North Northamptonshire Council

Item no: 9

North Northamptonshire Health and Wellbeing Board
26th September 2023

Report Title	Better Care Fund update 2023 -2025.
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Contributors/Checkers/Approvers	
Other Director/SME		

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1. Purpose of Report

1.1. To request that the Health and Wellbeing Board approve the Better Care Fund (BCF) for 2023/ 2025, for submission to NHSE including:

- North Northamptonshire BCF Narrative Plan 2022/23
- North Northamptonshire BCF Planning Template 2023-25

1. Executive Summary

1.1 Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:

- enable people to stay well, safe and independent at home for longer
- provide people with the right care, at the right place, at the right time

The BCF achieves this by requiring Integrated Care Boards (ICBs) and local government to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

1.2 The Health and Wellbeing Board have a duty to monitor the performance against the Better Care Fund plan.

1.3 The Health and Wellbeing Board are required to approve the 2023-25 End of Year Performance Template submitted to NHSE.

2. Recommendations

It is recommended that the North Health and Wellbeing Board:

2.1 Approve the Better Care Fund (BCF) schemes and performance template for 2023-2025 prior to them being submitted to NHSE.

2.2 Note the Better Care Fund 2023-2025 proposed timelines.

3. Report Background

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

3.2 Better Care Fund plan for 2023 to 2025 sets out the ambitions on how the spending will improve performance against the following BCF 2023 to 2025 metrics:

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

The approach to delivering these locally is set out in BCF Narrative Plan for 2023-25.

3.3 **BCF National conditions and metrics for 2023-25**

The national conditions for the BCF in 2023-25 were:

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

4. Issues and Choices

None.

5. Implications (including financial implications)

5.1 Resources and Financial

Please see Appendix 2 for financial details.

6. Legal

None.

7. Risk

None.

8. Consultation

No consultation was required.

9. Consideration by scrutiny

This report has not been considered by scrutiny.

10. Climate impact

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

11. Community Impact

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

12. Background Papers

None.

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

Appendix 1: North Northamptonshire BCF Narrative Plan 2022/23

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.

Integration and
Better Care Fund

Cover

1. Health and Wellbeing Board(s)

North Northamptonshire Council, and North Health and Wellbeing Board

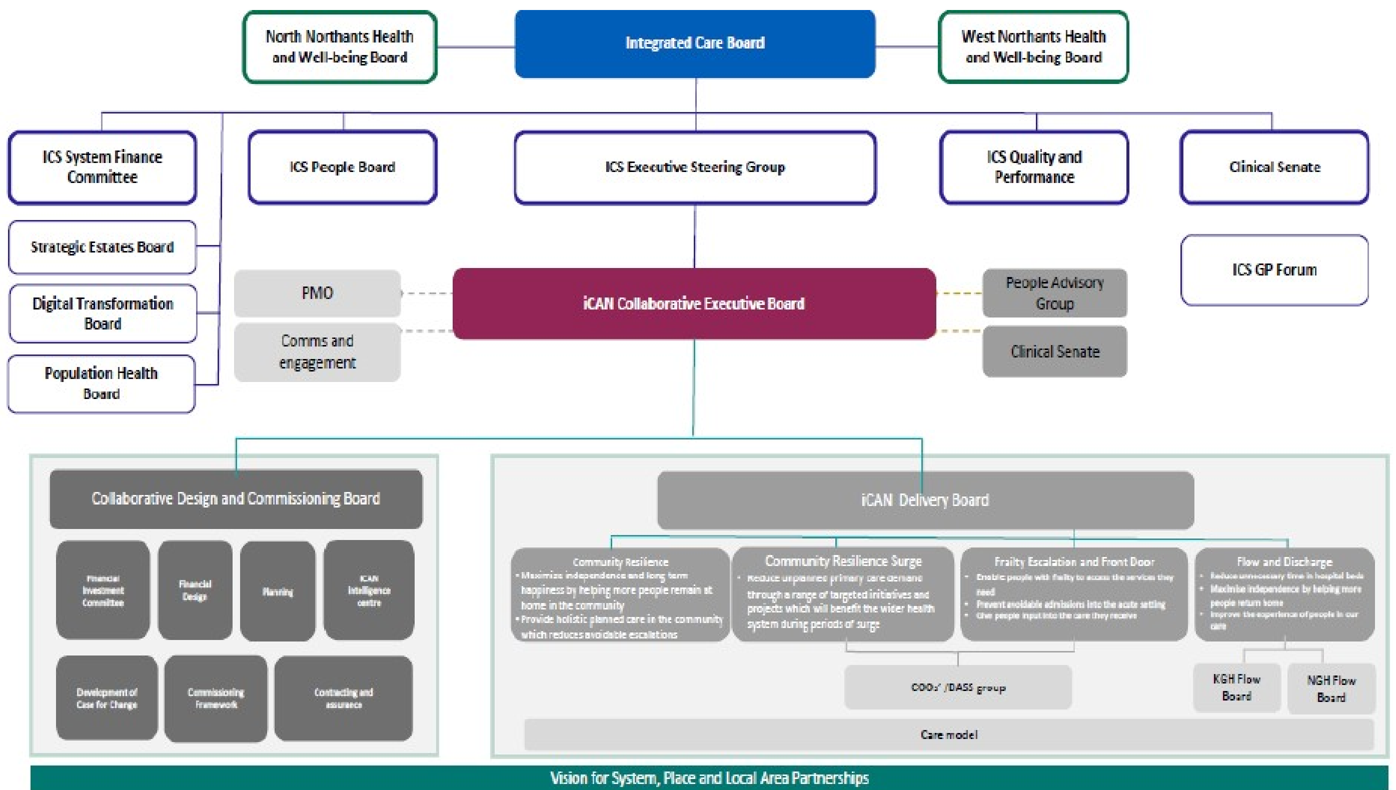
Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

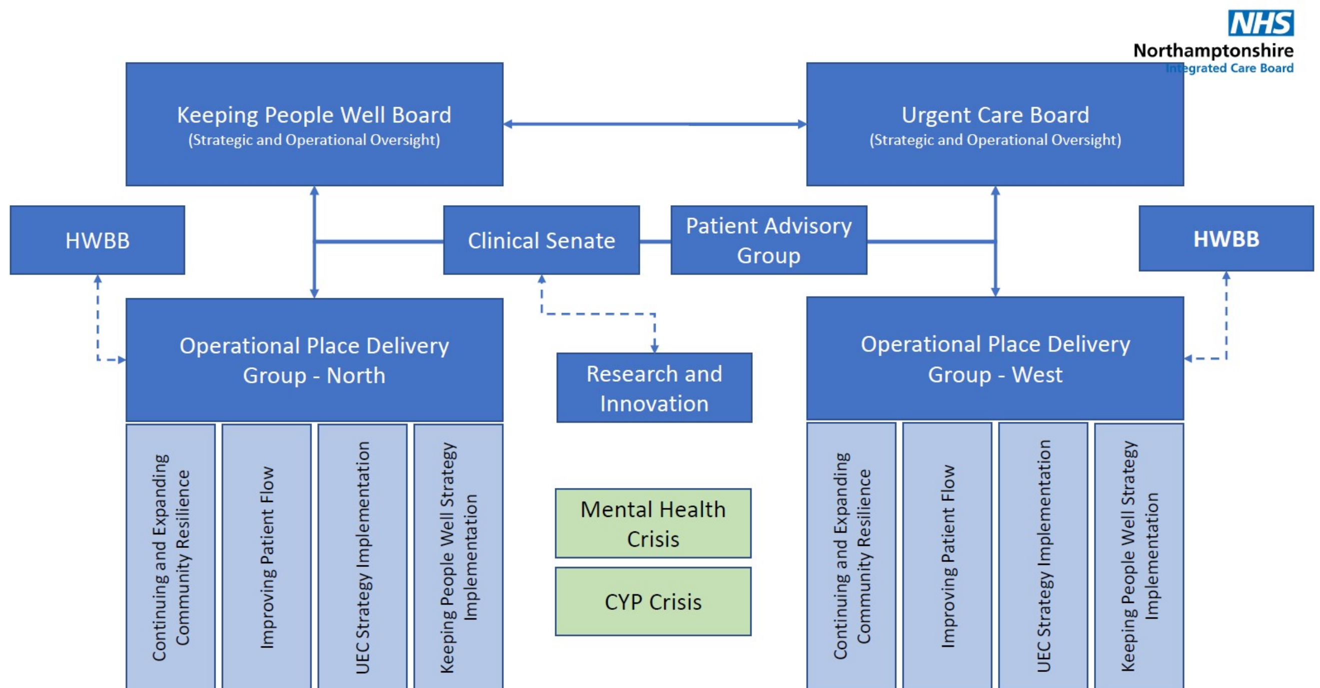
Organisation	Areas Engaged
North Northamptonshire Council	Adults, Health Partnerships & Housing
Northamptonshire Integrated Care Board	Commissioning Transformation and Strategy Finance
North Northamptonshire Health and Wellbeing Board	Public sector leaders
Northamptonshire Health Foundation Trust (NHFT)	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 Place-based version of ICAN Patient Advisory Group Age UK Alzheimer Society
Community Groups	Various representatives including those from town and parish councils

2. Governance

To deliver our ambitions, we have put in place the governance structure below that helps us oversee the Place-based version of Integrated Care Across Northamptonshire (ICAN) performance metrics and deliverables, while also helping us transition from a transformation programme to an integrated service delivery model within a collaborative.

This governance forms part of the ICB governance structure and ensures 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).





3. Executive Summary

Our 2023-24 BCF plan reflects some significant changes in our system since the last plan was submitted. 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 has developed the ten-year strategy focussed on improving the health and care of the population, supported by population health management approaches.

We will continue to shape our North Northants Place-Based Strategy throughout 2023-24 to ensure local services are targeted at a local need, by local 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.

We will continue to build on the transformation work done in 2022-23 as our main objective for this year; we will also progress our integrated out of hospital delivery model, described later in this plan. The main difference this year is that the delivery model will be more aligned to each of the two places by continuing to bring together place based health and care and voluntary services, resources, assets, and BCF and other funding sources through our place-based version of ICAN. Its 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 utilising the BCF as a key enabler in this to deliver:
- Reduction in unplanned hospital admissions.
- Reduction in escalations to Acute Care.
- Reduction in length of stay in acute hospitals including reductions in patients with no reason to reside and stranded patients.
- Reduction in the length of stay in community hospitals and rehab.
- Improvements in our community offer & intermediate care.
- Reduction in the reliance on and use of long-term care.
- Significant finance benefits to the system.

4. Background to North Northants

Our North Northants Place-based delivery model has been designed and is now live. We will continue to shape it over 2023/24 to ensure local services are targeted at a local need, by 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 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.

Each locality has been subdivided into seven Local Area Partnerships (LAPs) which provide a more detailed, and accurate, understanding of the communities within.

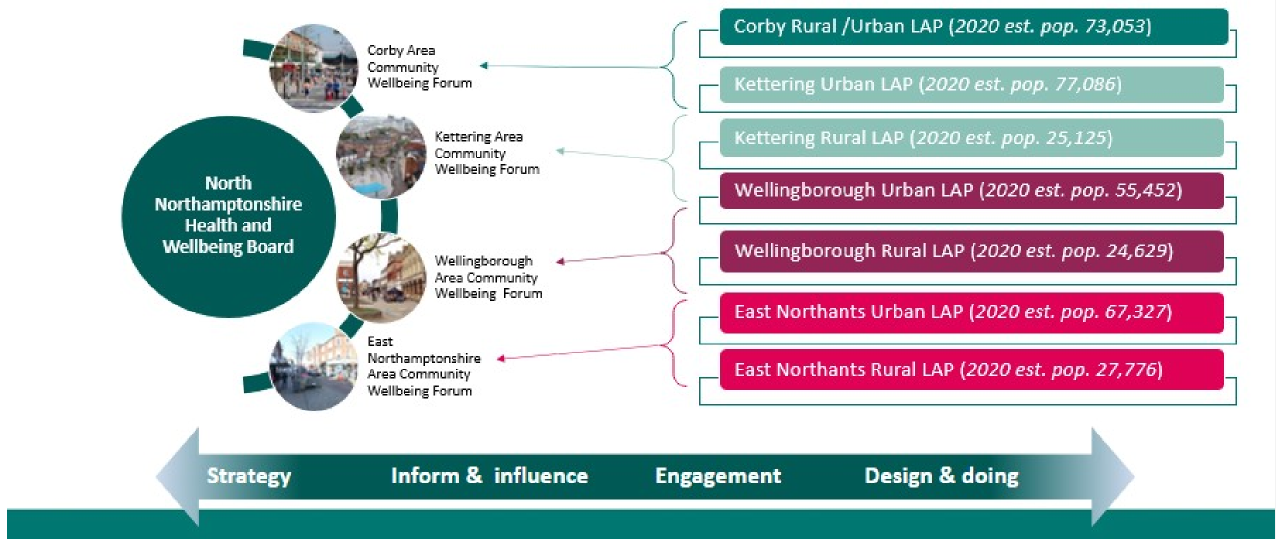
These LAPs mirror the electoral ward geographical footprints across Corby, Wellingborough, Kettering, and East Northants
It is the purview of the LAPs to provide local intelligence and data reflecting the needs of the population. Their function is to identify the priorities emanating from their communities and to support collaborative delivery with the public and workforce, bringing in the wider determinants of health and prevention approach.

On this basis LAP arrangements and boundaries are used for tailoring services and preventative measures to local needs and delivering them and will therefore align closely to the BCF plan.

The LAPs report into one of four Community Wellbeing Forums (CWFs). The CWFs hold oversight of the seven LAPs and are the mechanisms for influencing and informing the North Northamptonshire health and wellbeing ambitions and driving forward the priorities of the North Northamptonshire's Joint Health & Wellbeing Strategy. The CWFs have a seat of influence on the local Health and Wellbeing Board.

It is our plan to develop and link more focused LAPs for 30 to 50,000 population sizes as part of the wider ICS emerging operating model.

We will delegate more commissioning responsibility from the ICB and councils into the North to support the defined scope of the services being developed 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. Stakeholder Engagement

North Northamptonshire Council is a key stakeholder in the Northamptonshire Integrated Care System (ICS). The Northamptonshire Integrated Care Partnership (Integrated Care Northamptonshire - ICN) has developed a ten-year strategy – Live Your Best Life - which states the strategic alignment of all partners to improve the health and wellbeing of the population with a clear outcomes framework integral to this.

North Northamptonshire Council will continue to work on developing strong relationships with all strategic partners. In addition, we will develop the organisational culture as a new unitary authority via internal development within the council to align the vision, corporate plan, and service plans, alongside that of the Live Your Best Life strategy.

The new council has remained committed to continuing to support an integrated wider health and care approach. Both North and West Northamptonshire Councils are key stakeholders of the ICS covering Northamptonshire. 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 place-based Health and Wellbeing Boards; one for the North and one for the West, both aligned to the ICP.

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. The statutory responsibilities of the Health and Wellbeing Board will also influence the Integrated Care System strategy delivery, ensuring that where appropriate the nuances that set North Northamptonshire apart from West Northamptonshire are considered. This is reflected in the development of the North and West places as an integral element of the ICS operating model and new way of working, outlined in the Live Your Best Life Strategy.

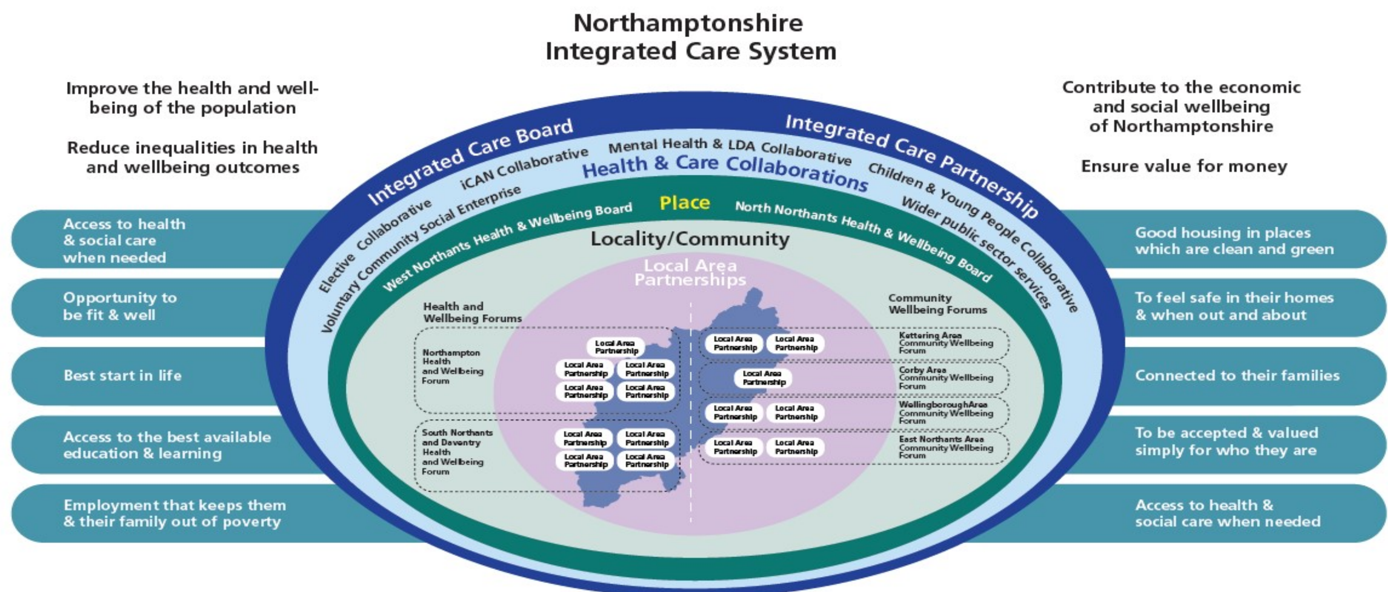
The BCF plan plays a fundamental part in delivering our ICS vision which sets out that:

We want to work better together in Northamptonshire to create a place where people and their loved ones are active, confident, and take personal responsibility to enjoy good health and wellbeing, reaching out to quality integrated support and services if and when they need help.

Live Your Best Life Shared Ambitions.

- The 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.
- Good housing in places which are clean and green.
- Safety in their homes and when out and about.
- Feel 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 ambitions means that we have to collaborate through the four system collaboratives. We collaborate, in particular, with Integrated Care across Northamptonshire (ICAN), local businesses, 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.



6. National Condition 1 – Overall BCF plan & Approach to Integration

6.1 Joint priorities for **2023-24**

We will continue with the place-based version of ICAN as our transformation programme; the majority of this year's BCF plan continues to link to ICAN services and schemes. We envisage the services within our place-based version of ICAN and the BCF will form the basis of a future collaborative and integrated service delivery at a local level.

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

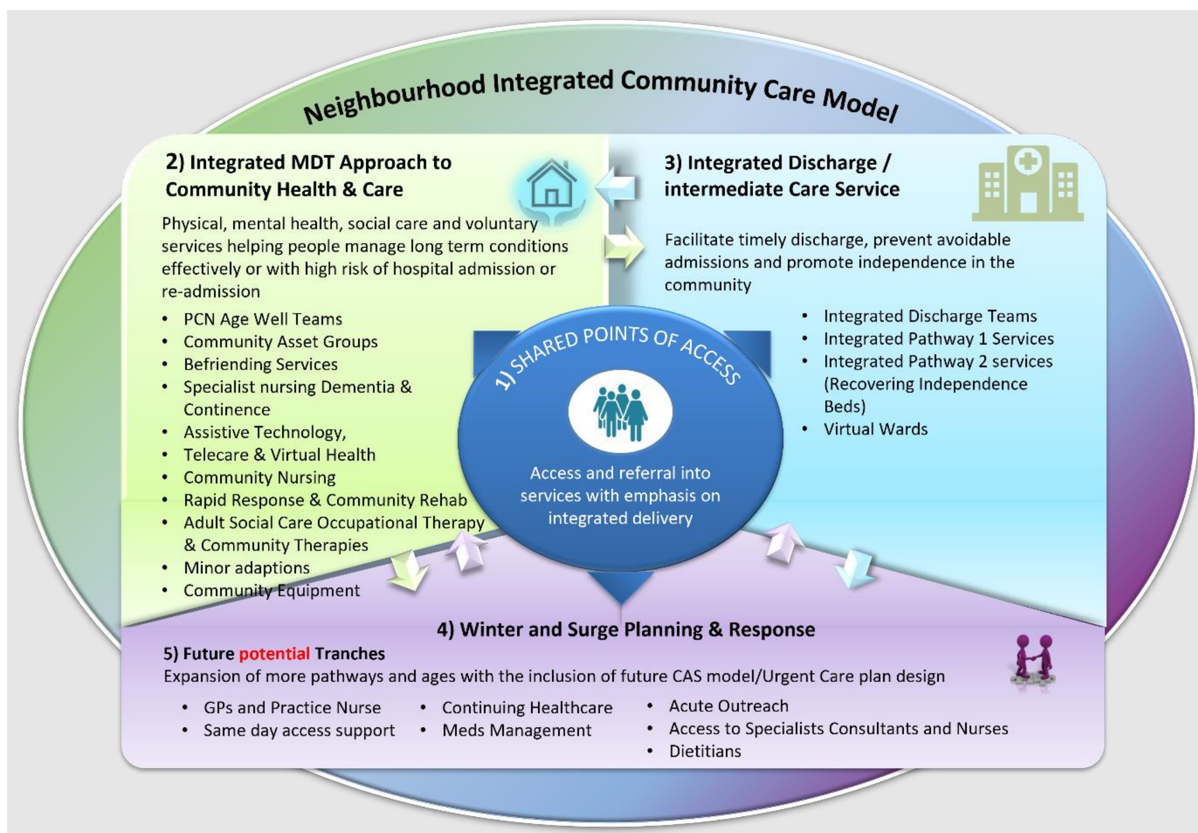
In 2023-24 we plan to continue building on the transformation work done in 2022-23 and progress our integrated out of hospital delivery model, described later in this plan.

We will bring together health and care, voluntary services, resources, assets, the BCF and other funding sources into a single collaborative, working within a single integrated delivery structure. We will continue to work towards this design through our place programme which is targeting key improvement and transformation as well as formalising collaborative arrangements.

Approaches to joint/collaborative commissioning

Our BCF plan has been agreed in principle by the ICB and North Northants Council. Its content and scope, including all the Discharge To Assess (DTA) schemes, the place-based version of ICAN and the additional investment made by partners have also been agreed by the ICB, Northamptonshire Group Hospitals (Acute Hospitals), Community Health Trust and North Northants Council, as well as the Directors of Finance for the System.

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



We plan to utilise the operating model to build on our work including all the services from 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, shared outcomes, and fewer hand-offs,
- Increase avoided escalations to hospitals with step up services to be developed working with GPs,
- Develop a flexible shared workforce that can respond to surges/winter using data to inform joint interventions,
- Expand 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.

In 2023-24 we will continue to maintain many of our previous schemes for delivering good quality integrated care with a strong focus on community and out of hospital care. This is designed to transform our elderly and frail pathways across organisations, and embed best practice (like Discharge to Assess, HICM 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.

Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support improvement of outcomes for people with care and support needs?

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 Improved Better Care Fund (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 placed based version of ICAN programme funded within the BCF is delivering several key winter schemes including: • D2A process improvement - implementing best practice model & live data to drive effective process. • Multi-Disciplinary Teams (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.
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.

Requirement	How it's being met
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, and admission avoidance reablement capacity
Additional discharge funding	Expansion of remote monitoring in care homes Block Reablement Partner including Admission Avoidance (TuVida) Digital companion DTA Brokerage Capacity Intermediate Care bed-based centre for reablement excellence (Thackley Green)

7. National Condition 2 – Enabling people to stay well, safe and independent at home for longer

The approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home.

Plans for supporting people to remain independent at home for longer.

Community Resilience / Keeping people Well

We will continue 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 to stay well or follow up after a crisis or hospital visit and avoid readmissions.

Remote Monitoring

Remote monitoring will enable earlier identification of changes in presentation which could indicate an emerging issue. Work has begun on this workstream which we will continue through 2023/24.

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, giving clinical advice and guidance to manage the situation within the community.

Emergency Community Response

The Rapid Response pathways seek to increase the number of people using Rapid Response rather than attending hospital. In addition to the success we have had in the community we are also now taking calls from the EMAS stack directly and from 111 more recently.

An example of our success is that 90% of long-wait fallers have already been supported to stay at home; the new pathway has saved an estimated 8.5 days of time where people would have been waiting on the floor.

Reablement North shall continue to work closely with NHFT Rapid response on Emergency Community response (2-day access to Reablement standard). Currently 30% plus of all monthly capacity in Reablement north is working with Urgent community response and A&E departments to support rapid access to reablement; we are achieving the 2-day access to Reablement Target.

Reablement North has focused on training to support falls in the last 2 months, upskilling key staff to be able to work with the Northamptonshire Falls model with the use of ‘Raizer’ Emergency Lifting Chairs. The system wide Northamptonshire Falls service is trialling and expanding the use of ‘Raizer’ Emergency Lifting chairs in care homes to reduce demand on Ambulance services.

Having completed the training Reablement North will continue to use ‘Raizer’ Emergency Lifting chairs to support people who have fallen within the service; this has now become normal practice for the service for fallers within Reablement North service.

We plan to roll out wider training and working with NHFT Urgent Community Response, who already respond to falls, to develop a joint health and social care reablement urgent community response model. This will support Reablement North to use 'Raizer’ Emergency Lifting chairs to lift non-injury falls and for Urgent

community response staff to be freed to support more injury falls this coming winter (23/24).

Steps to personalise care and deliver asset-based approaches

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.

The power of social inclusion and peer support, especially amongst those with shared lived experiences (person and carer), is recognised in Northamptonshire. Using our community asset programmes for people with COPD, 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.

Implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches.

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., by having an older person fitness class for all, delivered from a local Hindu Association Temple complex. This could also be by employing, through partnership with our Black Communities Together Group, staff who are recognised by communities and able to engage in their 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 will continue to review all of our activity data to test whether the use of our new solutions is reflective of the population served. For example, 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, work with community groups and leaders to coproduce solutions.

Throughout 2023/2024 we plan to prioritise a focus on 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.

We will work with families to change our dialogue and our content, where Dementia is not a recognised term or condition. 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.

We will continue to work closely with partners to develop the new community-based Support North Northants (SNN) Service. The service is a co-produced venture to encourage voluntary partners to work with statutory services to offer wrap around, holistic, care for the people of North Northants. It aims to promote greater relationships between partners, as well as reducing people's wait times to receive a service as the responsibility for delivery is shared among delivery partners.

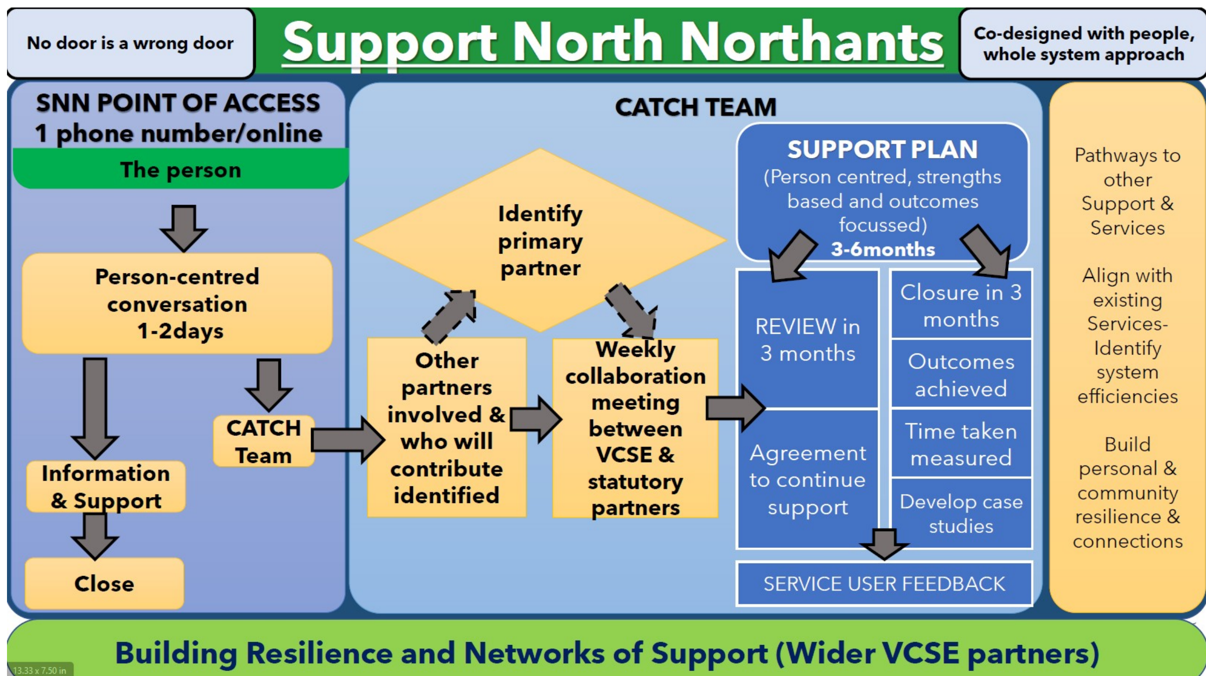
A collaborative service model with the Voluntary, Community, Social Enterprise (VCSE) sector and other agencies to provide early intervention and prevention, guide people to the right service/pathways quickly and build greater levels of community resilience. This service aims to provide sustainable prevention services that can withstand any future shock such as Covid 19.

'Don't give up on people' *and* ***'catch people early'***

Integrated Care Northamptonshire | A NEW *sense* OF PLACE

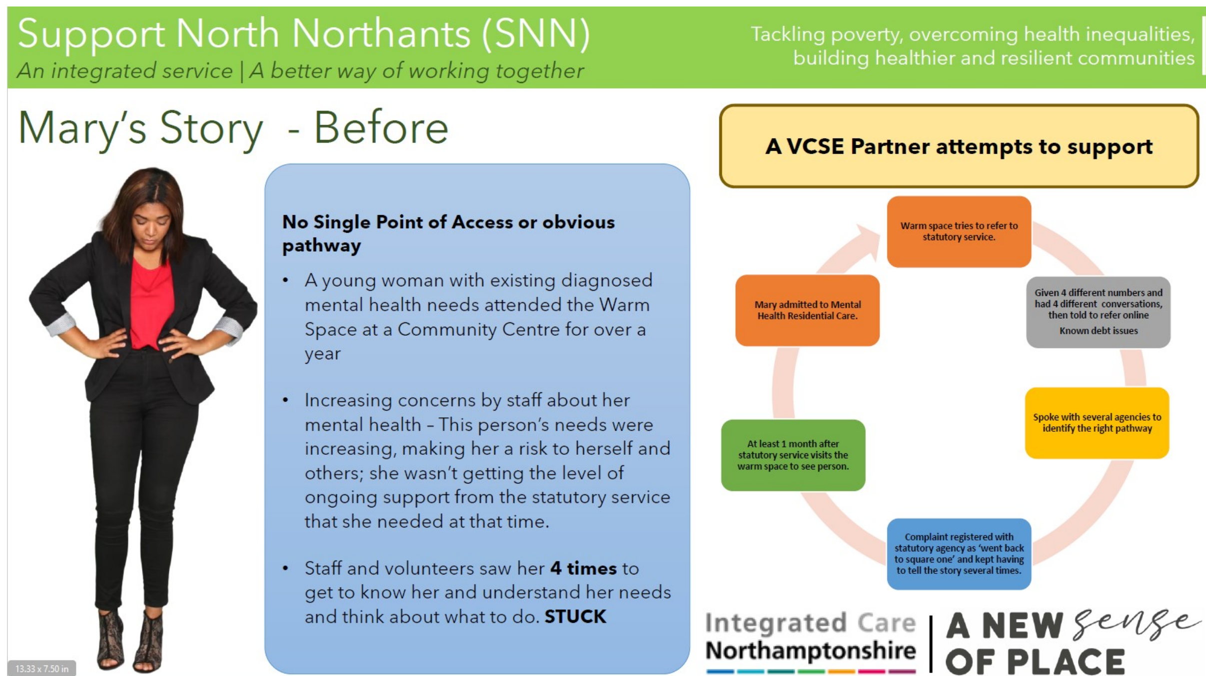
SNN aims to offer an environment where partners come together to contribute toward a support plan and delivery. This will ensure partners with capacity are utilised efficiently and those struggling with capacity see some of the delivery responsibility shared.

The service is not designed to replace anyone's responsibilities and is not designed to encourage handoffs between partners. It is a service supported by LAP priorities to help delivery partners identify support within the county and bring those bodies together more efficiently to support the community.



The existing system can unfortunately mean people are left behind as those referring do not know where to go to. Due to capacity within certain sectors, it is oftentimes that people are only seen when they reach a level of crisis, and not at a stage of early intervention.

It is the ambition of SNN to bring partners together, to discuss the presenting issues and act together to provide early intervention and retain people's independence and dignity.



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 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 between the gaps in the established responsibilities of others, reducing the need for back and forths.

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 these take pace in a person's own home through Microsoft TEAMs call with the Age Well Coordinator being with the individual. 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 locality Social Care 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 person holistically, 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.

We plan to extend the capacity of the team in 2023/24. 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 and housing as a solution.

8. National Condition 2 – Enabling people to stay well, safe and independent at home for longer.

Significant work has been taken within Northamptonshire looking at demand and capacity. Using tools such as our interactive Pathways dashboards enables us to have a live picture of demand as well as queue sizes, timescales, and trends to discharge once a person becomes ‘No reason to reside’. This enables us to monitor against our predicted versus actual demand across pathways and has informed how we have invested the additional funds.

An example of this is the investment in Pathway 2, and our remodelling of Thackley Green Intermediate care centre. Our shift to increased volumes through Pathway 1 has driven increased levels of acuity in those people on Pathway 2 What we saw over the winter period was due to these increased levels of acuity; our traditional Pathway 2 was not sufficiently equipped / staffed to accept the level of presenting need and therefore people were moved to less ideal provision.

We have sought to address this with additional investment which will not only increase capacity but the levels of incoming need and opportunities for increased independence for those accessing the centre.

We have taken the learning from our performance over winter and the introduction of our Block Reablement Partner and used the evidence to run the service at enhanced winter levels throughout the year. The Block Reablement Partner has significantly improved not only our capacity on Pathway 1 and Admission Avoidance, but the outcomes we are achieving for people via increased independence.

Enablers, such as increased brokerage capacity and digital champions, will ensure that our capacity is protected, ensuring timely step off the service and reducing levels of ongoing need.

National Condition 2 – Enabling people to stay well, safe and independent at home for longer

Frailty Units and Same Day Emergency Care
We aim 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.

Emergency hospital admissions following a fall for people over the age of 65

Emergency Community Response
The 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, 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.

Reablement North shall continue to work closely with NHFT Rapid response on Emergency Community response (2-day access to Reablement standard). Currently 30% plus of all monthly capacity in Reablement north is working with Urgent community response and A&E departments to support rapid access to reablement; we are achieving the 2-day access to Reablement Target.

Reablement North has focused on training to support falls in the last 2 months, upskilling key staff to be able to work with the Northamptonshire Falls model with the use of ‘Raizer’ Emergency Lifting Chairs. The system wide Northamptonshire Falls service is trialling and expanding the use of ‘Raizer’ Emergency Lifting chairs in care homes to reduce demand on Ambulance services.

Having completed the training Reablement North will continue to use ‘Raizer’ Emergency Lifting chairs to support people who have fallen within the service; this has now become normal practice for the service for fallers within Reablement North service.

We plan to use the BCF this year to expand Reablement North’s role in Urgent community response, working with NHFT Urgent Rapid response (who already respond to falls) to develop and embed a joint health and social care reablement urgent community response model. This will support Reablement North to be the first point of call for non-injury fallers in their own home, using 'Raizer’ Emergency Lifting chairs to lift non injury falls freeing our health Rapid response colleagues and EMAS to support injury falls this coming winter.

9. National Condition 3 - Provide the right care in the right place at the right time.

Reducing Length of Stay In hospital
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.

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 people. The work here includes the continued 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 Patient Discharge Needs Assessment (PDNA) forms that were over prescriptive and did not always represent the patient; these were 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.

How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds and implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring sustained improvements in outcomes for people discharged from hospital and wider system flow.

Pathway 1 We have commissioned 966 hours per week through TuVida, our short-term home care service. TuVida supports complex Pathway 1 cases with a reablement focus and working in partnership with our inhouse Reablement team and our single-handed care Occupational therapists.

We will use these hours to ensure we are maximising our Reablement capacity, whilst also ensuring that we maintain the think home first approach and getting the most independent outcome for our people.

Pathway 2 We will invest in our Pathway 2 capacity through our Intermediate Care, bed-based centre for 'reablement excellence' which holds 51 Beds. We will ensure that we are reducing the number of permanent admissions to residential and nursing placements and maximise all opportunities for independence. This will include an integrated approach between health and social care ensuring right place, right care at the right time.

Flow enablers We have invested additional capacity into our out of hospital brokerage service, ensuring that we are reducing length of stay within all DTA capacity, which will in turn create sustainable capacity for timely discharge. This team will work alongside the strength based social care team ensuring the focus is on maximising outcomes and choice, while also controlling any longer-term prevision of care.

Assistive technology We have invested in assistive technology and will continue to promote independence, reducing reliance on formal care and support, in the way of digital companions to be piloted within our reablement service. The benefits are anticipated to be:

- Provide remote care and support using digital technology, reducing the possibility of readmission to hospital.
- Monitor and support wellbeing, reducing loneliness by remotely connecting to family, friends and carers.
- Supporting remote monitoring of health and wellbeing through the introduction of a hybrid care model.

Extension to remote monitoring in Care homes will enable us to use a proactive, preventative, approach to assistive technology; this will make the hubs the beating heart, joining services across Health, Social Care and Housing. They will be enabled to provide an early response to support people to live where they want to be, stay connected to their local communities, stay fitter and active for longer, and will provide hubs the ability to trigger rapid support at times of rapid deterioration or crisis.

10. National Condition 3 - Provide the right care in the right place at the right time

Set out how BCF funded activity will support delivery of this objective, with reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics

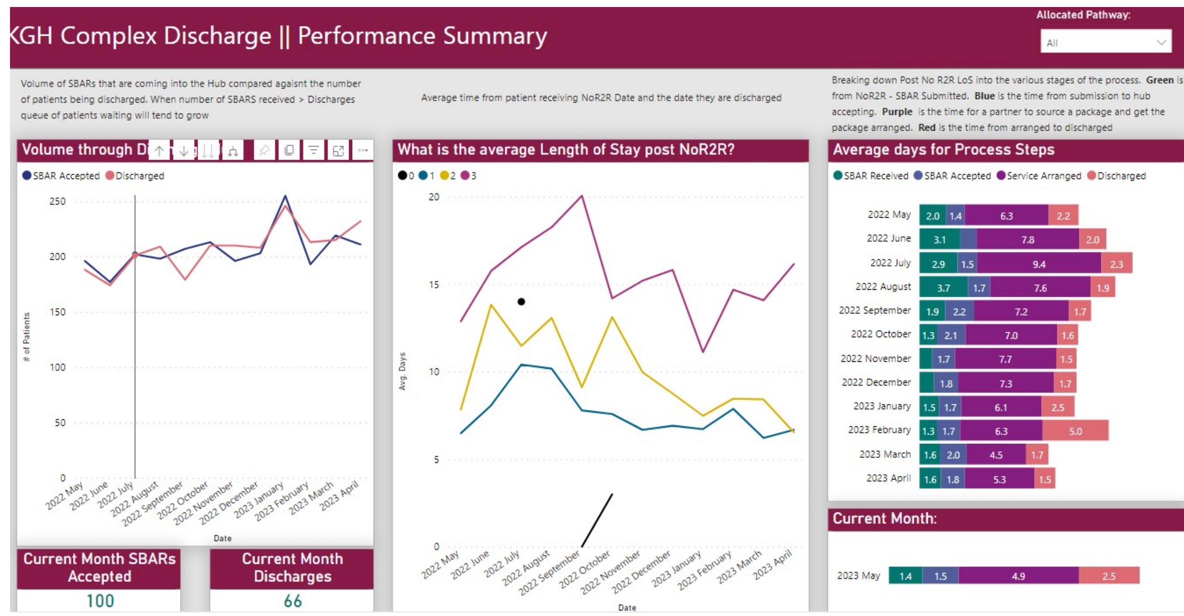
Discharge to usual place of residence

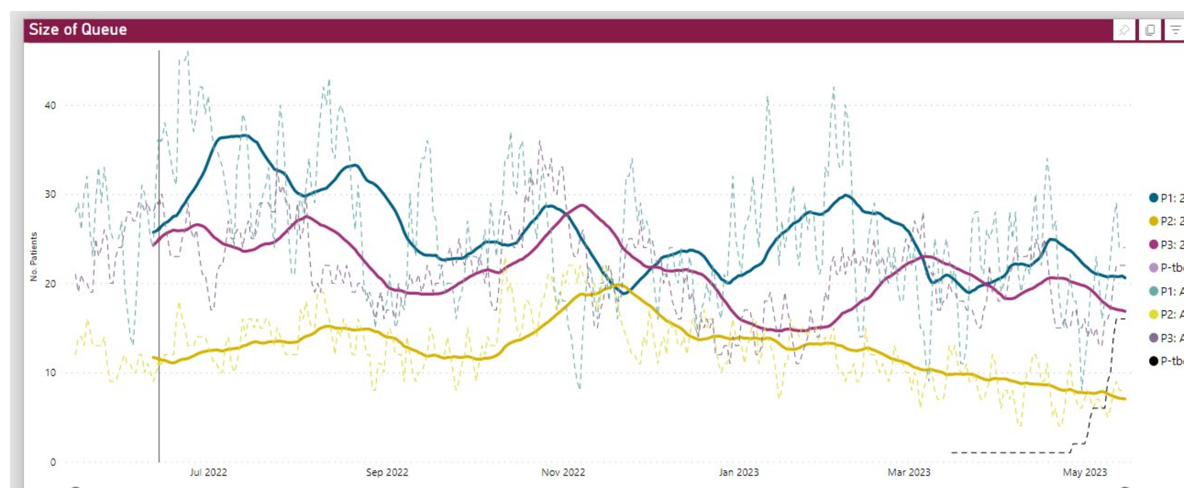
We have made and will continue to make, improvements in the ward referral and transfer of care hub processes to improve the speed of the discharge decision making processes. We have seen a reduction in our delays in discharge queues for both bedded and home-based intermediate care when delays are present. They are either when people are waiting for capacity to become available, or when a patient becomes not medically fit, but the referral process is kept open.

We have improved the visibility of queues and wait times for each pathway via our jointly owned dashboard, using data from both Transfer of Care Hubs and the Pathway Services. This has enabled targeted continuous improvement and data-

led decisions on capacity and when to use spot purchase or alternative pathways as the best option to maintain hospital flow, for example. We will continue to try to improve referral to discharge time, which will be most impacted by capacity improvements in services.

We will continue to work in a collaborative Health, Housing and Social care model within the discharge cell for North place, utilising multidisciplinary decision making from all parties including dedicated Housing posts supporting Pathway 0 and pathway 1 flow.





In 2022/23 we invested winter funding into additional capacity for Pathway 1 across North Northants via our new short-term home care service. Based on the benefits seen in 22/23 around flow on Pathway 1, we will extend the contract with the provider, via the BCF and continue to develop the integrated model and length of stay (LOS) through close working between health, inhouse reablement and the short-term homecare provider. The service protects the flow through the in-house reablement service for those with reablement potential. It does this 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, supporting our development and delivery of KLOE PR4. We have seen

positive results and outcome on this pathway with people being supported to stay at home with higher levels of independence.

50
People supported following discharge from hospital

28%
Of people needed less visits after using the service

4%
Of people had increased visits to avoid hospital admission

4
People left the service with no care requirements

14%
Service users reduced from 2 to 1 during service

Feedback
"Well be sorry to see all the carers go, everyone was lovely and helpful"

"They have made my life happier and make me smile with their empathy and care towards me"

Feedback
We asked service users and unpaid carers to rate services out of 5. On average, based on **60%** of service users, services were rated:

From **30** responses 93% showed an overall improvement

Service prior to TuVida rated **3.33/5**

TuVida's service **4.33/5**

Service Outcomes

Health and well-being, Quality of life, Independence, Experience of care and support, Personal dignity, Ability to exercise choice and control

Average Pre Service, Average Post Service

TüVida

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.

11. National Condition 3 - Provide the right care in the right place at the right time

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas of improvement identified and planned work to address these.

We have an established North Placed Discharge Cell that is an MDT of KGH Hospital staff, community health staff, North Northants Council, Adult Social Care (ASC) and housing staff, Continuing Health Care (CHC) and Voluntary Community and Social Enterprises (VCSE.) The discharge cell has been operational since 2020 and has been working across all partners to deliver the high impact change model.

The discharge cell has leadership from hospital Head of Capacity and from the Service Manager for NNC Adult Social Care, who together deliver functionality of SRO for discharge. They hold joint responsibility on delivery, utilising the hospital complex discharge dashboard to monitor internal hospital performance. They also monitor performance externally, looking at discharge flow, the effectiveness of the integrated discharge pathways and the delivery of aims from our contracts with market providers.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 1: early discharge planning	Hospital Discharge and Frailty teams in A&E to identify and start complex discharge planning at admission. Identification and monitoring of admission avoidance from A&E/SDEC/Frailty direct to pathway 1 and 2 services. Facilitated early discharge for therapy and IV fluid programmes in place. ASC feed direct into Discharge hub on complex community cases at point of admission (e.g., bariatric admissions from community) Discharge Harm Review Panel commenced to monitor and understand learning around harm from delayed discharges.	KGH have internal dashboard “patient time matters” to enable senior staff in capacity and partners, to look at and drill down into ward-based data to identify blocks in delivering productive ward / criteria led discharge / red green actions. Now dashboard is functional development of using data to inform decision making and develop KGH Action plans to address blocks and increase roll out of criteria-based discharge.	Active monitoring and development actions to address across Q2 and 3 of 2023 Targeted workstream on criteria led discharge in KGH	Improved performance on patient time matters and complex discharge dashboards by Q3 – Maintenance of improvement and fast recovery to that position across times of pressure in Q4 winter pressures.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 2 – Monitoring and responding to System demand and capacity	1. Variety of tools/ dashboards at hand that Discharge Cell utilises throughout the day to monitor demand and capacity 2. SHREWD to enable whole system visibility of live data issues. 3. Operational Pressures Escalation Levels (OPEL) escalation process and support system escalation calls to monitor on the day demand 4. Second year of using prediction and past performance data to model demand and capacity to identify gaps – this year gap in Pathway 2 identified hence action plan to invest BCP funding to develop capacity and complexity	1. Discharge dashboards are used to model flow on all pathways and used to monitor trends and pressures to inform both flexible response to demand as well as commissioning decisions. It was monitoring of demand on Pathway 1 that led to successful commissioning of additional Pathway 1 reablement capacity in 22/23 with TuVida which has been highly successful in getting people to right place first time and hence continued investment in BCF 23/24. 4. Development of Thackley Green Pathway 2 – based on data monitoring of demand outstripping	**1/2/3** Ongoing **4.** Commenced Q3 2022, development and expansion of model stage 1 for October 2023,	1. Maintenance of improvement in Discharge Dashboard and fast recovery to that position across times of pressure in Q4 winter pressures 2. Reduction in demand on pathway 3 non ideal pathways. 4. Increased capacity and capability of bed availability for Pathway 2 Monitoring of quantitative and qualitative outcomes and LOS for Pathway against baseline data in place. Workstreams kicked off May/June 2023 to review data and describe improvement required. Task and Finish groups to deliver

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
	of pathway 2 service in Thackley Green.	capacity and complexity of existing Pathway 2 service using BCF funds to develop and expand Thackley green service. Further ICB wide Urgent care strategic programmes on Pathway 1, 2 Single point of access for Urgent care, Pathway 2 integrated brokerage and "Dementia and Delirium" to test assumptions and model changes in approach needed to deliver better integration releasing capacity.		cross-organisation outcomes in year for Q4 Winter.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 3 Multidisciplinary working.	**1.** The North Place discharge cell is an MDT of health (hospital and community intermediate care), social care and VCSE to coordinate and plan discharge. **2.** Area of lacking support in MDT decision making is primary care in Discharge cell and mental health services. Mental health particularly of working age adults with enduring mental health presentations plus older people with acute confusion (delirium) remain a group of people who do not fit within standard pathway 1-3 services and needs often fall between commissioned services leading them	**4.** North Place we are commencing a pilot of community place based greater integration with VCSE in SNN (Support North Northants) to support demand for community demand management to support people to access support earlier in community avoiding crisis and admissions.	**4.** Soft launch of SNN in June 2023 with gradual expansion across communities across Q2 to Q4 of 2023/4 **1/2/3** Urgent care strategic programmes on specific known gap in Pathway 2 provision for people with delirium and dementia.	**4.** Good will be based on the outcome framework (e.g., outcomes on health and social wellbeing/ economic wellbeing and personal resilience, etc obtained directly from person/ service user feedback. Monitoring of SNN effect on system partners capacity. **1/2/3** Identification and multiagency solution finding using existing resources and some BCF funds to identify wrap around support on Pathway 2 and potentially Pathway 1 for this specific cohort of people and implement ahead of Q4 23/24.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
	to have protracted length of stay beyond no reason to reside. **3.** Discharge Harm Review Panel commenced to monitor and understanding learning around harm from delayed discharges.			
Change 4 – Home First, discharge to assess	**1.** This is fully embedded in North Northants. Additional capacity was invested with BCF 22/23 and social care discharge fund to support additional support on this pathway. We successfully avoided any Pathway 1 ideal discharge being discharged to a non-ideal pathway in 22/23 and as such the successful use of TuVida and Reablement North is continued model BCF investment for 23/24	**2** Commissioning utilising BCF digital companion from BCF funds to pilot effectiveness reduction in calls needed.	**2** Contracting process Q3 and mobilisation Q3/4. **1.** Short term homecare reablement partner contract extension complete – ongoing monitoring of performance and engagement of provider in wider Pathway 1 developments	**2:** Digital companion reducing care calls particularly for social isolation and calls for dementia to “prompt” self-care **1/ 2:** Maintain and see improvements in outcomes of enabling more people to independence and able to live at home. Monitoring via contract monitoring and effectiveness outcome dashboard, and short and long term (SALT) returns on effectiveness of reablement

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 5 – Flexible working patterns.	**1.** We have dedicated 7-day working on pathway 1 with both Reablement North and TuVida operating 7-day discharge and admission avoidance access into pathway 1. KGH discharge Cell has a 7 day presence with KGH employed discharge staff presence at weekends to support and ensure planned discharges at weekend go ahead.	**3.** Thackley Green model of development is focused on improving access to bedded reablement to avoid unnecessary admissions to acre homes on pathway 3, this service is in its infancy and currently accepts admissions 7 days a week and will be developed in the Thackley Green development to embed 7 day admission process. **4.** The decision-making cell is 5 days a week at present due to both staffing capacity across all partners and complex HR requirements that would be needed to workforce	**3.** Q3 2023/24 to have functioning new service with Extension of Number available beds from 25 to 35 by Q4 2023/24 with 7-day admissions as normal **4.** Not planned for commencement of delivery this financial year	**1/2/3** Aiming to deliver centre of excellence for reablement – able to achieve CQC rating of outstanding. Long term delivery programme over the 3-5 year Adult social care strategy.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 6 – Trusted assessment	**1.** Trusted assessment has been key focus of North Place Discharge Cell for several years. We have ward staff trusted to complete discharge paperwork and two-way communication between discharge cell and ward to enable decision making. Timeliness of decision making is monitored in Dashboard to ensure we have continued trust of assessments by ward staff. **2.** An Independent care home trusted assessor service is commissioned and in place supporting both care homes and discharge to assess into care homes. **3.** Trusted assessment has been key focus of	**1.** Continue to monitor effectiveness of process and challenge delays on processing in discharge cell to identify training and constructive challenge to Discharge Cell MDT on quality of trusted assessment enabling effective discharge planning. **2.** Independent provider of care home trusted assessor is in place as a previously funded pilot. Due for evaluation and recommissioning Q4 2023/4. **3.** Continue to monitor effectiveness of process and challenge delays on processing in discharge cell to identify training and constructive challenge to Discharge Cell MDT on quality of trusted assessment	**1.** Ongoing **2.** Review of pilot and identifying funding streams for permanent contracting of role, and recommissioning by Q4 2022/23 **3.** Ongoing **4.** Review of pilot and identifying funding streams for permanent contracting of role, and recommissioning by Q4 2022/23.	**1/2** Reduction of delay and maintenance of performance across times of pressure of stranded/super stranded data, and complex discharge dashboard performance data for people who are residents of care homes or being discharged under discharge to assess processes on Pathway 3 to a care home for the first time. **1/2** Reduction of delay and maintenance of performance across times of pressure of stranded/super stranded data, and complex discharge dashboard performance data for people who are residents of care homes or being discharged under discharge to assess processes on Pathway 3 to a care home for the first time.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
	North Place Discharge Cell for several years. We have ward staff trusted to complete discharge paperwork and two-way communication between discharge cell and ward to enable decision making. Timeliness of decision making is monitored in Dashboard to ensure we have continued trust of assessments by ward staff. **4.** An Independent care home trusted assessor service is commissioned and in place supporting both care homes and discharge to assess into care homes	enabling effective discharge planning. **4.** Independent provider of care home trusted assessor is in place as a previously funded pilot. Due for evaluation and recommissioning Q4 2023/4		

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 7 – Improved discharge to Care homes	**1.** We have embedded D2A in Pathway 3 and have established assessment processes for Care Act / CHC and finance assessments to be conducted after discharge in temporary care home placements. Independent care home trusted assessor in place.	**3.** Deficiency is access to reablement in some care homes and wanting to reduce unnecessary pathway 3 discharges to care homes and increase pathway 2 discharges to enable more patients to access bed based reablement. BCF 23/24 is aimed at development of Thackley Green to expand both bed base numbers based on trend data and also to develop skill set of staff to manage higher complexity to enable reduction of Pathway 3 and increase in Pathway.	**3.** Development and expansion of Pathway 2 Thackley Green in Q3/4 2022/23 **2.** Review of pilot and identifying funding streams for permanent contracting of role and recommissioning by Q4 2022/23.	**3.** Aiming to deliver centre of excellence for reablement able to achieve CQC rating of outstanding. Long term delivery programme over the 3-5 year Adult social care strategy. **2.** Review to identify effectiveness and long-term plan to commission independent care home trusted assessor from pooled budget source ongoing.

Impact Change	Where we are now	Plans to develop	Timeline to deliver	What success looks like
Change 8 – Housing and related services	**1.** We have dedicated housing officer in North Place discharge cell. Have VCSE who support with lower-level housing issues such as house cleans. We have had links with Adult Safeguarding Board and North Northants Council Safeguarding team on training across Housing/ KGH/ ASC regarding SAR learning around younger adults presenting in hospital as multi-exclusion Homelessness. **2.** Support North Northants (SNN) developing community based support of VCSE which will include housing needs such as white goods / deep cleans etc.	**3.** We continue to have identified lack of capacity of short-term and long-term housing solutions for people with physical care needs that cannot be met within standard temporary housing stock (hotel accommodation) such as wheelchair users and people requiring equipment such as Hospital beds. NNC ASC and Housing within one directorate in NNC looking at development opportunities and strategy 3-5 for ASC and housing and accessible housing.	**2.** Soft launch of SNN June 2023/24 for roll out to all communities by Q4 2023/24.	**2/ 3** Good will be based on the outcome framework (e.g., outcomes on health and social wellbeing/ economic wellbeing and personal resilience, etc obtained directly from person/ service user feedback. Monitoring of SNN effect on system partners capacity.

12. Supporting Unpaid Carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for 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 are an estimated 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; in almost 92% of cases it is 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, and 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.

We will continue to work with Northamptonshire Carers who 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.

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13. Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

What is your strategic approach to using housing support including DFG funding, that supports people staying at home?

- **have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a proportion of your DFG funding for discretionary services? 9Y/N)**

- **if so, what is the amount of funding that is allocated for these discretionary uses?**

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

From a housing and accommodation perspective as a unitary council, the housing function is part of the Executive Director for Adults, Health Partnerships, and Housing 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 and will continue to do so.

Our occupational therapy teams will continue to work 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. Therapy is working in collaboration with our housing colleagues through monthly meetings to understand our social housing stock (void properties), identify complex housing needs, and support matching people to accommodation that will support and maximise independence and wellbeing.

Private sector housing (PSH) is exploring discretionary grants which increase the scope for utilisation of DFG funds, particularly when more complex solutions are required. PSH continue to support Therapy, funding short term locums to manage demand into the service and reduce waiting times and improve response times moving to a more proactive & preventative approach.

Average minor request for Council owned properties submitted by Therapy: 30-40 per month
Number of DFG recommendations made: Approx 25 per month

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 will be 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 support and through end of life care, meeting the grant conditions**.**

14. Equalities and Health Inequalities

How will the plan contribute to reducing health inequalities and disparities in the local population taking account of people with protected characteristics? This should include

- **Changes from previous BCF plan**

- **How equalities impacts of the local BCF plan have been considered? and how they are being addressed through the plan and BCF funded services**
- **changes to local priorities related to health inequality and equality and how activities in this plan address these**
- **any actions moving forward that can contribute to reducing the differences in these outcomes**
- **how priorities and operational; guidelines regarding health inequalities as well as local authority priorities under the equality act and NHS actions in line with Core20PLUS**

Our BCF plan encompassing both our placed based version of 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 partnerships across organisations. We will aim to deliver care and join 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 a part of, our North Northants Place Based Strategy that we will continue to shape to ensure local services are targeted at local need and by local health inequalities. This will be done using 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. We will implement this 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.

Under the place-based version of 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.
Place-based version of 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 the place-based version of ICAN, is leading the expansion of personalised approaches giving individuals more choice and control over the way their care is planned and delivered.

Glossary of Terms

Term	Definition
ASC	Adult Social Care
BAME	Black, Asian, Minority Ethnicities
BCF	Better Care Fund
COPD	Chronic Obstructive Pulmonary Disease
DFG	Disabled Facilities Grant
DTA	Discharge To Assess
EMAS	East Midlands Ambulance Service
HICM	High Impact Change Model
HWB (sometimes HWBB)	Health and Wellbeing Board
IBCF	Improved Better Care Fund
iCAN	Integrated Care Across Northamptonshire
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ICT	Intermediate Care Team
JSNA	Joint Strategic Needs Assessment
KGH	Kettering General Hospital – The local Acute Hospital to North Northamptonshire
LAPS	Local Area Partnerships
MDT	Multi-Disciplinary Team

NHFT	Northamptonshire Health Foundation Trust
NHSE/I	National Health Service England / Improvement
NNC	North Northamptonshire Council (One of two Unitary Authority Councils in Northamptonshire)
ONS	Office for National Statistics
PCN	Primary Care Network
SNN	Support North Northamptonshire – A new service that fosters integrated working between the Voluntary Sector and statutory services
WNC	West Northamptonshire Council (One of two Unitary Authority Councils in Northamptonshire)
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.

Appendix 2 : North Northamptonshire BCF Planning template 2023-25

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: North Northamptonshire

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,561,759	£2,561,759	£0	£2,561,759	£2,561,759	£0
Minimum NHS Contribution	£26,657,250	£26,657,250	£0	£28,166,051	£28,166,051	£0
iBCF	£11,523,432	£11,523,432	£0	£11,523,432	£11,523,432	£0
Additional LA Contribution	£128,000	£128,000	£0	£128,000	£128,000	£0
Additional NHS Contribution	£2,661,114	£2,661,114	£0	£2,661,114	£2,661,114	£0
Local Authority Discharge Funding	£1,615,567	£1,615,567	£0	£1,615,567	£1,615,567	£0
ICB Discharge Funding	£1,908,708	£1,908,708		£1,908,708	£1,908,708	£0
Total	**£47,055,831**	**£47,055,830**	**£1**	**£48,564,631**	**£48,564,631**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£7,575,377	£16,728,244	£0	£8,004,143	£17,641,926	£0
Adult Social Care services spend from the minimum ICB allocations	£6,607,058	£8,659,477	£0	£6,981,017	£9,185,288	£0

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
1	Carers Support Services (CCG Contract)	This Service provides Carers health support ensuring that they can continue to	Carers Services	Respite services		786	955	Beneficiaries	Other	Northamptonshire Carers	NHS			Private Sector	Minimum NHS Contribution	Existing	£327,629	£346,173	
2	Carers Support Services NNC Contract	Council Contracted Service hosted by North Northants on behalf of both Councils -	Carers Services	Other	Assessment & Advice services	1625	1950	Beneficiaries	Other	Northamptonshire Carers	LA			Private Sector	Minimum NHS Contribution	Existing	£436,080	£460,762	
3	Continuing Healthcare	LD Health care at home/CHC/domiciliary care	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Continuing Care		NHS			Private Sector	Minimum NHS Contribution	Existing	£8,491,603	£8,972,228	
4	LD Service Delivery	LD service delivery-community based health support	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£3,464,905	£3,661,019	
5	Integrated Discharge Teams	Social Care Hospital assessment staff to support discharge/D2A processes,	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	Existing	£591,919	£625,422	
6	Integrated Discharge Teams	Social Care Hospital assessment staff to support discharge/D2A processes,	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF	Existing	£572,632	£572,632	
7	Telecare and Assistive technology	Assistive technology and call lifelines designed to help keep people safe in their	Assistive Technologies and Equipment	Community based equipment		2000	2000	Number of beneficiaries	Social Care		LA			Local Authority	iBCF	Existing	£200,000	£200,000	
8	Intermediate Care Teams (ICT)	Intermediate Care Teams (ICT)	Home-based intermediate care services	Reablement at home (to support discharge)		1326	1326	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	Existing	£4,379,334	£4,627,204	
9	Community Equipment (Health)	provision of universally available equipment and minor adaptions to support	Assistive Technologies and Equipment	Community based equipment		650	650	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	Existing	£901,019	£952,017	
10	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	Home-based intermediate care services	Joint reablement and rehabilitation service (to support discharge)		1775	1775	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£4,691,441	£4,956,977	
11	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	Home-based intermediate care services	Joint reablement and rehabilitation service (to prevent admission to hospital or residential care)		3350	3450	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£1,714,588	£1,847,317	
12	Safeguarding (Assurance) Teams	quality and safeguarding team responsible for monitoring the quality of	Care Act Implementation Related Duties	Other	Provider Quality, Advice and improvement				Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£346,706	£366,330	
13	Acute Psychiatric Liaison	Multi-disciplinary psychiatric liaison - service operating 24/7 at both acute	Community Based Schemes	Integrated neighbourhood services					Community Health		LA			NHS Community Provider	Minimum NHS Contribution	Existing	£300,155	£317,144	
14	Commissioning & Intelligence Capacity	Provision of commissioning capacity and expertise to support accelerated market	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution	Existing	£313,804	£331,565	

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	New/ Existing Scheme	Expenditure 23/24 (£)	Expenditure 24/25 (£)	% of Overall Spend (Average)
15	Demographic and care cost pressures	Demographic and care cost pressures	Residential Placements	Care home				Number of beds/Placements	Social Care		LA			Local Authority	iBCF	Existing	£7,043,715	£7,043,715	
16	Domiciliary Care	underlying pressure and provision for additional Dom care provision covering the	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Social Care		LA			Local Authority	iBCF	Existing	£3,707,085	£3,707,085	
17	Additional Reablement Capacity Tuvida	Tuvida	Home-based intermediate care services	Reablement at home (to support discharge)		396	475	Packages	Social Care					Local Authority	Local Authority Discharge Funding	New	£1,615,567	£1,615,567	
18	Remote monitoring in Care Homes	Remote monitoring	Assistive Technologies and Equipment	Assistive technologies including telecare		650		Number of beneficiaries	Community Health		LA			Local Authority	Minimum NHS Contribution	New	£84,720	£89,515	
19	Digital Campanion	Digital Companion	Assistive Technologies and Equipment	Digital participation services		40	40	Number of beneficiaries	Social Care					Local Authority	Minimum NHS Contribution	New	£100,000	£105,660	
20	Thackley Green	Thackley Green	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	Bed-based intermediate care with reablement (to support discharge)		432	432	Number of Placements	Social Care					Local Authority	ICB Discharge Funding	New	£1,760,789	£1,760,789	
21	Commissioning & Intelligence Capacity	Additional provision of commissioning capacity and expertise to support	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	ICB Discharge Funding	New	£147,919	£147,919	
22	Residential Short Breaks	Residential Short Breaks for Children	Carers Services	Respite services				Beneficiaries	Other	NHS	LA			NHS Community Provider	Minimum NHS Contribution	New	£403,574	£426,416	
23	Contingency	Unallocated	Other						Other	NHS	NHS			NHS	Minimum NHS Contribution	Existing	£64,773	£35,302	
24	Disabled Facilities Grants	The DFG provides funding through local councils to make adaptations to a	DFG Related Schemes	Adaptations, including statutory DFG grants				Number of adaptations funded/people	Social Care		LA			Local Authority	DFG	Existing	£2,561,759	£2,561,759	100%
25	Age Well													Local Authority	Additional LA Contribution	New	£128,000	£128,000	5%
26	Age Well													NHS	Additional NHS Contribution	New	£2,661,114	£2,661,114	95%
27	Commissioning & Intelligence Capacity	Additional provision of commissioning capacity and expertise to support	Enablers for Integration	Joint commissioning infrastructure										NHS	Minimum NHS Contribution	New	£45,000	£45,000	