
- **Focus on support in the community:** so that people are supported to stay well and are supported in the community
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver the right care in the right place, first time:** so that people are looked after in the most appropriate care setting for their needs
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible in our communities and capacity is ring-fenced for frailty services in our acute hospitals
- **Best use of available resources:** so that we can provide the best service we can with the resources that we collectively have as a system

Dedicated to excellence

We will improve integrated care pathways over the next 3-5 years

University Hospitals of Northamptonshire NHS Group

One integrated care record across Northamptonshire collaborative

Prevention/ community and welfare support

- Focus on lifestyle, risk and prevention education on A&E alternatives from school age up
- Waiting times of all alternatives on digital solutions with advice
- Primary care support
- Support for families and carers

Community MDT and frailty support

- Community MDT support and case management for patients identified as frail
- Community diagnostic hubs – BP, ECHO, ECG
- Strong and dignified end of life services

Entry to pathway through ED

- Timely and accurate streaming at the front door
- EMAS and GP direct to specialist beds

Discharge w/o hospital stay

Community response and same day emergency care

- Single point of access for patients
- Community response to manage a crisis in the community
- Effective working with EMAS to avoid admission
- Effective and consistent frailty and same day emergency care
- Mental health support in the right place and time
- Direct diagnostics

Non-elective hospital stay

- Consistent frailty model to support frail patients in ED and on the wards
- 7-day ward rounds by consultant team to support effective patient flow
- Sufficient Mental Health bed provision locally
- Clear discharge expectations for patients and their families
  - Home first discharge approach
  - Supported discharge 24/7
- Specialist pathways for fractured neck of femur, heart failure, etc.
- Ward/ED pharmacy

Community support

- Effective discharge to assess model
- Investment in health and care capacity to meet people's needs
- Remote monitoring
- Pharmacist-led medicines review
- End of life care

Dedicated to

System enabler strategies: workforce, research & innovation (academic), quality and governance, modernising infrastructure (digital & estates)

There are key enablers required to support the successful implementation of the strategy over 3-5 years

University Hospitals of Northamptonshire NHS Group

Workforce

- Organisational/team development
- Consistent frailty model across both organisations
- System-wide workforce planning
- Investment in county wide community services to support patients in the community
- Support the development of the care workforce in the system
- Develop a true multi-professional approach

Research and innovation (academic)

- Expand patients involved with trials
- In-house training of staff with University, expand the frailty training being provided across the system

Quality and governance

- Establish safe and effective admission avoidance and discharge pathways
- Establish joint multi-professional teams and system governance
- Work closely with EMAS, NHFT and the local authorities on pre-hospital pathways
- Develop the integrated care across Northamptonshire collaborative

Modernising infrastructure (digital & estates)

- Single patient record between all system partners
- Community hubs to support care in the community
- Appropriate ring-fenced estate for frailty hubs

Dedicated to excellence

Women and children's services

Women and children's services are currently provided on both sites, with a midwife-led unit at NGH

University Hospitals of Northamptonshire NHS Group

Both KGH and NGH provide maternity and paediatric services. Women who choose to give birth at NGH women have the choice of three birth settings: midwife-led birth centre, labour ward, home birth. At KGH have the choice of two birth settings: labour ward or home birth. There are plans to construct a midwife-led unit at KGH in the near future.

Women's and Children's @ KGH

Women's

- Labour ward and home births
- Antenatal and postnatal care
- Local (Level 2) Neonatal Unit (LNU)
- Fetal Health Unit
- Gynaecology (emergency and elective)

Children's

- Paediatrics medical inpatient and outpatient
- Paediatrics ED & PAU
- Community paediatrics

Births 2020/21: 3,207

Women's and Children's @ NGH

Women's

- Labour ward, midwife led birth centre & home births
- Antenatal and postnatal care
- Local (Level 2) Neonatal Unit (LNU)
- Fetal Health Unit
- Gynaecology (emergency and elective - incl. Northamptonshire Gynaecological Cancer Centre)

Children's

- Paediatrics medical inpatient and outpatient
- Paediatrics ED & PAU
- Community paediatrics

Births 2020/21: 4,200

- Northamptonshire Maternity Services is a partnership with NGH, KGH and Northamptonshire Healthcare Foundation NHS Trust (NHFT).
- Both Trusts are part of the East Midlands Neonatal Operational Development Network (EMNODN).
- Both Trusts are working as part of the LMNS Partnership Programme, which includes maternity & neonatal digital transformation and transforming Neonatal Care, and with the NHCP Children & Young People Transformation Board.

Dedicated to excellence

Local and national strategies set the strategic context for our proposals for women and children's services

University Hospitals of Northamptonshire NHS Group

There are several national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary of the key recommendations

NATIONAL

- **NHS Long Term Plan (2019):** women should receive continuity of the person caring for them during pregnancy, during birth and postnatally. Children's mental health services are expected to grow to deliver integrated mental and physical health care. Where possible care will be delivered closer to home for children and their families.
- **Better Births (2016, 2021):** women should have continuity of carer and 'should make decisions about the support they need during birth and where they would prefer to give birth whether this is at home, in a midwife unit or in an obstetric unit'.
- **Saving Babies Lives Care Bundle (2019):** services should offer choice and personalised care for women and promote availability of continuity of carer.
- **Ockenden Report (2020):** there must be robust pathways for dealing with complex pregnancies. Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.
- **Royal College of Paediatrics Facing the Future (2010):** consultant cover is present and readily available in peak hours 7 days a week. Trusts should reduce the number of inpatient sites and increase the no. of consultants to improve senior cover.
- **Neonatal Critical Care Transformation Review (2017-date):** plans to address issues in neonatal workforce and capacity

GROUP

- **Group Nursing, Midwifery, Allied Health Professional Strategy 2021-24:** ambition to become the first group hospital accredited as Pathway to Excellence – a positive practice environment that allows nurses to flourish because of job satisfaction, professional growth, development, respect and appreciation.
- **Group Digital Strategy:** ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

LOCAL

- **The KGH Clinical Strategy 2020:** ambition to set up new clinics and hubs in the community. Ambition to provide a comprehensive maternity service alongside NGH incl. sub-specialising care between the two services and working under congruent policies and procedures. Increase access to gynaecology service, enhance facilities and adopt new workforce models
- **The NGH Strategy 2019-24:** build a dedicated paediatric emergency facility at NGH.
- **Local Maternity and Neonatal Strategy:** providing continuity of care across Northamptonshire, with a focus on prenatal and postnatal care
- **NHCP Children's & Young People Transformation Board:** Bringing together partners across health, care and education to improve outcomes for children and young people
- **East Midlands Neonatal Network:** Ensuring that babies and their families receive high quality care which is equitable and accessible for all

Our case for change shows that there are several issues that we must address

University Hospitals of Northamptonshire NHS Group

As well as responding to the recommendations of key strategies, there are several other drivers for change that services facing. These are addressed within our proposals for children and women's services.

There is growing demand for our services

- Northamptonshire population is projected to increase by 14% 2018- 2038. In 20-64 year olds there is projected to be a 7% increase [1].
- In North Northamptonshire, govt-backed plans could see 33,000 new homes built likely to be for primarily young families, increasing demand for maternity and paediatric services [2].

Our services are not joined up leading to poor patient experience

- There is a lack of integration with community services
- Transition between child and adult services is not always seamless and in some cases a total gap with some subspecialties running to 16 but adult services start at 18.

There is some quality and efficiency improvements we need to make

- Day case rates and length of stay needs to improve for gynaecology.
- Paediatrics at KGH are not efficient in outpatients clinics

There is variation in service across Northamptonshire

- **Obstetrics:** there is obstetric clinical variation across Northamptonshire [3]
- **Paediatrics:** there are different services available across the county (e.g. end of life, allergy)

We need to do more to prevent ill health during pregnancy

- The number of mothers smoking at birth is higher than the England average in both Northampton and Kettering.
- Smoking is the single biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal health outcomes [2].

Some of our estates and facilities are not fit for purpose

- Both NGH and KGH estates shortfall for neonatology, maternity and gynaecology. In neonatology this has been highlighted in GIRFT (2021) and an NHS Neonatal Critical Care Transformation Review (2019).
- The development of integrated community centres provide an opportunity to deliver services more locally

CQC Performance

Maternity
KGH: Good (2019)
NGH: Requires Improvement (2019)

Services for children & young people
KGH: Requires Improvement (2018)
Northampton: Good (2017)

Friends and Family Test

% of people likely to recommend the provider's maternity services to friends or family

KGH	**100%**
NGH	**96.9%**
National median	**98.7%**

Sources: [1] ONS Population Projections 2018-2028 [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20, [4] CQC.org.uk [5] Model Hospital

Dedicated to excellence

We have developed a vision for Children and Women's services in Northamptonshire

University Hospitals of Northamptonshire NHS Group

Our ambition for paediatrics is to **continue to provide inpatient services on both sites** whilst **improving the resilience of our sub specialist services**. We will also **develop our integrated approach with community based services** so that there are no boundaries for patients.

Our ambition is for women's services is to be **a centre of excellence**. We will seek to **address health inequalities**, achieve the **best outcomes for women**, have the **best trained staff** in the country and be **leaders in research and education**.

We are working with partners to develop a joint vision and commitments for children and women's services in Northamptonshire.

- Community health services
- Local authority partners
    - Social services
    - Education

Dedicated to excellence

Children and women's services will deliver our key principles for excellent care

- **Integrated, seamless care for patients:** so that people get the care they need when they need it without having to re-tell their story, supported by multi-disciplinary team working wherever possible
- **As close to home as possible:** so that people don't need to travel further than necessary to access services, saving the time and inconvenience
- **Delivered equitably across the county:** so that everyone has equal opportunity to access high quality services
- **Focus on prevention and early detection:** so that people don't become ill and don't progress to more severe illness
- **Supports research and innovation:** so that we can offer the latest treatments to improve health outcomes and contribute to the development of new treatments and technologies
- **Attract and retain high quality staff:** so that we can provide the highest quality service for patients
- **Deliver cutting edge treatment, as quickly as possible:** so that people don't need to wait long for treatment, reducing worry and improving health outcomes
- **Fit for purpose facilities and estate:** so that services can be delivered as efficiently as possible with improved quality in areas such as infection control
- **Best use of available resources:** so that we can provide the best service we can with the resources that we have

We will collaborate across the two hospital sites to support our more specialised paediatric services

University Hospitals of Northamptonshire NHS Group

Ambition	Services to include	Rationale for collaboration	Benefits for patients
There is an ambition for some highly specialised services to be provided county- wide on one site, by one consultant team.	• Immunology • Rheumatology • Pain, Chronic fatigue and Medically unexplained symptoms (MUS)	• There is not enough demand throughout the county to warrant such highly specialist consultants on both sites for these services.	• Reduce patient travel times – currently have to travel out of area
Some services, where there are concerns about sustainability, will be prioritised to set up a networked service, with the same pathways and protocols and regular joint working/ group posts.	• Oncology • Palliative care & end of life • Gastroenterology • Haemoglobinopathy (further work required on one consultant team) • HIV • Endocrinology including link to LRI provided Q service • Nephrology • Epilepsy • Cardiology • Allergy • Eating disorders • Align with the full spectrum of Allied health professionals with NHFT pathways • Enhanced community paediatrics and acute paediatrics collaboration • Closer integration with Child And Adolescent Mental Health Services (CAMH) to provide holistic physical and mental health services for this vulnerable group • Enhanced community paediatrics and acute paediatrics collaboration	• These are areas where there is low case load / workforce challenges that collaboration could support e.g. joint consultant role for gastroenterology • These are specialties with high demand, where capacity is pressured. Networked working should support demand management and reduce workforce pressures	• Equity of access across the county • Increased access to more specialist input • Workforce sustainability

In the next two years, we will take steps to support our more specialised paediatric services

University Hospitals of Northamptonshire NHS Group

Area	Changes	How we will know we succeeded	Benefit
Acute management/ treatment	◗ Build sub-specialty services (Year 1) ◗ Gastro: recruit group post for countywide service ◗ Asthma: single team and recruit specialist nurse and consultant ◗ Cystic fibrosis: dedicated post and develop specialist centre for training registrars ◗ Haemoglobinopathy: develop MDT service with co-located clinic at Nene Park ◗ Neurology: develop county-wide epilepsy pathway • Strengthen transition arrangements with all sub specialties between 14-19 years and develop young adult services 19-25 years' service for long term conditions (diabetes, asthma and epilepsy) ◗ Build sub-specialty services (Year 2) ◗ Repatriate immunology and rheumatology ◗ Single team for end of life ◗ Ambulatory cancer care at both sites ◗ Align pathways for diabetes and endocrine ◗ Integrate eating disorders service with community ◗ Closer integration with Child And Adolescent Mental Health Services (CAMH) to provide holistic physical and mental health services for this vulnerable group	◗ Year 1 ◗ Gastroenterology available at both sites ◗ Establish haemoglobinopathy service at Nene Park ◗ Neurology non-stop clinics established ◗ Year 2 ◗ End of life support provided consistently across county ◗ All oncology ambulatory care provided locally ◗ Single pathway/tertiary provide for diabetes and endocrine ◗ Integrated eating disorder service established ◗ Clinical networks work plan aligned for long term conditions for asthma, epilepsy, diabetes, endocrinology, cardiology, neonatology, paediatric surgery and critical care networks	◗ Equity of access for patients ◗ More efficient use of resources ◗ Improved outcomes for patients ◗ More resilient acute paediatric services

We have developed some initial proposals for collaboration in gynaecology alongside a proposed ambulatory centre of excellence

University Hospitals of Northamptonshire NHS Group

The ambition is for Gynaecology to be provided in both acute sites by networked teams with the same protocols and pathways, delivering equity of care for all patients across the county. Short term ambitions and priorities are to align models of care and services provided and collaborate to drive improvements and excellence across the Group. This includes aligning ways of working (e.g. nurse-led model), reviewing and aligning pathways and offering joint training.

Initial proposals for collaboration are:

- Development of nurse practitioners for urogynaecology, early pregnancy care and termination of pregnancy service
- Align pathways including endometriosis and ambulatory gynaecology
- Repatriation and development of more specialised services including paediatric and adolescent gynaecology, infertility, and advanced endometriosis treatment (including robotic surgery)
- Develop a 7-day service for ultrasound gynaecology across Northamptonshire
- Implement a 7-day gynaecology Same Day Emergency Care (SDEC) service
- Establish a specialist counselling service in partnership with primary care

To do this we need to:

- Establish joint training, research and project teams
- Develop joint governance including M&M meetings and joint pathways

A key ambition is around improving accessibility to our services. Ambulatory gynaecology services will increasingly be **delivered closer to home** with a **nurse-led model** minimising disruption to our patients lives. We will also increase access through self referral.

In the next 2-3 years, we propose developing Women's Health Hubs with our partners, providing outpatient appointments and minor procedures in a 'one-stop' environment, co-located with community services. These centres of excellence will deliver high performance against national targets, high quality estates and equipment, high patient satisfaction and patient choice. This is dependent on recommendations of national women's health strategy currently in development and consideration of patient and staff travel times. Further work will be undertaken to develop this proposal.

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We are continuing to develop our proposals for fetal medicine

University Hospitals of Northamptonshire NHS Group

There are several drivers for change for fetal medicine..	• There are currently challenges around the fetal medicine workforce at KGH. • KGH currently have an SLA with Leicester that isn't fulfilling needs, due to Leicester's capacity constraints and there are also challenges with Oxford (NGH). • There is a strategic driver to continue to meet RCOG / Public Health fetal medicine access standards (access to fetal medicine sub-specialist within 5 days)[1] • There is growing demand for the fetal medicine service
… and potential opportunities for collaboration that address these challenges.	• There are workforce opportunities for collaboration, for example, joint recruitment. A Group role should increase attractiveness of the role. • There are opportunities to align the offer within the group and deliver equity of care across the county
The next steps for developing these collaboration opportunities further will be detailed clinical engagement.	• There will be further discussion with the team of fetal medicine specialists to understand what the service could look like in the future across the county.

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Appendix 7 Diagnostics

Diagnostic services are currently provided on both sites, with vascular interventional radiology at NGH

University Hospitals of Northamptonshire NHS Group

Both KGH and NGH provide a full range of diagnostic services.

Diagnostics @ KGH

- Pathology including:
  - Andrology
  - Biochemistry
  - Blood transfusion
  - Cellular pathology
  - Haematology
  - Immunology
  - Microbiology
  - Phlebotomy
  - Mortuary
- Radiology: CT, MRI, X-RAY, Ultrasound (non-obstetric & obstetric), breast imaging, nuclear medicine, non-vascular interventional radiology, DEXA.
- Endoscopy
- Satellite services
- Private services

Cardiology diagnostics in Cardiology Centre of Excellence detailed proposal

Diagnostics @ NGH

- Pathology including:
  - Biochemistry
  - Blood transfusion
  - Cellular pathology
  - Haematology
  - Immunology
  - Microbiology
  - Phlebotomy
  - Mortuary
- Radiology: XRAY, CT, MRI, Ultrasound (non-obstetric & obstetric), vascular and non-vascular interventional radiology, fluoroscopy, DEXA, PET-CT, nuclear medicine, breast imaging.
- Endoscopy
- Satellite services
- Private services

Cardiology diagnostics in Cardiology Centre of Excellence detailed proposal

- Vascular interventional radiology is provided at NGH as a county wide service.
- Nuclear medicine run by NGH since Feb 2021.
- Both KGH and NGH are in the ME2 pathology network and EMRAD

Dedicated to excellence

Local and national strategies set the strategic context for our plans for diagnostic services

University Hospitals of Northamptonshire NHS Group

There are a number of national, regional and local strategies and guidelines that have been considered as part of the joint clinical strategy design. The below provides a summary the key recommendations

NATIONAL

- **NHS Long Term Plan:** sets ambition for pathology networks by 2021 to improve access to more complex tests, diagnostic imaging networks by 2023 to enable the rapid transfer of clinical images from care settings close to the patient. The plan introduces more stringent cancer standards for cancer (28-day diagnosis) which diagnostics will be required to help deliver.
- **Diagnostics: Recovery and Renewal 2020:** recommends split of emergency and elective where possible. Community diagnostic hubs should provide highly productive elective diagnostic centres for cancer, cardiac, respiratory and other conditions. Major expansion in the workforce is required and increase in roles such as advanced practitioner radiographer and assistant practitioner.
- **GIRFT Radiology 2020**: Recommendations include hot/ cold splits of activity, staff working at the top of their license, review of the efficiency and management of MDTs, robust clinical pathways supported by clinical decision making tools such as iRefer.
- **Cancer Alliance 2019/20:** Priorities include: implementation of faster diagnosis standard, improvements in cancer screening programmes and delivery of rapid diagnostic centres.

REGIONAL

- **Midlands & East 2 Pathology Network Update**: ambition to create a single operating model for Pathology across ME2 to release benefits for workforce, procurement, logistics and consistent clinical pathways, allowing patients to move seamlessly between Trusts.
- There are a number of regional networks and groups that our proposals must align to: **East Midlands Imaging Network (EMRAD), Regional Radiology Group and Regional Pathology Group** for example
- **NGH/KGH Group Digital Strategy**: ambition to implement a shared electronic patient record, ambition to enable staff to virtually monitor patient's and deliver care through virtual appointments where safe and appropriate
- **Group Academic Strategy:** ambition to achieve international recognition as an academic centre that promotes and delivers better health service and provision and health outcomes to our patients

LOCAL

- **The KGH Clinical Strategy 2020**: establish an imaging hub in the community to scan routine patients. Increase in-house capacity to focus on urgent diagnostics and interventional radiology to diagnose and treat patients more quickly. Improve cancer diagnosis and treatment in line with national standards.
- **The NGH Strategy 2019-24**: ambition to establish an imaging hub in the community in partnership with KGH to provide a range of diagnostic services. This will help manage increasing demand and support colleagues in Primary Care Networks.

Our case for change shows that there are several issues that we must address

University Hospitals of Northamptonshire NHS Group

As well as responding to the recommendations of key strategies, there are several other drivers for change that services are facing. These are addressed within our proposals for diagnostic services

Growth in demand

- Northamptonshire population is projected to increase by 14% 2018-2038. In 20-64 yr olds there is projected to be a 7% increase, in the 65yrs+ there is projected to be a 50% increase [1]
- Demand for radiology services is predicted to grow by 8% by 2024 placing additional pressures on services [2]
- Growth in endoscopy demand in addition to national driver for age extension of bowel cancer screening
- Increase in one-stop-shop services pressures on diagnostic services
- Estates will, and are already, constraining growth required to meet this demand

Digital advancements

- Emerging role of AI in decision making (NHS LTP)
- Radiology services nationally will need to make better use of digital technologies and future advances in artificial intelligence that will become vital tools for imaging teams [2]
- Different ways of working embracing digital technologies

Capacity: workforce

- Workforce impacted by national shortages e.g. radiologists and in pathology. Lack of substantive workforce sustainability e.g. IR and breast radiology [3]
- KGH & NGH have some gaps in radiologist and radiographer capacity, impacted by delays in overseas recruitment due to COVID
- Opportunity to adopt flexible working contracts and remote working for some parts of the radiology and pathology service [2]

Networks

- Need for off-site diagnostic hub. Limited estate capacity at NGH for pathology and radiology.
- Collaboration between KGH and NGH will support discussions with regional imaging networks, supporting care provided outside of the East Midlands.

Opportunities to increase services

- Targeted healthy lung checks (THLC) are currently provided by a third party provider. There is an opportunity to bring this in-house.
- Neither hospital currently provides 7 day endoscopy services

CQC Performance

Diagnostic Imaging
KGH: Good (2019)
Northampton: Good (2017)

Diagnostic Waiting Times

NGH: Prior to COVID, Trust was variably meeting 6 week referral target of 99%. Current metric (Nov 2020) is 77% [6]

KGH: Prior to COVID, Trust was meeting 6 week referral target of 99%. Current metric (Dec 2020) is 87%. [7]

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Sources: [1] ONS Population Projections 2018-2028 [2] KGH Clinical Strategy Jan 2020, [3] NGH Clinical Service Model Reviews 19/20, [4] CQC [5] Royal College of Radiologists support and wellbeing report 2021 [6] NGH Board of Directors report, Jan 2021 [7] KGH Board of Directors report, Jan 2021

We have developed a vision for a diagnostic services for Northamptonshire

University Hospitals of Northamptonshire NHS Group

SHORT TERM

- ✓ Diagnostic services across the Group will work in a collaborative, integrated way developing **shared pathways and protocols, joint access policy** (in development) to enhance care across the county. Both organisations will work together to share capacity in order to reduce waiting times for patients.
- ✓ Diagnostics services will develop services in order to minimise disruption to patients lives, **delivering care closer to home** and **increasing one-stop services.**
- ✓ Diagnostics will **strengthen links with both Leicester and Northampton Universities** in line with the Group academic strategy to increase delivery of high-quality research and improve recruitment and retention.

LONG TERM

- ✓ Services will embrace **new technologies such as AI** to increase **efficiency and effectiveness of care**, supported by a seamless shared IT system with the Group and wider system partners.
- ✓ Diagnostic services will collaborate to develop **shared strategies for procurement of equipment and required expansion of estate.**
- ✓ Diagnostic services across the Group will **share waiting lists and reporting lists** where appropriate.

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We have developed proposed clinical priorities for diagnostics (1/3)

University Hospitals of Northamptonshire NHS Group

There are five services within diagnostics that have been identified as priorities, because of the positive impact that collaboration is expected to deliver in terms of easing workforce pressures, standardising diagnostic care and expanding patient access to specialist expertise. The five services are imaging, interventional radiology, nuclear medicine, pathology and endoscopy.

The ambition for all 5 services is for teams across NGH and KGH to work closely together to develop and implement shared pathways and protocols. Longer term this will be the basis for moving towards sharing waiting and reporting lists.

Priority Specialty	Drivers for Collaboration	Ambition
Imaging	**STRATEGIC DRIVERS** ◗ NHS Long Term Plan: diagnostic imaging networks by 2023 ◗ Diagnostics: Recovery and Renewal: community diagnostic hubs **GROWTH IN DEMAND** ◗ Increased demand for imaging as population grows and estate capacity is already constrained particularly at NGH. Collaboration could allow resource to be maximised across both sites to better meet patient demand **WORKFORCE CHALLENGES** ◗ Gaps across the group in radiologist and radiography capacity caused by national shortages and delays in overseas recruitment ◗ Overseas recruitment is time and resource intensive ttherefore collaboration on recruitment could increase efficiency of this process for both organisations **EFFICIENCY OPPORTUNITIES** ◗ Working together will avoid duplication of expensive kit and services on both sites	**The ambition is for imaging to be maintain service on both acute sites by a networked team working to the same protocols and pathways. The Group will work together to establish a community diagnostic hub.** ◗ The group will work together to rapidly address capacity constraints particularly at NGH. This will reduce waiting times for patients, allowing them quicker access to treatment. ◗ Group ambition to achieve joint QSI accreditation; combining expertise and resource will expedite process to achieve accreditation. ◗ The Group imaging services will embrace the emerging role of digital technologies and artificial intelligence to improve quality and efficiency of services. ◗ Group imaging will share best practice and learning to increase delivery of one-stop services to improve patient experience and streamline their care. **Workforce ambitions:** ◗ The Group will work together to explore and expand alternative workforce roles to ease capacity pressure. This will include recruiting 2-3 clinical fellows at a Group level who can be appointed into substantive posts. ◗ The Group will integrate training to jointly offer a wider range of courses; the Group will also develop a Group-wide support network for those on a consultant trajectory. The scale provided through collaboration will expand the support and development network offered to staff. ◗ Overseas recruitment will be progressed at a Group level e.g. joint interview days, to reduce administrative burden of the recruitment process on both organisations. ◗ The Group will introduce rotating radiographers (specialist areas or lower banding) who will facilitate cross-site learning and sharing ways of working. **Service location ambitions:** ◗ PET-CT will continue to be delivered solely at NGH (nationally commissioned service). ◗ Cardiac MRI will continue to be delivered solely at KGH *(subject to Cardiology proposals.)*

We have developed proposed clinical priorities for diagnostics (2/3)

Priority specialty	Drivers for Collaboration	Ambition
Interventional radiology	**WORKFORCE CHALLENGES** ◗ Significant workforce pressures including lack of substantive workforce sustainability. ◗ No KGH out of hours cover for non-vascular IR currently. NGH offers an ad hoc 1 in 2 rota. Challenges with out of hours cover results in patients being sent to Leicester for care. **EXISTING COLLABORATION** ◗ Vascular IR is already consolidated on NGH	**The ambition is for non-vascular IR to continue be provided on both acute sites by networked teams working to the same protocols and pathways. Vascular IR will continue to be provided on a single site (NGH).** **Non-vascular IR will work collaboratively across the group to provide a shared rota for out of hours cover.** The teams will work together to provide joint training and secondment opportunities; sharing expertise to increase career opportunities for staff. The Group will continue to explore and build on alternative roles within IR, including recruiting clinical fellows at a group level who can be appointed to substantive posts. This collaboration will help to ease workforce pressures across the Group. **Vascular IR** (inpatient and complex) will continue to be provided on a single site (NGH). There is potential to expand OP services at KGH to provide day case vascular IR procedures. Rare complex cases will continue to be referred elsewhere as they require access to cardiothoracic surgery.
Nuclear medicine	◗ **EXISTING COLLABORATION** ◗ Nuclear Medicine currently run for the group by NGH, this is a temporary arrangement and a great example of current collaborative working. **EFFICIENCY OPPORTUNITIES** ◗ Underutilised Nuclear Medicine department at KGH	**The ambition is for Nuclear Medicine to continue to be provided on both sites, building on the existing collaborative working this service will be delivered by a single team working to the same protocols and pathways.** Nuclear medicine will be delivered across both sites by a single team, ensuring capacity across the Group is fully maximised. Note: there may be some challenges re single team given NGH radiographers dedicated to NM, KGH radiographers are not.

We have developed proposed clinical priorities for diagnostics (3/3)

University Hospitals of Northamptonshire NHS Group

Priority specialty	Drivers for Collaboration	Ambitions
Pathology	**STRATEGIC DRIVERS** ◗ NHS Long Term Plan: pathology networks by 2021 **GROWTH IN ONE-STOP SERVICES** ◗ Increase in demand for pathology services ◗ Similar ways of working required between the trusts to enable one-stop services **WORKFORCE CHALLENGES** ◗ Pathology workforce challenges caused by national shortages ◗ Opportunity to adopt flexible working contracts and remote working. Implementing this is critical to addressing workforce pressures. Collaboration will enable more rapid roll out of these new ways of working via economies of scale. ◗ Microbiology, Histopathology and Blood Sciences are having challenges recruiting medically qualified staff nationwide	**The ambition for Pathology is for both trusts to continue work together collaboratively within the ME2 Network.** The priorities and objectives highlighted in the ME2 include: ◗ A staffing strategy to include resolving operational issues with staffing, appointing joint posts and delivering joint training ◗ Adopting consistent processes to reduce unwarranted variation ◗ Digital pathology/diagnostics implementation ◗ Common performance and risk management dashboard **The Group will have shared on-call provision for Microbiology** these discussions are already in train and this will address the current fragility of this service. The Group will collaborate to develop **shared ambitions for future use of molecular pathology** in line with national recommendations.
Endoscopy	**MANAGING DEMAND** ◗ Growth in endoscopy demand in addition to national driver for age expansion of bowel cancer screening ◗ This will incur further challenges meeting diagnostic targets **WORKFORCE CHALLENGES** ◗ Challenges around consultant and nursing numbers. Alternative roles have been developed, however this hasn't closed the gap. **SERVICE PROVISION** ◗ Neither KGH or NGH provide 7 day endoscopy services (24/7 OOH provision is provided).	**The ambition for Endoscopy is to be provided on both acute sites by networked teams working to the same protocols and pathways, with integration of specialist services.** The Group will have joint meetings and regular contact to share learnings and work together to deliver equity of service across the county including services offered in the community. This will build on the successful existing collaboration around bowel cancer screening. There is opportunity for further integration of specialist endoscopy services, e.g. EUS (currently key-man risk at NGH) and ERCP (pressured at both trusts), as these services require specialist expertise and equipment, Opportunities include single site service or networked waiting list. The Group will collaborate to discuss jointly delivering 7 day services and new technologies such as Spyglass. This will require significant investment.

Our ambition is to deliver diagnostic services closer to home

University Hospitals of Northamptonshire NHS Group

There is a clear ambition to deliver diagnostics services outside of the acute setting, closer to patients' homes. This will improve access and patient experience. Delivering services in the community could release capacity in the acute setting which is currently constrained.

Collaboration is an opportunity to explore the development of **Community Diagnostic Centres** across the county.

The ambition to deliver care closer to home could be achieved by delivery of Community Diagnostic Centres	The Group will collaborate to develop a strategy and delivery plan for Community Diagnostic Centres (CDC). **Initial ambitions for CDC include:** • To include GP services (including primary care cancer pathway) and outpatient services such as fracture clinic. • Diagnostics provision that could be included: CT, MRI, ultrasound and bloods. The hubs could also offer therapy provision.
There are a number of potential opportunities for location of the CDC(s)	• We are considering the opportunity to establish a CDC in Northampton, Nene Park, Isebrook or Corby.
There are benefits of delivering diagnostic care closer to home for patients and the trusts..	• Delivering care closer to home will improve patient experience and minimise unnecessary visits to the acute site. • NGH currently has limited space on site (2 CTs and MRI needed). CDC will help to reduce estate pressure. • A CDC supports delivery of the GIRFT recommendation to split elective and emergency activity. This allows better protection of elective services during periods of high emergency demand such as was seen during the pandemic.
However there a number of challenges and considerations with CDC that the Group must take into account.	• Funding has not yet been agreed • Any CDC will have to be staffed from existing workforce. This may increase workforce pressures although reducing estate capacity pressures.

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Appendix 8: Financial impact assessment

Financial impact assessment of clinical strategy (DRAFT) 1/2

University Hospitals of Northamptonshire NHS Group

The Group clinical strategy includes plans to co-locate and consolidate several specialties and collaborate with the system, which will require significant investment, but has potential to result in long-term efficiency and productivity savings

Ref	Theme	Description of initiative	Timing	Investment Required? (Y/N/M)	Investment Type?	Savings Possible?* (Y/N/M)	Savings Type?	Finance Support Required	Comments
1	Creating Centres of Excellence ('CoE')	Establishing CoEs for cancer and cardiology including co-locating services, delivery by single team, single governance structure	Beyond 12 months	Y (High)	Capital and revenue	Y (Medium)	Efficiency	Cost / benefit analysis support; business case support required for capital-intensive co-locations; tracking of savings from pooled workforce	Significant dependency on estates function to deliver co-locations; potential income generation from CoEs Savings from reduction in on call payment (shift system), reduced locum and agency cost, reduced length of stay.
	System Collaboration	Working with system partners to develop strategies, set up networked services or deliver services within the community (iCAN and elective collaborative)	Beyond 12 months	Y (High)	Capital and revenue	Y (High)	Efficiency and Productivity	Financial analysis support	Significant transformation in ways of working required to deliver services in partnership Initiatives will reduce bed requirement but cost of reprovision in the community is substantial (cost transfer to community)
3	Co-location of specialised services	Co-location of highly specialised and fragile services	Beyond 12 months	Y (Medium)	Capital and revenue	Y (Low)	Efficiency	Financial analysis and business case support	Savings from reduced cost of locums, outsourcing and agency, testing and diagnostics
4	Income generation	Income generation through repatriating activity to the Group	Beyond 12 months	Y (Medium)	Capital and revenue	N	n/a	Tracking increased activity against capacity	Income generated likely to net off costs – i.e. c£1-5m income expected.

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*Savings will be against a projected baseline. Note: The above information is based on the Group Clinical Ambitions Nov 21, and assumptions on the initiatives in terms of investment need, scale, and savings.

Key

Investment Type	• Infrastructure (Capital) • Operational Capacity (Revenue) • Both	**Savings Type**	• Productivity • Efficiency • Both	**Scale (£ Cost)**	• Low (Green): 0-1m • Medium (Amber): 1-5m • High (Red): 5-10m	**Scale (£ savings)**	• Low (Red): 0-1m • Medium (Amber): 1-5m • High (Green): 5-10m

Financial impact assessment of clinical strategy (DRAFT) 2/2

University Hospitals of Northamptonshire NHS Group

A key initiative is streamlining existing processes and functions, including back-office functions which, if implemented effectively, could potentially result in significant savings for the Group

Ref	Theme	Description of initiative	Timing	Investment Required? (Y/N/M)	Investment Type?	Savings Possible?* (Y/N/M)	Savings Type?	Finance Support Required	Comments
5	Alignment of systems	Implement common systems to support joint working (e.g. system for scans to be read on both sites, common performance and risk dashboard, AI technology)	Within 12 months	Y (Medium)	Capital and revenue	Y (Medium)	Efficiency and productivity	Financial analysis and business case support required for capital-intensive investments	AI technology considered longer-term and requires significant investment, however majority of initiatives are short-term Savings from reduction in duplicate tests and appointments
6	Staff retention	Aligning pay rates, extending existing roles and expanding staff support network and improving learning and development for staff	Within 12 months	Y (High)	Revenue	Y (Medium)	Efficiency and productivity	Tracking effect of increased recruitment on agency costs	Investment depends on direction of pay alignment – assumed increase in pay required. Savings from reduction in sick leave and subsequent bank agency cost, reduce costs associated with attrition rates
7	Streamlining processes and functions	Streamlining patient pathways, procedures and back office functions	Within 12 months	Y (Medium)	Revenue	Y (High)	Efficiency	Tracking of savings from pooled workforce	Single Group approach to back-office functions, including Boards, likely to save c£10m
8	Patient quality / access targets	Achieving specific patient quality / access targets such as delivering to national quality standards and improving access to specialist cardiac services.	Beyond 12 months	Y (Medium)	Revenue	Y (Medium)	Productivity	Tracking increased activity against capacity / resource available	Additional income may be available via Payment by Results (PBR) tariff Savings would largely be from GIRFT, but would be difficult to quantify

*Savings will be against a projected baseline. Note: The above information is based on the Group Clinical Ambitions Nov 21, and assumptions on the initiatives in terms of investment need, scale, and savings.

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Key							
Investment Type	• Infrastructure (Capital) • Operational Capacity (Revenue) • Both	Savings Type	• Productivity • Efficiency • Both	Scale (£ Cost)	• Low (Green): 0-1m • Medium (Amber): 1-5m • High (Red): 5-10m	Scale (£ savings)	• Low (Red): 0-1m • Medium (Amber): 1-5m • High (Green): 5-10m

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Developing our clinical strategy

May 2022

Matt Metcalfe and Rabia Imtiaz – Medical Directors
Polly Grimmett - Director of Strategy

NHS
University Hospitals of Northamptonshire
NHS Group

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Clinical Ambition

NHS
University Hospitals of Northamptonshire
NHS Group

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Our clinical ambition – case for change

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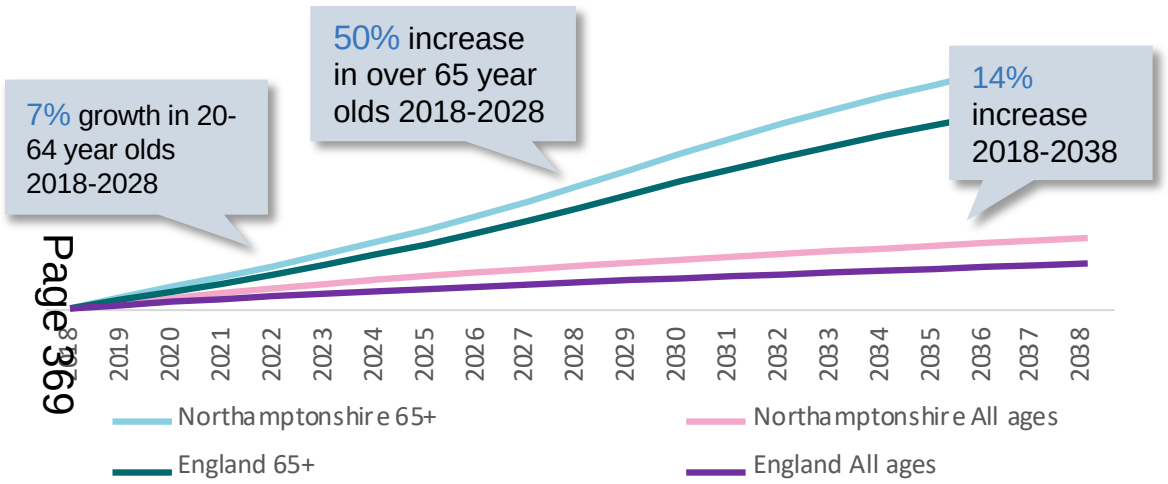

Our population is growing and ageing faster than national average

- Our population is older and growing faster than the national average
- Difficulty recruiting and retaining staff in some areas
- Our patients want 'joined up' services to avoid duplication and delay
- Inequity in access to services across Northamptonshire, and variation in pathways.
- National drive for greater integration and collaboration

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What our patients think

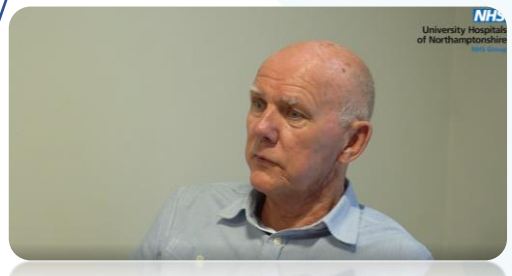
The board have previously heard patient experience stories describing the current problems related to poor service collaboration, and they have described clearly through our engagement, what they want:

A more holistic approach to my follow up care

Nicky Breast surgery

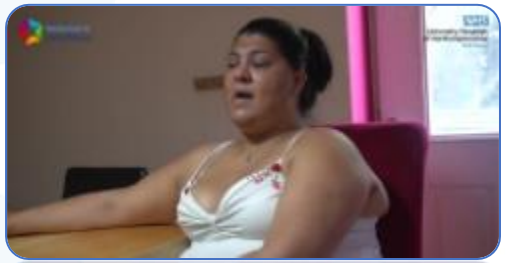
Growing services in county

Need to talk to patients in ways they understand



Keith heart attack

The services need to be more joined up and talk to each other



Bernadette ENT

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Engagement in developing the clinical strategy

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Engagement during the development of our strategy

- Our clinical ambition has been developed together with our staff, and in particular our senior clinicians.
  - Development of the clinical ambition in 2021 involved senior clinicians from across the Group in a number of workshops and discussions involving over 200 clinicians

Through the all-staff survey and discussions with patient engagement leads, an initial set of hypotheses was developed.

These hypotheses were further developed through established clinical forums and extensively tested through 20+ pillar workshops with clinical and non clinical teams

Hypotheses were tested and developed through:
- ✓ **Clinical Reference Group**
- ✓ **NGH Clinical Leads Group**
- ✓ **KGH Clinical Leads Group**
- ✓ **Strategic Collaboration Group**
- ✓ **Joint pillar & specialty discussions**
- ✓ **UHN Group Clinical Senates**

Initial thinking and hypotheses were also tested with PA's Clinical Panel.

  - A Clinical Senate was formed to consider in detail each element of the ambition with member clinicians reflecting the views of themselves and their colleagues. Over 200 attendances at both conferences combined
  - East and West Midlands Clinical Senate brought a wider breadth of clinical engagement and views

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Engagement on the approved Clinical Ambition

Clinical Ambition approved at the November 2021 Boards

From March 2022, after taking time out for winter pressures, the document was shared within the Group:

- Multiple Medical Director online meetings to which all staff were invited
- Group internet site:
  - Clinical Ambition
  - Details on how staff, partners and the general public can provide feedback.
  - Summary version of the Clinical Ambition with information on public sessions
  - Online survey; and
  - Dedicated email address

Medical Directors attendance at various partner committees to share the Clinical Ambition and receive feedback:

- Northamptonshire Health Care Partnership Board

NHCP sub-committees

Partner groups:

- NHFT
- Invitations to the Health and Wellbeing Committees

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Engagement on the approved Clinical Ambition

- We have spoken to:

600+ internal staff:
- 102 consultants
- 70 nurses
- 56 Clinical Support
- 280 Other

ICS Partners, including:
- Northants CCG
- NHFT
- North Northamptonshire UA
- West Northamptonshire UA
- 360 Care Partnership

Grade distribution:
- 232 Senior management
- 52 Middle management
- 62 Junior
- 77 Other

Members of the public
- Website
- Survey
- Social media
- Public sessions

A number of groups, including:
- Primary Care
- Governors

Detailed breakdown of our engagement is provided in Appendix 1

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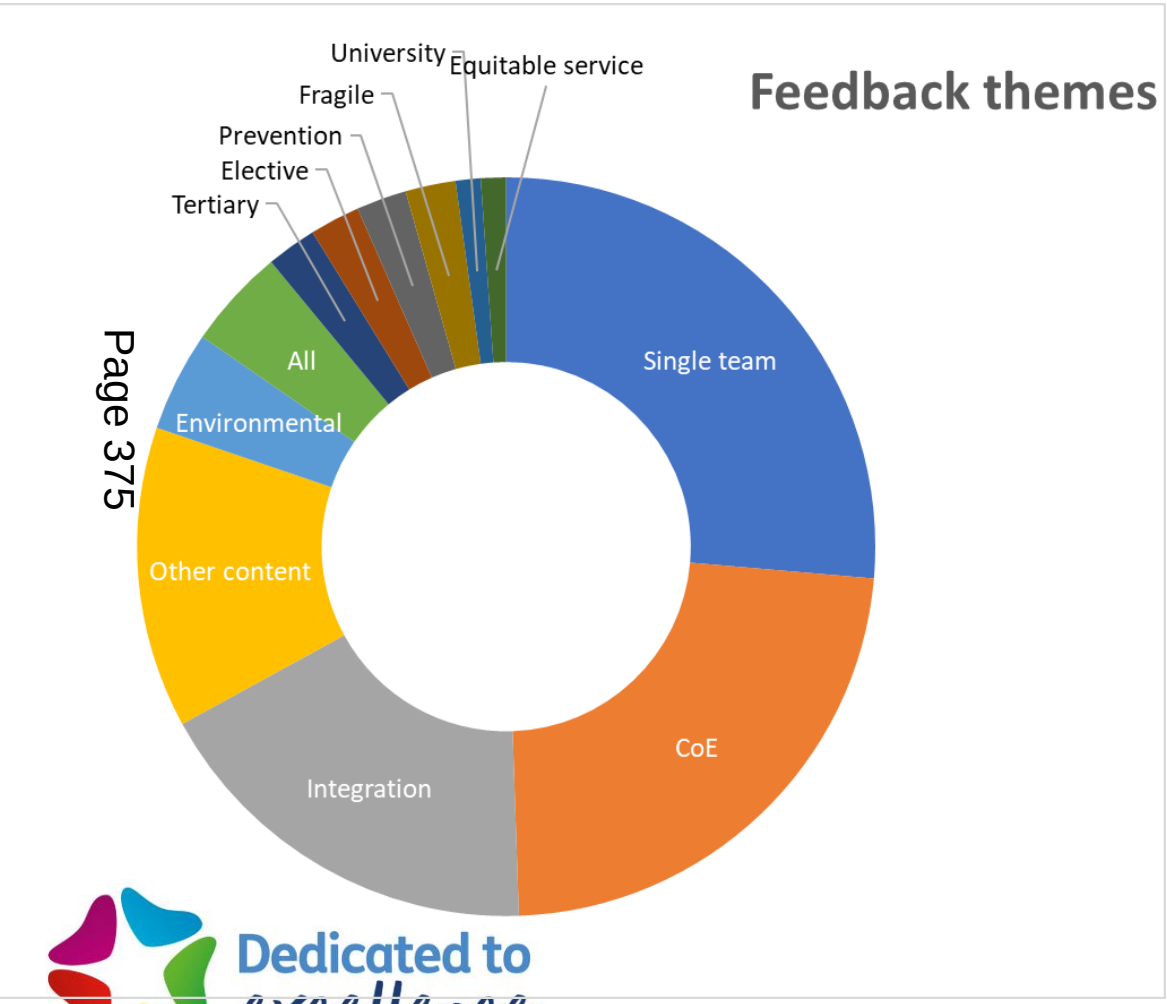
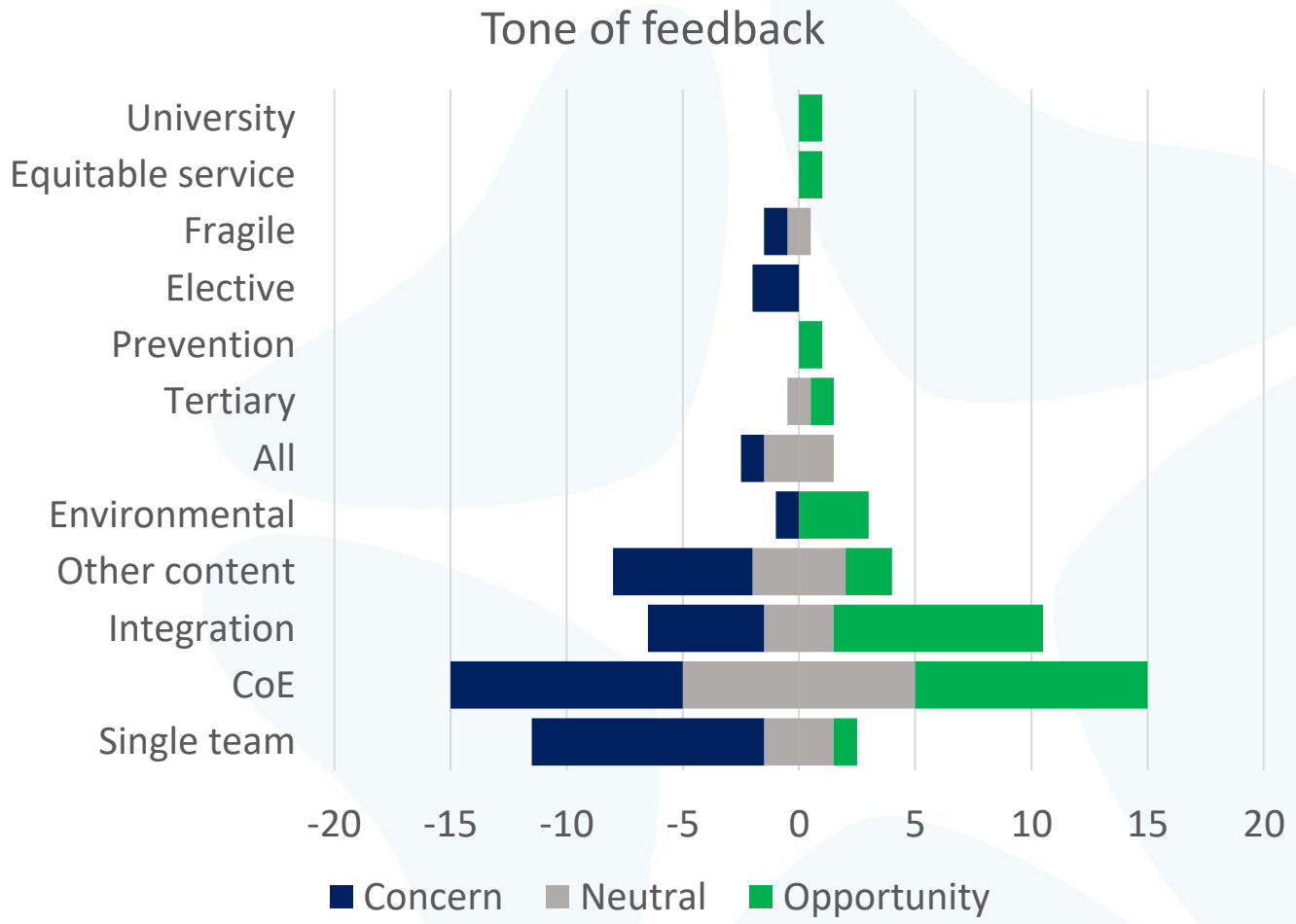
What have we heard?





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Centres of Excellence - You said, our response

You said…	Our response…
There is **enthusiasm to develop services in other areas** than those already outlined in the clinical strategy. These include: renal, respiratory, maternity, plastics, colorectal, paediatrics and tertiary services.	We are keen to support our staff to develop their ideas to improve quality and access for our patients and local people, and we welcome their enthusiasm. We commit to working with staff as part of the development of service strategies over the coming year to expand these ideas. Our planned next steps to do this are set out in the timeline on pages 71 and 72
People want to better understand the **plans for robotics and where robots would be located**.	We have already invested in robot-assisted technology at Northampton General Hospital. No decisions have yet been made on the location of other robots or timescales, but we expect to locate them in line with the needs of our local population. This will be worked up as part of the development of the services strategies over the coming months and in discussion with staff.
There is some **confusion about the Centre of Excellence proposal** and what this will actually mean for patients and staff for example would it disadvantage the careers of staff not on the lead site.	We are clear that a centre of excellence will be across both hospitals and that patients will access the same, high quality care wherever they access services. Our centres of excellence will be for all of Northamptonshire rather individual hospitals. We are proposing consolidating some of the more specialist services on a single site where this can be evidenced to be best for patients, but equally, we are also proposing providing many services at both sites or closer to home where possible. More detail and a refined language to explain our ideas more clearly are set out on pages 48 to 51 and 55. It is likely we will move towards single teams delivering care across the centre of excellence where this will deliver improved care and experience for staff and patients, and over the coming months we will work with teams and patients to develop these proposals in more detail and we will only implement changes following wide staff and patient engagement.

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Single team - You said, our response

You said…	Our response…
People are keen to **work together across the two organisations within the Group** (Kettering General Hospital NHS Trust and Northampton General Hospital NHS Trust) to support the clinical strategy. There were questions about clinical leadership and governance across both hospitals and support such as HR and finance.	We already have a single lead across the Group in many non-clinical areas and we will explore moving towards single teams for each clinical area, taking best practice from across both sites. We have a single Group Quality and Safety Committee and will have further discussions on how we might have more shared governance across the hospitals. We have set out initial timelines for this discussion in section 6. Our Group People Plan, shown on page 61 to 63, also sets out how we will develop our organisations and support people to work together.
There is some concern about **access to services** and travelling to site, including by public transport, physically accessing services (for example, parking and disability access) and equality of access.	With our partners, our strategy will see many services being delivered closer to home and we will only move services where there are evidenced clear clinical quality benefits. This approach is set out in more detail on page 56. Access to services is very important and a key consideration before any service change is made. We will fully consider the potential impact of any proposed changes to the location of services, including inequality groups, as part of an Integrated Impact Assessment prior to making any changes.
People are enthusiastic about the potential **benefits of the clinical strategy in supporting recruitment and retention** but **concerned about lack of staff in some key areas** such as theatres, and the **potential impact on staff of possible changes in the location of services**.	We recognise that the capacity and capability of our staff underpins successful delivery of our clinical strategy. We believe that the clinical strategy will make our hospitals more enjoyable places to work and that the proposed changes will improve job satisfaction with, for example, more sustainable rotas and better development opportunities. We will continue to work with and engage our staff throughout the development of more detailed speciality clinical strategies and through into implementation. Our Group People Plan sets out more details of our recruitment and retention plans for 2021 to 2024 ,as shown on page 61 to 63.

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Integrate with community - You said, our response

You said…	Our response…
People **like the focus on prevention** and working with partners to prevent ill health and hospital admissions, where possible.	We are working with partners across the whole care pathway to improve health and outcomes for patients, as shown on page 8. The development of the Integrated Care Board (ICB) gives us a real opportunity to integrate services and tackle the causes of ill health, as shown on page 45 and 46.
There is a **general welcome for the plans around greater integration of services** with lots of ideas about how integration could go further and faster. This includes ideas for further collaboration for cardiology, diabetes and respiratory alongside the wider use of allied healthcare professionals in the community.	We are committed to integrating services where possible, alongside our partners in the Integrated Care System (ICS) as set out on page 45 and 46. As we develop more service strategies, we will work with staff to look for further opportunities for integration, as set out in our implementation plan on page 71 to 77.
Community diagnostic hubs are seen as an opportunity to provide diagnostics closer to home and add vital diagnostic capacity.	We are working hard with system partners to develop a community diagnostic hub in 2022/23, moving diagnostics currently done on the acute site into that setting where appropriate, and improving faster access to diagnostics for our population. We have added some further detail about the plans for community diagnostic hubs in our Diagnostic section from page 143.
Mental health was flagged as an important part of the clinical strategy, especially for children. Our ambition document was quiet on supporting patients with mental health concerns when in our hospital for acute treatments.	Mental health is a priority for the Integrated Care System and we have included it within this clinical strategy on page 46. Supporting those requiring emergency treatments is included on page 131, but is now a thread throughout the document as it is a key part of supporting the holistic needs of all our patients regardless of which service they are accessing. Mental health will be an important focus when we are developing our service strategies.

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Environment - You said, our response

You said…	Our response…
People want to focus on sustainability and environmental impact and are keen to understand more detail of the **possible impact of the clinical strategy on sustainability and the environment.**	There has already been £20m “green” investment in Northamptonshire for schemes such as electric vehicle charging points and solar panels. Both hospital sites have investment agreed in 22/23 to replace old energy infrastructure with new energy centres delivering a significant impact on improving our carbon footprint. This investment is complementary to our proposals for hospital development as part of the New Hospitals Programme, which will be net carbon neutral. Further integration and digitalisation will also have a positive environmental impact as people don’t need to travel so far to access services. More detail on the potential impact of our proposals on sustainability is shown on page 69 of this document, or is available through both Trust Green Plans.

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University status - You said, our response

You said…	Our response…
People highlighted the **importance of research and supporting learning and development**, with questions about dedicated research space, support for students and the availability of learning and development for all staff.	Supporting research and learning and development is an incredibly important part of our Group strategy, and the Group Academic Strategy shows what we plan to do in this area over the coming years. This is outlined on page 27, 65 and 87. We have already increased academic posts and increased the dedicated research space in buildings.

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‘Other’ - You said, our response…

You said…	Our response…
There are some **concerns as to whether the ringfencing of elective capacity is realistic** but **general positivity about the plans for the elective collaborative**.	Our strategy is to put geographical and physical distance between elective and emergency capacity, as set out on page 51 and from 132. The elective collaborative will allow us to work most closely with other providers, including the independent sector, to integrate elective care provision and offer equal access across Northamptonshire. We commit to include patient and public representatives in elective workstreams.
People recognise that **digital and IT development will be crucial to delivery of the clinical strategy**, for example, having shared access to notes and results. There were several detailed questions about which IT systems would be used and when digital roll-out would happen.	We have a comprehensive digital strategy that sets out our plans for digital implementation, and we know this will be crucial to delivering this clinical strategy. These plans are summarised on page 61 and include plans and timelines for implementing shared access to patient notes and results. We are committed to a single Patient Administrative System (PAS) across the Group and expect this to be in fully implemented by the end of 2023.
Stakeholder engagement and communication in the clinical strategy is key and people are keen to understand **how we would communicate and engage with key stakeholders.**	We have undertaken an extensive engagement exercise in developing this clinical strategy, as set out on page 19-22 as this response evidences. We will continue to engage and communicate with stakeholders as we develop the next detail of our plans, as shown on page 17,79 and 80. We are always happy to hear about any further groups that we could usefully engage and welcome any groups or individuals contacting us to get involved.
People have **questions about the timeline and resources required to implement the clinical strategy**, particularly whether clinical leads will have enough dedicated time for successful implementation. Dedicated support will also be required to support team development and cultural change.	We know time and resources will be required to successfully implement the clinical strategy. New Group leadership roles have already been agreed as the way forward with support provided to deliver the cultural and operational changes required. This will be fully agreed in July 22 The development of the Group Clinical Director role provide a single leadership role for each clinical area and these roles will be focussed on service transformation rather than performance reporting.
Theatre capacity is a current concern. There were also questions about whether there will be sufficient bed and theatre capacity in future with a growing population and planned closures of some wards (e.g. Thomas Moore). The New Hospital Programme capital development is seen as a real opportunity to increase capacity within the hospitals.	Theatre capacity is a priority area for the Group and plans are being progressed rapidly to develop our elective capacity. We have shown more detail about these plans on page 67, 67 and from page 112. This clinical strategy will be an important part of our site development plans and will form the basis of our bids for new capital, as outlined on page 66.

Clinical strategy
Matt Metcalfe and Rabia Imtiaz

Our clinical strategy

University Hospitals of Northamptonshire NHS Group

Work with health and care partners **to prevent ill-health and reduce hospitalisation**

★★★

Develop **Centres of Excellence** across all services, starting with cardiology and cancer

Ring-fence elective capacity to reduce waiting list and variation between sites, and increase efficiency

Build on our University Hospital status to become a **hub for innovation and research**

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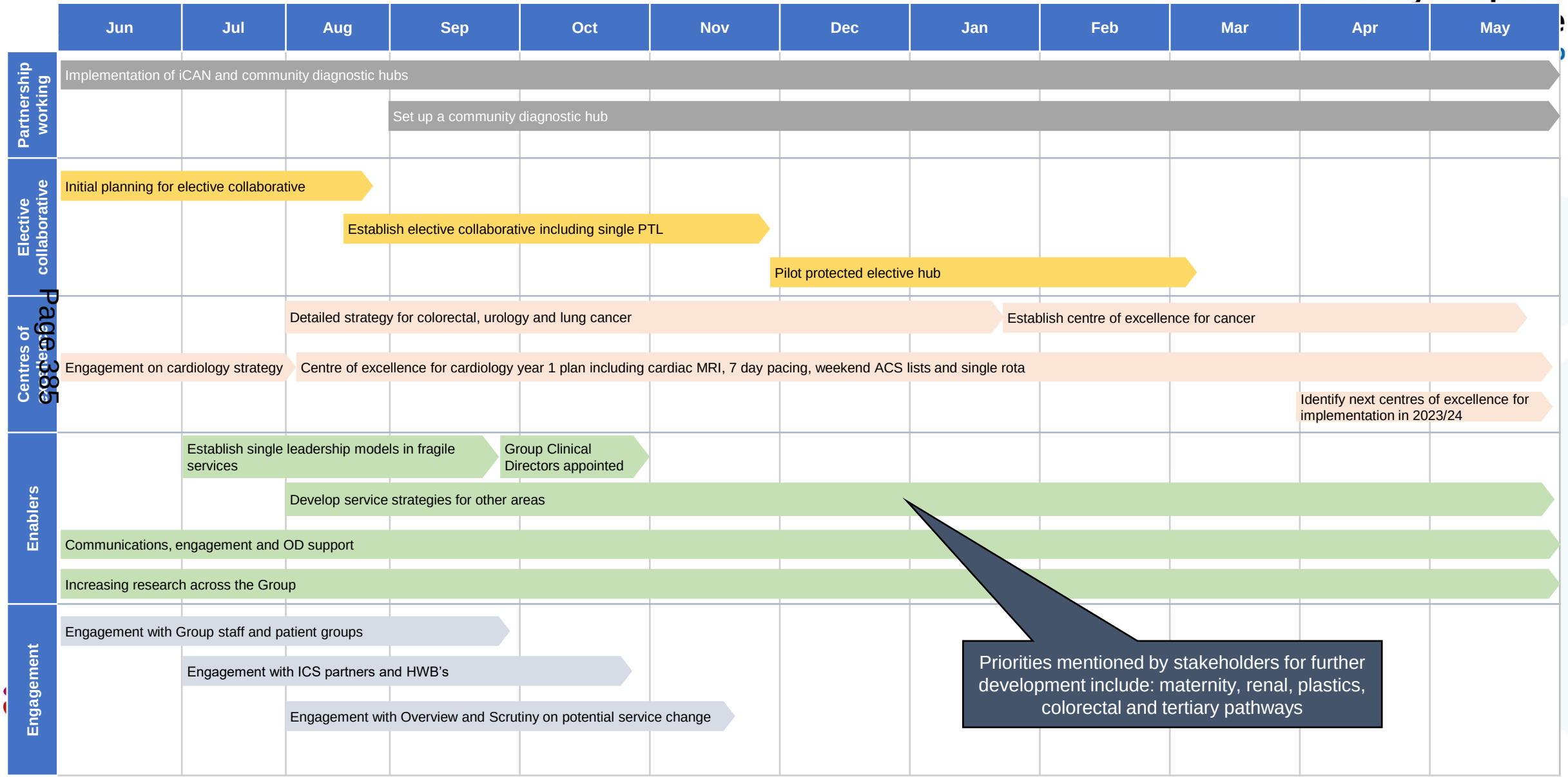
Engagement next steps

We remain committed to continuing the strong engagement and co-design that has been at the centre of the development of this document and our journey so far.

June and July:

- Feedback to staff with You said, we did' and the approved strategy with next steps:
  - the internet
  - staff briefings
  - regular updates thereafter
- Public and patients with the approved strategy and next steps:
  - UHN website
  - Healthwatch
  - Northamptonshire Carers
  - Invite patients to join groups developing individual strategies
- Partners, share the approved strategy and next steps
  - ICS meeting
  - Invite ICS representatives to support development of individual service strategies
- Statutory Bodies
  - Health and Wellbeing Board
  - Overview and Scrutiny Committees (to follow)

Over the coming year, we will focus on developing clinical service strategies and start to implement changes



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North Northamptonshire Council

Item no: 14

NORTH NORTHAMPTONSHIRE HEALTH AND WELLBEING BOARD

5th July 2022

Report Title	**Northamptonshire Suicide Prevention Strategy 2022-2025**
Report Author	**Sally Burns, Director of Public Health, West Northamptonshire Council**

List of Appendices

Appendix A Northamptonshire Suicide Prevention Strategy
Appendix B Northamptonshire Suicide Prevention Action Plan

1. Purpose of Report

- To seek approval of the Northamptonshire Suicide Prevention Strategy 2022-2025 from North Northamptonshire Health and Wellbeing Board.

2. Executive Summary

- The Northamptonshire Suicide Prevention Strategy 2022-25 provides an update on national and local context for suicide. It provides a short review of the previous strategy, then sets out the seven priorities for the strategy.
- These are:
    1. Reduce the risk of suicide in key high-risk groups
    2. Tailor approaches to improve mental health in specific groups
    3. Reduce access to means of suicide
    4. Provide better information and support to those bereaved or affected by suicide
    5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
    6. Support research and data collections
    7. Reduce the rates of self-harm as a key indicator of suicide risk.
- The corresponding action plan sets out the key objectives and actions for each priority. The strategy will be reviewed annually, and the report will be made available to the public.

3. Recommendations

- It is recommended that the Health and Wellbeing Board:
    - Endorse the Northamptonshire Suicide Prevention Strategy 2022-2025 and Action Plan
    - Endorse the recommendation that the Suicide Prevention Steering Group lead the implementation of strategy, working closely with local partners and communities
    - Endorse the recommendation that the Mental Health Learning Disability Autism (adults), and Healthy Minds and Healthy Brains (children and young people) Collaboratives maintain strategic oversight of the implementation of strategy
    - Endorse the recommendation that the Mental Health Learning Disability Autism Executive Board signs of strategy

- Reasons for recommendation:
    - To comply with the new statutory duty as the strategy and action plan will be in the public domain. The *"Cross-government suicide prevention workplan"* [Jan 2019] commits every Government area to take action on suicide.
    - Offers a sensible approach to reducing the level of suicide through a coordinated response to suicide prevention, improving services and outcomes for all those affected, building on work at all levels in the health and care system, including community-based activities targeted at the wider factors that affect mental health and wellbeing.
    - Identifies priority groups and the actions needed to reduce suicides across the life course (young people, middle-aged adults, the homeless, people with mental health problems)
    - Development and implementation of structures and processes to improve the reporting and analysis of suicides, working with the coroner's office to provide real time data on suicides

3 Report Background

- The current Northamptonshire Suicide Prevention Strategy was developed for 2017-2020. During the Covid-19 pandemic, the strategy was extended till 2022. With a Suicide Prevention Public Health Officer and Data Analyst in post, the strategy has been reviewed and updated to reflect the current situation.
- Suicide continues to be recognised as a nationally growing concern. The "*Preventing suicide in England: A cross-government outcomes strategy to save lives"* report sets the following overall objectives: a reduction in the rate of suicide in England's general population; and better support for those affected or bereaved by suicide. The National Strategy is committed to tackling suicide and presents seven key areas of action, as highlighted in section 2.2 above.
- Northamptonshire's prevalence of suicide is statistically similar to the England and East Midlands regional averages. North Northamptonshire's prevalence of suicide resembles the England and East Midlands averages, and West Northamptonshire's prevalence of suicide is

statistically better than the England average, and similar to the East Midlands average. There is some variation in the prevalence of suicide across the county.

- We will review the outcomes of this Strategy by monitoring the progress of the action plan through the Suicide Prevention Steering Group. The outcomes of the review will be reported through the Mental Health, Learning Disabilities & Autism Collaborative (ICS) Programme and to the North Northants and West Northants Health and Wellbeing Boards.
- An Annual Report will be produced reviewing progress against the Strategy and summarising changes in intelligence and policy which may require adaptation to our local approach. The Annual Review will be publicly available online.

4 Issues and Choices

- The new strategy is a single document for all-ages across the whole county. The Suicide Prevention Steering Group partners involved operate across the whole county. To ensure a coordinated approach, a single action plan has been produced.
- In addition to the county-wide approach, future intelligence and data sources will be developed to reflect any locally specific issues and opportunities across North Northamptonshire and West Northamptonshire and at neighbourhood level.
- The Northamptonshire Suicide Prevention Strategy 2022-2025 has seven priorities:
    1. Reduce the risk of suicide in key high-risk groups
    2. Tailor approaches to improve mental health in specific groups
    3. Reduce access to means of suicide
    4. Provide better information and support to those bereaved or affected by suicide
    5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
    6. Support research and data collections
    7. Reduce the rates of self-harm as a key indicator of suicide risk.
- The Northamptonshire Suicide Prevention Strategy 2022-2025 has been informed by the:
    - National strategy, “Preventing suicide in England: A cross-government outcomes strategy to save lives,” 2012.
    - National Mental Health Taskforce, “The five year forward view for mental health,” 2016.
    - Public Health England (now Office of Health Improvement and Disparities), “Local suicide prevention planning: a practise resource,” 2020.
    - NICE guidance, “Preventing suicide in community and custodial settings,” 2018.
    - Report, “Preventing suicide in England: Fifth progress report of the cross-government outcomes strategy to save lives,” 2021.
- The Strategy was also informed by six Task and Finish Groups. Each group addressed one or two of the identified priorites. The objectives of the groups were:
    - To provide an update on current priorities in Northamptonshire
    - To highlight key areas of improvement
    - To guide the priorities and actions for the new strategy
- Each group had wide membership from local agencies involved in the suicide prevention across Northamptonshire, and people with lived experience of suicidal ideation. The groups produced and approved the approaches and actions to be taken for the seven priorities, which were then reviewed and approved by the Suicide Prevention Steering Group.

5 Implications (including financial implications)

5.5 Resources and Financial

- There are no resources and / or financial implications arising from the proposals at this stage.
- Currently the NHS Wave 3 Transformation funding supports the delivery of the suicide prevention strategy and will fund some of the actions set out in the action plan.
- In 2021/2022, the Northamptonshire Clinical Commissioning Group received NHS Wave 3 Transformation, an allocation of £198,000, against the following criteria:
    - Prevention beyond secondary services: place-based community prevention work - middle-aged men, self-harm primary care support
    - Reduction within services via quality improvement - self-harm care including within acute hospitals and general within mental health services
- The Wave 3 Transformation funding has been approved for 2022/2023.
- There may be additional resources or financial implications arising from the proposals during 2022-2023.

5.6 Legal

- Recommendations in the paper do not include any specific legal obligations, other than the council having a coordinated approach to reducing the level of suicides in the area and providing effective support to those affected.

5.7 Risk

- There are no significant risks arising from the proposed recommendations in this report.
- The risk of not making a decision is that the Council will not be complying with national recommendation of local areas having a suicide prevention strategy. In addition, the Council will not be moving forward on agreed plan to reduce suicides and improve the wellbeing of people affected by suicides.

5.8 Consultation

- The Northamptonshire Suicide Prevention Strategy 2022-2025 was coproduced by a wide range of partners and local agencies, including people with lived experience of suicidal ideation.
- We have a consultation plan to obtain endorsement from key partnerships from example, Children and Adult Safeguarding Boards, Children's Trust and Health and Wellbeing Boards.

5.9 Consideration by Overview and Scrutiny

- To incorporate feedback from meetings where strategy has been discussed.

5.10 Climate Impact

- There are no climate/environmental impact that may arising from the strategy and action plan.

5.11 Community Impact

- The strategy gives considerations to community impact and details specific actions to address priority groups and places.

6 Background Papers

- The list of background papers to the strategy are set out in section 5.4 above.

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Northamptonshire Suicide Prevention Strategy

2022-2025

Northamptonshire Suicide Prevention Steering Group
May 2022

Contents

Foreword

To be completed

Executive Summary

To be completed

Introduction

Suicide is defined as the deliberate act to intentionally end one's life [1]. The effects of a suicide can be devasting and the impact felt by many – including family, friends, neighbours, employers, colleagues, professionals, and the wider community. It is estimated each suicide case costs the economy around £1.67million [2], the majority of this attributed to the support and reduction in quality of life to those affected. People bereaved by suicide are also more likely to experience poor mental health and have an increased risk of suicide.

In Northamptonshire, around 60 people take their own life each year. As a partnership, we believe that every death by suicide is one too many. Each of these deaths can potentially be prevented therefore suicide prevention is a priority for everyone. This strategy and action plan aims to reduce suicide and self-harm in Northamptonshire, through a whole-county, all-age multi- collinearity approach.

Our Vision:

We aim to achieve a 10% reduction in annual deaths by suicide in Northamptonshire from 2022 to 2025, by improving our understanding and awareness around suicide, and promoting and improving our local supports and services.

Our Approach

In line with the Preventing suicide in England: fifth progress report, the partnership is taking a cross-system collective approach to suicide prevention [6]. The national suicide prevention strategy identifies 7 priorities to contribute to reducing suicide and self-harm in England. This strategy is aligned to these priorities, which are:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research and data collection
7. Reduce the rates of self-harm as a key indicator of suicide risk

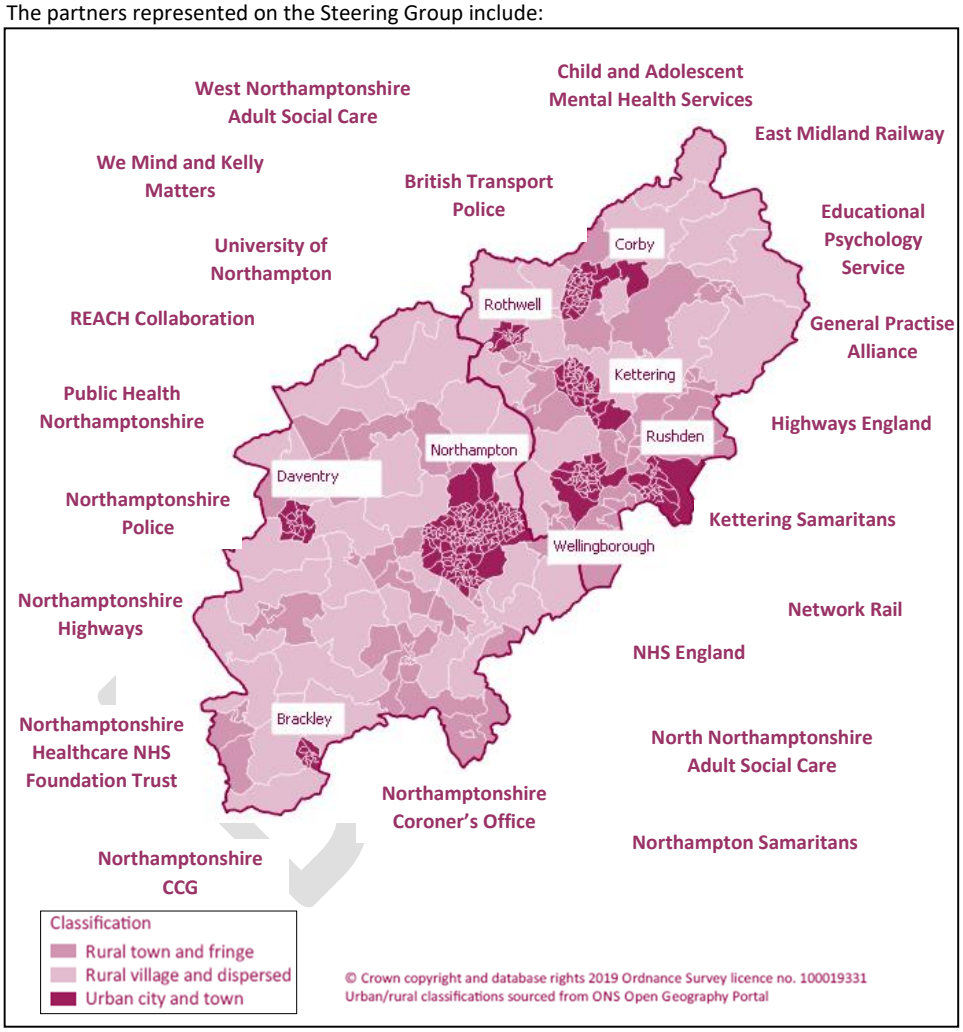
This will help ensure local resources can be used with greater effectiveness.

This strategy and the accompanying action plan have been developed after reviewing national, regional, and local intelligence, holding task and finish groups, and engaging with partners and service users.

Who will deliver this strategy?

Partner agencies on the Northamptonshire Suicide Prevention Steering Group have been instrumental in developing this strategy, and will lead the implementation and monitoring of the priority actions including annual reviews.

The partners represented on the Steering Group include:



Further details about the function and the governance of the Steering Group can be found online Suicide prevention - Health and wellbeing (northamptonshire.gov.uk).

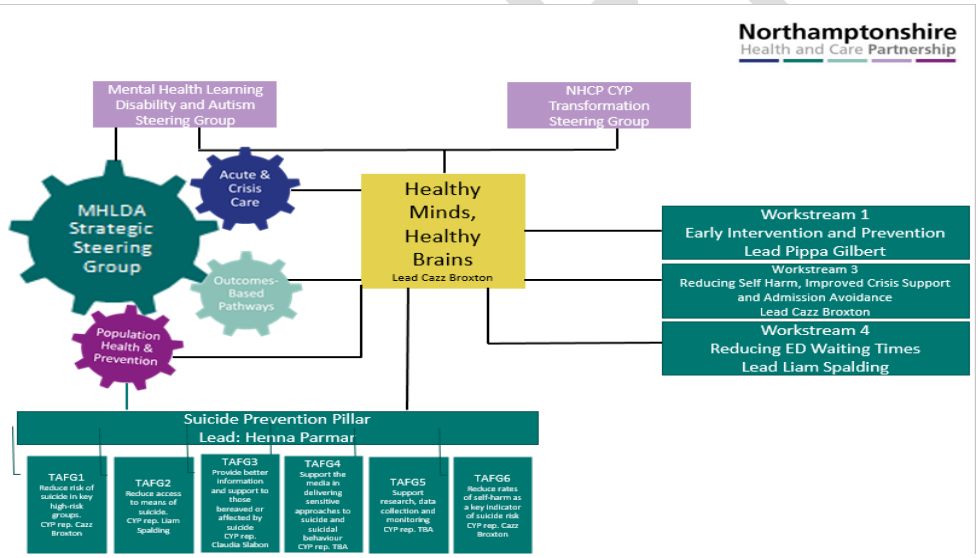
Suicide prevention is part of the wider mental health promotion and prevention agenda and is a key priority in the Northamptonshire Mental Health Prevention Concordat to be finalised by summer 2022. The Concordat will demonstrate local ambition to promote positive mental health and prevention, in order to improve mental health and wellbeing for all and address health inequalities. The three key features:

- Shared commitment to improve mental health and wellbeing
- Partnership working and coproduction at all levels
- Evidence based planning and commissioning

The Northamptonshire Mental Health Learning Disability Autism Population Health and Prevention (adults) and Healthy Minds Health Brains (children and young people) Pillars will maintain strategic oversight of the implementation of the suicide strategy.

Progress and outcomes will be reported through the Mental Health, Learning Disabilities Autism Collaborative and to the North Northants and West Northants Health and Wellbeing Boards.

Strategic Context and Governance



National Context

Suicide continues to be recognised as a nationally growing concern. The "*Preventing suicide in England: A cross-government outcomes strategy to save lives"* [3] report sets the following overall objectives: a reduction in the rate of suicide in England's general population; and better support for those affected or bereaved by suicide.

The National Strategy is committed to tackling suicide and presents seven key areas of action, detailed in the previous section.

It is a key recommendation in the Mental Health Taskforce's report [4] to UKHSA (United Kingdom Health Security Agency), which corresponds to the key areas of action. The Office for Health Improvement and Disparities (OHID) has published a practise resource [5] to support local authorities and partners to implement local suicide prevention plans. The National Institute for Health and Care Excellence (NICE) have developed suicide prevention recommendations [6], which can be used alongside NHSE and OHID's guidance.

Since 2012, there have been national progress reports published, the latest of which is a fifth progress report [7]. The report sets out: data and evidence on suicide and self-harm; progress made against existing commitments designed to prevent suicides and self-harm; and further actions for government and its agencies, particularly in the context of COVID-19. This report also sets out a refreshed cross-government suicide prevention work plan, which updates the commitments outlined in the previous work plan.

The report identifies four groups as vulnerable to suicide: middle aged men; people who self-harm; children and young people; and people with a mental illness. Concern that exacerbation of risk factors during the pandemic for these vulnerable groups would lead to an increase in suicides has not been borne out by the present data.

Suicide: The National Picture

The ONS released the most recent figures for suicide in England and Wales in September 2021 [8]. Statistics on suicide are based on the year of death registration – due to registration delays in 2021 because of the COVID-19 pandemic, approximately half of these deaths will have occurred in the previous year.

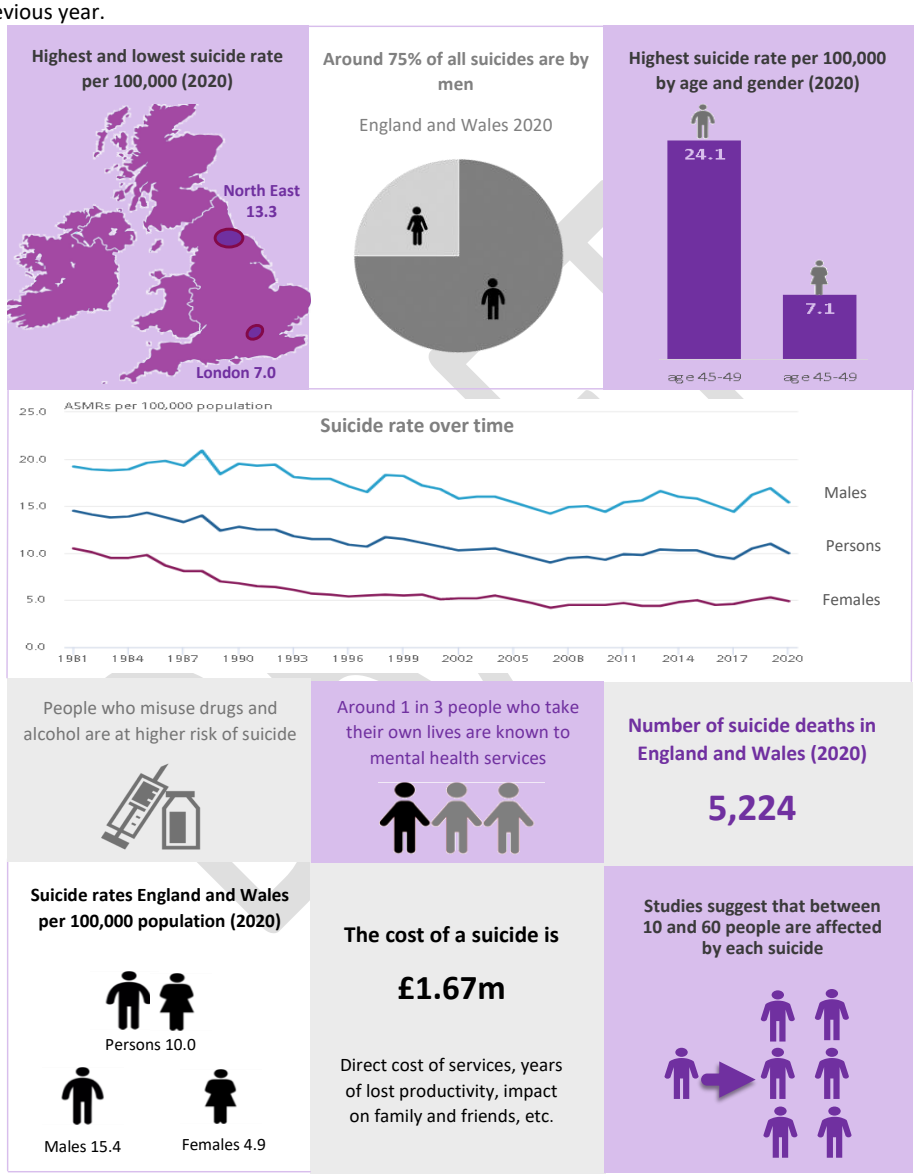


Figure 1: Summary of the national picture for suicide. [8] [9] [10]

Key Findings

Figure 1 summaries the national picture for suicide in 2020. The age-standardised mortality rate is statistically significantly lower than the 2019 rate. The decrease is likely to be driven by two factors: a decrease in male suicides at the start of the COVID-19 pandemic; and delays in death registrations because of the pandemic. The male suicide rate is statistically significantly lower than 2019, but consistent with rates in earlier years. The female suicide rate is consistent with the past decade. The most common method of suicide for both males and females continued to be hanging, strangulation and suffocation. The second most common method continued to be poisoning.

Impact of COVID-19 on Suicide

The National Strategy played a pivotal role in shaping the response to the pandemic. It highlights that there appears to be no current increase in suicides that occurred during COVID-19, but there has been an increase in people having thoughts about self-harm and suicide and more people looking for support from services.

A Mental Health Foundation study [11] reports that the proportion of UK adults regularly questioned having had suicidal thoughts and feelings within the previous two weeks, because of the pandemic, increased from 8% of those surveyed in April 2020 to 13% in November 2020. Self-reported suicidal ideation, feelings of hopelessness and self-harm reflected rises in demand as seen across the voluntary sector, indicating the need for proactive measures to address suicide risk. It is important to identify the more vulnerable and the more resilient groups, and the factors associated with this.

New actions in the context of COVID-19 have been added with a focus on those that could address the vulnerabilities of several groups of people who may be disproportionately affected by the pandemic:

- ⇒ People who are economically vulnerable
- ⇒ People in contact with mental health services
- ⇒ People who have been disproportionately impacted by lockdown
- ⇒ Children and young people
- ⇒ NHS and social care staff
- ⇒ People in contact with criminal justice system
- ⇒ Financial support for suicide prevention VCSE sector to manage COVID-19 pressures.

Local analysis of suspected suicides to November 2020 suggested that rates of suspected suicide had not statistically significantly changed in recent months after the pandemic arrived in the UK. Suspected suicides were used because at time of analysis there was a backlog of inquests due to pandemic affecting service activity. Suspected suicide counts from both the Police and Coroner data followed a similar pattern across the months examined.

Local Context

Northamptonshire's prevalence of suicide is statistically similar to the England and East Midlands regional averages. North Northamptonshire's prevalence of suicide resembles the England and East Midlands averages, and West Northamptonshire's prevalence of suicide is statistically better than the England average, and similar to the East Midlands average. There is some variation in the prevalence of suicide across the county.

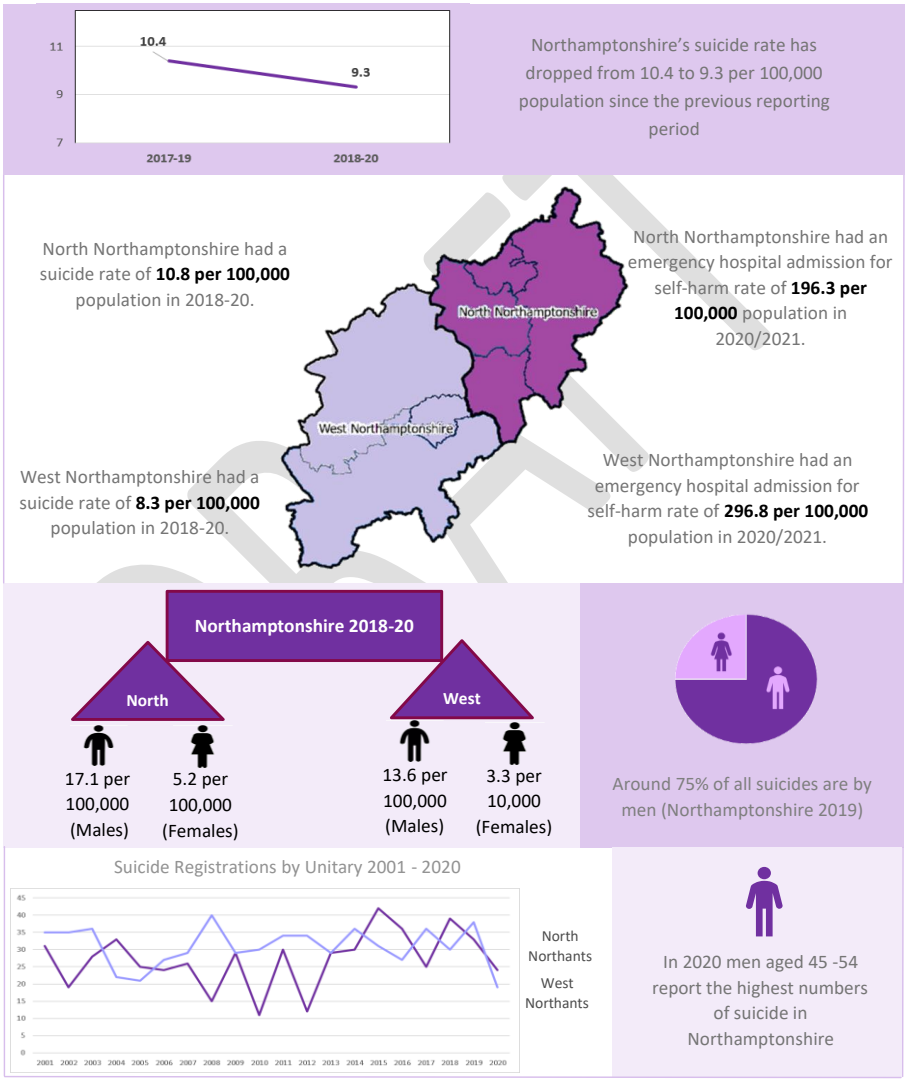


Figure 2: Summary of the local context for suicide. [8] [9] [12] [13]

Key Findings

Local context of suicide in Northamptonshire, 2020

Figure 2 summaries the local context for suicide in Northamptonshire, in 2020. The suicide rate for North Northamptonshire is statistically similar to the East Midlands and England averages in 2018-2020. The suicide rate for West Northamptonshire is statistically better than the England averages in 2018-2020, and statistically similar to the East Midlands averages in 2018-2020. The rates for both North and West Northamptonshire are statistically similar to each other and the all-Northamptonshire figure for 2017-19. The rate for all-Northamptonshire has dropped between 2017-2019 and 2018-2020. This is not a statistically significant change, and although it sits below the national and regional average, it is statistically similar to both. The rate for males is significantly higher than the rate for females in both North and West Northamptonshire in 2018-2020, both of these are statistically similar to the male and female rates for England and East Midlands.

Local Inequalities in Suicide

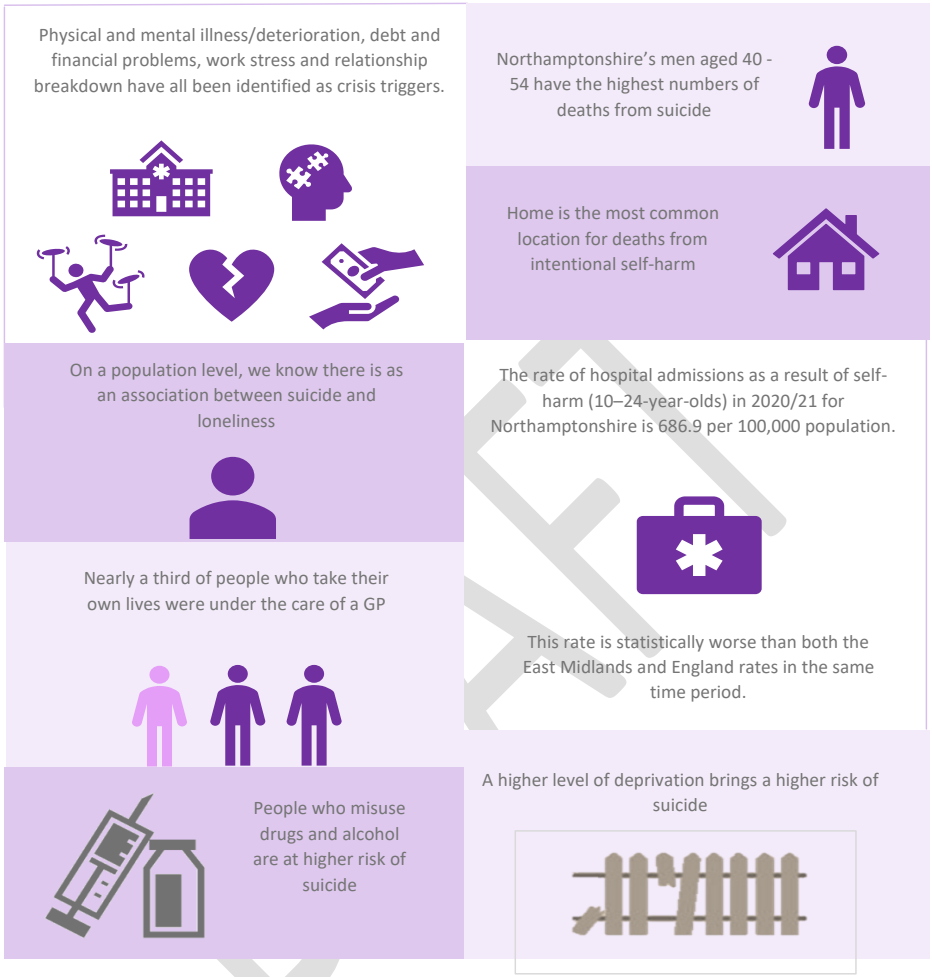


Figure 3: Summary of the local inequalities in suicide. [8] [9] [12] [13] [14]

Review of Previous Strategy

The agencies who make up the Northamptonshire Suicide Prevention Steering Group (SPSG) have worked in partnership towards the priorities identified in the previous strategy [1]. Below is a summary of our headline achievements since 2017:

Working in partnership

We have liaised with regional colleagues to keep the SPSG informed about regional and national networks and events, to help improve our local understanding and awareness of good practice.
Northamptonshire SPSG have participated in national, regional, and local events, and have applied this learning to inform our local activities.
We have improved information sharing with partners, so they are better informed.
We have improved the online information to support partners and service users in locating local mental health services and support available.

Improving our understanding of the cases and effects of suicide

We have established a real-time surveillance system which provides us with a better understanding of each case of suspected suicide in the county.
We undertook an audit of suicide cases and presented this to the Northamptonshire Health and Wellbeing Board.

Reducing the risk of suicide in key high-risk groups

An ongoing programme of STORM training has been delivered to frontline staff working in secondary care.
A Specialist Perinatal Service has been developed and is being delivered by NHFT. It involves a range of psychological therapies, including a Maternity Mental Health service for mild and moderate presentations. The period of care available has been extended from 12 to 24 months where clinically indicated.
We have successfully achieved regional Wave 3 programme funding which has supported a number of prevention workstreams focussing on suicide in high-risk groups including middle aged men, families bereaved by suicide, inpatient and secondary care services.

[1] The original Northamptonshire Strategy was published for the period 2017-2020, however due to the Covid pandemic the end date was extended to 2022.

Improve positive emotional health and wellbeing and resilience among high-risk groups, including young people

A collaborative of Voluntary, Community and Social Enterprise (VCSE) counselling providers has been funded, to deliver support and care for mild-moderate mental health issues across Northamptonshire. An additional Child and Adolescent Mental Health Service has also been commissioned for more severe presentations.

A Transitions Workstream has commenced, to manage the challenges of transferring from child/adolescent to adult mental health and social care services. This includes a new Enhanced Support Service for 16–25-year-olds who are making the transition to adulthood.

An application for additional funding from the NHS Prevention Programme, for a Liaison and Engagement Service to focus on service users with dual-needs (alcohol-use disorder and mental illness).

Commented [HP1]: Awaiting information from Cathryn Andrews

A Health and Justice Intervention Programme supporting physical and mental health has recently commenced.

The School Nursing Service has developed pathways for children and young people at risk of self-harm.

Community based. Bio-psycho-social pathway linked to anti-depressant guidelines with pharmacists. Improving Access to Psychological Therapies (IAPT) and social prescribing included in pathway. Awaiting confirmation of governance.

Commented [HP2]: Awaiting information from Paul Flecknoe

Individual Placement and Support (IPS) employment support has been expanded to provide support to mental health patients with getting into employment. The team is embedded within the Place-Based Community Mental Health Teams, in order to contribute to personalised and needs-led care planning. The team is due to be expanded further in 2022.

Mental Health Northants Collaboration are increasing awareness of the mental health prevention scheme. Additional funding has been secured and will be implemented in 2022-23, to develop a series of preventative initiatives based on national and local data, and via system collaboration.

Capacity has been enhanced within the psychology workforce which will be embedded within mental health inpatient services. The 'Red to Green' bed management system is being applied to ensure patients are discharged in the earliest and safest way.

An extensive mental health crisis pathway has been developed, which has been identified as an example of regional best practice. This has included alternatives to admission for those in mental health crisis, including expansion of the Crisis cafes, Hospital at home packages, Crisis Houses, 24/7 Integrated Response Hub, and Liaison Teams based in the Acute settings.

Priorities for Northamptonshire

Priority 1: Reduce the risk of suicide in key high-risk groups

There can be a wide range of contributing factors to someone's death by suicide. These factors can help to highlight those at an increased risk. National data has identified high-risk groups, including: young men (18-19 years), middle-aged men, those in the care of mental health services, those in contact with the criminal justice system, specific occupational groups, those with a history of self-harm, misuse of alcohol and/or drugs, socioeconomic disadvantage, physical health conditions, social isolation, problems with gambling and presence of adverse circumstances [5] [15]. In the majority, Northamptonshire's high-risk groups have shown to follow the national profile regarding prevalence, demographic and socioeconomic factors.

This priority will contribute to the work of this strategy by directly supporting those groups at higher risk of suicide and providing a better understanding of the local population and its risk groups and ensuring all future suicide prevention approaches are tailored to meet the needs of those at high risk.

We plan to:

- Coordinate a countywide prevention campaign aimed at groups identified at high-risk of suicide
- Deliver a suicide prevention training programme to upskill frontline staff in the early identification of risk factors
- Continue to monitor suicide data and intelligence to maintain our understanding of high-risk groups and inform trends and emerging issues
- Explore opportunities to enhance intelligence on local suicide across the suicide prevention partnership
- Explore solutions that enhance the development of protective behaviours and suicide prevention

Priority 2: Tailor approaches to improve mental health in specific groups

Certain groups have been identified at higher risk of taking their life or attempting to take their life. This priority considers the specific measures that can be implemented that may improve outcomes for the specific groups. National data has identified these specific groups, including: children and young people, users of drugs and alcohol services, perinatal mental health, people on receipt of employment benefits, people who are lesbian, gay, bisexual or gender reassigned, Black and Minority Ethnic groups, people with long-term physical health conditions, people with untreated depression, survivors of abuse or violence, veterans, people who are especially vulnerable due to social and economic circumstances, people who live alone, people who are anxious, isolated, or lonely, particularly as a result of the COVID-19 pandemic, patients who receive care under community services and acute settings [16]. In the majority, Northamptonshire follows the national profile for specific groups with a higher risk.

This priority will contribute to this strategy by improving awareness of those at risk of suicide and self-harm across our health and care workforce. It will also support and develop our understanding of local services, informing where improvements can be made to the delivery of mental health provision across Northamptonshire.

We plan to:

- Improve public awareness of local mental health services targeted to identified priority groups
- Analyse intelligence to improve understanding of local mental health services and service users
- Monitor trends in data and intelligence to inform priorities
- Support the design of evidence-based pathways, processes and protocols for service users presenting with suicidal ideation
- Sign up to the Prevention Concordat
- Maintain delivery of the Wave 3 Transformation Programme

Priority 3: Reduce access to the means of suicide

The fourth progress report [15] highlights the reduction in deaths by suicide where actions to reduce access to means of suicide have applied.

Systematic reviews [17] have found reducing access to the means of suicide to be one of the public health approaches with the best evidence for reducing suicide. This focus on access is also found in several national and international guidelines [18].

This priority will contribute to the work of this strategy by providing an improved understanding of locations and methods in Northamptonshire, which will support the development of suitable prevention interventions.

We plan to:

- Work with partners to prevent public places being used for suicide
- Engage with partners and retailers to influence policy change to reduce access to certain means of suicide
- Continue to monitor existing suicide data and intelligence sources to inform emerging methods and local trends

Priority 4: Provide better information and support to those bereaved or affected by suicide

The death of a family member or friend is a traumatic time, with implications on the mental health on these individuals. It is known that the suicide of a family member or friend is a risk factor for suicide. The "Preventing suicide in England" [3] report highlights this key area for action and outlines the following key aspects: providing support that is effective and timely; providing effective local responses to the aftermath of suicide; providing information and support for families, friends and

collages who are concerned about someone who may be at risk of suicide.

This priority will contribute to the work of this strategy by developing partnerships with agencies working with people and communities affected by suicide and developing and improving awareness of local suicide bereavement services to those who require support.

We plan to:

- Coordinate a campaign to improve public awareness of suicide bereavement services available in Northamptonshire
- Work with emergency service partners to explore opportunities to better support staff involved with suicide intervention
- Coordinate a countywide suicide prevention package to support educational establishments
- Work with commercial organisations to shape postvention support and policy
- Explore opportunities to develop intelligence and data on bereavement services and those bereaved by suicide from across the suicide prevention partnership
- Embed the local Bereavement Real-Time Referral Pathway

Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The fourth progress report [15] emphasises the importance of the media continuing to cover the subject of suicide. This approach can aid a reduction of stigma and an increased awareness of suicidal behaviour and suicide prevention. The "Preventing suicide in England" [3] report highlights the significant influence the media can have on attitudes and behaviour. There is evidence to suggest that media reporting can lead to copycat behaviour, particularly amongst those at risk and younger people [19]. Concern around the misuse of the internet to promote suicide and suicidal methods continues to grow [20]. However, by developing the internet, social media and local media to support vulnerable people and reduce online harms, there are opportunities to reach those at risk and less willing to access support.

This priority will contribute to the work of this strategy by supporting the effective reporting of suicide in Northamptonshire, enable improved collaboration with local media agencies and provide improved signposting to local support and services.

We plan to:

- Develop a local Media Framework to support responsible reporting of suicide
- Establish a local media monitoring system

Priority 6: Support research and data collection

The "Preventing suicide in England" [3] report highlights the importance of research, data collection and monitoring for suicide prevention.

This priority can enhance our understanding of statistical data and display trends and changes in patterns. It can inform interventions and strategies and enhance understanding of high-risk groups.

It supports the evaluation and development of interventions and contributes to the suicide prevention evidence base approach of what works.

This priority will contribute to the work of this strategy by providing a better understanding of suicide at a local level, supporting the developing of improved suicide prevention approaches tailored to those at high-risk.

We plan to:

- Undertake an audit of Coroners cases to enhance our understanding of the local situation audit since last audit)
- Continue to work with partners to maintain the Northamptonshire Suicide Real Time Surveillance System (RTSS)
- Develop an escalation protocol for suspected suicide cases
- Support the development of the Mental Health JSNA to inform future actions
- Explore opportunities to develop intelligence and data sources from across the suicide prevention partnership

Priority 7: Reduce the rates of self-harm as a key indicator of suicide risk

The fifth progress report [7] highlights the previously agreed four groups to prioritise the reduction of deaths by suicide in.

People who self-harm are one of the prioritised groups and the reasons highlighted include evidence suggesting around 50% of people who have died by suicide previously self-harming and an estimated 200,000 attendances at hospital for self-harm. The report continues with emphasising the heightened risk of suicide particularly in the first year after self-harm.

This priority will contribute to the work of this strategy by providing a better understanding of self-harm at the local level, and current support services which will inform the development of future self-harm initiatives.

We plan to:

- Improve awareness and understanding of services offering support for self-harm in Northamptonshire
- Develop a pilot Self-Harm Real Time Surveillance System (SHRTSS) which will provide an insight into those who self-harm but do not present to primary or secondary care services

Review

We will review the outcomes of this Strategy by monitoring the progress of the action plan through the Suicide Prevention Steering Group. The outcomes of the review will be reported through the Mental Health Pillar structure and to the North Northants and West Northants Health and Wellbeing Boards.

An Annual Report will be produced reviewing progress against the Strategy and summarising changes in intelligence and policy which may require adaptation to our local approach. The Annual Review will be publicly available online.

Acknowledgements

Public Health Northamptonshire would like to express thanks to the Suicide Prevention Steering Group partners for supporting the production of this strategy. A special thanks for those who supported the task and finish groups, with their time and knowledge. In addition, we would like to thank North and West Northamptonshire Council for supporting this area of work.

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Support

This document discusses sensitive information. If you, or someone you know, has been affected by suicide or self-harm in any way, the following agencies may be able to help.

Mental Health Number	0800 448 0828	Open 24/7 for everyone - Offering support for your mental health needs
Samaritan Helpline	116 123	Open 24/7 for everyone - If you need someone to talk to
Childline	0800 1111	Open 24/7 for young people aged 18 and under - Offering emotional support
CYPMHS Crisis Team	0800 170 7055	Open 24/7 for young people aged 18 and under - If you are in crisis, at risk of self-harm or suicide

Contact Information

For further details about the contents of this Strategy, please email Northamptonshire Public Health: publichealth.ncc@northnorthants.gov.uk.

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Priority 1: Reduce the risk of suicide in key high-risk groups					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
1.1 Coordinate a countywide prevention campaign aimed at groups identified at high-risk of suicide	1.1.1 Coordinate a prevention campaign, with partner agencies, targeted at reducing suicide in high-risk groups and raising awareness of local suicide support and prevention services	Summer-Autumn 2023		- Suicide prevention campaign - Campaign evaluation - Suicide Indicators	- CCG - NHFT - Public Health Northamptonshire - Service users - SPSG Partners - SPSG Partner Communication Teams
1.2 Deliver a suicide prevention training programme to upskill frontline staff in the early identification of risk factors	1.2.1 Identify appropriate frontline staffing groups and undertake a training needs assessment. Design and deliver a suicide awareness and mitigation training programme using a tiered/stepped approach	Summer 2022-Summer 2024		- Staffing groups - Training needs assessment - Training Programme - Delivery Plan - Training data - Training evaluation - Suicide Indicators	- Identified frontline staffing groups - Northamptonshire Adult Learning - Public Health Northamptonshire
	1.2.2 Explore opportunities to incorporate suicide prevention in staff induction and training programmes of all suicide prevention partners	Summer 2023-Summer 2025			
	1.2.3 Align Suicide Prevention Strategy to NHCP People Plan to develop approaches to system wide training of all staff in Compassion-Focussed/ Trauma-Informed care	April 2023		- NHCP People Plan - Pillar Updates - Training Implementation Plan - Staff Feedback	- Integrated Care Board - Health & Wellbeing Boards - NHCP People Plan (authors/ leads) - Population Health Management Programme leads
1.3 Continue to monitor suicide data and intelligence to maintain our understanding of high-risk groups and inform trends and emerging issues	1.3.1 Evaluate the findings from the Coroner's Audits	September 2022		- Coroner's audit reports - Mental Health JSNA - RTSS intelligence - RTSS quarterly reports - Safeguarding partnership outcomes - Suicide Indicators	- Coroner's Office - Northamptonshire Police - Northamptonshire Safeguarding Children Partnership - Northamptonshire Safeguarding Adults Board - Public Health Northamptonshire
	1.3.2 Use the findings from the Mental Health JSNA to enhance the understanding of high-risk groups	Winter 2023			
	1.3.3 Evaluate findings from the local Real Time Surveillance System	Ongoing			
	1.3.4 Establish and embed links with local safeguarding partnerships	Summer 2022			
1.4 Explore opportunities to enhance intelligence on local suicide from across the suicide prevention partnership	1.4.1 Work with partners to establish additional sources of data and intelligence	Ongoing		- Additional intelligence and data source	- Public Health Northamptonshire - SPSG Partners
	1.4.2 Align Suicide Prevention Strategy with MHLDA Equalities Enabler Group and Population Health Management Programme	Summer 2022		- NHCP Population Health Strategy - MHLDA Equalities Toolkit	- MHLDA Equalities Enabler Lead - Population Health Management Programme Leads
	1.5.1 Implement, monitor and evaluate Emotional Coaching Pilot initiative for parents/ carers of children with suicidal ideation	Winter 2022		- Project Initiation Documents - Pillar updates - Service level data (access & outcomes) - Evaluation Report	- Healthy Minds Healthy Brains Pillar - NHFT (CAMHS) - NHFT (Suicide Prevention Lead) - Public Health Northamptonshire
1.5 Explore solutions that enhance the development of protective behaviours and suicide prevention	1.5.2 Monitor and evaluate Psychoeducation & Respite pilot for Mental Health carers	Winter 2022		- Pillar updates - Service level data (access & outcomes) - Evaluation Report	- MHLDA Population Health & Prevention Pillar - Northamptonshire Carers - Northamptonshire MIND
	1.5.3 Expand IAPT Talking Therapies Service in line with Long-Term Plan ambitions, and implement Long-Term Conditions (Physical Health) pathways into the model	April 2025		- Pillar Updates - Service Level Data (access and outcomes)	- MHLDA Outcome Based Pathways Pillar - NHFT (IAPT) - NHFT (Suicide Prevention Lead)

	1.5.4 Strengthen dual needs policy (mental health & substance misuse) via new 'access-to-care' protocols, information sharing agreements, and partnership working models	September 2022		- Production of Standard Operating Procedures - Staff feedback - Service user feedback	- MHLDA Outcome Based Pathways Pillar - NHFT (CMHTs) - NHFT (Suicide Prevention Lead)
	1.5.5 Expand Individual Placement & Support services in line with Long-term Plan ambitions to assist with SMI to obtain and maintain employment	April 2024		- IPS Expansion Plan - Service Level Data (access & outcomes)	- MHLDA Outcome-Based Pathways Pillar - NHFT (IPS)
	1.5.6 Expand access to Specialist Perinatal Mental Health and Maternity Mental Health service in line with Long-Term Plan ambitions (to 10% of live birth rate). Incorporate assessment & signposting for perinatal partners	April 2023		- Perinatal Expansion Plan - Service level data (access & outcomes) - Service user feedback - 'I want great care' feedback	- NHFT (Perinatal Service) - NHFT (Suicide Prevention Lead)
	1.5.7 Investigate viable solutions with partners and providers for future consideration	Ongoing		- Suicide Indicators	- Public Health Northamptonshire - SPSG Partners

Priority 2: Tailor approaches to improve mental health in specific groups					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
2.1 Improve partner and public awareness of local mental health services targeted to identified priority groups	2.1.2 Identify and map Northamptonshire mental health services working with the priority groups identified in the Strategy and pathways.	Autumn 2022-Winter 2023		- Service and pathway map - Mental health services campaign - Campaign evaluation - Self-harm and Suicide Indicators	- NHFT - Northamptonshire CCG - Public Health Northamptonshire - Service users - SPSG Partners - SPSG Partner Communication Teams
	2.1.2 Coordinate a communication campaign for mental health services targeted at the priority groups.	Winter 2023			
2.2 Analyse intelligence to improve understanding of local mental health services and service users	2.2.1 Analyse existing sources of data and intelligence and identify issues for future consideration.	Ongoing		- Self-harm and Suicide Indicators	- Coroner's Office - Northamptonshire Police - Northamptonshire Safeguarding Children Partnership - Northamptonshire Safeguarding Adults Board - Public Health Northamptonshire - SPSG Partners
	2.2.2 Review outcomes from the Mental Health JSNA for future consideration.	Summer 2023			
	2.2.3 Review findings from the Real Time Surveillance System and Coroners Audits to inform understanding of mental health services and service users.	Ongoing			
	2.2.4 Establish and embed links with local safeguarding partnerships and review findings to inform understanding of mental health.	Ongoing			
	2.2.5 Work with partners from across the suicide prevention partnership to explore opportunities for access to additional sources of data and intelligence to inform analysis of services and service users.	Ongoing			
2.3 Monitor trends in data and intelligence to inform priorities	2.3.1 Analyse existing sources of data and intelligence to inform local groups for prioritisation for mental health improvements and issues for further consideration within this Strategy.	Ongoing		- Self-harm and Suicide Indicators	- Public Health Northamptonshire - SPSG Partners
	2.3.2 Work with partners to enhance data and intelligence sources on mental health in specific groups.	Summer 2025			
2.4 Sign up to the Prevention Concordat	2.4.1 Coordinate sign up to the Prevention Concordat.	Summer 2022		- Prevention Concordat Application - Prevention Concordat Action Plan	- ICS Partners - Public Health Northamptonshire
	2.4.2 Represent suicide prevention priorities within the Prevention Concordat Action Plan.	Summer 2022-Summer 2023			
2.5 Maintain delivery of the Wave 3 Transformation Programme	2.5.1 Continue delivery of STORM training.	Summer 2023		- STORM training - Stay Alive app subscription and usage data - Protect Cards	- NHFT - Northamptonshire CCG - Public Health Northamptonshire - SPSG Partners
	2.5.2 Coordinate subscription to Stay Alive app.	Summer 2023			
	2.5.3 Coordinate production and distribution of Protect Cards through partner channels.	Summer 2023			
2.6 Strengthen and enhance response to people with suicidal ideation/ self-harm across Place-Based Community Mental Health Teams	2.6.1 Enhance & Embed Suicide Prevention Best Practice into delivery models for Place-Based Community Mental Health Teams (aligned to principles of biopsychosocial, personalised, needs-led care & removal of Care Programme Approach)	Winter 2023 – Summer 2024		- Delivery Plan - Production of Standard Operating Procedures - Service user feedback	- MHLDA Outcome Based Pathways Pillar - NHFT (CMHTs) - NHFT (Suicide Prevention Lead) - Public Health Northamptonshire
	2.6.2 Strengthen the links between Place-Based Community Mental Health Teams & Crisis Pathway to ensure fluid boundaries and continuity of care for people with suicidal ideation	Winter 2023 – Summer 2024		-	- MHLDA Acute & Crisis Care Pillar - NHFT (CMHTs) - NHFT (Crisis Pathway) - NHFT (Suicide Prevention Lead)

	2.6.3 Implement Core 24 (Crisis Response) standards across all acute hospital and community settings, to facilitate compassionate/ responsive models of care & aftercare to all those in crisis	Winter 2023 – Summer 2024		- Implementation of Mental Health Ambulance model - Service level data (Core 24 standards) - Service user feedback	- MHLDA Acute & Crisis Care Pillar - NHFT (Crisis Pathway) - NHFT Patient Experience Group - NHFT (Suicide Prevention Lead)
	2.6.4 Align mental health response to the Northamptonshire Care Record to enhance quality and timeliness of care and treatment via digital innovations	Winter 2023 – Summer 2024		- Delivery Plan - Staff feedback - Service Level Data	- MHLDA Acute & Crisis Care Pillar - MHLDA Outcome-Based Pathway Pillar - NHCP Digital Strategy Leads
	2.6.5 Design and Propose Community Dialectical Behavioural Therapy Pathway for people with Personality Disorders, aligned to best practice principles for suicidal ideation and self-harm.	Winter 2023 – Summer 2024		- Community DBT pathway proposal - Community DBT mobilisation plan - Community DBT EQIA - Risk & Issues log	- MHLDA Acute & Crisis Care Pillar - MHLDA Outcome-Based Pathways Pillar - NHFT (Individual Funding Team) - NHFT (Place-Based CMHTs)
	2.6.6 Review existing provision for service users presenting with suicidal ideation and work with partners to design and implement viable pathways, processes, and protocols.	Winter 2023 – Summer 2024		- Pathway review - Updated process and protocols	- CCG - NHFT - Public Health Northamptonshire - Service Users
2.7 Strengthen and enhance response to people with suicidal ideation/ self-harm making transition from CYP to Adult pathways	2.7.1 Accelerate Transition Workstream, including involvement from suicide prevention leads in development of Transitions Strategy.	Winter 2023 – Summer 2024		- NHCP Transitions Strategy - Pathway Plan documents - Pillar updates	- Children's Trust - CYP Collaborative Programme - Health & Wellbeing Boards - Integrated Care Board - MHLDA Collaborative Programme - North & West Northants Councils - NHFT
	2.7.2 Expand the model of 16-25's Enhanced Support (wrap around) service and align to the wider transitions workstream in 2022-23.	Winter 2023 – Summer 2024		- 16-25's Enhanced Support Model of Care - Pillar Updates - Service level data (access & outcomes)	- Healthy Minds Healthy Brains Pillar - LA Leaving Care Team - MHLDA Outcome-Based Pathways Pillar - NHFT (CAMHS) - Public Health Northamptonshire - Youth Works (ESS Lead provider)
	2.7.3 Align Enhanced Support Service with LA Care Leavers Team to create Community of Practice for young people transitioning from CYP to adult pathways	Winter 2023 – Summer 2024		- NHCP Transitions Strategy - Pathway Plan documents - Pillar updates	- CYP Collaborative Programme - Children's Trust - Integrated Care Board - Health & Wellbeing Boards - MHLDA Collaborative Programme - North & West Northants Councils - NHFT - Public Health Northamptonshire
	2.7.4 Review existing provision for service users presenting with suicidal ideation and work with partners to design and implement viable pathways, processes, and protocols.	Winter 2023 – Summer 2024		- Pathway review - Updated process and protocols	- CCG - NHFT - Public Health Northamptonshire - Service Users

Priority 3: Reduce access to means of suicide					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
3.1 Work with partners to prevent public places being used for suicide	3.1.1 Work with transport partners and the emergency services to create a Northamptonshire map of priority suicide risk locations and structures.	Autumn 2022		- Suicide risk location map - Suicide rates at high-risk locations	- British Transport Police - Coroner's Office - East Midlands Railway - Highways England - KierWSP - Network Rail - Northamptonshire Police - Public Health Northamptonshire
	3.1.2 Work with partners to explore opportunities for mitigation at high-risk locations.	Summer 2025			
3.2 Engage with partners and retailers to influence policy change to reduce access to certain means of suicide	3.2.1 Evaluate data and intelligence to prioritise local means of suicide.	August 2022		- Self-harm and Suicide Indicators - Retailer policy and practice	- Local Authority Trading Standards - Northamptonshire retailers - Public Health Northamptonshire
	3.2.2 Engage with partners and local retailers to explore opportunities for changes to existing policies.	June 2025			
3.3 Continue to monitor existing suicide data and intelligence sources to inform emerging methods and local trends	3.3.1 Evaluate the findings from the Coroner's Audits.	Ongoing		- Coroner's audits - Real Time Surveillance data - Safeguarding partnership	- Coroner's Office - Northamptonshire Police - Northamptonshire Safeguarding Children Partnership - Northamptonshire Safeguarding Adults Board - Public Health Northamptonshire - SPSG Partners
	3.3.2 Evaluate findings from the local Real Time Surveillance System.	Ongoing			
	3.3.3 Establish and embed links with local safeguarding partnerships.	Ongoing			
	3.3.4 Work with partners to explore opportunities for access to additional sources of data and intelligence to inform analysis of suicide methods.	Ongoing			

Priority 4: Provide better information and support to those bereaved or affected by suicide					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
4.1 Coordinate a campaign to improve partner and public awareness of suicide bereavement services available in Northamptonshire.	4.1.1 Identify and map Northamptonshire suicide bereavement services.	Winter 2023		- Service and pathway map - Suicide bereavement campaign - Bereavement service users - Campaign evaluation	- Public Health Northamptonshire - Service Six - SOBS - SPSG Partner Communication Teams - We Mind and Kelly Matters
	4.1.2 Create and deliver a promotion plan.	Winter 2023-Winter 2024			
4.2 Work with emergency service partners to explore opportunities to better support staff involved with suicide intervention	4.2.1 Engage with emergency service partners and undertake a needs assessment of existing postvention support for staff. Agree adjustments which complement and enhance existing service provision.	Autumn 2022-Autumn 2023		- Emergency Service staff postvention support analysis - Postvention service usage - Postvention service evaluation	- British Transport Police - East Midlands Ambulance Service - Northants Fire and Rescue Service - Northamptonshire Police - Public Health Northamptonshire
4.3 Coordinate a countywide suicide prevention package to support educational establishments	4.3.1 Work with partners to map existing postvention services and carry out a needs assessment and gap analysis on the current position. Use the results of the needs assessment and gap analysis to identify and coordinate essential service and information requirements, to develop a comprehensive package which will provide support to the affected community.	Summer 2022-Autumn 2022		- Education postvention service map - Educational establishment package - Package and service evaluation - Self-harm and Suicide Indicators	- Local Authority Education Teams - NHFT - Northamptonshire CCG - Public Health Northamptonshire - Samaritans - University of Northampton
	4.3.2 Work with partners to maintain the package and look for opportunities to develop and enhance it.	Ongoing			
4.4 Work with commercial organisations to shape postvention support and policy	4.4.1 Engage with relevant commercial organisations, review existing practice and policy, and identify areas requiring development.	Winter 2023		- Policy and protocol - Self-harm and Suicide Indicators	- Commercial organisations - Public Health Northamptonshire - SPSG Partners
4.5 Explore opportunities to develop intelligence and data on bereavement services and those bereaved by suicide from across the suicide prevention partnership	4.5.1 Work with partners to devise a monitoring system to provide intelligence on Wave 3 support bereavement services.	Summer 2022-Summer 2023		- Postvention support data - Additional intelligence and data sources - Self-harm and Suicide Indicators	- Northamptonshire CCG - Public Health Northamptonshire - Service Six - SOBS - SPSG Partners - We Mind and Kelly Matters
	4.5.2 Work with partners to explore further intelligence and data sources.	Summer 2023			
4.6 Embed the local Bereavement Real-Time Referral Pathway	4.6.1 Work with partners to evaluate existing referral pathways for local bereavement services, and devise solutions to develop and embed the pathways across the system.	Summer 2022-Summer 2023		- Referral evaluation - Updated pathways - Communication plan - Self-harm and Suicide Indicators	- Northamptonshire CCG - Public Health Northamptonshire - Service Six - SOBS - SPSG Partners - We Mind and Kelly Matters

Priority 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
5.1 Develop a local Media Framework to support responsible reporting of suicide	5.1.1 Work with local media organisations to produce a framework that provides guidance on reporting and includes the promotion of prevention and sources of support, to encourage good standard practice and minimise impact on communities.	Autumn 2022-Summer 2023		- Media Framework - Established relationships with media organisations - Evaluation of reporting - Self-harm and Suicide Indicators	- Local media organisations - Public Health Northamptonshire - Samaritans - SPSG Partner Communication Teams
	5.1.2 Develop and sustain good working relationships with local media organisations to support cooperative and transparent working partnerships.	Ongoing			
5.2 Establish a local media monitoring system	5.2.1 Develop a local system to monitor reporting of suicide and self-harm across local, regional, national, and social media channels. Review outcomes and identify recommendations for adjustments to existing practice.	Winter 2022		- Data on monitoring media streams	- Public Health Northamptonshire - Samaritans

Priority 6: Support research, data collection and monitoring					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
6.1 Undertake an audit of Coroners cases to enhance our understanding of the local situation (audit since last audit) Annual audit ongoing	6.1.1 Complete an audit on closed Coroners cases between September 2018 and April 2022. Analyse findings and identify findings and recommendations for future consideration.	June 2022-October 2022		- 2022 Audit report - 2023 Audit report - 2024 Audit report - 2025 Audit report	- Coroner's Office - Public Health Northamptonshire - SPSG Partners - We Mind and Kelly Matters
	6.1.2 Commence an annual audit programme to maintain intelligence.	June 2023 onwards			
6.2 Continue to work with partners to maintain the Northamptonshire Suicide Real Time Surveillance System (RTSS)	6.2.1 Monitor and analyse data from the SRTSS and identify findings and recommendations for future consideration.	Ongoing		- SRTSS quarterly reports	- Coroner's Office - Northamptonshire Police - Public Health Northamptonshire - SPSG Partners
6.3 Develop an escalation protocol for suspected suicide cases	6.3.1 Establish a Suicide Prevention partnership protocol to undertake a timely review relating to suspected suicide cases which require escalation following notification via the RTSS.	Summer 2022		- Escalation protocol - Escalation outcomes	- Co-opted SPSG Partners - NHFT - Northamptonshire CCG - Public Health Northamptonshire
6.4 Support the development of the Mental Health JSNA to inform future actions	6.4.1 Support the development of the Mental Health JSNA and identify recommendations for future consideration within this Strategy.	Winter 2023		- Mental Health JSNA	- Public Health Northamptonshire - SPSG Partners
6.5 Explore opportunities to develop intelligence and data sources from across the suicide prevention partnership	6.5.1 Work with partners to maximise opportunities for access to existing intelligence and data and look for additional opportunities to increase sources utilised	Ongoing		- Accessible data and intelligence	- Public Health Northamptonshire - SPSG Partners

Priority 7: Reducing rates of self-harm as a key indicator of suicide risk					
Objective	**Action**	**Timescale**	**RAG Status**	**Monitoring**	**Stakeholders**
7.1 Improve awareness and understanding of services offering support for self-harm in Northamptonshire	7.1.1 Produce a map of current self-harm services and support available in Northamptonshire to enable prioritisation and identify areas for future consideration.	Summer 2022-Summer 2024		- Self-harm service and support map - Data on service users	- Public Health Northamptonshire - Service users - SPSG Partners
7.2 Develop a pilot Self-Harm Real Time Surveillance System (SHRTSS) which will provide an insight into those who self-harm but do not present to primary or secondary care services	7.2.1 Work with identified partners to design a pilot SHRTSS	Summer 2022-Spring 2023		- SHRTSS pilot - SHRTSS evaluation	- Identified SPSG Partners - Northamptonshire CCG - Public Health Northamptonshire - Service users
	7.2.2 Evaluate the pilot with a view to designing and implementing a system wide process.	Spring 2023-Summer 2025			

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