2021/22 Better Care Fund – Narrative Plan

Better Integrated Care Across Northamptonshire

This plan covers the Health and Wellbeing Boards of:

- West Northamptonshire Council
- North Northamptonshire Council

The plan is common to both because the two councils sit within the Northamptonshire ICS and are working to a common plan and approach to our future ICS in terms of its organisation and delivery at County, Place, and neighbourhood levels. We will work towards a single system Integrated Care Strategy, supported by population health management but anticipate that each Health and Wellbeing Board will have its own Placed based Care and wellbeing Strategy that will see local services targeted at local need and delivered within local communities.

The organisations engaged in the creation of this plan include:

- West Northamptonshire Council Social Care
- North Northamptonshire Council Social Care
- Northamptonshire CCG
- Northamptonshire Health Foundation Trust (NHFT)
- Northamptonshire Hospitals Trust (incorporating Northampton Kettering Hospitals)
- ICAN Patient Advisory Group (PAG) – Voluntary sector representatives
- Primary Care and PCNs

This Year's BCF plan and scheme reflects the scope and activity with our system programme ICAN (Integrated Care Across Northamptonshire) and our plans to meet the national Discharge to Assess (D2A) Guidance which is also aligned to ICAN activity.

ICAN is one of the four priority areas across our Northamptonshire Health and Care Partnership (NHCP) and will form the basis of one of our key collaboratives as we move towards the legal creation of our ICS. The ICAN programme has been supported across the system and has been subject to a system and regulator approved business case and is supported by key stakeholder groups like the PAG to ensure that our plans deliver the outcomes our residents and patients want to see.

1. Executive Summary

Our vision for the future of Northamptonshire's health and care services is to create the conditions for all residents to enjoy "**a positive lifetime of health, wellbeing and care in our community**" This where we want to get to as a health and care system, with an emphasis on enabling good health and wellbeing as much as treatment and care.

Our mission working together is about: Empowering positive futures; choose well, stay well, live well. Wherever we work and whatever our role we all share this common aim for the people of Northamptonshire, and this reflects our narrative shift towards empowering healthy lifestyles and prevention of ill health.

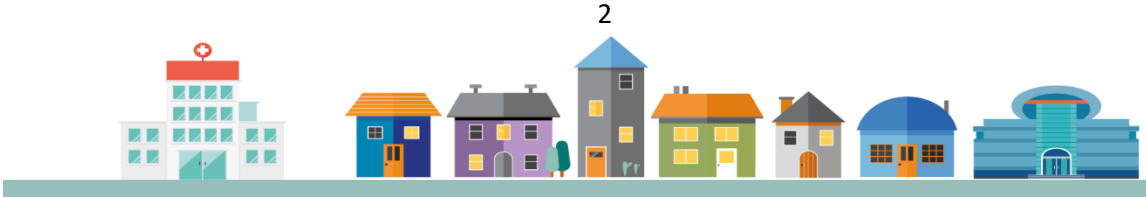
Our past inability to make lasting positive transformational change to the way we work in health and care has been the result of many factors including the increasing and sustained demand we face, particularly from our frail and elderly residents, an over reliance on acute hospital and bed-based care, organisational barriers to working differently and our challenging finances. Post COVID these pressures are significant, and our hospitals and community care service face a stark winter with very full hospitals, workforce challenges and significant work to do to achieve our ambitions.

But we are working more closely than ever in partnership now and our shared ambition for greater integration across health, care and voluntary sector will be focused on improved population outcomes. If we achieve our ambition, at a personal level it will also mean people will only need to tell their story once, they will navigate more easily between organisations, experience greater continuity of care and be supported to choose well, live well, and stay well. The benefits to patients and carers will however be limited if we continue working as individual organisations and the consequences are unsustainable financially.

With the creation of the formal ICS' around the country we have a chance to reset and a mandate to work and act differently. If we do not make use of the opportunity we now have, to collectively come together as an ICS, change things locally by focusing on the wider determinants of health challenge and join up our services, we will soon no longer be able to manage the problem without spending more, building bigger hospitals, and significantly growing our workforce. None of these are viable in the current climate. We have committed at a fundamental level of key population health management principles that will help in the longer term to reduce ill health and demand and ensure our residents get better outcomes, these are:

- **Improving health outcomes** which must have just as much focus as treating illness.
- **Reducing health inequalities** to ensure that the most vulnerable in our society get better care and better and accelerate and improve their health outcomes.
- **Achieving parity of esteem**, making sure that we are just as focussed on improving mental as well as physical health

In 2020-21 our system agreed four core priority areas where we want to start our ICS journey and where we knew our performance fell below what we wanted for residents. These are key



catalysts for a thriving ICS and the basis of our four initial ICS collaboratives. The four priorities are:

- Mental Health
- Children and Young People
- Integrated Care Across Northamptonshire (ICAN), and
- Elective Care

The priorities reflect the areas we have agreed are most important to our resident wellbeing and population health and the inequalities that exist in our system and following the COVID Pandemic. We envisage that each of these areas will in time inform the foundation of Collaboratives where our resources, contracts, staff, and services come together to deliver shared contracted outcomes and improved performance within pooled budgets.

Our BCF schemes and plans have been refreshed and focused on our ICAN programme on the basis that these will then form the scope and basis for a collaborative underpinned by an outcomes contract and with the services/scheme set out in our template as well as the shared staff, assets, and contracts to deliver the contracted outcomes. Given the national directives around D2A we have also encompassed our D2A schemes and funding within the BCF as we believe this represents a more cohesive, integrated, and cross cutting means to deliver better care in our area.

While this is the 2020-21 BCF Plan, ICAN is a five-year programme to deliver our shared vision of "A positive lifetime of health, wellbeing and care in our community". The programme is our most ambitious joint programmes and focuses on the frail and elderly as the biggest area of demand and pressure but equally an area where we believe we can make a significant and positive difference to people's lives. The programme has commenced with a whole system transformation plan to shift care into our communities and away from Acute based care. We want to change our ways of working to centre around the person and the community and to establish and develop our future collaborative arrangements to secure lasting change and improved outcomes. Because of its importance to our long-term ICS goals, ICAN services, contracts, and expenditure and our D2A initiatives are now be the focus of all our BCF arrangements and agreements.

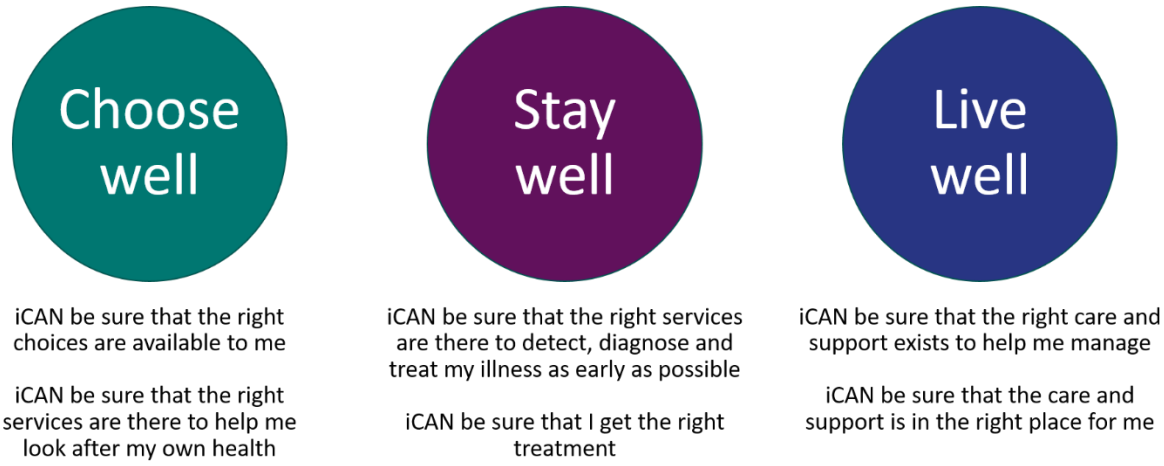
2. What is ICAN and what's in Scope?

ICAN will deliver across all our health and care settings. It has three key pillars of work:

- Community Resilience,
- Frailty Escalation and Front Door (FEFD), and
- Flow and Grip.

These core pillars are designed to correct the immediate issues in our system creating the shift from hospital-based care to community care but also build longer term community solutions to keeping people well in their own homes longer and helping people stay well in their communities with support. ICAN also supports our ICS vision of "staying well, living well and ageing well" as the programme aims to put in place the services and pathways to

make the vision a reality as shown below. It is the first time we have focused on outcomes not just input and activity changes.



Why ICAN and why the Change in Focus?

In 2018 the CQC System Review showed that we were not focused enough on resident's outcomes and we were we were not consistent in what we did and how we did it. As a result, patient experience for people aged 65+ was varied and sometimes unsatisfactory and we did not always get good outcomes. Compared to our peers 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 – overall, on average, one in three patients in acute beds and one in two in community beds no longer need to be there), and
- were 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 a current underlying system deficit of £89m as of October 2021, it is not sustainable.

In Northamptonshire barriers such as the above can lead to care which is not fully aligned with the needs of the care user, in conflict with our current vision. Such barriers often produce a situation where people end up accessing the care system in an unplanned or individually undesirable manner, leading to negative impact on BCF national outcomes such as an increase in Emergency Admission rates. This leads to unnecessary pressures throughout the care system and can result in a poor user experience, unsatisfactory clinical outcomes, and financial pressure. If we do nothing the situation will become untenable.

There are many reasons for this including the lack of joined up thinking or care centred, not enough focus on outcomes, the piecemeal nature of our plans and an over reliance on tactical fixes and acute bed-based care. As a result of not making lasting and sustained changes to how we work and not moving towards more integrated and community-based care the pressure on our system resources has continued with high occupancy in our hospitals, pressure on staffing and finances and difficulties in delivering our desired levels of care. Doing nothing is not an option as by 2039 we will face critical levels of demand and cost that cannot be met.

If we do nothing

Increased demand – the growing and ageing population means that health and care are treating more patients with more complex conditions

Northamptonshire will see a 27% increase in older people aged over 65 by 2029.

150 more GPs needed to manage 500,000 more patient contacts every year.

10,000 more hospital admissions a year and 516 additional acute beds for over 65s (which is the same as needing a new hospital).

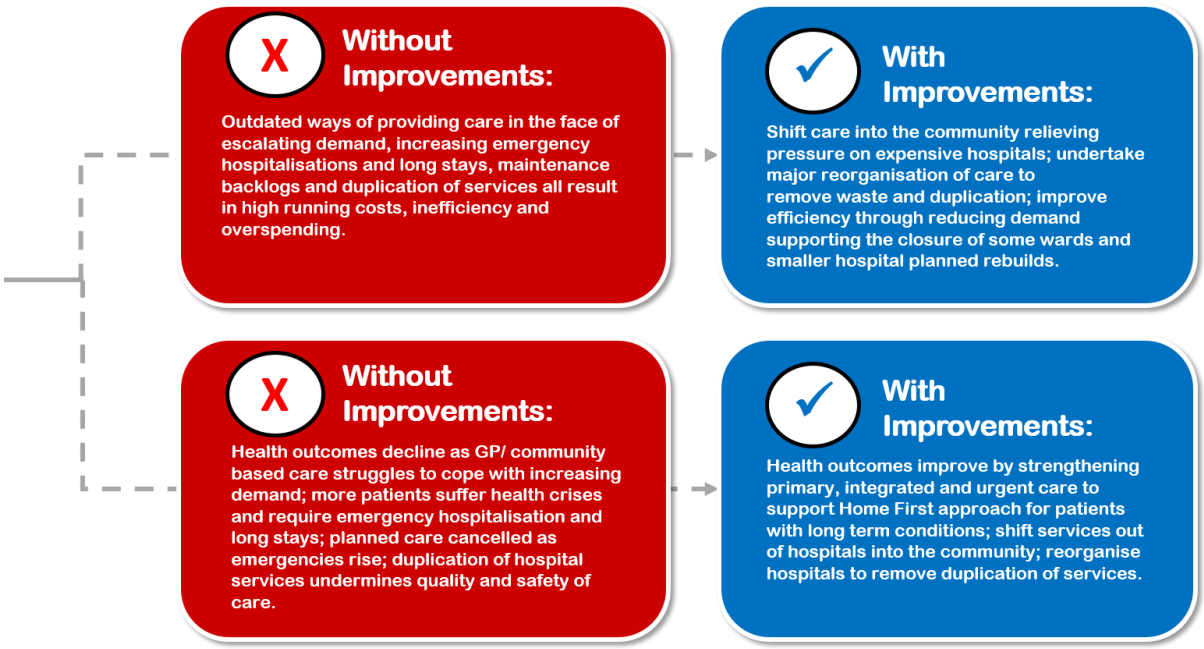
£90 million additional cost on older people unplanned hospital admissions and recovery care.

2,500 more requests each year for social care support

Annual shortfall of £148 million related to all costs of health and social care.

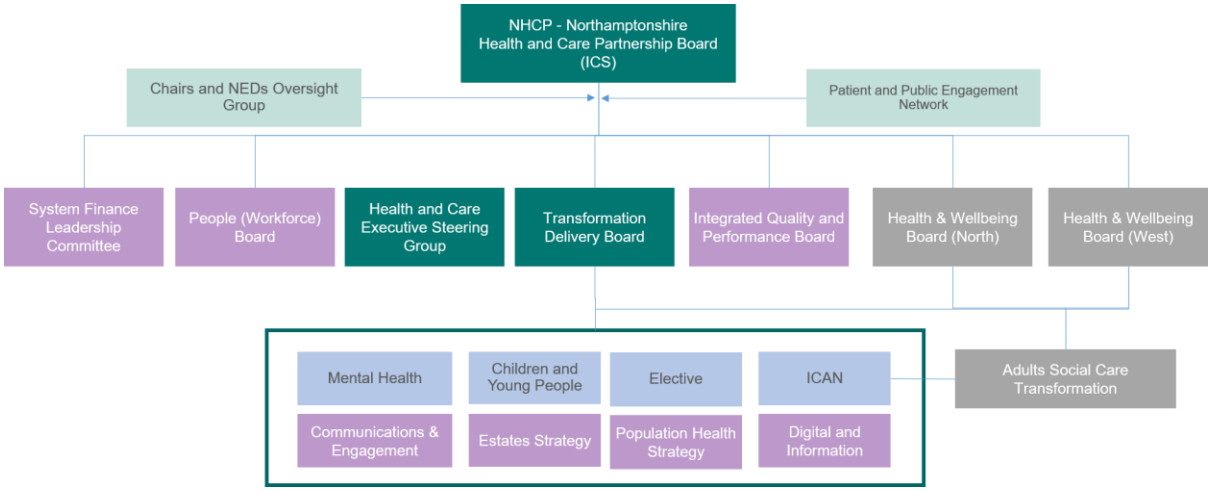
While some improvement has been seen in terms of hospital occupancy and delayed discharges prior to COVID our levels of occupancy in our hospitals, the levels of over 65 admissions and the lengths of stay have remained high and are rising. COVID created a new focus on integrated working and on discharge to assess models of care to create capacity for the pandemic, but that capacity is already under pressure from increasing demand, and we are facing a very challenging winter 2021/22 at the same time as trying to restore elective and specialist care.

The challenge is significant and despite this we have in 2020-21 developed, agreed, and commenced the ICAN and D2A programmes in full to help mitigate the effects of winter, deliver the national D2A guidance and build a long-term sustainable model of care for the frail and elderly. The rationale for ICAN and a BCF reset is clear - doing nothing is not an option as shown below.

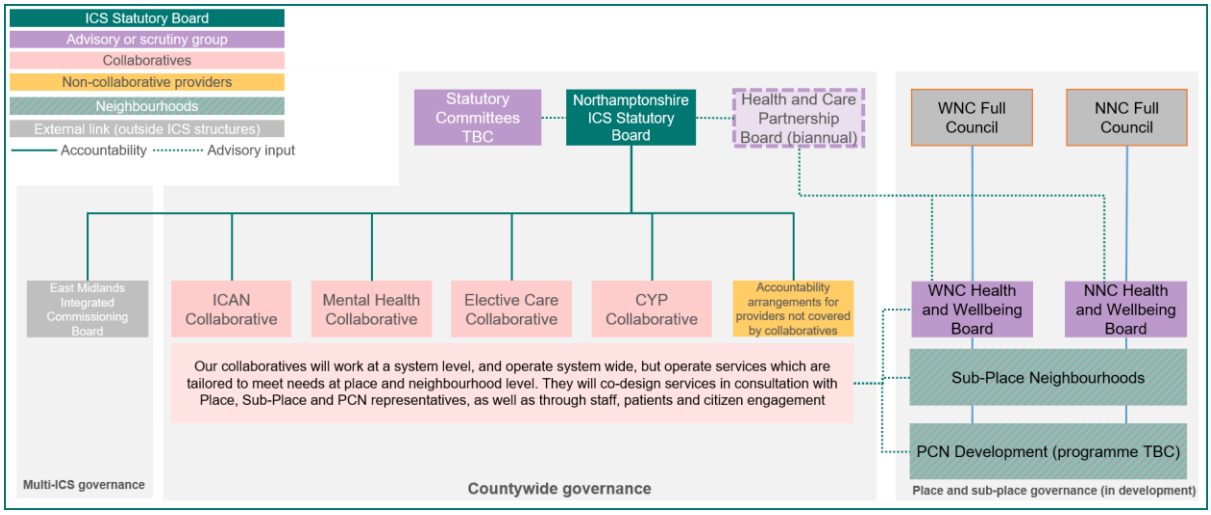


1. Governance

The 2021-22 Northamptonshire BCF plan is different this year as it reflects the changes in local government from a two tier 1 County Council and 7 District Council model to two unitary councils, West and North Northamptonshire Councils. The current governance arrangements are set out below.



The governance model of our system is also changing to reflect how our ICS will operate across the ICS footprint (at County level) and Place based delivery (at unitary footprint level). The diagram below sets out an initial proposition for ICS governance from April 2022 (when ICS statutory bodies will be formed) and is the basis of our current shadow operation. It aims to simplify and clarify accountability for delivering improved outcomes, as the Statutory ICS Board will directly oversee our four Collaboratives, each one of which will include both provider and commissioner representatives, working to improve outcomes for a defined population group.



Health and Wellbeing Boards will anchor ICS arrangements at place-level, continuing with their current functions as overseeing place-level commissioning

Our ICS will have two places – aligning with the footprints for the new Unitary Authorities. Our two HWBs will maintain their current roles and responsibilities around needs analysis, strategic planning, and scrutiny. ICS's will require an overall system strategy to be developed by the Health and Care Partnership Board. The recommendation is to merge this requirement with the current Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs across the County.

The Public Health team will work with the Health and Wellbeing Boards to create a Joint System Needs Analysis and System Strategy, ratified by the Partnership Board.

Joint commissioning will continue to take place at Place level (through Better Care Fund and current joint programmes). The ICS strategic commissioner and Local Authority commissioners will form virtual 'joint teams' for each Place, to undertake this activity.

2. Overall Approach to Integration

There are four broad longer-term themes and priorities for ICAN agreed by all system partners. These are set out below and over time additional services and resources will be added to those in the BCF and included in the ICAN collaborative, so we expand and extend integrated services and focus our pooled resources on sustaining strong community based and preventative care. These long-term aims are aligned to the key BCF metrics and are:

Keeping more people well & out of Hospital

Through better public health and prevention and management of long-term conditions we will support more patients at home and in their community. We will strengthen primary and community care to help people make the right lifestyle choices and improve access to GPs and practice teams. Integrated teams will be created at a local level, across different health and care organisations, to meet the needs of an ageing population and patients with complex conditions to better care for local people and reduce reliance on urgent and emergency care.

More Care closer to home

From the management of long-term conditions to planned procedures and follow-ups. We will maintain a “Home First” approach to care for people at home or in community facilities, avoiding unnecessary hospital stays or rehabilitating them when they leave hospital as they regain their independence. Some planned care will be moved from acute hospitals to the community and unnecessary follow up and outpatient appointments will be avoided in future years with more outreach services in place.

Care in a crisis

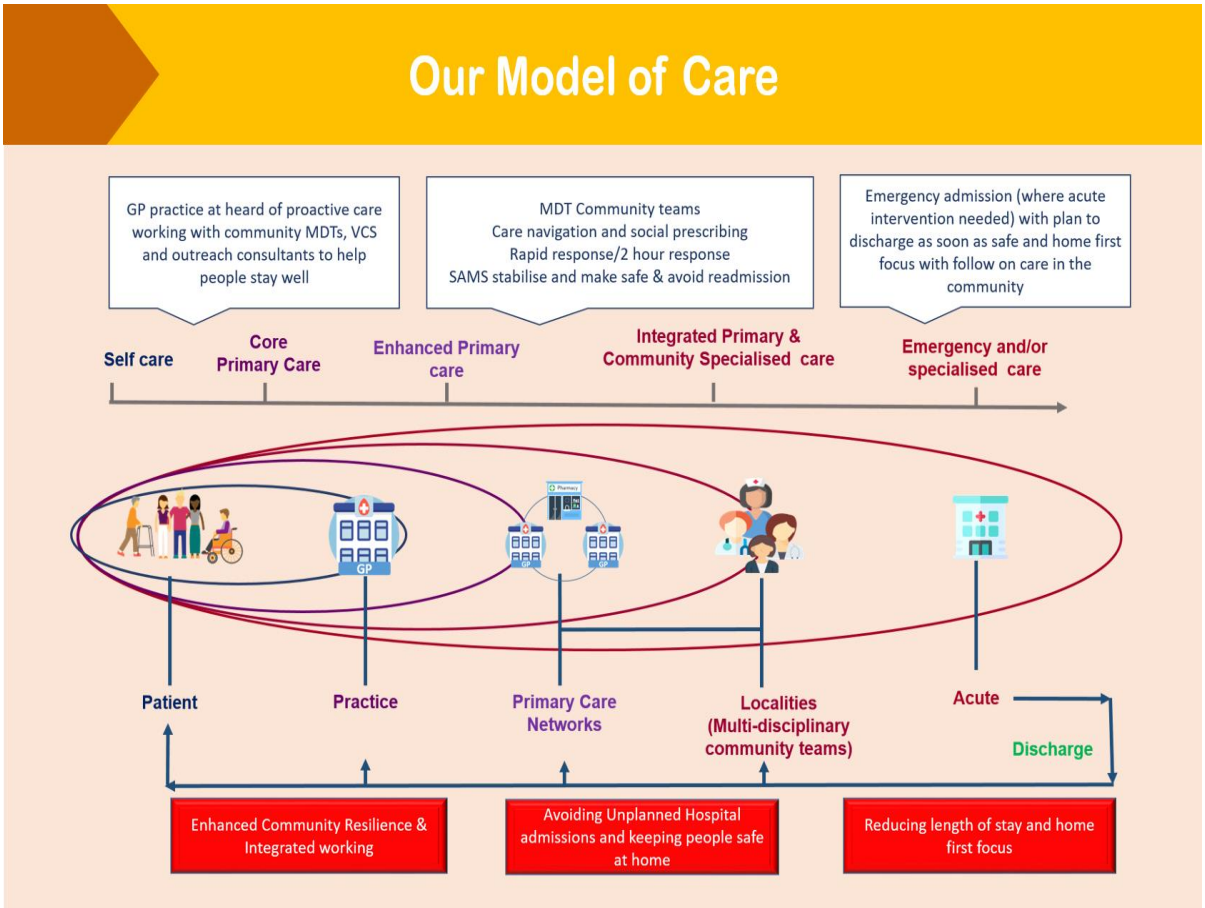
We will improve urgent and emergency care by extending services and the ability to offer step up care in the community where a short intervention is needed. We will introduce a 2-hour rapid response service that can attend an emergency call in the community and where possible implement a short-term intervention to avoid an admission to hospital. Pressure on emergency care will be reduced through the NHS 111 service, offering GP support at A&E, and improving the flow of patients through the hospital with the use of frailty units and same day emergency care at the front door, no one should be admitted or stay if they have no reason to reside.

High quality specialist care

Designed to support patients in their homes, community facilities and hospitals to get the best possible outcomes where more specialist care is needed for specific and long-term conditions. We will create specialist pathways that include staff from different NHS and local authority organisations to provide joined up, high quality care for those with long term or multiple conditions, dementia and other longer term need that needs to be managed to help them maintain independence and living well.

Our model of care will recognise that people will come to us at different points in their life and that our response needs to be good quality, appropriate and with a focus in maintaining their independence and helping them to stay well. This model of care is shown below

Joined up care will be delivered across health and care partners and supported and supplemented by the voluntary sector. Supporting a shift to better and more comprehensive primary and community care will take time and the BCF reflect the initial schemes and services that will form the foundation of ICAN 2021/23 but over time and the collaborative delivery model embeds we envisage more services; specialist outreach clinics and services and more solutions will be found in communities with Acute care reserved for those that need an acute medical intervention.



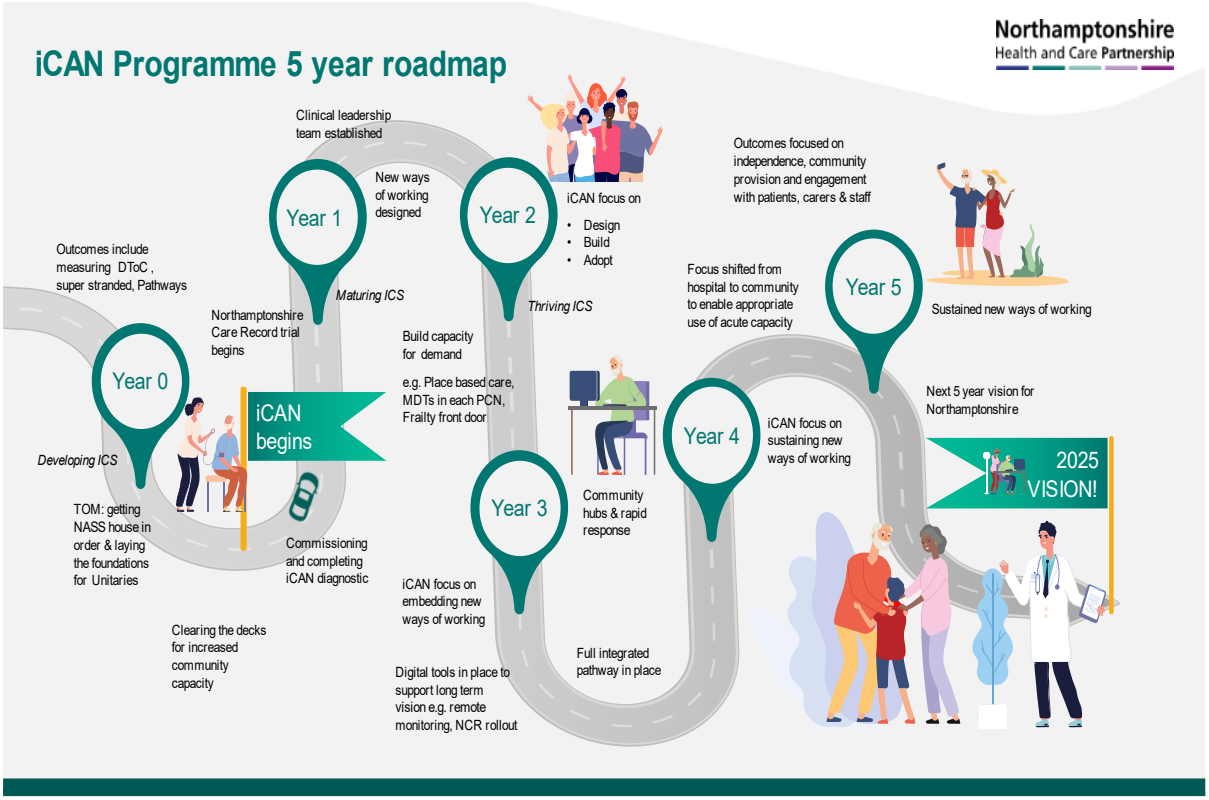
The evolving model of care will create a far more clinically effective and cost-efficient system. But most of all it will improve resident outcomes as it is built around individuals, supporting them to be as active and as independent as they can be. Wherever it is clinically appropriate we will aim to treat people at or close to home. We will always ask 'how best can we keep this person at home?' or 'why is this patient not at home?'.

The GP list of registered patients will remain the central pillar of local care. GPs will be supported by integration of care for people with long-term and complex conditions through multidisciplinary teams and practices working more closely together in localities, increasing the capacity and options available

This aligns with the "Integration and Innovation" white paper published in 2021 and builds on the 2018 NHS Long Term Plan. It also delivers on our plan to address health inequalities, and our priorities to reduce risk in our older population and further develop social prescribing.

Given its priority and scale of the work we need to do to address our system issues around frailty we have decided to reset out Better Care Fund Plan to focus on this single priority and the delivery of both the transformation of frail and elderly care and creation of our integrated collaborative. This plan therefore sets out our rationale for this, the services, and resources that we will commit to ICAN and how this will lead to improved performance across the ICS and national metrics. This will be supported by a section 75 agreement that commits partners and investment to ICAN aims, outcomes and benefits

As Northamptonshire Health and Care Partnership we have created a five-year transformation programme, Integrated Care Across Northamptonshire ('iCAN'), to deliver our shared vision of "A positive lifetime of health, wellbeing and care in our community.". It is a five-year programme, with detailed workstreams for each of the three areas. Every year will build on the achievements that have gone before to achieve the full benefits from 2025, as set out in the roadmap below.



We have identified three key areas of services and improvement to delivery within the BCF and ICAN programme to improve prevention, improve outcomes, and shift activity from our acute hospitals to the community:

- **Community resilience** – 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, underpinned by care plans for all, social prescribing, education, information, and urgent community care wrapped around the patient
- **frailty, escalation, and front door –** ensuring people avoid hospital admissions where possible, maximising use of outpatients, the intermediate care team, same day care and short-term stays, and if they do need to come to hospital, they are seen in the best environment by staff trained in frailty
- **flow and grip –** ensuring no one is in hospital without a 'reason to reside', eliminating admissions for diagnostics and IV antibiotics if not otherwise necessary, improving ward discharge processes, and ensuring patients are discharged to settings that maximise their independence and wherever possible to their homes.

Our approach aligns with the "Integration and Innovation" white paper published in 2021 and builds on the 2018 NHS Long Term Plan. It also delivers on our ICS plan to address health inequalities, and our priorities to reduce risk in our older population and further develop social prescribing.

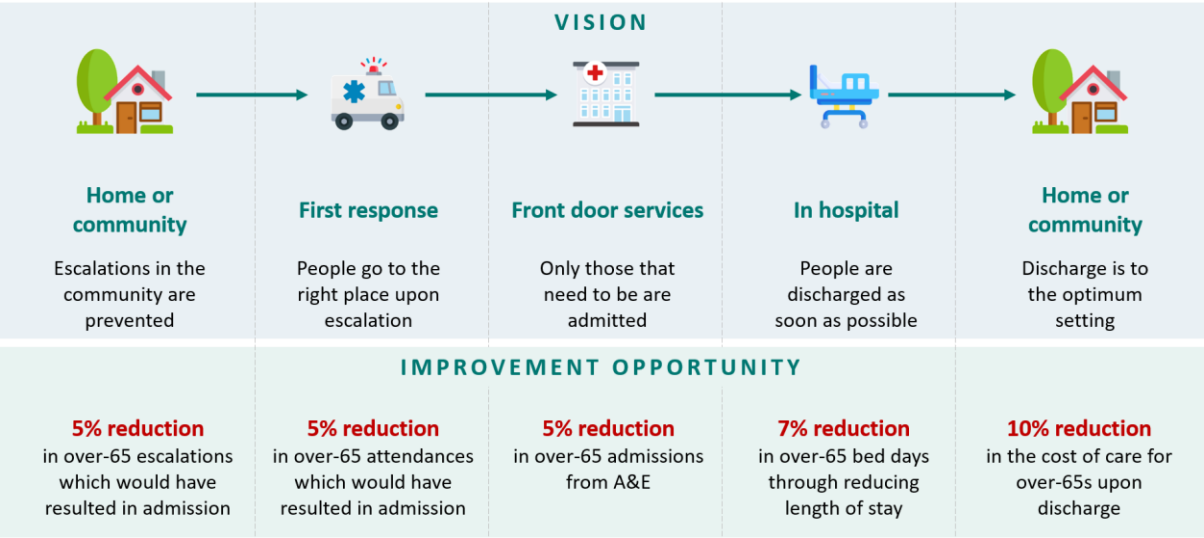
ICAN will help us achieve several key benefits and resolve several key performance challenges that have made us an outlier in some national metrics and objectives including DTOC, D2A principles and length of stay. By 2025, the iCAN programme will be delivering the following reductions as follows:

- 5% reduction in escalations to the emergency department, attendances, and admissions – improving care for 7,300 people a year1
- 7% reduction in hospital length of stay – reducing delays for 36,500 people a year, and meaning 170 people in hospital right now could be at home
- 20% reduction in reliance on long term care, with reductions to 1100 social care packages, reducing long-term care costs by 10%
- reduction in growth of 170 acute hospital beds – making the capital and revenue costs of the Kettering General Hospital new build feasible. If demand for acute care continues to grow unchecked, the new build required will be unaffordable.

This means we now have the defined opportunity to:

- improve the care pathway for frail, mainly older, people in Northamptonshire
- deliver financial savings to assist in achieving our system control total
- improve operational delivery to support Covid19 recovery and winter 2021.

Operationally several things will change as summarised below



As the ICAN Programme embeds and we move towards a maturing and delivering ICAN collaborative within our ICS plan we will aslo be delivering the following system benefits which will be tracked as part of our management metrics:

- improved patient outcomes
- less hospital or bedded care and length of stay
- increased use of reablement and home first care
- improved patient experience of health and care services
- improved staff engagement
- improved staff experience and job satisfaction leading to better recruitment and retention
- greater surge capacity for winter

[1] 3,000 fewer escalations, 2,800 fewer ED attendances, 1,500 fewer admissions.

- improved flow across pathways
- improved quality of life scores for frail patients and citizens
- reduced need for new acute hospital estate and infrastructure.

And it will deliver much of what local people said they want in a survey as part of the 2020 diagnostic:

- better communication between services and better communication with patients/the public
- faster access to services, particularly GP appointments
- care and support close to home to help people stay well, age well, and stay in their own homes for as long as it is safe
- care for the whole person, that treats them as individuals and has wellbeing at its centre.

Delivery of the National Conditions

The creation of our countywide ICS from April 2021 was the culmination of years of work across the BCF, STP and ICS planning. We are in the process of developing our operating model for ICS but our four priorities areas of integarted delivery; ICAN, Elective Crae, Mental Health and Children and Yound People are the agreed initial areas of integrated wokring. All four areas are underpinned by system agreement of a number of key aspects:

- A genuinely co-designed vision for integrated health and social care across Northamptonshire
- Buy-in to the Integration and Transformation Programme plan by all system partners to place-based delivery of local services to meet local need but set within an overaching single System population health management function and single health and Care Strategy for the population as a whole,
- Genuine and continued agreement on planning, governance, accountability and risk-sharing arrangements underpinned by a robust understanding of the impact and benefits of all four planned collaboratives and joint working, including the pooling of budgets
- A renewed and concerted effort and commitment from all delivery partners to achieving our priorities of a greater focus on prevention, reduced hospital admissions and occupancy, reduced lengths of stay, a home first focus and helping keep people well at home.

Condition 1: Joint agreement of plans between health and social care

There is a commitment across Northamptonshire to deliver ICAN as one of the four ICS priorities agreed by our health and care system partners and that our BCF should contain the required services, schemes and investment to deliver improvememts in health and care.

The key changes to this 2021/22 BCF for Northamptonshire are:

- The commitment as a system to additional tranformation invetsment and ICAN programme over 18 months and to build the strong foundation required to make this a successful future collaborative and expecetd to deliver £13m of savings by year 3. The schemes we have included are designed to deliver the ICAN outcomes and aims and we have removed schemes that do not align to this.
- the inclusion of our national D2A funding and schemes that are targted on maintaining flow in line with the national guidance and utilise partners, the voluntary sector, private providers to ensure as many people as possible go home with short term care or rehabilitation and only those who require long term care are discharged to bedded care.

Since the creation of the two new Unitary Councils in Northamptonshire: West Northamptonshire Council (WNC) and North Northamptonshire Council (NNC) the County has moved to two Health and Wellbeing boards covering County and sitting within within our ICS footprint. The BCF approach and plans were signed off by both the WNC and NNC Health and Wellbeing boards during October 2021, with delegated powers given to the chairs to sign off the final Financial details in order to align the timing of the boards and the national assurance timescales. These sign offs have happened as well as the plan, expenditure and funding being subject to sign off by all system Directors of Finance on 5th November, all Chief Executives and to be underpinned by a shared Section 75 arranagements.

Condition 2: Maintain provision of social care services

The planned contribution from the CCG minimum contribution towards social care is agreed and in line with national plans and guidelines.

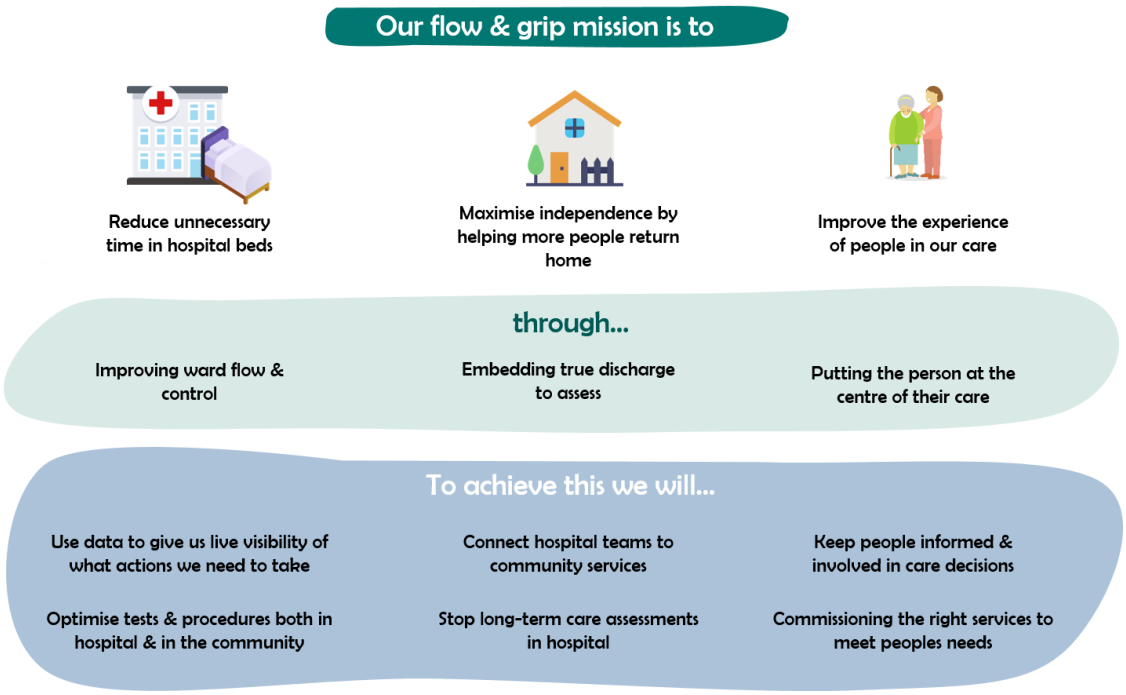
Condition 3: Out of Hospital spend

There is a clear commitment and agreement to invest in NHS out of hospital services and the largest pillar of work within ICAN is purposely Community Resillience to ensure that we have the support infrastructure, assets, data sahrting and services to keep people well and out of hopsital and to provide more care closer to home including avoiding readmissions following a hospital discharge. The graphic below summarises the key aims and goals of the Community Resillience pillar and how we will achieve these aims.

Condition 4: Managing Transfers of Care

One of the key outcomes of the ICAN work relates to imporving peoples outcomes on discharge through our Flow and Grip Pillar. This will aim to improve in hopsital processes and particularly the key national drives around "reason to reside" and reducing lengths of stay. We are implementing national best practice in relation to D2A trying to drive up discharge by pathways 0 and 1, using pathway 2 bedded rehab only where required to deliver better long term outcomes and recovery and as a last option pathway 3 long term care. We have commissioned a number of scheme and partners to help provide the capacity to do this effectively in winter 2021-22.

The pillar also goes beyond the boundaries of the hospital and looks at the end to end pathway and all organsiations. In partivulat it craetes a strong focus, where possible, of returning people to their normal place of residence. The graphic below summarises the key aims and goals of the pillar and how we will achieve these aims.



Supporing people to remian in their own homes, avoiding unnecessary admissions and returning people to their homes as soon as no longer need acute care sit at the core of the ICAN/BCF plans. Our diagnostic clearly showed the scale of opportunity we have here to imporve peoples outcomes and in so doing reduce demand, length of stay and costs in our system.

Additional resources have been made available to support the ICAN/BCF objectives particularly the home first priority with considerable additional investment of £2.7m being released within ICAN for increased reablement teams and community based nursing and the inclusion of additional capacity to support better outreach care and community welfare support teams.

Our ICAN Better Care Plan is based on our overarching ambition to secure a fundamental shift in the ways in which care and support is provided to residents. All our ICAN/BCF schemes and areas of investment are summarised by under three of our longer term system aims as of

- Keeping more people well & out of Hospital
- More Care closer to home
- Care in a crisis
- High quality specialist care

Admission avoidance and keeping people out of hospital is as important to our system and managing discharges effectively and our past track record shows this as vital element of improving outcomes. This is particularly true for our over 65s and increasingly our over 75s as we historically have admitted over 90 over 65s a day to hsopital and our 2018 CQC system review showed that they were more likley to be admitted than in other araes, they stayed too long and they did not always get the best outcome. Our own 2019 Diagnostic found we were still missing the opportunity to avoid admissions as shown below:

Home or Community?

Are we preventing escalations from occurring in the community?

35% of escalations were non-ideal and may have been preventable

First Response

Are we ensuring people go to the right place upon escalation?

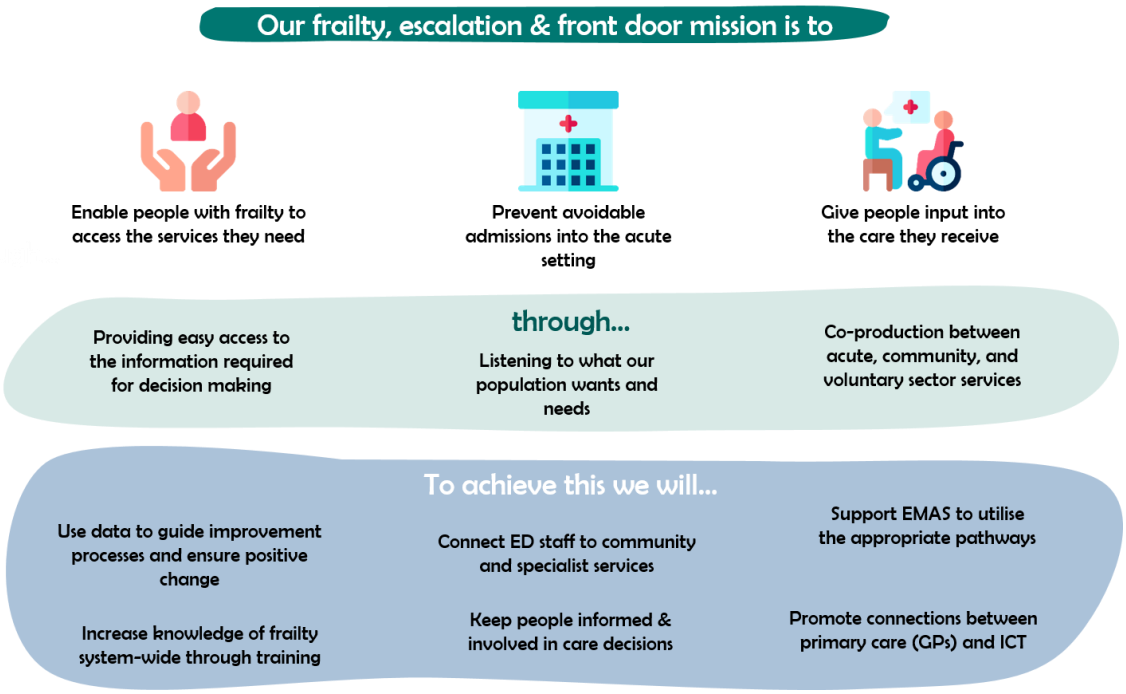
29% of escalations reviewed could have gone to a lower acuity setting

Front Door Services

Are we ensuring the right people are admitted?

25% of admissions reviewed could have been avoided

The Third pillar of our ICAN trabsformatio is therefore our Frailty, escalation and Front Door programme which is a cross system clinically sponsored programme involving our two acutes, EMAS and the use of our new Same Day Emergecy Care hubs and frailty units. It recognises the critial role of primary care and community care in avoiding escalations and prevent a default to admissions.



3. Disabled Facilities Grant (DFG) and Wider Services

The creation of the two new Unitary Councils has removed one the barrier of operating two tiers of government creating the opportunity in both Councils and as part of our place based thinking to develop strategic plans that join up public health, adults social care, housing and wider wellbeing services like leisure and economic development. Both Councils have craeted a single Directorate of

Adults, Communities and Wellbeing with these services included to help craete joined up thinking and maximise the ability to help more people stay well and indpendant for longer.

Both Adults social care services have recently completed significant transformation programmes that have seen a a strengths based working model adopted based on the “three conversations” and have

extended the use of DFGs, reablement, therapy and careted community hubs that connect to wider services and partners in the community.

It is important for both Councils to work with partners to achieve the highest quality service and best outcome for our residents. We are breaking through organisational barriers and building more professional relationships and links to make this easy, this includes;

- Getting to know our communities is a key part of how we work in future at a place level. We are organising services around our communities and actively building relationships with local providers and services such as volunteer groups, community groups and parish councils
- We will have better links with partners such as GPs and the Police to our teams helping to build their understanding of our service and ours of theirs. Picking up the phone will be the default than a system referral form to adults. We now have social workers based in some surgeries and we are working with the community teams to grow more proactive services and eraly interventions.
- Relationships and service development with Health is a priority and is being developed through the three integrated care system priorities in Mental Health, Children and Young People and ICAN, all of which will become collaboratives with shared outcomes based contracts and aims, pooled resources, joint commissioning and a focus on ineqaulities in future.

From a housing and accomodation perspective we are working together to incraese the capacity we have across the county that can support independent living through a number of lenses.

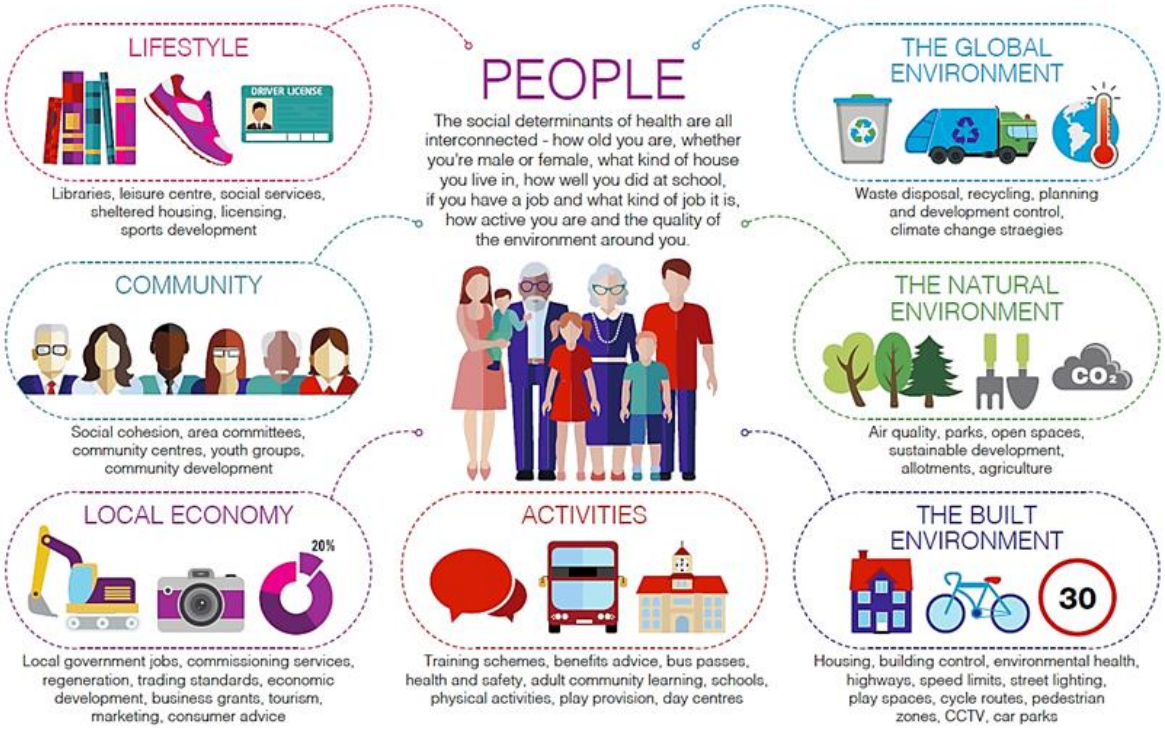
- Disabled facilities grants – our occupational therpay teams are now working alomgside the housing DFG teams as part of plans to invest in improving accomodation earlier, removing

waiting lists and considering more signifcant conversions that can support complex care and be used by future residents.

- Extra Care – we have a number of extra care facilities supporting older people to stay indpendant and the CCG are also commisioning some of the flats as facilities for complex medical rehabilitation and step down for non-weight beraing patients leaving hopsital.
- We have opened our first Leraning disabled supported living village “Oak Rise” which is based on a national best practice model and is jointly funding through the CCG and Councils to provide a community supported living facility for some of our most complex shared patients. This helps them remain independent and out of residential and hospital care for longer and live the best life they can, protected by on site care staff.
- We have just opened our first Community based complex Mental Health and Physical disability supported living facility, Morray Lodge. This has 20 flats equipped with assistive technology and equipment and provides a level of indpendance with on site specialist support and is our fisrt shared step down faclity for decades for these cohorts.
- Virtual Wards – we have succesfully rolled out the first of our virtual wards schemes that allow patients with respiratory conditions to be monitoted in their own home when they no longer need to reside in hospital and can be dealt with through out patiemt services. Similar models are being looked at now for Cardiac and other patients with full clinical and community support.
- Telecare and Telehealth – as well as a significant assistive technology presence across 5000 residents we are also now developing a number of pilots to monitor residents out of hopsital and we are now looking at schemes to support care homes to monitor residents of concern. This will avoid unnecessary conveyances when hospitals are not the best place for an ederly person but give confidence to homes to manage health witgh clinicains support and through and end of life care.

4. Equalities and Health Inequalities

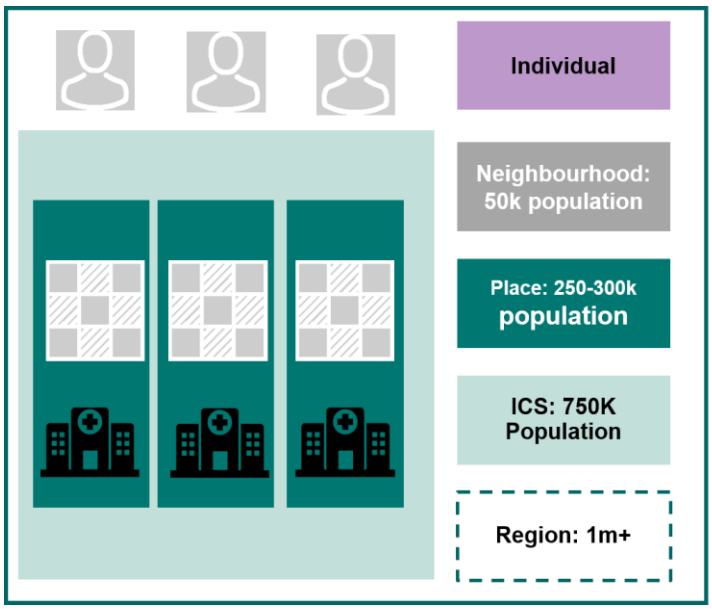
The Northamptonshire LTP submission used evidence from our analyst teams within the CCG and County Council, and DPH annual report on inequalities to inform its approach to inequalities within Northamptonshire. Underpiinning this is a fundamental understanding of the wider determinants of health (shown below) and therefore of the need to consider not just health care services but also to link housing, skills, jobs, ecconomic prosperity and environmental aspects when we consider how best to deliver our services at a county, place, neighbourhood and personal level.



As part of our developing ICS we have agreed that we will adopt a Population Health Management (PHM) focus to underpin our future decision making. Our vision for this is "to develop population health management skills, insights and expertise across Northamptonshire Health and Care Partnership (NHCP) to impact positively on local determinants of health, and subsequently the physical and mental health of the local population". We have commenced a programme to put in place the key components of good PHM and the aims of the programme, in line with NHS England's aims for population health, are to:

1. Improve the health and wellbeing of the population
2. Enhance the experience of care
3. Reduce the per capita cost of health and care services and improve productivity
4. Address health and care inequalities
5. Increase the wellbeing and engagement of the workforce

The principles of PHM across the different geographical levels in Northamptonshire should be the same but the purpose, process and delivery will differ to be relevant and appropriate to the different population groupings and their specific needs and local inequalities.



- At the **individual** level PHM can be used to help personalise care according to need
- At the **neighbourhood** level care pathways and interventions will be considered (PCN) and delivered so there is consistency of access to universal service
- At the **place** level PHM techniques should inform integrated care design bring agencies together to meet local population need
- At the **Integrated Care System (ICS)**level PHM techniques can inform strategic planning of large scale prevention or tertiary services. Our ICS footprint covers the county of Northamptonshire
- At the **regional** level PHM approaches require collaboration across other ICS footprints and NHSE to provide insights and commission specialist care services

In terms of BCF plans specifically and the ICAN/BCF schemes we are addressing inequalities throughout our activities and bearing in mind some key priorities emerging from the COVID 19 pandemic, including:

- Embedding prevention in all pathways of care including early identification of risk or deterioration, tailoring offers to address specific issues within specific populations. within ICAN we are undertaking extensive work in the community resillience pillar to increase the use of frailty scores using a common method and tool, annual frailty assessments and also other key ageing well inclding the development of memory hubs in Corby and elasewhere and Get up and Go sessions at a range of places wihin the community including for example the Hindu Temple.

- Targeting work with those communities who are not often heard and vulnerable groups to better understand their need and how best to meet them. We plan to take more services and outreach clinics to communities, with Geriatricians and other specislsists working with GPs and community teams to advise and support patients.

- Promote self-management in patients with long term conditions, reducing inequalities in access and outcomes. We are undrtaking work within ICAN and the BCF to extend virtual wards and long term condition management through local teams and triage sessions where there are concerns or the need for a rapid response, step up or step down care.

- Improving uptake of annual health checks for people with learning disability and autism. These priorities align with our anticipated focus for our recovery plans. One of our IACN/BCF is that evey patient with a frailty risk score is annually assessed and intervebtions (including housing or adapations, care or Assistive technology) is put in place to prevent escalatng risk

- Reducing risk in our older population through targeted access to preventative services such as strength and balance classes or physical activity, information and advice on early identification of risk factors, greater uptake of influenza and pneumococcal vaccinations and support to care home colleagues.

- Continuing preparations for implementing a social prescribing offer at scale for people with long term conditions.