BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans but use of this template for doing so is optional. Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

An example answers and top tips document is available on the Better Care Exchange to assist with filling out this template.

Cover

1. Health and Wellbeing Board(s)

North Northamptonshire Council

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

Organisation	Areas Engaged
North Northamptonshire Council	Adult's Social Care Housing & Communities (incorporates housing, leisure, and community safety) Public Health Finance
Northamptonshire ICS	Commissioning Transformation and Strategy Finance
Northamptonshire Health Foundation Trust (NHFT)	Transformation and Strategy Community Services operations Finance
Northamptonshire Group Hospital	Kettering General Hospital (KGH) Transformation and Strategy Acute SRO – Clinical Lead
General Practice	PCNs and Practices in North Northants GP SRO – Practice lead
Voluntary sector representatives	Healthwatch Northamptonshire ICAN Patient Advisory Group Age UK Alzheimer Society
Community Groups	Various representatives including town and parish councils

2. How have you gone about involving these stakeholders?

North Northamptonshire Council are continuing to work on developing strong relationships with all strategic partners. In addition to internal development within the council to align the vision, corporate plan, and service plans.

The new council has remained committed to continuing to support an integrated wider health and care approach. Both North and West Northamptonshire Councils sit within a single County ICS covering Northamptonshire and significant collaboration has been required to maintain existing arrangements and bring them forward in developing new BCF plans for both areas, with oversight being held by the two existing Health and Wellbeing Boards.

Our ICS County wide and Integrated Care Partnerships (ICPs) arrangements have been agreed. The ICP will play a crucial role in influencing the North Northants Health and Wellbeing Board strategy (See **Appendix B**), but the statutory responsibilities of the Health and Wellbeing Board will also influence the Integrated Care System strategy development ensuring that where appropriate the nuances that set North Northamptonshire apart from West Northamptonshire are considered and integrated into the ICS strategy.

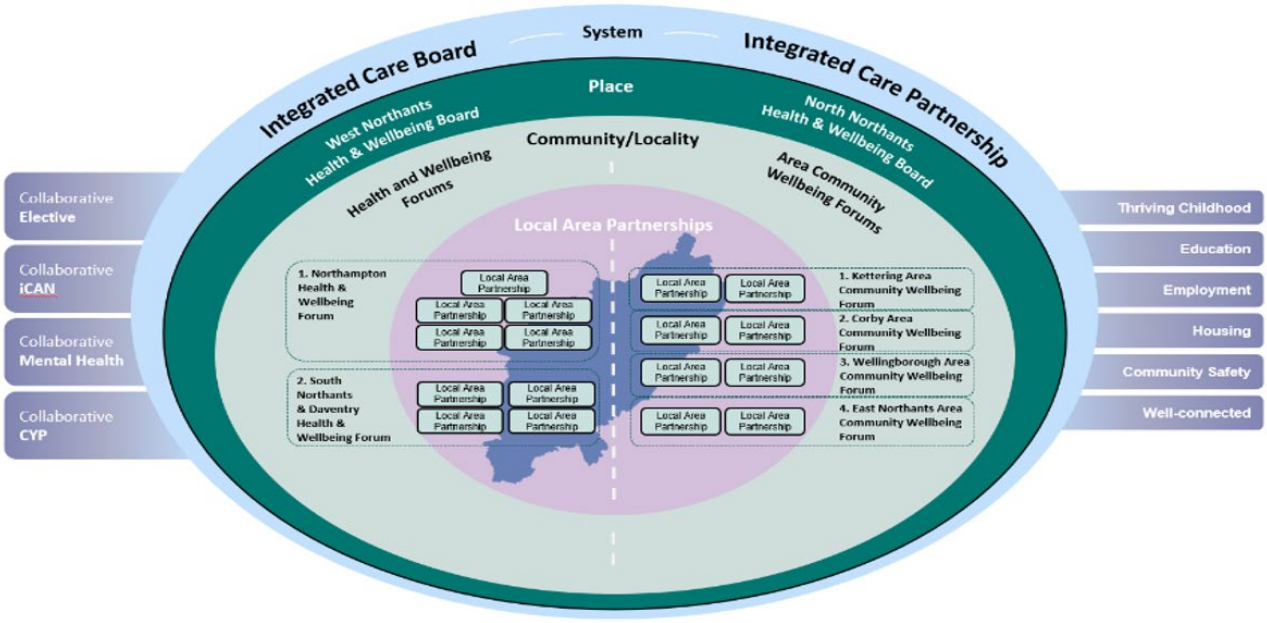
The BCF plan plays a fundamental part in delivering our ICS ambitions which sets out that:

We want children, young people and adults to have every opportunity to live their best life. Living your best life, for us means people have equity of opportunity to be the best version of themselves. To be the best version of themselves we recognise that people need:

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

To support our people with these 10 domains means that we have to collaborate; not just with our partners and local business but also with local people to ensure we understand the uniqueness of each of our Local Area Partnerships and the people who live in them. Understanding this uniqueness enables us to ensure the right support, environment and interventions are in place to support people to live their best life

Northamptonshire
Integrated Care System (ICS) Operating Model



3. Executive summary

Our 2022-23 BCF plan reflects some significant changes in our system since the last plan was submitted. The CCG moved into shadow ICB form and has now been constituted since the 01 July 2022. We have the one Hospital Group Trust sitting across our two acutes in Northamptonshire. This forms part of the overarching Integrated Care System (ICS) operating model, with collaborative development and place development integral to this. An Integrated Care Partnership across Northamptonshire has also been established and will be responsible for developing the five-to-ten-year strategy focussed on improving the health and care of the population, supported by population health management approaches.

Our North Northants Placed based Strategy will continue to be shaped over 2022-23 to ensure local services are targeted at local need and health inequalities (using a North Northants JSNA, Council intelligence and population health data) and delivered within local North Northants communities. In the meantime, our North Northamptonshire Health and Wellbeing Board have supported the schemes set out in this plan which will lay the foundation for the future strategy.

Our main objective in 2022-23 is to build on the transformation work done in 2021-22 and progress our integrated out of hospital delivery Model, described later in this plan. This will mean bringing together health and care and voluntary services, resources, assets and BCF and other funding sources into a single collaborative working within a single integrated delivery structure. In 2022-23 we continue to work towards this design through our ICAN programme whose 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 by:

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

Targeting key improvement and transformation, as well as formalising collaborative arrangements with delegated commissioning responsibility and single outcomes contract for delivery, with delegation coming from the ICB and HWBB to deliver:

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

4. Background to North Northants

Our North Northants Placed based Strategy will continue to be shaped over 2022-23 to ensure local services are targeted at local need and health inequalities (using a North Northants JSNA, Council intelligence and population health data) and delivered within local North Northants communities. In the meantime, our North Northamptonshire Health and Wellbeing Board have supported the schemes set out in this plan which will lay the foundation for the future strategy.

North Northamptonshire residents have a strong association with the previous sovereign council geographical areas, and we see differing demographics and challenges across those areas. ONS (2021) found that in North Northamptonshire, the population size has increased by 13.5%, from around 316,900 in 2011 to 359,500 in 2021. This is higher than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800.

There are three main urban conurbations of Corby, Kettering, and Wellingborough but also several smaller market towns. The demographics across the three main conurbations still show very different challenges and very different demographics. Similarly, within the rural areas there are differences in demographics that again will mean different rural communities with both market towns and smaller villages that will require local approaches. Applying a place-based lens and focus to integration of health, care and other services that impact on wellbeing and wider determinants is vital if we are to reduce inequalities in care and health.

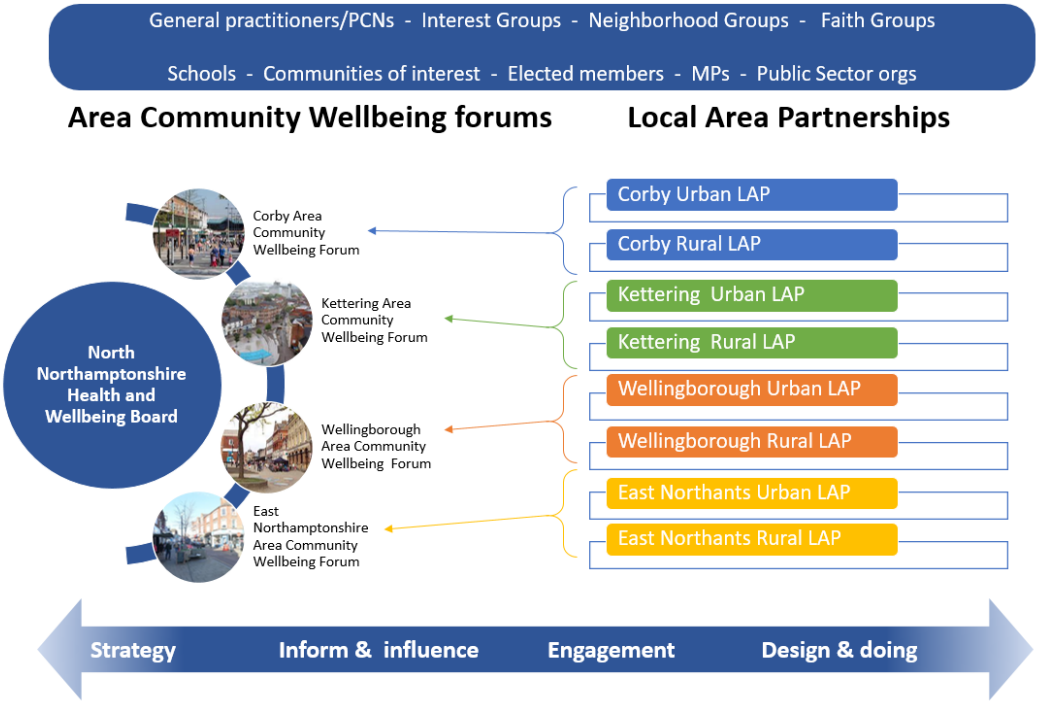
During 2021-22, and ahead of ICSs formally commencing in July 2022, we had been working with our system partners to define and agree how we will be organised for the delivery services at County, Place, and local partnerships (LAPS) in Northamptonshire.

The North Northamptonshire landscape is progressing with place development of its communities at the heart of this. The intention is to develop and link more focused local area partnerships (LAPS) for 30 to 50000 population sizes as part of the wider ICSP emerging operating model. There will be eight LAPs mirroring the electoral ward geographical footprints across Corby, Wellingborough, Kettering and East Northants. Two in each and their function will be a delivery and engagement one with the public and workforce, bringing in the wider determinants of health and prevention approach.

On the basis that local area partnerships (LAPS) arrangements and boundaries will be used for tailoring services and preventative measures to local needs and delivering them and will therefore align closely to the BCF plan.

Whilst both North and West Northamptonshire will be submitting separate BCF plans there will be many similarities as the plans are based on those developed collaboratively around our Integrated Care Across Northamptonshire (ICAN) programme and many of the interventions are happening at an ICS/county footprint. There is a live proposition currently moving through the ICB and unitary council governance, placing a case for change forward on how to transition the ICAN transformation programme into a formal ICAN collaborative.

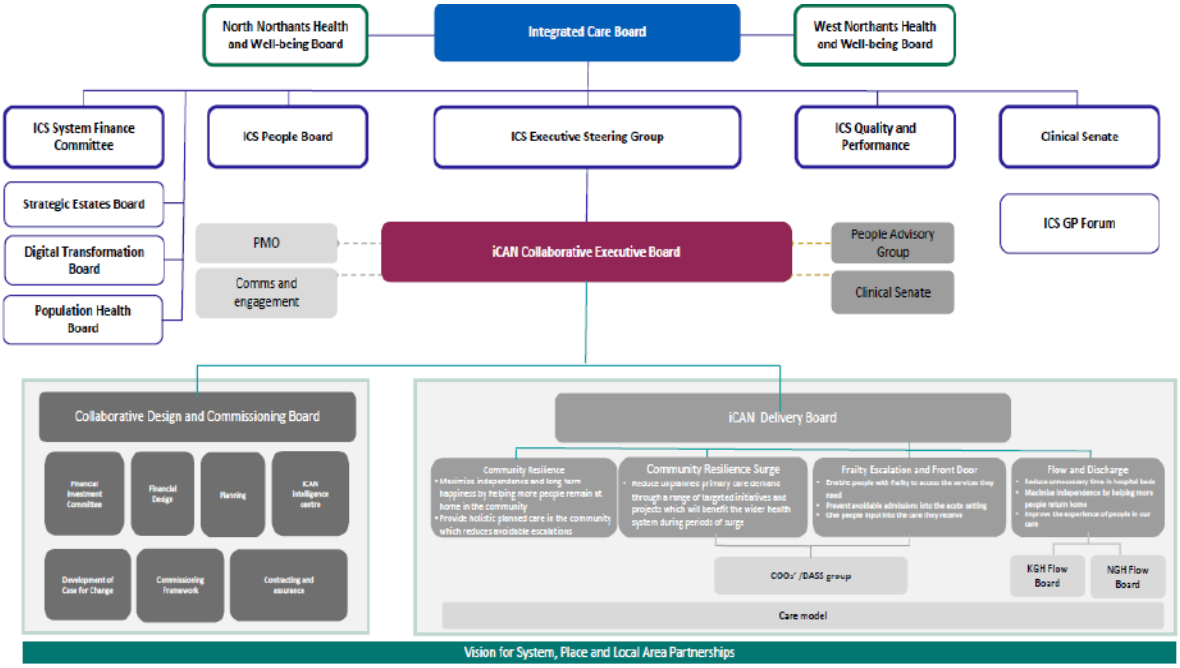
The intention is to then to delegate more commissioning responsibility from the ICB and councils into the ICAN collaborative to support the defined scope of the services being developed together as part of the transformation work underway. The case for change on the table currently includes potential elements of the BCF, the scope of which has yet to be worked through.



5. Governance

To deliver our ambitions, we have put in place the governance structure below that helps us oversee the ICAN performance metrics and deliverables, while also helping us transition ICAN from a transformation programme to an integrated service delivery model within a collaborative.

This governance forms part of the ICB governance structures and ensure that the BCF performance is monitored via the ICS planning and resources committee (for BCF finances) and through the delivery and performance committee (in terms of service delivery for BCF metrics).


North Northants Health and Well-being Board
Integrated Care Board
West Northants Health and Well-being Board
ICS System Finance Committee
ICS People Board
ICS Executive Steering Group
ICS Quality and Performance
Clinical Senate
Strategic Estates Board
Digital Transformation Board
Population Health Board
PMO
Comms and engagement
iCAN Collaborative Executive Board
People Advisory Group
Clinical Senate
ICS GP Forum
Collaborative Design and Commissioning Board
Financial Investment Committee
Financial Design
Planning
ICAN Intelligence centre
Development of Case for Change
Commissioning Framework
Contracting and assurance
iCAN Delivery Board
Community Resilience
Maximise independence and long term happiness by helping more people remain at home in the community
Provide holistic planned care in the community which reduces avoidable escalations
Community Resilience Surge
Reduce unplanned primary care demand through a range of targeted initiatives and projects which will benefit the wider health system during periods of surge
Frailty Escalation and Front Door
Enable people with frailty to access the services they need
Prevent avoidable admissions into the acute setting
Give people input into the care they receive
Flow and Discharge
Reduce unnecessary time in hospital beds
Maximise independence by helping more people return home
Improve the experience of people in our care
COOs' /DASS group
KGH Flow Board
NGH Flow Board
Care model
Vision for System, Place and Local Area Partnerships

6. Overall BCF plan and approach to integration

6.1 Joint priorities for 2022-23

Our system agreed four core priority areas where we know we are falling short in these outcomes, for all these emerging collaborative's cases for change are in development.

Mental Health, Learning Disability, 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 several years to really make a difference delivering better care for our communities.

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.

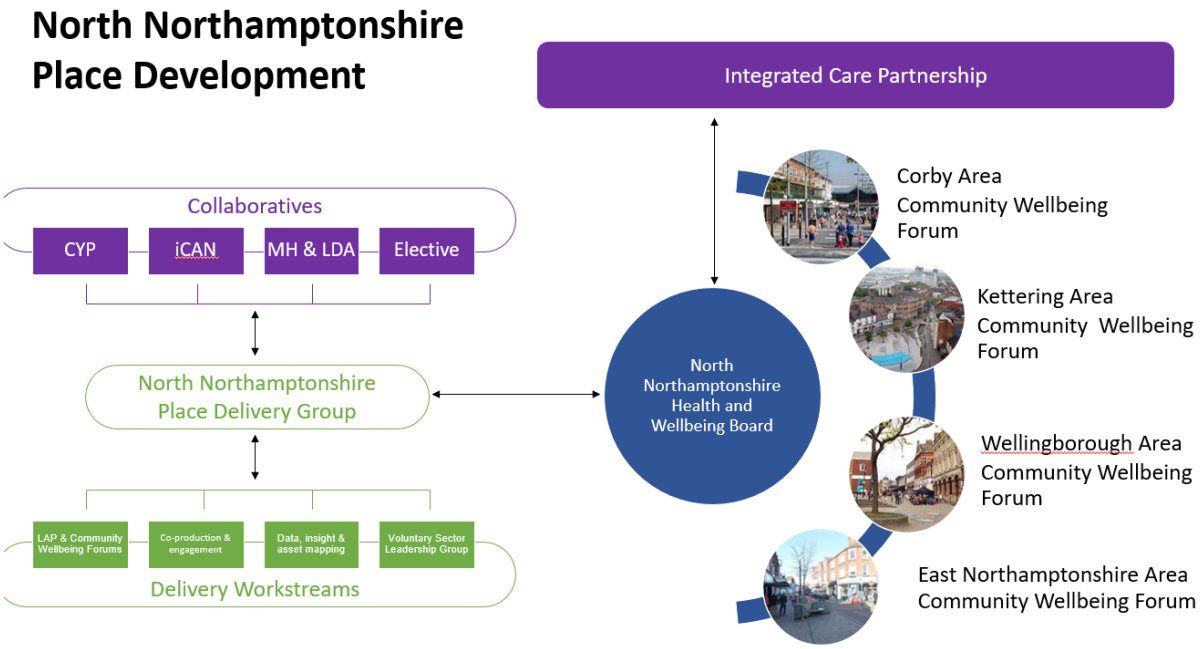
Collectively, the CYPTP pillars provide the infrastructure for a strategic plan to identify needs and deliver joined-up, proactive and personalised services which provide high quality care for children, young people, and families at all levels of our ICS.

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

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



ICAN is a system transformation programme and most of this year's BCF plan is now linked to ICAN services and schemes. We envisage the services within our ICAN and the BCF will form the basis of a future collaborative and integrated service delivery.

While ICAN is a five-year programme to deliver our shared vision for the frail and elderly. Our BCF includes significant additional funding for ICAN to transform frail and elderly care. This cohort of residents drives significant demand in North Northamptonshire where our population is forecast to grow 20.5% by 2041 but by 24.26% in the over 65s across the county, with a forecasted 25.58% increase in the 65+ age group predicted by 2029 in North Northamptonshire. Over 65s also account for 90 admissions a day, driving further focus on this cohort across the BCF, IBCF and transformation.

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

We have targeted several key and specific improvements in the over 65s cohort as part of ICAN BCF schemes and these are:

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

- **Community Resilience** - We are continuing to expand our work within the community with community MDTs. These combine community health, social care, the

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

- **Remote Monitoring** – One of our iCAN BCF objectives is to help older people stay well in the community. Remote monitoring will enable earlier identification of changes in presentation which could indicate an emerging issue.

  We have increased the level of remote monitoring instances both through the Virtual Ward programme for respiratory illness but also in peoples own homes. We have put in place the first large scale joint remote monitoring hub with combined council and nursing staff using an array of equipment to keep people safe. This project has introduced equipment to do the monitoring of patients' clinical observations and well-being, remotely by a team of senior clinicians; they then monitor and respond to the data that the equipment is feeding back.

  The Virtual Clinical Care Team is operating from 8am to 8pm daily and has the ability to respond within two hours to any significant abnormal data the system receives given clinical advice and guidance to manage the situation within the community.

- **Emergency Community Response** – Our new Rapid Response pathways seek to increase the number of people using Rapid Response rather than attending hospital. As well as the success we have had in the community (with an average of 35 referrals a day and 80% of calls needing a 2-hour response meeting targets), we are also now taking calls from the EMAS stack directly and from 111 more recently.

  At maximum throughput, this trajectory expects 6 additional EMAS referrals per day and 2 additional 111 referrals per day. One example of our successes is that 90% of long-wait fallers have already been supported to stay at home and the new pathway has saved an estimated 8.5 days of time where people would have been waiting on the floor.

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

- **Frailty Units and Same Day Emergency Care** - our aim is to create a high performing and specialised team at the front door of our hospitals to support frail people to go home rather than be admitted into hospital.

  Both Hospitals now have frailty units in place with skilled teams who seek to screen, assess, and then discharge (with support if needed) and reduce the need to admit

unnecessarily. It aims to discharge home 78% of patients referred. Despite a slow start with COVID the scheme is now meeting its target for referrals.

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

- **Board Rounds & Timely discharges -** Adopting new processes such as board rounds based on discharge best practice to enable a smooth and speedy flow through the hospital for our patients. The work here includes the development of an integrated Discharge Hub, improved early discharge expectations and a sustained focus on home first pathways.

- **Improved timeliness of diagnostics and use of community IV solutions –** Past assessments have shown we over-use some diagnostic tests. Delays occur when people wait for tests and during that time they decondition.

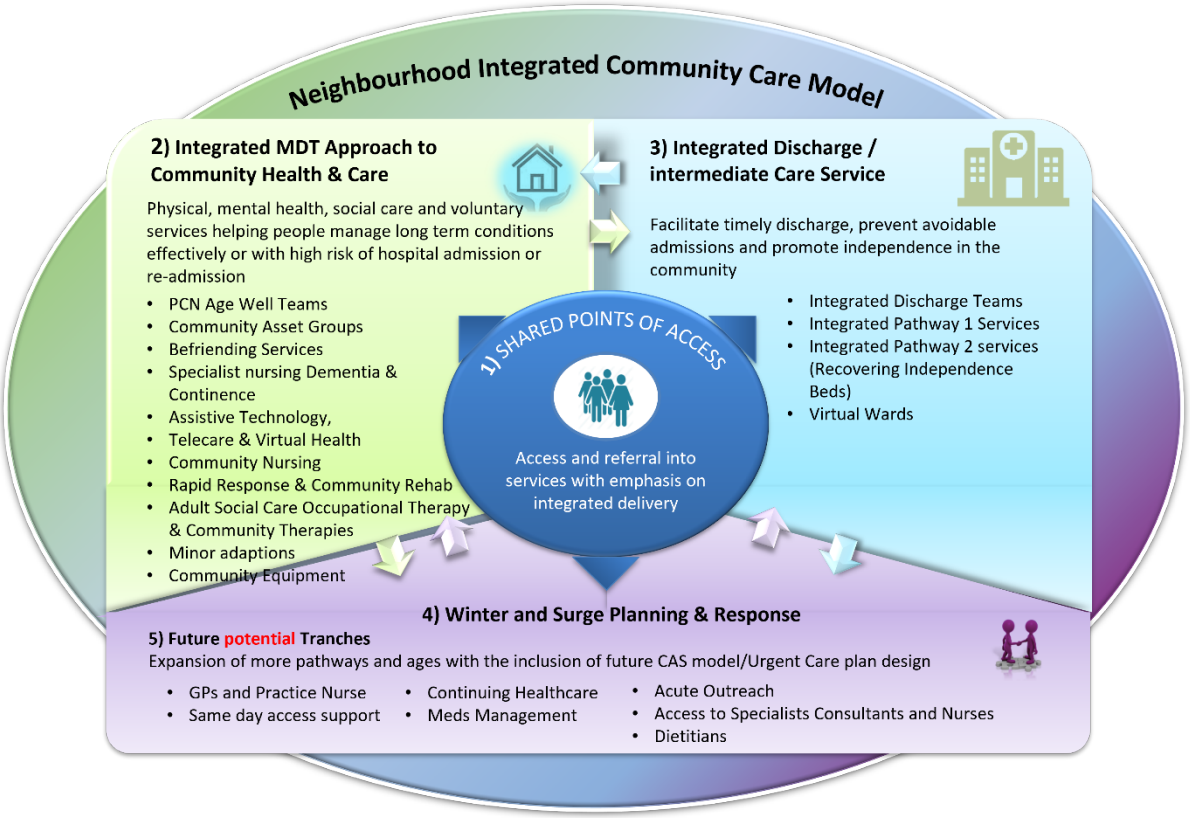
  We are now maximising the utilisation of all diagnostic systems and are now sending more people home with oral antibiotics or community IV rather than relying, as we have in the past, on hospital based IV solutions.

- **Trusted Assessments -** New forms are now being used in all wards replacing our PDNA forms that were over prescriptive and did not always represent the patient causing issues with Trusted assessments – the new 'What Matters to Me' focus creates a strength based, home first focus on all patients so they don't stay in hospitals when they no longer need acute care.

6.2 Approaches to joint/collaborative commissioning

Our BCF plan has been agreed in principle by the ICB and North Northants Council but its content and scope, including all the DTA schemes, the ICAN collaborative and the additional investment made by partners, has also been agreed by the Integrated Care Board, Northamptonshire Group Hospitals (Acute Hospitals), Community Health Trust and North Northants Council, as well as the Directors of Finance for the System. The ICAN collaborative will deliver an outcomes-based contract through the BCF.

Our BCF plans are set to deliver a new model of integrated care, keeping more people well at home, supporting earlier discharge and return home and keeping people well in the community and move away from acute based care. This is better for people, better for our finances & sustainable.



The operating model will build on our ICAN work including all the services from ICAN and the BCF detailed in sections 1 to 4 in the diagram to:

- Create formal structures and shared ownership of pathways,
- Develop more trusted assessor approaches with shared referral points in hospitals and from the community,
- Operate integrated Pathway 1 and Pathway 2 models with shared SLAs, less hand-offs and shared outcomes,
- Increase avoided escalations to hospitals with step up services to be developed working with GPs,
- Develop a flexible shared workforces that can respond to surges/Winter using data to inform joint interventions,
- Expand ICAN pilots and integrate more prevention and wellbeing services that can help avoid escalation for e.g. falls, supporting independence,
- Work within the Neighbourhoods and interact with the emerging Local Area Partnerships and wider services that effect wider determinants of health.

6.3 BCF support to integration and changes to services through the BCF from 2022-23.

In 2022-23 we have maintained many of our previous schemes for delivering good quality integrated care with a strong focus on community and out of hospital care but supplemented

by significant additional schemes and funding for ICAN. This is designed to transform our elderly and frail pathways across organisations and embed best practice (like Discharge to Assess, HICT and Ageing Well principles) across the system in an integrated programme. The leadership for this programme is distributed across partners and settings with Senior Responsible Officers (SROs) and staff from social care, Acute hospitals, GP practice, community health and the voluntary sector coming together to create joined up care

See **Appendix A** for list of schemes and expenditure

Our BCF plan is comprehensive and wide reaching and contains both short term improvements in performance and longer changes to deliver joined up working and improved outcomes. It meets the require grant conditions as set out below:

Requirement	How it's being met
IBCF - Meeting adult social care needs	The IBCF funding includes funding towards additional home care market capacity to meet increased demand including increased hours of care and complexity coming from hospital discharges
IBCF - Reducing pressures on the NHS, including seasonal winter pressures	Our ICAN programme funded within the BCF is delivering several key winter schemes including: • New Board Round SOP - Prioritised & targeted support for wards most susceptible to winter pressures. • D2A process improvement - implementing best practice model & live data to drive effective process • MDTs in acute frailty hubs - Enabling effective decision making & reduce frailty admissions • Ensuring EMAS conveyances are aligned with the frailty processes / reduce avoidable acute attendances • Home monitoring/ equipment - left shift care into community • 2hr Integrated ICT / Rapid Response service • Supported by revised onward referral procedures (such as direct referral to reablement) • Frequent flyer care management to reduce unnecessary attendance and readmission
IBCF - supporting more people to be discharged from hospital when they are ready	We have maintained our reablement capacity and increased the packages of referrals in Social Care. Further private sector and voluntary sector commissioned services are also being commissioned including the Overnight sitting service, Hospital at Home, and the use of Welfare checks for recently discharged patients to ensure they are safe and recovering.

Requirement	How it's being met
IBCF - ensuring that the social care provider market is supported	Ongoing underlying care cost pressures (volume, complexity, and cost increases to meet needs) from sustained and increased demand, discharges, and long-term costs of care in Care Home Placements.
Health funding for care Act duties	The funding supports the care act safeguarding assurance teams and requirements for carers assessments for support.
Health funding for Carer specific support	The plan includes investment in Northamptonshire carers services
Health funding for Reablement	The plan includes investment in health and social care reablement and specialist dementia reablement services.

7 Implementing the BCF Policy Objectives (national condition four)

7.1 Enable people to stay well, safe, and independent at home for longer

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

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

The power of social inclusion and peer support, especially amongst those with shared lived experience (person and carer), is recognised in Northamptonshire. Using our 2017 award winning community asset programme for people with COPD (Breathing Space) we have extended this to provide asset groups for Heart Failure, Diabetes and Dementia.

These are all facilitated and run by our Voluntary Sector partners with specialist input and masterclasses provided on a rolling basis by a range of professional health, care and specialist advisors, e.g. Financial Advisors, Bereavement Counsellors etc.
Feedback from those attending, and the staff delivering, continues to be excellent reinforcing the oft heard view that small things make a massive difference to a person's wellbeing. "It's great to feel I am not alone and there are others just like me".

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

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

7.1.1 *Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care,*

Whilst the themes we hear through co-production are consistent around what good looks and feels like to age well, we know that the bespoke solutions are required to meet the diverse spread of the people we serve. Asset groups in town centre venues, well serviced by public and voluntary transport, are great

but do not provide a viable option for the many older persons living in our rural areas where pop-up or rotating session programmes work better. We also ensure a choice in mix of face to face and on-line group support.

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

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

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

For 2023/2024 a priority focus for us is through our partnerships with Alzheimer's Society and Dementia UK to develop our support offer for persons with cognitive impairment associated with age, recognising the lower volume of persons from minority communities seeking timely help.

Working with families to change our dialogue and our content where Dementia is not a recognised term or condition and helping to remove stigma will be essential as we know that early support can massively improve outcomes for many years, significantly reducing demand for long term care services.

7.1.2 Multidisciplinary teams at place or neighbourhood level.

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

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

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

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

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

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

Our 2023 /2024 priority is to extend the capacity of the team. At present there is limited resilience as there is no cover for leave or unplanned sickness. The volume of referrals is increasing and we need to further embed remote monitoring and assistive technology as core tools to aid independence and confidence of the person / carer.

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

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

We have also engaged in developing a strategic and joined up plan for DFG spending & housing as a solution.

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

In addition to the work outlined in section 7.1, We have made improvements in the ward referral and transfer of care hub processes to improve the speed of the discharge decision making processes. The majority of our delays in discharge queues for both bedded and home-based intermediate care are either then when patients are waiting for capacity to become available, or when a patient becomes not medically fit, but the referral process is kept open. As far as possible we try to avoid moving people to other bedded settings purely while they wait for the appropriate pathway to be available.

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

We have also invested in additional capacity for Pathway 1 in North Northants via a new short-term home care service. This service protects the flow through the reablement service for those with reablement potential by working with our more complex Pathway 1's, which predominantly have needs indicative of two carer visits, but with a dedicated reablement ethos and working closely with single handed care.

This has seen the length of stay in reablement service decrease, allowing more starts and supporting more people to be discharged home overall. As well as increased hospital flow and a reduction in delays.

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

This closely aligns to the work being undertaken in North Northamptonshire in relation to the 100-day discharge challenge and many of these themes are priorities under ICAN but funded via BCF.
This includes elements of our continued improvement around supported discharge, such as:

- Identifying the needs of complex discharge support early, via our multidisciplinary transfer of care hubs,
- The active dashboards that enable us to see live data, enabling us to work flexibly within surges of demand while maintaining positive outcomes for our people.

8 Supporting unpaid carers.

Northamptonshire Carers Service

Unpaid carers are the largest source of care and support within North Northamptonshire. They provide a vitally important contribution to the health and social care economy, and it is in everyone's interests that they are supported to help manage their individual and changing needs. In North Northamptonshire there is an estimate of 35,250 unpaid carers.

Evidence suggests that unpaid carers can be at greater risk of negative outcomes, such as limiting or giving up paid work, poorer physical and mental health, and social isolation. However, early intervention and prevention has been proved to have a positive impact on these outcomes.

Over 85% of carers in North Northamptonshire are either retired or not in paid work. The most common activities provided by unpaid carers are practical assistance such as dealing with paperwork, finances and benefits, emotional support, keeping them company and taking them out and in almost 92% of cases just keeping an eye on the person they care for. Over a third of unpaid carers in North Northamptonshire are giving more than 100 hours of care a week. 56% are giving more hours than could be considered a full-time job (35 hours or more). A quarter of all carers are over 65. More than half of North Northamptonshire's unpaid carers have been providing care for more than 5 years, almost a third have been doing so for 10 years or more.

Northamptonshire has a very successful history of multi-agency work to support unpaid carers in particular through the Carers Partnership. This consists of a range of partners including Age UK, Alzheimer's Society, Nene Valley Community Action, Family Support Link, Serve, NCC, NHS and Hospital representation, NHFT. A comprehensive carers JSNA chapter was developed two years ago, which helps to guide the commissioning activities for the future carer's services. As a system, Health and Care invest over £1m of our BCF funding annually in Northamptonshire carers as the main provider of Care Act Carers assessments, support and advice for carers, respite breaks for both adult and child carers and wider services to help support unpaid carers in their key role. We have commissioned services that seek to ensure carers are recognised and valued and that they can access the right support/advice/information at the right time, that they can enjoy a life outside their caring role and that carers own health and wellbeing is a priority.

NCA have been commissioned by the North Northamptonshire and West Northamptonshire Council to deliver carers' services and to engage with the wider Carer's agenda, delivering the statutory duties outlined towards Carers under the Care Act 2014. The specific requirements of the Council had been separated into two lots; Lot 1, which focusses on the delivery of statutory carers assessments and Lot 2, which focuses on creating community resilience.

9 Disabled Facilities Grant (DFG) and wider services

The DFG plans and approaches within the plan has been agreed by North Northants Council as a Housing Authority and takes advantage of the change to a single tier Council where Housing, DFGs, occupational therapy and social care come together to ensure that DFG funding is used effectively to help people stay I their own homes longer.

From a housing and accommodation perspective, as a unitary council housing function is part of the Executive Director for Adults, Communities and Wellbeing who is also responsible for adult social care and health integration. Our health, care and housing leads have worked together to increase the capacity we have across the county that can support independent living through several lenses**.**

Our occupational therapy teams are now working alongside the housing DFG teams as part of plans to invest in improving accommodation earlier, removing waiting lists and considering more significant conversions that can support complex care and be used by future residents. We have also engaged officers in supporting discharges at KGH where housing issues are a potential cause for delay.

Telecare and Telehealth – as well as a significant assistive technology presence across 5000 residents we are also now developing several pilots to monitor residents out of hospital, 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 elderly person but give confidence to homes to manage health with clinician's support and through and end of life care. Meeting the grant conditions

10 Equality and health inequalities

Our BCF plan encompassing both our ICAN and DTA improvements is ambitious and aims to address some long-term issues and inequalities in our health and care system. We are working in a more joined-up way by delivering the health and care services people need via collaborative working across organisations, deliver care and joins up services, staff and activities in a way that makes sense for North Northamptonshire residents and the wider county where collaborating at ICS level delivers shared benefits.

This is alongside, and as part of, our North Northants Placed based Strategy that will continue to be shaped over 2022-23 to ensure local services are targeted at local need and health inequalities (using a North Northants JSNA, Council intelligence and population health data) and delivered within local North Northants communities.

The Integrated Care Partnership (ICP) will set the system-wide strategic priorities using the Core 20 +5 approach to drive targeted action in health inequalities, 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.

Our full plan for how we will address Equality and health inequalities can be found in appendix C.

Under the ICAN transformation programme, and supported by the BCF, we will be able to ensure that residents can access health and wellbeing services to promote good health, while also preventing ill health.
ICAN is also to striving to make health and social care services accessible to all and targeted to those with the most need or at risk of poor outcomes.
As an example, the community resilience pillar, as part of ICAN, is leading the expansion of personalised approaches giving individuals more choice and control over the way their care is planned and delivered.

Further examples of how iCAN links to the Northamptonshire health inequalities plan, please see appendix C, page 10 of the action plan (page 38 overall).

See next sheet for Scheme Type (and Sub Type) descriptions

Appendix A

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: North Northamptonshire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,561,759	£2,561,759	£0
Minimum NHS Contribution	£25,229,273	£25,229,273	£0
iBCF	£11,523,432	£11,523,432	£0
Additional LA Contribution	£630,447	£630,447	£0
Additional NHS Contribution	£2,601,472	£2,601,472	£0
Total	**£42,546,383**	**£42,546,383**	**£0**

#REF!

#REF!

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 11 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,169,579	£16,031,624	£0
Adult Social Care services spend from the minimum ICB allocations	£6,253,131	£7,871,076	£0

>> Link to further guidance

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet Complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Carers Support Services (CCG Contract)	This Service provides Carers health support ensuring that they can continue to undertake a carers role - Northamptonshire carers commissioned	Carers Services	Respite services		Other	Northamptonshire Carers	CCG			Private Sector	Minimum NHS Contribution	£321,836	Existing
2	Carers Support Services NNC Contract	Council Contracted Service hosted by North Northants on behalf of both Councils - carers support commissioned through Northamptonshire carers - support, advice, assessments and breaks and respite	Carers Services	Other	Assessment & Advice services	Other	Northamptonshire Carers	LA			Private Sector	Minimum NHS Contribution	£436,080	Existing
3	Continuing Healthcare	LD Health care at home/CHC/domiciliary care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as anticipatory care		Continuing Care		CCG			Private Sector	Minimum NHS Contribution	£8,036,725	Existing
4	Hospital Discharge Programme	D2A programme of services and Interventions to reflect national polocy of not assessing ongoing need in hospital and enusring timely discharges take palce with the majority of patients supported through short term assessment and support within their own homes.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Social Care		LA			Local Authority	Additional NHS Contribution	£2,601,472	New
5	LD Service Delivery	LD service delivery- community based health support	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£3,420,462	Existing
6	Integrated Discharge Teams	Social Care Hospital assessment staff to support discharge/D2A processes, Flow and HICT work	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£591,919	Existing
7	Integrated Discharge Teams	Social Care Hospital assessment staff to support discharge/D2A processes, Flow and HICT work	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		Social Care		LA			Local Authority	iBCF	£572,632	Existing

8	Telecare and Assistive technology	Assistive technology and call lifelines designed to help keep people safe in their home through remote monitoring and crisis call alarm and response services to support indpendent safe living	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Local Authority	iBCF	£200,000	Existing
9	Intermediate Care Teams (ICT)	Intermediate Care Teams (ICT)	Reablement in a persons own home	Reablement to support discharge -step down (Discharge to Assess pathway 1)		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£4,252,601	Existing
10	Community Equipment (Health)	provision of universally available equipment and minor adaptions to support both health and social care needs and designed to help maintain people in their own homes	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Minimum NHS Contribution	£1,415,766	Existing
11	Community Equipment (Social Care)	provision of universally available equipment and minor adaptions to support both health and social care needs and designed to help maintain people in their own homes	Assistive Technologies and Equipment	Community based equipment		Social Care		LA			Private Sector	Additional LA Contribution	£630,447	Existing
12	Community Reablement Team	Reablement Team - managing hospital discharges home with support and short term reablement and community based reablement episodes for those recovering from hospital stay or crisis and needing support to return to independence	Reablement in a persons own home	Reablement service accepting community and discharge referrals		Social Care		LA			Local Authority	Minimum NHS Contribution	£4,691,441	Existing
13	Community Occupational Therapy	Community Occupational Therapy Teams - The occupational therapy team provide post hospital recovery support, rehabilitation, adaptions assessment. They also respond to community referrals from GPs and families for post falls support and/or DFG adaptation assessments	Reablement in a persons own home	Reablement service accepting community and discharge referrals		Social Care		LA			Local Authority	Minimum NHS Contribution	£858,146	Existing
14	Disabled Facilities Grants	The DFG provides funding through local councils to make adaptations to a person's home if they are disabled or need to make changes to accommodate changes required to ensure mobility or safety	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£2,561,759	Existing
15	Safeguarding (Assurance) Teams	quality and safeguarding team responsible for monitoring the quality of Care home providers, supporting providers who face embargo or quality issues to remain in operation and support for improvement schemes	Care Act Implementation Related Duties	Other	Provider Quality, Advice and improvement	Primary Care		LA			Local Authority	Minimum NHS Contribution	£346,706	Existing
17	Acute Psychiatric Liaison	Multi-disciplinary psychiatric liaison - service operating 24/7 at both acute Hospitals providing assessment, early intervention & diversion of patients to mainstream MH services - The acute Liaison service is designed to avoid admissions	Community Based Schemes	Integrated neighbourhood services		Community Health		LA			NHS Community Provider	Minimum NHS Contribution	£300,155	Existing
18	Commissioning & Intelligence Capacity	Provision of commissioning capacity and expertise to support accelerated market development, options and services in order to support future need. Also supports the NCC social care intelligence hub that supports evidence based commissioning	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£313,804	Existing
19	Demographic and care cost pressures	Demographic and care cost pressures	Residential Placements	Care home		Social Care		LA			Local Authority	iBCF	£7,043,715	Existing
20	Domiciliary Care	underlying pressure and provision for additional Dom care provision covering the increased hours of care and complexity coming from hospital discharges.	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess pathway 0)		Social Care		LA			Local Authority	iBCF	£3,707,085	Existing
21	Contingency	Unallocated	Other		Contingency	Other	Contingency	LA			CCG	Minimum NHS Contribution	£243,632	Existing

Appendix B

Northamptonshire
Health & Wellbeing Board

Supporting Northamptonshire to Flourish

Northamptonshire's Joint Health and Wellbeing Strategy 2016-2020

Table of Contents

Foreword

In Northamptonshire, we believe the improvements to the health and wellbeing of our residents are critically dependent on collaborative working, an ambitious view of the future and delivering good quality services to achieve outcomes.

This strategy, produced through working with all public sector agencies, voluntary sector, residents and significant input from our academic colleagues at the University of Northampton, is a testament to our ability to work together.

We rely heavily on evidence of what works, carefully prioritising available resources to ensure the most vulnerable in our communities are supported, that our children have the best start in life. We have a clear intention to shape Northamptonshire as an environment where our health and wellbeing ambitions are designed in at the outset.

We are conscious that preventing ill-health is a daunting task and have worked hard to bring all our efforts to bear on ensuring preventative actions are built into our plans. There is no health without mental health, and therefore we have prioritised action to improve mental wellbeing, tackle social isolation and ensure all of us, no matter what our physical ability, can participate fully in the county.

We believe that with the promotion of good health, helping people to help themselves and creating a healthy environment, when ill-health strike we would have adequate resources to provide the best possible care through our treatment services. We definitely want this care to be as close to home as possible and wherever possible at home.

This strategy, fully endorsed by the Health and Wellbeing Board and all partners, outlines how we aim to achieve these goals and outcomes for our residents. We urge you to read this in conjunction with all operating plans from statutory and voluntary sector organisations in the county, who are working tirelessly to improve the health and wellbeing of our residents.

Robin Brown

Councillor Robin Brown
Chair, Northamptonshire Health and Wellbeing Board

Endorsements

Organisation	Signature
Northamptonshire County Council	Jim Harker, Paul Blantern, Robin Brown, Heather Smith, Prof Akeem Ali, Dr Carolyn Kus, Alex Hopkins
Nene CCG	Dr Darin Seiger, John Wardell
Corby CCG	Dr Miten Ruparelia, Carole Dehghani
Northampton General Hospital	Paul Farenden, Dr Sonia Swart
Kettering General Hospital	Graham Foster, David Sissling
Local Medical Committee	Dr Jonathan Ireland
University of Northampton	Prof Nick Petford
Elected Member representative for districts and boroughs -	Cllr Chris Millar, Norman Stronach
Healthwatch	Prof Will Pope
NHS England Local Area Team	Trish Thompson
Northamptonshire Police	Simon Edens
Voluntary Impact Northamptonshire	Jane Carr
Northamptonshire Healthcare Foundation Trust	Paul Bertin, Angela Hillery
Cambridgeshire and Peterborough Clinical Commissioning Group	Dr Gary Howsam

Executive Summary

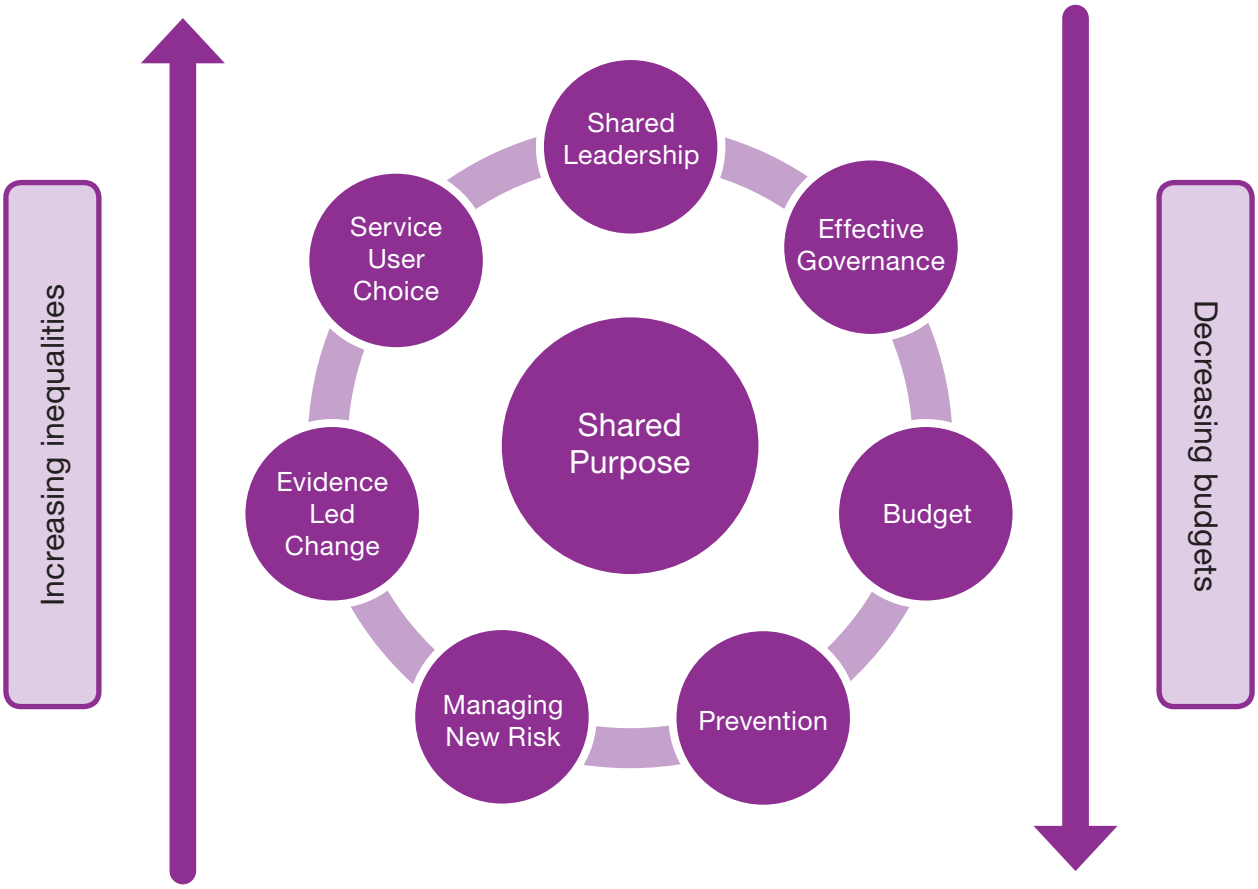
Vision

Improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves

- Working in partnership
- Reducing health inequalities
- Long-term impact

Priority	What will we do?
1. Every child gets the best start	• Healthy choices from pre-birth • Increase agency and build resilience • Support before a crisis • Hear Children and young people's voice
2. Taking responsibility and making informed choices	• Family health and wellbeing: focus on the causes of preventable disease • Parity of esteem: mental and physical health • Reduce obesity, increase physical activity • Connected and in control: Having the connections, information, skills, tools and support to make informed choices
3. Promoting independence and quality of life for older adults	• Person centred integrated collaborative care • Anticipate changing needs and facilitate access to services that sustain independence • Recognise and support carers • Integral to the community; care closer to home, home based and community provision, social isolation
4. Creating an environment for all people to flourish	• Embed prevention and wider determinants of ill health and wellbeing into strategies and policies • Community ownership of issues and solutions • Create environments that promote health and wellbeing

Approach to delivery



Why? So that if we get it right...

- More families receive assistance before they reach crisis
- More children are breastfed, and for longer
- More children achieve a higher level of development in the prime areas of learning
- Fewer children gain weight during primary education
- Fewer children and young people are admitted to hospital for unintentional and deliberate injuries
- Fewer young people self-harm
- Fewer young people misuse drugs and alcohol
- More children and young people have positive mental wellbeing

- More people maintain a healthy weight
- Fewer people smoke; fewer people are problematic or binge drinkers
- Fewer people misuse drugs
- More people feel in control of their lives and their health, reflected in their mental wellbeing
- Fewer people experience long term mental ill health
- Increase in healthier, stronger and more resilient families across generations

- Fewer avoidable hospitalisations
- Reductions in delayed transfers of care
- Fewer people re-admitted to hospital following discharge
- More people enabled to live in their own homes longer
- Carers' satisfaction with services increases
- More people are supported to participate in community life and community-based activities
- Fewer people experience social isolation and loneliness

- Outcomes in Northamptonshire's most deprived areas improve, reducing the social gradient of health
- Fewer people are living in poverty
- Fewer people are unemployed and fewer young people are not in education, employment or training (NEET's)
- Demand for social housing decreases
- More people feel safe in their community
- Domestic abuse rates decrease
- Community resilience increases

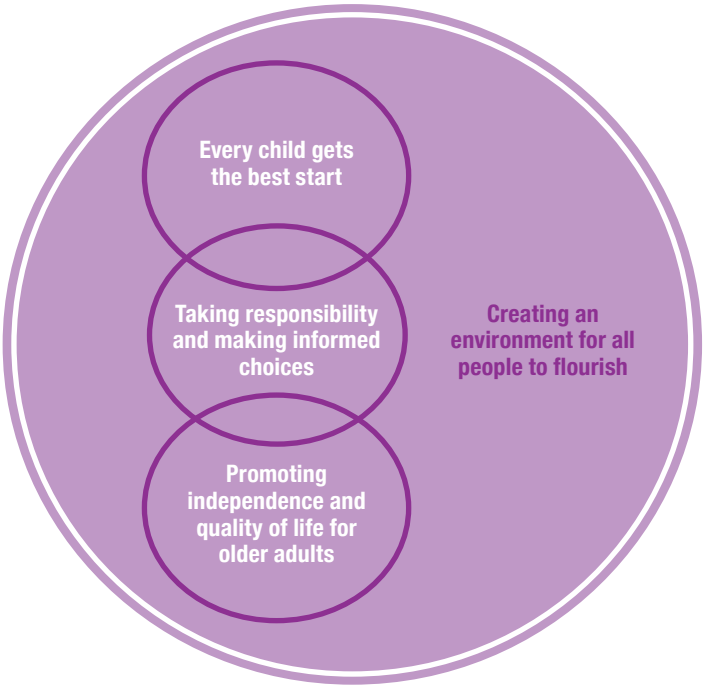
Introduction

We are delighted to launch *Supporting Northamptonshire to Flourish*, our Joint Health and Wellbeing Strategy for Northamptonshire 2016-2020. The strategy builds upon *In Everyone's Interest* 2013-2016 and outlines our intentions as a Health and Wellbeing Board moving forward. It has been developed by the Board in collaboration with local partners from around the county.

This strategy is based on the available evidence locally, nationally and internationally. We have taken into consideration local organisational health and wellbeing strategies, national priorities, the Joint Strategic Needs Assessment, and health and wellbeing trends in Northamptonshire. Three underpinning principles guided the selection of priorities for the strategy: those that can only be tackled by working together as a Board; those that will have a significant impact on health inequalities; and those that have a longer term impact, beyond the period of the strategy.

Four priorities have emerged:

1. **Giving every child the best start**
2. **Taking responsibility and making informed choices**
3. **Promoting independence and quality of life for older adults**
4. **Creating an environment for all people to flourish**



While we must deliver progress within each priority, it is important that we recognise the connections and interdependencies between them.

Prevention, early help and early intervention is fundamental to our strategy. If we fail to fully embed a prevention model into Northamptonshire, health inequalities will worsen and outcomes will be poorer for all[1]. By creating communities that are strong and resilient, empowering people to proactively keep themselves well, and achieving parity of esteem between mental and physical health, the burden on our health and social care system will be eased. This strategy makes explicit our commitment to include housing, infrastructure and planning, public safety and crime, education and employment as wider determinants of health and wellbeing. We recognise that unless people's fundamental needs are met they will not be able to undertake radical lifestyle changes to keep themselves well. Our ultimate goal is to help people help themselves where they are able to do so.

The Board recognises that there is a need to work more closely in partnership to develop sustainable economies that enable the best outcomes. We are launching this strategy at a time of economic constraint combined with rapid growth in Northamptonshire's population. Our aim is to lead the development of equitable collaboration in the county, creating a place-based system[2] of care for Northamptonshire to meet the needs of our population.

The successful delivery of the Health and Wellbeing Strategy for the county is critically dependent on the **integration of system level operational plans** championed by local organisations. The current Sustainability and Transformation Plan, whose footprint matches the Health and Wellbeing Board for Northamptonshire, will form the basis of frontline delivery of the strategy. However, this integrated approach will work only if all Board member organisations, and those within the overall system, commit to align their organisational priorities with this strategy and the Sustainability and Transformation Plan. Whilst accepting this will have implications for historical funding models, we are nonetheless committed to meeting the challenges this will pose in order to achieve the best possible outcomes for the people and communities of Northamptonshire.

[1] Five Year Forward View

[2] The Kings Fund (2015) Place-based systems of care: A way forward for the NHS in England.

Vision and Principles

This strategy provides the basis for improvements in the health and wellbeing of all people who live and work in Northamptonshire. We want to meet the aspirations of local people and organisations to have better-than-average health and wellbeing outcomes, while reducing inequalities. We want people to want to help themselves.

The Board recognises many different factors are at play in shaping how people access health and wellbeing services in their day to day lives. We are all individuals with different needs and wants. It is the quality of the interactions with healthcare services that matter, not the quantity.

Given this we all need to do more to address avoidable health and wellbeing inequalities. The Marmot Review (2010) tells us that inequalities in health arise because of inequalities in society – the environments in which people are born, grow, live, work, age and die. All people benefit by giving more people the life chances they deserve. Reducing inequalities will be at the heart of everything that we plan and do. To achieve this, our approach must be universal but proportionate to the level of disadvantage: where individuals, families and communities require more support to improve their health and wellbeing, they must be given it. We will continue to strengthen our safeguarding arrangements for the most vulnerable members of our society.

Our vision is simple:

> **"Improve the health and wellbeing of all people in Northamptonshire and reduce health inequalities by enabling people to help themselves"**

Strategic direction:

- We recognise targeted improvements in one area have positive knock-on effects for overall health and wellbeing, and the environments in which people live, work and play. We have thus taken into consideration wider determinants of health and wellbeing such as housing and transport in our strategic thinking.
- We recognise the need to plan long-term, taking into account trends and patterns within our demographic and health profiles. The cultural changes we wish to affect may take generations to achieve. Therefore we have ensured that our short-term goals (next 5 years) reflect the medium and long-term (5 to 25 year) ambitions and vision for the health and wellbeing of people and communities in Northamptonshire.
- We will shift our primary focus to prevention and early intervention to address the root causes and determinants of health and wellbeing whilst establishing sustainable and evidence-based outcomes.

A County in Change: 2012-2021

The JSNA Demography Profile (2014) provides a good overview of Northamptonshire's population. This section captures key messages from this resource. The impact of demographic trends within the population has been used to inform the desired outcomes in each of the four priorities.

Population Growth and Drivers

Northamptonshire has experienced significant population growth, well above national and regional growth trends. Our population is projected to increase by 100,000 people to over 800,000 in the next decade.

- Population growth has been highest in those aged 65 years and over, but the total number of older people in the county remains comparatively low compared to the national profile;
- We have experienced growth in, and have a comparatively large, child population (0-15 years);
- Growth in Black, Asian, and Mixed ethnicity groups has been high;
- Growth in new and emerging migrant communities.

Urban/Rural Disparity

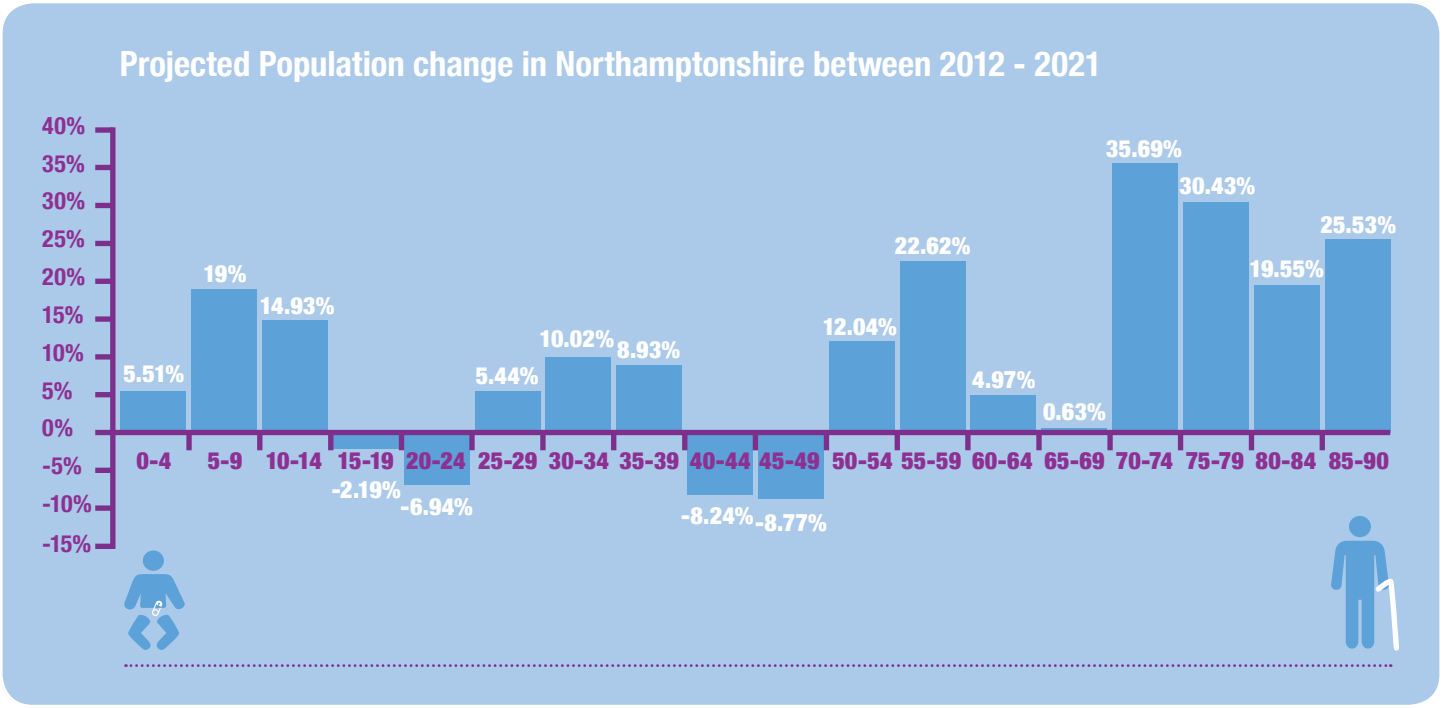
Northamptonshire has a mixture of urban and rural areas, creating disparities in terms of health and wellbeing outcomes, service provision and access.

- A third of the county's population live in rural areas;
- Rural areas tend to have better health and wellbeing outcomes with lower service requirements but limited access to support services;
- Urban areas have concentrations of poor health, wellbeing and deprivation, but have better access to support services.

Deprivation

Socio-economic deprivation is an important health and wellbeing determinant. There are notable differences in life expectancy between the most and least deprived areas in Northamptonshire and nationally.

- Deprivation is mainly concentrated in urban areas of the county;
- 15% of Lower Super Output Areas fall in the top 20% most deprived in England;
- Health deprivation has a higher occurrence than overall deprivation, concentrated in Corby, Northampton and to a lesser extent Kettering.



Priority 1:

Every Child gets the Best Start

Giving every child the best start in life is fundamental to the philosophy and approach of **Supporting Northamptonshire to Flourish**. This strategy is based on the principles of prevention, early intervention and early diagnosis, which begins pre-conception. The Marmot Review[3] (2010) tells us that "what happens during these early years (starting in the womb) has lifelong effects on health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status". Evidence to date shows the health and wellbeing of Northamptonshire's children must be improved if we are to achieve long-term, sustainable improvements in health and wellbeing overall.

Where we are now?

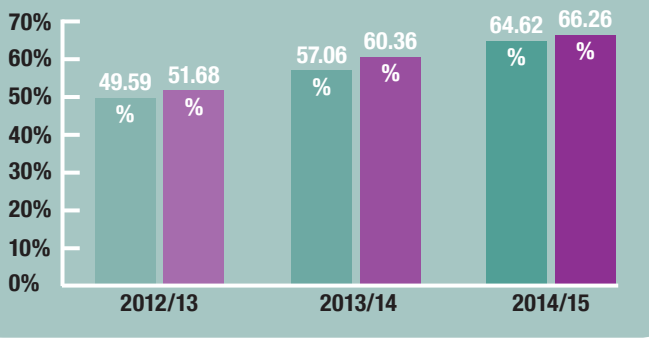
- We have a comparatively large population of 0-15 year olds, which is set to increase by approximately 15%[4];
- There is a strong commitment to improving the health and wellbeing of children and young people, but we could be better enabled to work more efficiently and effectively across organisational boundaries;
- Not enough children achieve a good level of development at the end of their reception school year (aged 5) in terms of the prime areas of learning (personal, social and emotional development)[5];
- Children in Northamptonshire gain excess weight during primary education[6], however more children in the county are at a healthy weight compared to the national average.
- Too many young people have poor mental wellbeing, resulting in high rates of self-harm, hospital admissions for injuries and substance misuse[7];
- Too many young people are not reaching their educational potential[8], which limits their future options.

We have a comparatively large population of 0-15 year olds, which is set to increase by approximately 15%[4]

0-15 year olds

School Readiness:

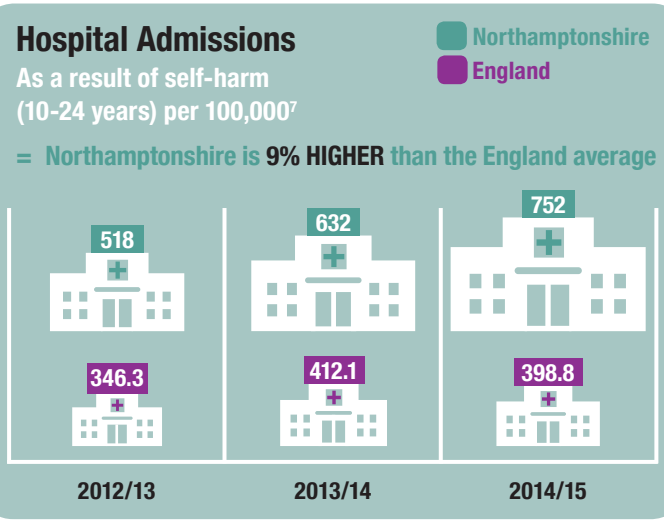
The percentage of children achieving a good level of development at the end of reception[5]



Hospital Admissions

As a result of self-harm (10-24 years) per 100,000[7]

= Northamptonshire is **9% HIGHER** than the England average



[3] The Marmot Review (2010) Fair Society, Healthy Lives.

[4] Northamptonshire Joint Strategic Needs Assessment, Demography Profile (2014)

[5] Public Health Outcomes Framework (2013/14)

[6] Public Health Outcomes Framework (2013/14)

[7] Public Health England (2012-2015)

[8] Department of Education (2016)

As a Board, our approach will be to focus on supporting all children and young people, regardless of the complexity of their needs, to build resilience and positive mental wellbeing. This means they are better prepared to negotiate key transitions in their life course and are better able to mitigate any impact of Adverse Childhood Experiences[9]. We will adopt a family-based approach and recognise the importance of creating environments with parents, schools and communities that nurture children's and young people's development to prevent Adverse Childhood Experiences, such as violence in the home, parental mental ill health or abuse. We will support children and young people's ability to make their own decisions and strengthen their skills and capabilities, providing them with greater capacity to make better choices, and resist and cope with life's challenges.

Where do we want to be?

- Everyone will recognise their role in our collective responsibility to improve children and young people's health and wellbeing, including parents, families, friends and schools;
- Our communities will raise children to become healthy adults, who themselves raise healthy families and are net contributors to a healthy society;
- Children's agency and resilience will be strengthened from birth, ensuring they have the capacity to negotiate key transitions (both planned and unplanned) positively;
- Young people want to make healthy choices and will seek support for their needs before they reach crisis;
- Our children and young people will have a voice in the decisions that affect them, supporting them to be involved in the identification of problems and creation of positive solutions;
- We use the assets available to us, breaking down organisational boundaries by delivering together;
- The services and support systems available to children and young people will be consistent and stable.

How will we get there?

- Prevention, early intervention and early diagnosis will begin from conception, with holistic support throughout the 1001 Critical Days;
- Adopt a family-based approach, developing the skills, knowledge and expertise in families and communities to better support children and young people's development;
- Create nurturing environments that promote and educate the importance of healthy lifestyles from birth and throughout childhood so they are sustained into adult life, reducing the likelihood of obesity, alcohol and smoking-related diseases;
- Focus on lifelong resilience, providing the skills and tools to resist and cope with life's challenges to reduce the likelihood of mental ill health;
- Ensure children and young people have a voice and are listened to, especially in child protection work;
- Work with children and young people, valuing and incorporating their perspectives into service delivery and community development;
- Strengthen connections and information sharing between services and support provided at different points across the life course.

[9] Adverse Childhood Experiences Study; Centres for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic.

What outcomes do we want to achieve?

If we are getting it right, we would see the following outcomes for children and young people:

- More families receive assistance before they reach crisis;
- More children are breastfed, and for longer;
- More children achieve a higher level of development in the prime areas of learning;
- Fewer children gain excess weight during primary education;
- Fewer children and young people are admitted to hospital for unintentional and deliberate injuries;
- Fewer young people self-harm;
- Fewer young people misuse drugs and alcohol;
- More children and young people have positive mental wellbeing.

Key Enabling Strategies in Northamptonshire:

Early Help Northamptonshire Strategy (2015-2020)
Emotional Health and Wellbeing Strategy for Young People
Child Sexual Exploitation Strategy
Breastfeeding Strategy
PE2020 Active Healthy Minds
Northamptonshire Interpersonal Violence Strategy
Race to the Top

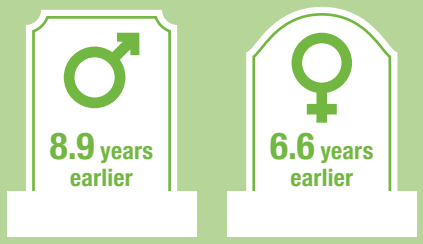
Key National Strategies:

Fair Society, Healthy Lives (The Marmot Review)
The Munro Review of Child Protection (Department for Education)
Moving More, Living More (H M Government)
Obesity and Healthy Eating (Department of Health)
Children's Health (Department of Health, Department for Education)
Early Education and Childcare (Department for Education)
Child Poverty Strategy (Department for Education
The 1001 Critical Days (Cross-Party Manifesto)
Start4Life (Department of Health)
The Future of Child Health Services: New Models of Care (Nuffield Trust)
Closing the Gap with the new primary national curriculum (Carmel Education Trust)

Priority 2:

Taking Responsibility and Making Informed Choices

Supporting adults to take responsibility and make informed choices in their everyday lives is a priority for Northamptonshire. Healthy Lives, Healthy People[10] (2010) tells us that by changing adult behaviour it is possible to reduce premature death and illness including circulatory disease and cancer. Moreover, men and women living in the most deprived areas of Northamptonshire die on average 8.9 and 6.6 years earlier[11], respectively, than those in the least deprived areas and the gap is widening.



Men and women living in the most deprived areas of Northamptonshire die on average 8.9 and 6.6 years earlier[11], respectively, than those in the least deprived areas and the gap is widening.

Where are we now?

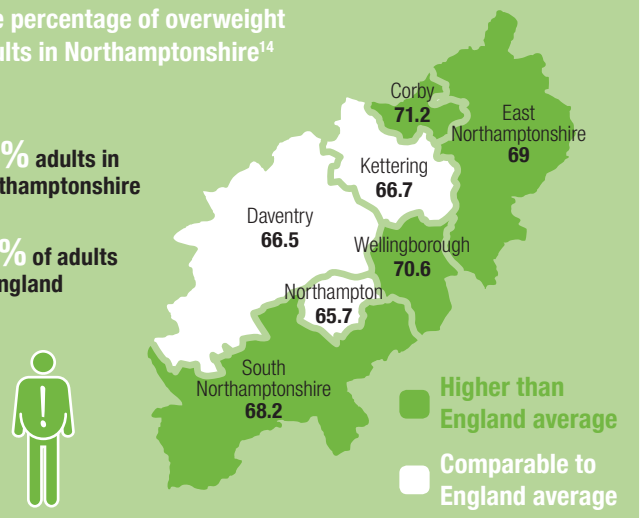
- At a county level we have comparable adult lifestyle outcomes to the national average[12], for example the prevalence of smoking, alcohol consumption, and dietary risks, however these are the leading causes of preventable diseases in Northamptonshire;
- At a local level there are concentrations of poor health and wellbeing outcomes, linked with inequalities[13]. For example, one in three people in Corby smoke compared to one in ten people in South Northamptonshire, and twice as many people in lower paid jobs smoke compared to people in higher paid jobs;
- Too many of our adults carry excess weight; 68% of the adults in Northamptonshire are overweight or obese, compared to the national average of 65%[14];
- Outcomes related to mental wellbeing are similar to the national average, and are improving[15]. However, there are some stark inequalities within this: people in poor health, who are unemployed or are within BME communities are more likely to experience poorer mental wellbeing[16];
- Prevalence of common mental health disorders and severe mental illness is expected to increase in Northamptonshire. This expectation is underpinned by an increase in people reporting long term mental health problems; mental health admissions, particularly emergency admissions, being amongst the highest in the Country; and, poor recovery and completion rates for IAPT[17];
- Lifestyle behaviours are extremely difficult to capture in data and reliable evidence takes too long to get into the hands of people and organisations that need it.

Obesity:

The percentage of overweight adults in Northamptonshire[14]

68% adults in Northamptonshire

65% of adults in England



As a Board, our approach will be to empower people with the information, skills, tools and support to address their own particular needs – however complex those needs are. We will create enabling environments where people can make informed choices that improve physical and mental health and wellbeing. We will create opportunities to participate in a range of community activities that create meaningful connections to others with shared interests.

[10] HM Government (2010) Healthy Lives, Healthy People.
[11] Public Health Outcomes Framework (2015)
[12] Public Health Outcomes Framework (2014)
[13] Public Health Outcomes Framework (2014)
[14] Public Health Outcomes Framework (2014)
[15] Public Health Outcomes Framework (2012-2014)
[16] Public Health Outcomes Framework (2014)
[17] Northamptonshire Mental Health Summary Profile: Common Mental Health Disorders and Serious Mental Illness (2016)

Where do we want to be?

- Families will engage with health and wellbeing promotion, support and intervention, enabling intergenerational transfer of positive lifestyle behaviours and skills;
- Lifestyle choices will be addressed holistically, recognising the connections between different public health indicators of lifestyle, for example smoking and alcohol;
- Our services and specialists will deliver integrated 'whole person' care, achieving a parity of esteem between mental and physical health;
- We will have the social and environmental conditions in which people want to make better and more informed choices, promoting enhanced quality of life for themselves and others as they age;
- People will feel connected to their communities and in control of their lives;
- Transformation of primary care will embed resources to help people to help themselves in the community;
- Our acute services will be required to respond to fewer people in crisis, enabling services to prevent and respond earlier to mental and/or physical ill health.

How will we get there?

- Focus both on individuals' behaviours and choices and the norms and cultures of communities;
- Work with people to understand the barriers to improving health and wellbeing and deliver support and information that is holistic, accessible and useable;
- Facilitate wider access to a range of resources including First for Wellbeing CIC, community pharmacies and digital/ technological innovation;
- Create the spaces, facilities and infrastructure to enable people to make healthier choices, for example improve access to leisure facilities, guide planners on how to help in creating healthy weight and food environments, and review the licensing of unhealthy establishments;
- Provide opportunities to enable people to create meaningful connections to others with shared interests, building their self-esteem, confidence and resilience;
- Work with communities, families and individuals and the technology sector to develop and implement technological innovations that support healthier lifestyles;
- Consider the longer and broader implications of service redesign, ensuring integration provides person-centred care that delivers better outcomes;
- Better and more timely information about trends and patterns of health and wellbeing.

What outcomes do we want to achieve?

If we are getting it right, we would see the following outcomes for adults:

- More people maintain a healthy weight;
- Fewer people smoke;
- Fewer people are problematic or binge drinkers;
- Fewer people misuse drugs;
- More people feel in control of their lives and their health, reflected in their mental wellbeing;
- Fewer people experience long term mental ill health;
- Increase in healthier, stronger and more resilient families across generations.

Key Enabling Strategies in Northamptonshire:
Sport and Active Recreation Strategy
Alcohol Harm Reduction Strategy
Substance Misuse Strategy
Corporate Parenting Strategy
Interpersonal Violence Strategy
Health Protection Strategy
Joint Carers Strategy
District and Borough Housing Strategies

Key National Strategies:
Healthy Lives, Healthy People (Department of Health)
No Health without Mental Health (Department of Health)
Living Well for Longer (Department of Health)
Changing Behaviours in Public Health: To nudge or to shove? (Local Government Association)
Transforming Care for People with Learning Disabilities (Transforming Care Delivery Board)

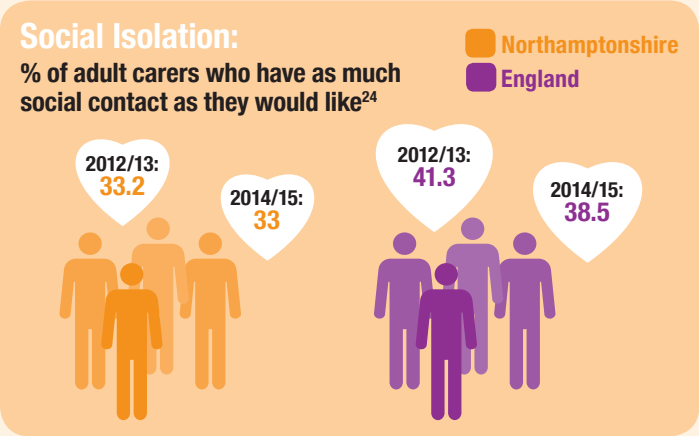
Priority 3:

Promoting Independence and Quality of Life for Older Adults

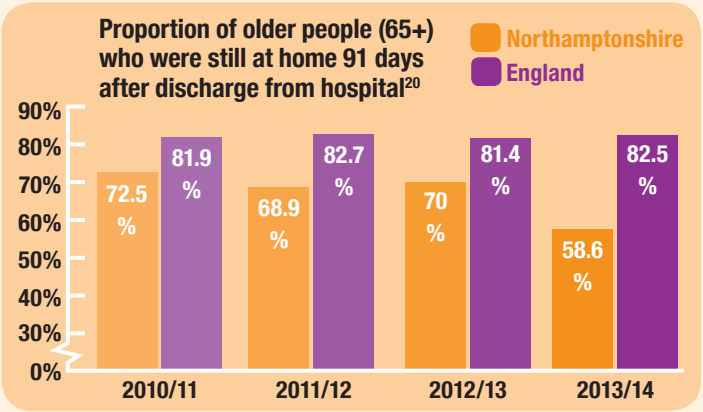
Our demographic profile shows population growth is highest in the over 70s, emphasising the importance of promoting independence and quality of life for adults as we age. The number of people in the 75-84 age group is expected to increase by 21% over the next 5 years[18]. According to The Kings Fund[19] (2012), the median age of patients admitted to hospital with hip fracture is 84, of whom one in three have dementia, one in three suffer delirium and one in three never return to their former residence. Evidence from Northamptonshire suggests that if our communities and integrated collaborative care systems are strengthened, the current pressure on our acute services would reduce.

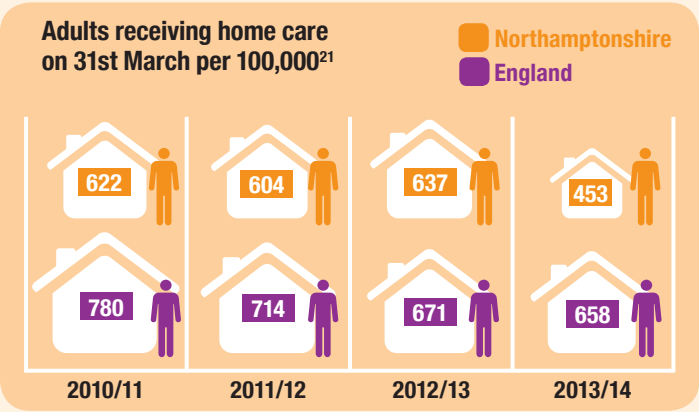
Where are we now?

- There is a commitment to delivering integrated collaborative care closer to home, working in partnership to improving outcomes for older people as part of the developing Out of Hospital Strategy element of the Sustainability and Transformation Plan;
- There has been much focus on Delayed Transfer of Care (DTOC) as part of a wider system change, though it is too early to assess the sustainability of actions;
- Too many people are re-admitted to hospital within 90 days of discharge[20], suggesting that community-based supportive systems do not achieve sustainable outcomes for people following hospitalisation;
- Home-based and community provision, including technological innovation, is low in the county[21];
- Too few people die in accordance with their wishes, with a very low proportion of people dying at home[22] ;
- Many carers do not have a good quality of life, are not involved in discussions about the person they provide care for, and experience low satisfaction with services[23];
- Social isolation and loneliness are critical issues that affect the quality of life (including mental wellbeing) for older people, as well as their carers[24].



As a Board, our approach will be to enable better access to those preventative services essential to sustaining independence, by ensuring greater integration of both physical and mental health, and provision of clinical and Adult Social Care services. We will work more closely and effectively with the voluntary sector, strengthening the roles that local communities play in terms of social and practical support. We recognise carers do not care only for older adults and will work to improve their quality of life by valuing and supporting them alongside those being cared for. Finally, we will focus on the experience of people who require health and social care services, removing the barriers people face to get support, making care as effective and efficient as possible.





[18] Northamptonshire Joint Strategic Needs Assessment, Demographic Profile (2104)

[19] The Kings Fund (2012) The care of frail older people with complex needs: Time for a revolution.

[20] Adult Social Care Profile, Public Health England (2013-2014)

[21] Adult Social Care Outcomes Framework (2006-2014)

[22] NHS Outcomes Framework (2012-2014)

[23] Adult Social Care Profile, Public Health England (2012-2013); Adult Social Care Outcomes Framework (2014)

[24] Public Health Outcomes Framework (2012-2013)

Where do we want to be?

- We will have achieved parity of esteem and an integrated health and social care centred around individual needs within the wider context of family and community;
- We will maintain and promote independence across all care settings with emphasis on the home;
- All health and social care organisations, including Care Homes, will have the ethos, capacity and facilities to meet the changing demand for services;
- Carers will be universally recognised, valued and empowered with information, advice and support;
- We will recognise and meet the needs of people who are not in the social care system, ensuring they are part of a supportive community that promotes their quality of life;
- Older people, including those with complex needs, will be recognised as valuable and integral members of our communities.

How will we get there?

- Continually promote parity of esteem between physical and mental health;
- Strengthen the delivery of all aspects of the Better Care Fund and in particular the Integrated Care Closer to Home work-stream;
- Better anticipate the diverse and changing needs of an ageing population, reflected in the development of the work force, housing stock and technical innovation;
- Reduce practice variation across health and social care;
- Provide adaptions and support to ensure people's homes are enabling environments to live a good quality of life;
- Ensure carers are actively involved in care decision making and provided with the support they require;
- Help communities to provide greater emotional, physical and social support to older people in their everyday interactions reducing barriers to accessing communities and services, including the development of dementia friendly communities;
- Reduce the impact of sensory loss (hearing, sight etc.) to facilitate meaningful and instrumental activities of daily living and participation in community life.

What outcomes do we want to achieve?

If we are getting it right, we would see the following outcomes for older adults:

- Fewer avoidable hospitalisations;
- Reductions in the Delayed Transfers of Care;
- Fewer people re-admitted to hospital following discharge;
- More people enabled to live in their own homes for longer;
- Carers' satisfaction with services increases;
- More people take part in community life and community-based activities;
- Fewer people experience social isolation and loneliness.

Key Enabling Strategies in Northamptonshire:

Falls Prevention Strategy
Adult Social Care Accommodation Strategy
Safeguarding Adults Board Strategy
Joint Carers Strategy
Dementia Strategy
Social Isolation Needs Assessment
"Standing Up For Ourselves" Reducing Falls & Promoting Bone Health – A Strategic Commissioning Framework for Northamptonshire (2015 – 2020)
District and Borough Housing Strategies

Key National Strategies:

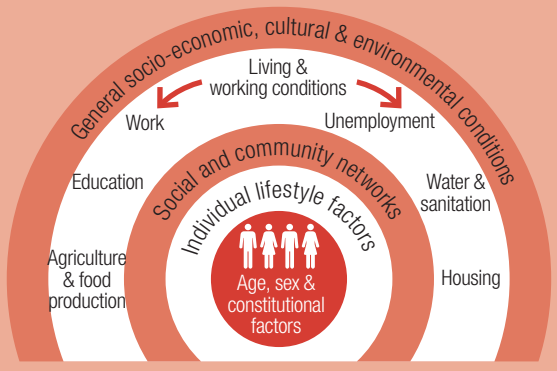
Five Year Forward View (NHS England)
National Dementia Strategy (Department of Health)
One Chance to Get it Right (Leadership Alliance for the Care of Dying People)
The Health Impacts of Cold Homes and Fuel Poverty (Friends of the Earth and the Marmot Review Team)
Housing for Older and Vulnerable People (H M Government)
Better Care Fund (NHS England)

Priority 4:

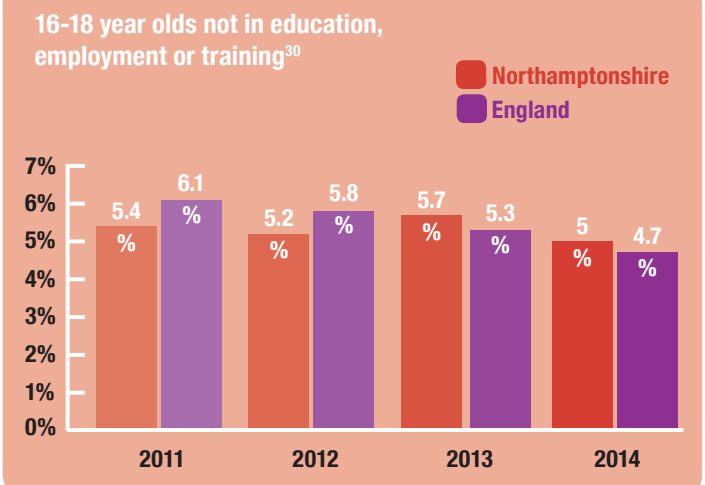
Creating an Environment for all People to Flourish

Creating environments for all people to flourish makes explicit our focus on the wider determinants of health and wellbeing. This holistic priority cuts across and underpins delivery of the other three.

Our outcomes show localised but significant inequalities exist in the county[25]. Health deprivation is predominantly focussed in Corby and Northampton, where 34% of Corby's population live in the most deprived areas of Northamptonshire[26]. While not a county-wide issue there are health implications of deprivation linked to smoking, alcohol consumption and diet, alongside the environmental impact of the quality of housing, urban development, and the public realm[27].



Source: King's Fund (http://www.kingsfund.org.uk/time-to-think-differently/trends/broader-determinants-health)



Where are we now?

- Synergies exist within the county's strategies to tackle wider determinants of health and wellbeing, but needs to be more joined up if the desired positive outcomes are to be achieved;
- There are some significant inequalities between and within localities and communities;
- All localities have an increasing proportion of people in work with long-term unemployment rates declining[28]. Average monthly salaries are mostly flat[29];
- Northamptonshire has a significantly higher proportion of young people who are not in education, employment or training (NEET) than the national average, and those in the most deprived areas are almost twice as likely to be NEET than those in the least deprived[30];
- Demand for social housing is greatest in East Northamptonshire and Corby, but Northampton requires the greatest increase in housing stock to meet demand[31];
- Northamptonshire has a significantly higher proportion of first time entrants to the youth justice system, with twice as many entrants in the most deprived areas as the least[32];

25 Northamptonshire Joint Strategic Assessment, Demography Profile (2014)

26 Indices of Multiple Deprivation (2015)

27 Northamptonshire Joint Strategic Assessment, Demography Profile (2014)

28 Northamptonshire Analysis (2015)

29 Office of National Statistics (2015)

30 Public Health Outcomes Framework (2014)

31 Office of National Statistics (2015)

32 Public Health Outcomes Framework (2014-2015)

- The rate of violent offences is higher than the national average, and has increased significantly in recent years[33];
- 38% of violent crime in Northamptonshire is domestic abuse[34];
- Overall, the proportion of children in poverty in Northamptonshire is below the national average; only Corby is significantly above the national average[35].

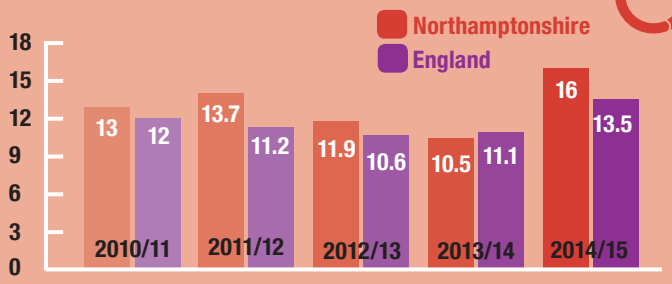
As a Board, we will champion the health and wellbeing agenda, seeking inclusion and consideration of the impact on health and wellbeing in all relevant strategies and policies, including housing, transport and education. Our focus will be to plan, create and manage environments that encourage and facilitate healthier and safer lifestyles, building upon community assets and ensuring the development of our county supports both new and existing communities. This will include public environments and Northamptonshire's assets (such as country parks, leisure spaces and green spaces), working with businesses to create healthier workplace environments and maximising the potential of a diverse and vibrant voluntary sector.

Where do we want to be?

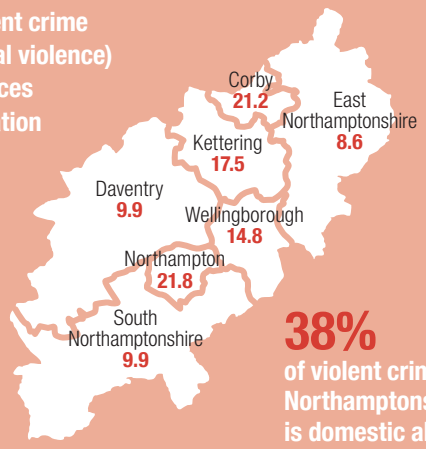
- We will be proactive in preventing and reducing ill health and poor wellbeing caused by wider determinants;
- We will better recognise the connections between the spaces in which people live and work and the choices they make in everyday life;
- Communities will have ownership of their issues and solutions, taking action to design, create and manage localities that encourage healthier lifestyles;
- People will live in safe communities and healthy homes, having meaningful employment and contribute to the county's economic prosperity;
- People will have access to leisure spaces, green and natural spaces, recreational facilities and community assets that promote health and wellbeing;
- Northamptonshire will have an integrated transport system, enabling greater access across the county.

Violent crime

The rate of violent crime (including sexual offences) per 1000 population[33]



The rate of violent crime (including sexual violence) - violence offences per 1000 population



38%
of violent crime in Northamptonshire is domestic abuse[34]

How will we get there?

- Encourage consideration of health and wellbeing in all relevant strategies and policies, taking into account the wider determinants of health and wellbeing;
- Create environments which support, promote and sustain healthier lifestyle choices, including healthier food environments and active travel options;
- Encourage employers to actively support the wellbeing of their workforce through the Healthier Workplace Initiative;
- Work with employers and education providers to ensure young people are best placed to obtain meaningful work;
- Housing Authorities, Northamptonshire Police and Northamptonshire Fire and Rescue Service will support residents to create healthy, warm and safe home environments with practical support, information and advice;
- Community Safety Partnerships will work to improve safety and eliminate cultures of violence;
- Improve access to Northamptonshire's open, green and natural environments, including our country parks;
- Provide and improve walking, cycling and public transport within an integrated transport infrastructure to support people to travel more easily.

[33] Public Health Outcomes Framework (2014-2015)
[34] Northamptonshire Police (2015)
[35] Public Health Outcomes Framework (2012)

What outcomes do we want to achieve?

If we are getting it right, we would see the following outcomes:

- Outcomes in Northamptonshire's most deprived areas improve, reducing the social gradient of health;
- Fewer people are living in poverty;
- Fewer people are unemployed and fewer young people are not in education, employment or training (NEETs);
- Demand for social housing decreases;
- More people feel safe in their community;
- Domestic abuse rates decrease;
- Community resilience increases.

Key Enabling Strategies in Northamptonshire:

Planning – Joint Core Strategies
Early Help and Prevention Strategy
Interpersonal Violence Strategy
Violence Strategy
Transportation Plan
Prevention Strategy
Police and Crime Plan
Strategic Economic Plan
Strategy for Learning
Race to the Top
Health and Wellbeing in the Environment Report: Natural Environmental Solutions for a Healthier Northamptonshire
District and Borough Housing Strategies

Key National Strategies:

Five Year Forward View (NHS England)
Healthy Lives, Healthy People (Department of Health)
Fair Society, Healthy Lives (The Marmot Review)
Caring for Our Future (H M Government)
The Munro Review of Child Protection (Department for Education)
Social Justice: Transforming Lives (Department for Work and Pensions)
Prevent Duty Guidance (H M Government)

Approach to Delivery

In order to deliver the aims of *Supporting Northamptonshire to Flourish* within the context of decreasing budgets and the need for greater integration and system-level thinking at all levels, the Board has agreed the following approach.

Shared Leadership

Board member organisations are committed to working in partnership to deliver a place-based system of care, using Northamptonshire as its agreed footprint, which shifts the focus from organisational health to population health in order to collectively improve the health and wellbeing of Northamptonshire citizens. The Board will act as a guiding coalition, offering partners the opportunity to go beyond collaboration by developing the shared decision making needed to deliver *Supporting Northamptonshire to Flourish*. This will require all organisations, and their regulators, to move in the same direction in a coordinated way. Healthier Northamptonshire, the Better Care Fund and the Northamptonshire Sustainability and Transformation Plan are critical guiding documents underpinning and helping operationalise the overarching Health and Wellbeing Strategy.

Effective Governance

The Board will reflect on its governance arrangements to ensure a balance between organisational autonomy and accountability with a commitment to partnership working and collective responsibility[36]. Utilising the lessons learnt from recent system-wide change initiatives, the Board will develop a structure that will allow both the monitoring of progress against the key objectives of the strategy and the Northamptonshire Sustainability and Transformation Plan, and the flexibility to deliver according to local need. This will require strong alignment and sustained commitment to quality improvement between the four priorities of *Supporting Northamptonshire to Flourish*, the seven Locality Forums, and the Northamptonshire Sustainability and Transformation Plan.

Budget

In order to deliver in a climate of economic constraint, the Board will focus on actively supporting a sustainable financing model for the system[37] across three levels:

1. The combined resources available to achieve the aims of the system
2. The way these resources flow down to providers
3. How resources will be allocated between providers and the way that costs, risks and rewards are shared.

To achieve this, we will think about the resources available in Northamptonshire as a whole. Delivering the system-wide Sustainability and Transformation plan gives us the opportunity to shift from a fortress mentality to system mentality[38], identifying the best places to invest resources in the short term to create the space to deliver differently over the longer term.

[36] Local Government Association (2014) Making an impact through good governance: A practical guide for health and wellbeing boards

[37] The Kings Fund (2015) Place-based systems of care: A way forward for the NHS in England.

[38] The Kings Fund (2015) Place-based systems of care: A way forward for the NHS in England.

Prevention, Early Diagnosis and Early Intervention

Prevention is not only the responsibility of Public Health; it is widely recognised by the Board member organisations that many of the county's health and wellbeing problems are avoidable and could be improved through prevention and early intervention. As such, all organisations within the health and care system are required to make prevention a focus, embedding it in their organisational processes at all levels. Leading and investing in this approach at a system-wide level will result in savings further down the care pathway that can be reinvested to tackle priority issues[39]. This will ensure the Board prioritises long-term goals while building momentum through short-term wins.

Managing New Risk

The Board recognises the importance of identifying and mitigating new and emergent risks to health and wellbeing in Northamptonshire. To achieve this, we must be proactive and flexible in our delivery. This will include planning for wider risks not exclusive to Northamptonshire, for example anti-microbial resistance and terrorist threat, and taking proportionate action to protect against and prevent ill-health.

Evidence Led Change

There is a commitment to evidence-based decision making at all levels. Evidence will be drawn from a wider range of relevant sources including the Outcomes Frameworks, the Joint Strategic Needs Assessment, published research, robust evaluation of new ways of working. Public feedback through for example Healthwatch and the Health and Wellbeing Fora provide additional evidence. The Board has a role in ensuring all relevant data are shared across organisational boundaries to ensure improved service delivery. *Supporting Northamptonshire to Flourish* is an evidence-based strategy which will lead the way in prioritising resources and taking action.

Service User Choice

Service users have more choice than ever before about where and how to access support. Recognising that people's needs are multiple and overlapping, involving the public in service design is an important part of the strategy. This will require greater collaboration across the health and social care system. First for Wellbeing CIC will play a key role in coordinating services across and between providers to meet this end.

In summary, by working together our aim is to create a better quality of life and improved outcomes for the people of Northamptonshire. *Supporting Northamptonshire to Flourish* sets out a new vision for the county and provides an unrivalled opportunity to establish for the first time a unified approach to health and wellbeing with potential to achieve real and meaningful change for the benefit of all.

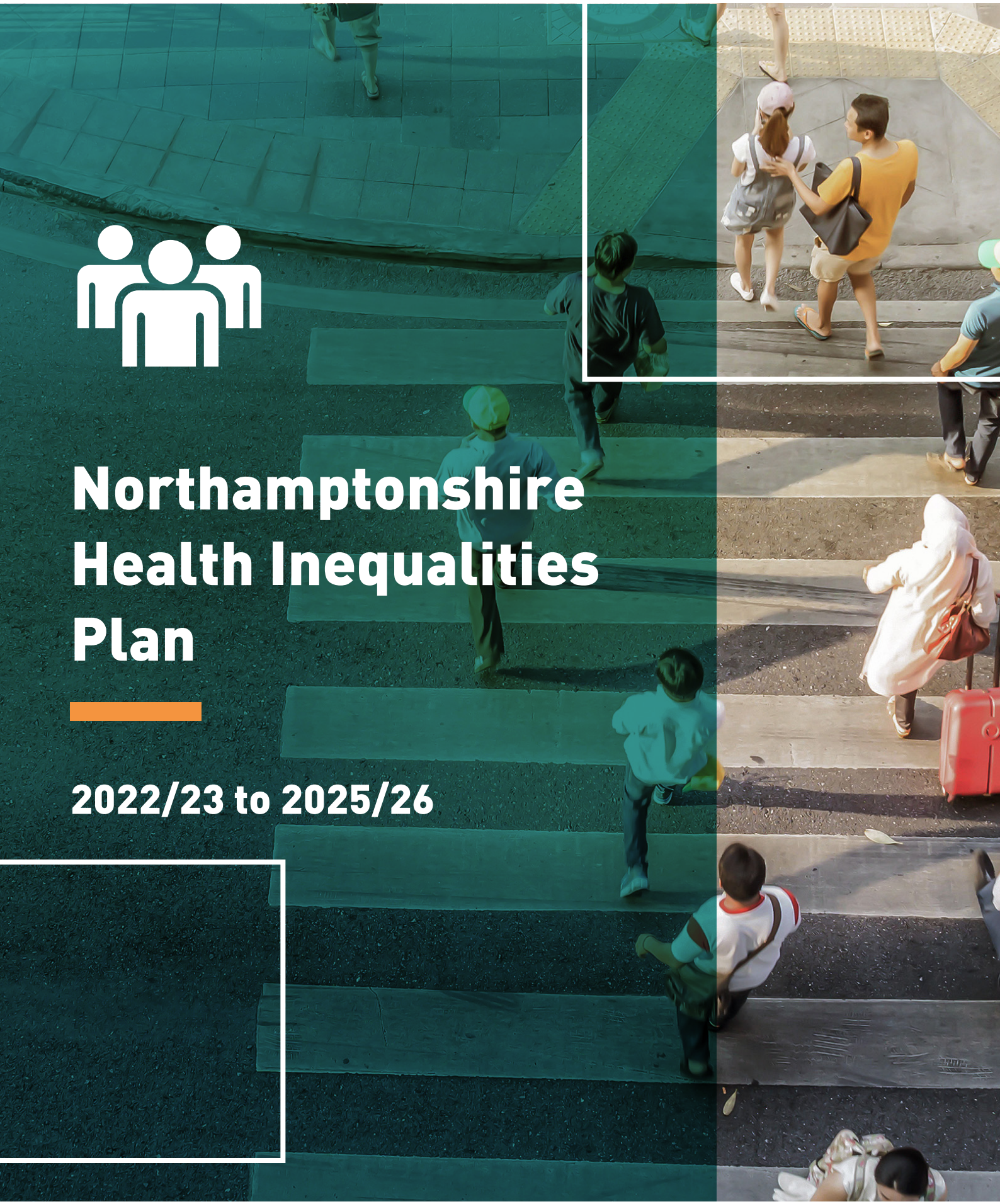
[39] NHS England (2014) Five Year Forward View

Northamptonshire Health & Wellbeing Board

CDS/NCC149648

Appendix C

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

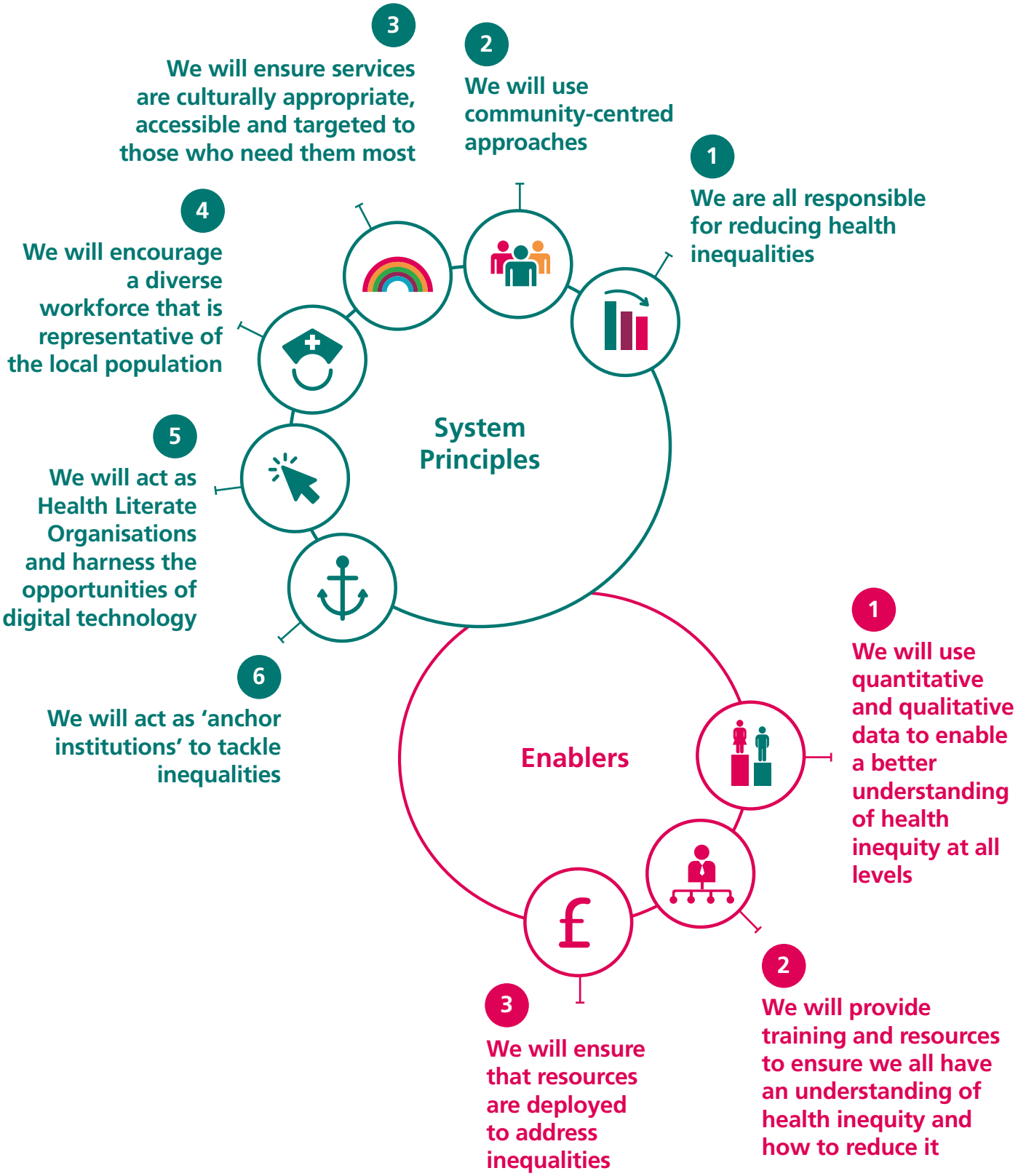


Fig. 1: Principles of our approach to reducing health inequalities in Northamptonshire

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]

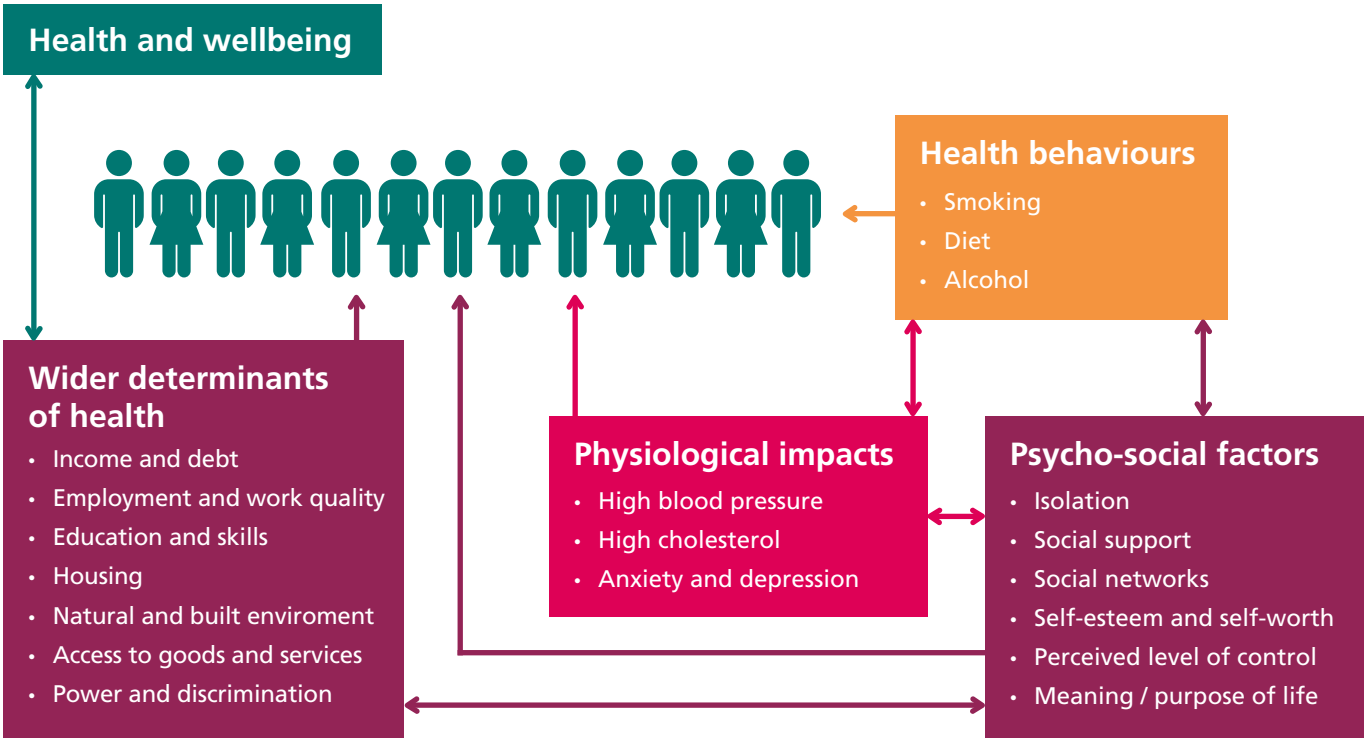


Fig. 2: System map of the causes of health inequalities

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].

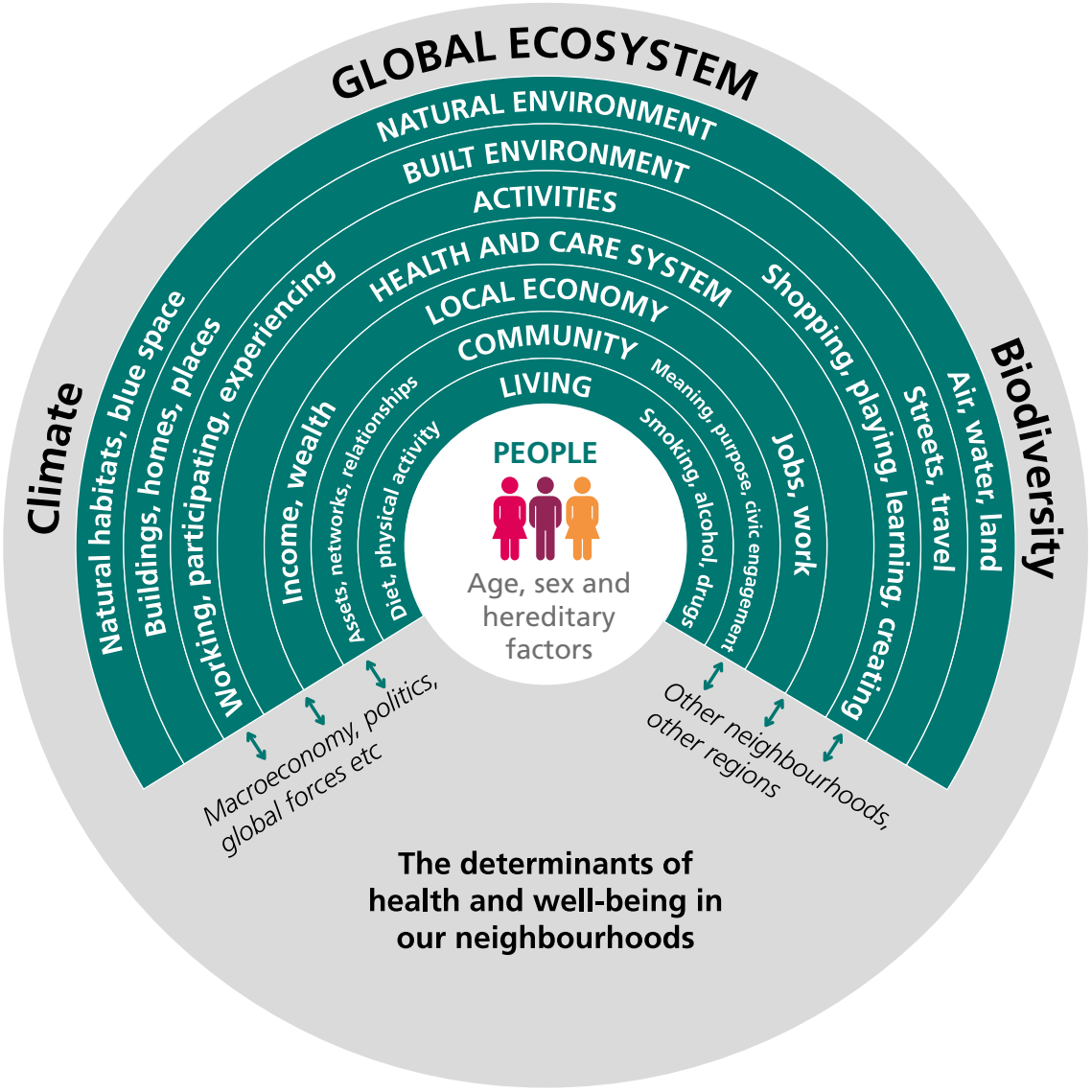


Fig. 3: The determinants of health and wellbeing in our neighbourhoods.

'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].

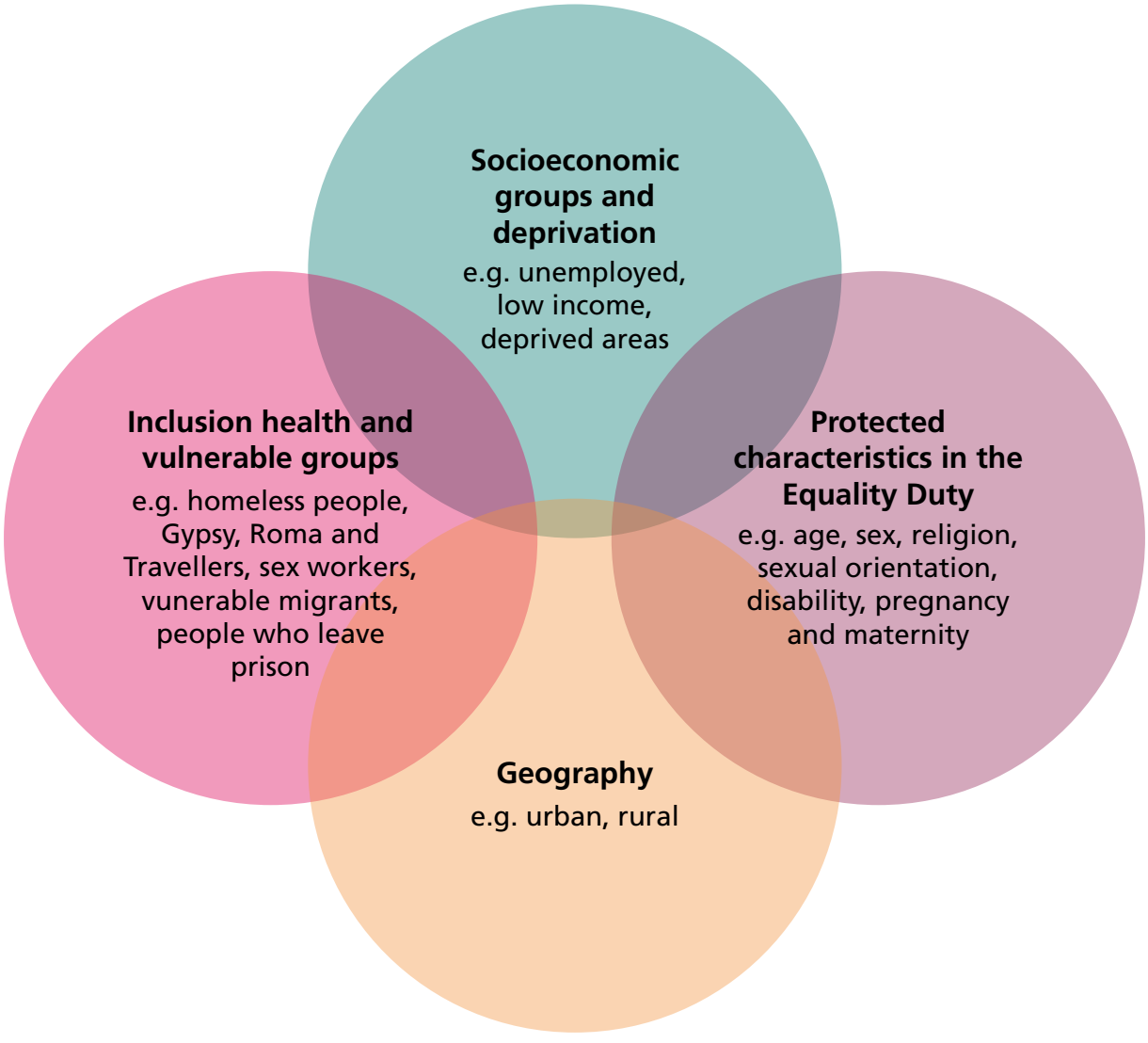


Fig. 4: The overlapping dimensions of health inequalities.

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.

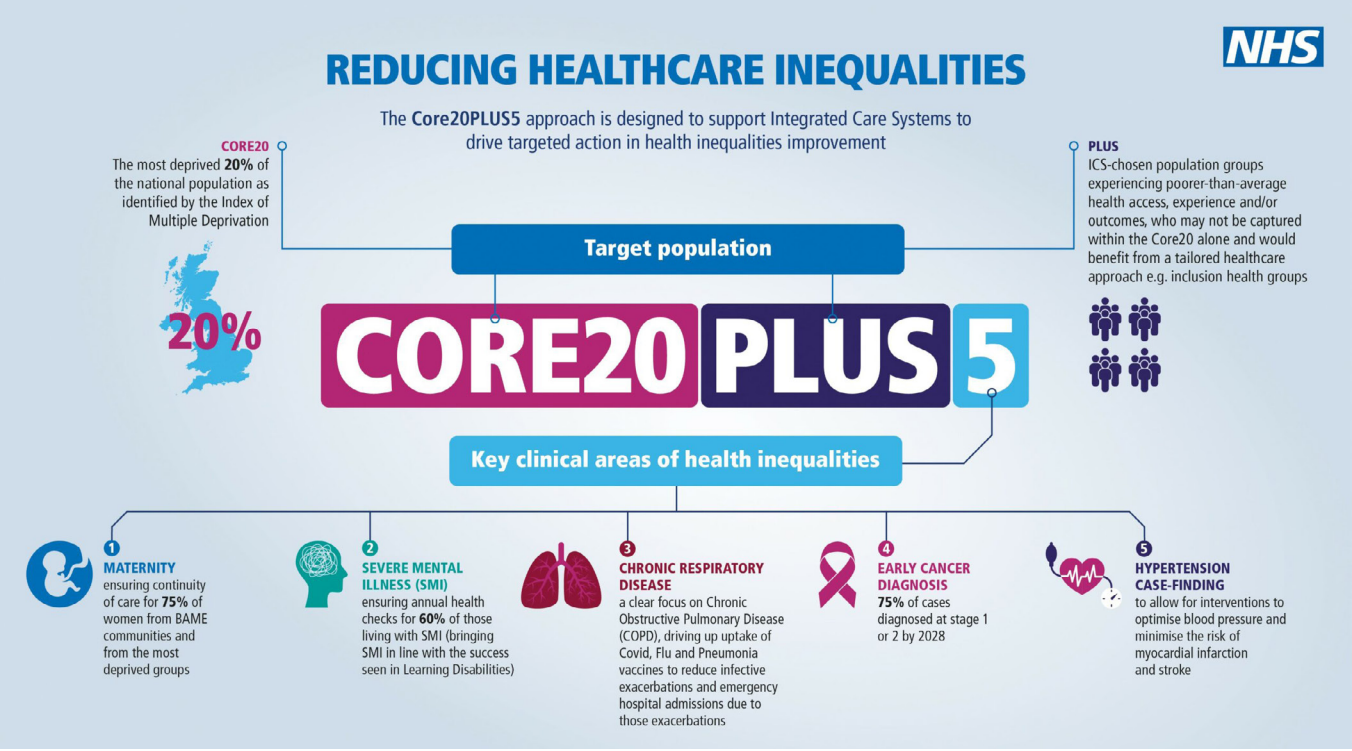


Fig. 5: The Core20PLUS5 approach to reducing healthcare inequalities.

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

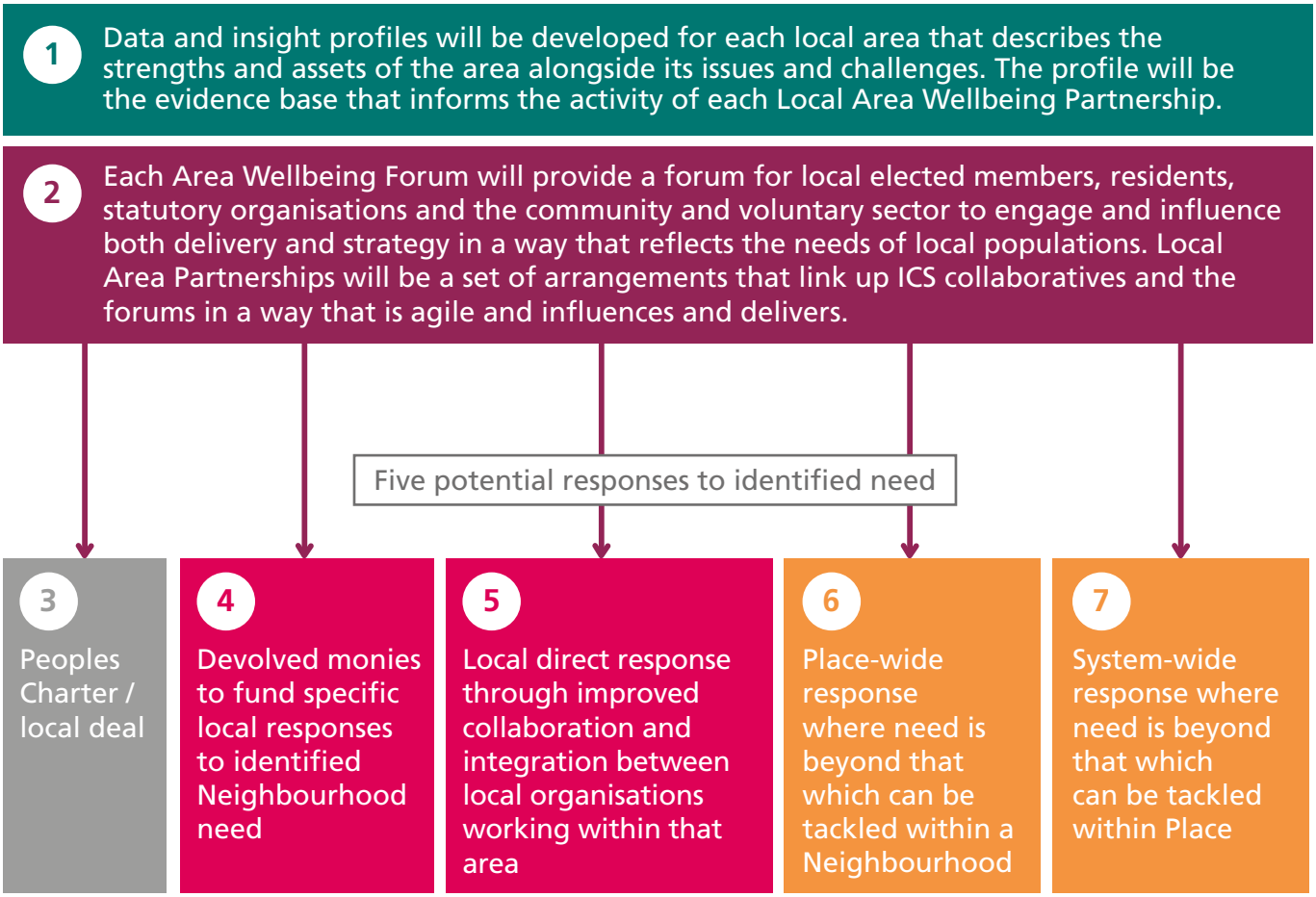


Fig. 7: Development of place-based plans, Wellbeing Forums and neighbourhood partnerships

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

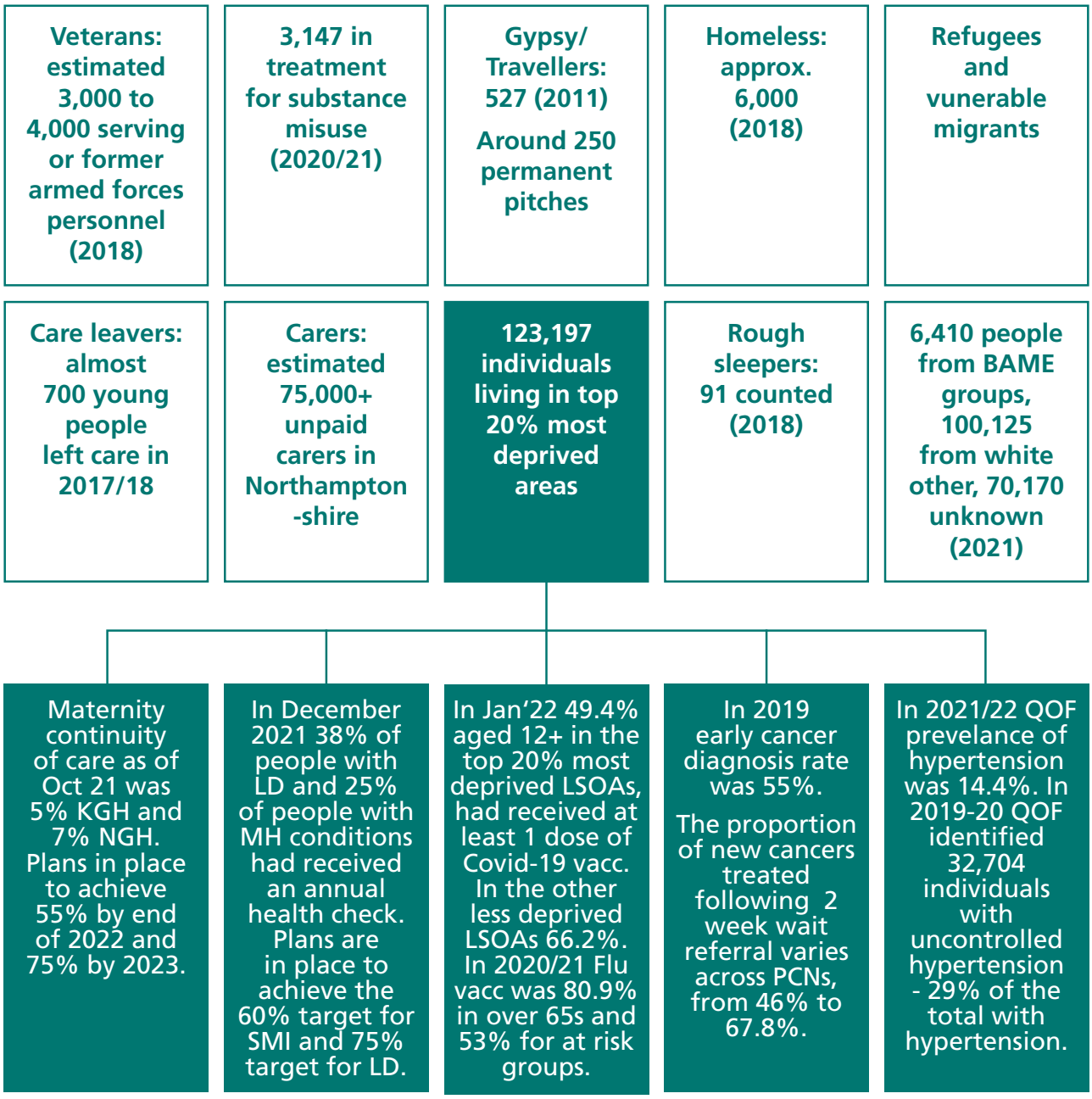


Fig. 8: Core20PLUS5 applied to Northamptonshire

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.

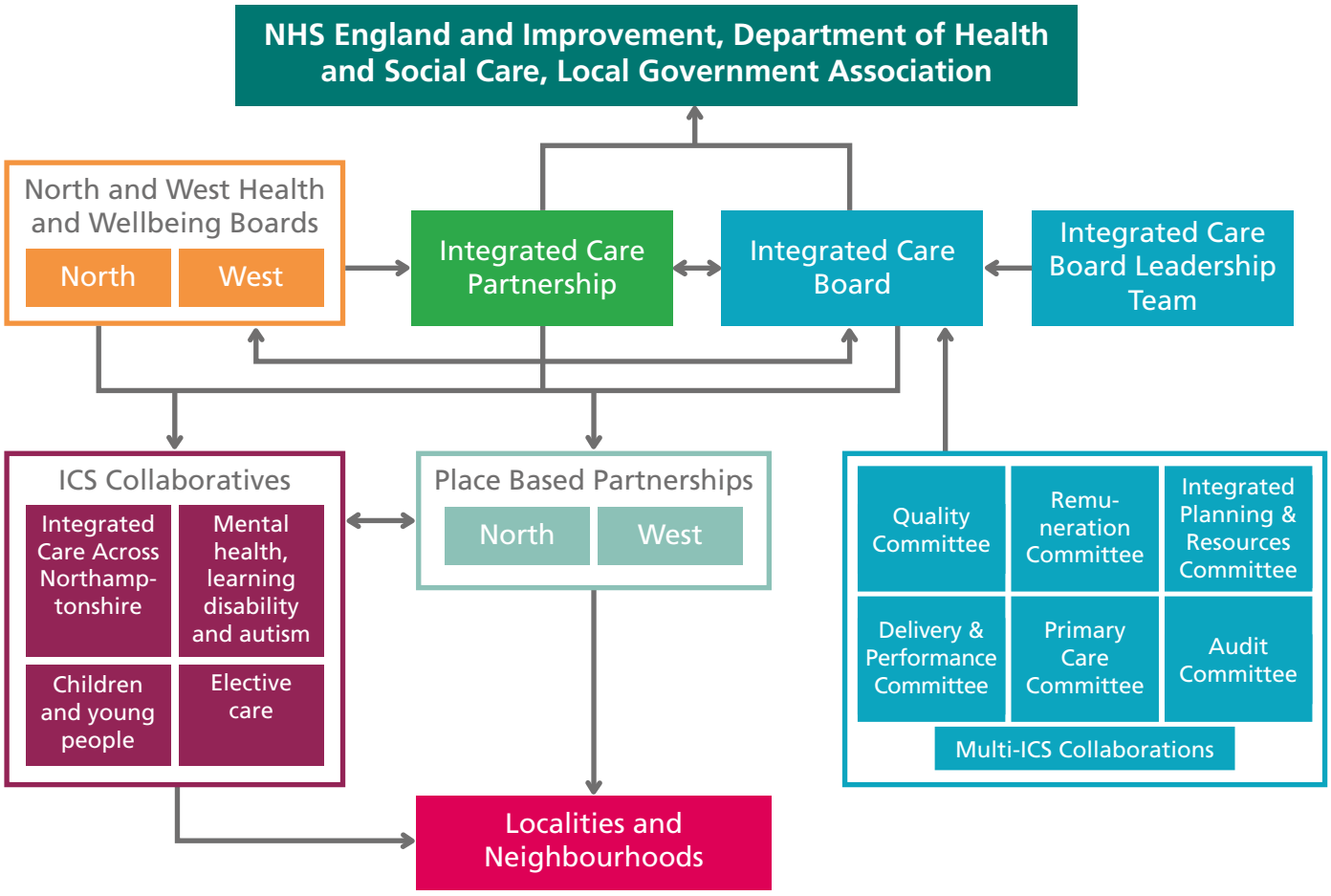


Fig. 9: DRAFT structure of the Northamptonshire Integrated Care System (correct as of May 2022)

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

North Northamptonshire Council

Glossary

Term	Definition
AEW	Assessment and Enablement Worker
BAME	Black, Asian, Minority Ethnicities
COPD	Chronic Obstructive Pulmonary Disease
CYPTP	Children and Young People Transformation Programme
DFG	Disabled Facilities Grant
DTA	Discharge To Assess
EMAS	East Midlands Ambulance Service
iCAN	Integrated Care Across Northamptonshire
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICSP	Integrated Care and Support Plan
JSNA	Joint Strategic Needs Assessment
LAPS	Local Area Partnerships
MDT	Multi-Disciplinary Team
NHCP	Northamptonshire Health Care Partnership
NHSE/I	National Health Service England / Improvement
PCN	Primary Care Network
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer/Questioning This is the modern abbreviation for the LGBT community
Left Shift	This refers to moving toward working closer with the community to co-produce services rather than services being dictated by the system
Warm Transfer	Involving the individual in any 'handover' of their care so they are aware at all times what is to happen and who will be involved. This is opposed to cold transfer which is when it is passed on to someone but the individual is none the wiser
Cold Onwards Referral	This refers to when a worker passes on an element of care to another professional without informing the individual it is intended for. Often this leads to confusion and sometimes professionals duplicating efforts where it's not needed.