North Northamptonshire Council

Meeting: Health and Wellbeing Board

Date: Tuesday 6th September, 2022

Time: 1.30 pm

Venue: The Council Chamber, Corby Cube, George Street, Corby, NN17 9SA

To members of the North Northamptonshire Health & Wellbeing Board

Cllr Jon Paul Carr - Chair	North Northamptonshire Council
John Ashton	Director of Public Health, North Northamptonshire Council
Dr Jonathan Cox	Chair Local Medical Committee
Cllr Scott Edwards	Portfolio Holder Childrens, Families, Education and Skills, North Northamptonshire Council
Naomi Eisenstadt	Chair, Northamptonshire Health and Care Partnership
Colin Foster	Chief Executive, Northamptonshire Childrens Trust
Shaun Hallam	Assistant Chief Fire Officer, Northamptonshire Fire and Rescue
Cllr Helen Harrison	Portfolio Holder Adults, Health and Wellbeing, North Northamptonshire Council
Michael Jones	Divisional Director, EMAS
David Maher	Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust
Cllr Macaulay Nichol	North Northamptonshire Council
Mike Naylor	Director of Finance, East Midlands Ambulance Service
Deborah Needham	University Group Hospitals Northamptonshire
Dr Steve O'Brien	University of Northampton
Dr Raf Poggi	Primary Care Network Representative
Toby Sanders	Chief Executive, NHS Northamptonshire CCG
Assistant Chief Constable Ashley Tuckley	Assistant Chief Constable, Northamptonshire Police
David Watts	Director of Adults, Communities and Wellbeing, North Northamptonshire Council
Sheila White	Healthwatch Northamptonshire

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Adele Wylie, Monitoring Officer
North Northamptonshire Council

Proper Officer
26 August 2022

This agenda has been published by Democratic Services.
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Health and Wellbeing Board
At 1.30pm on Tuesday 5 July 2022
Held at North Northamptonshire Council Offices, The Council Chamber, Corby Cube, George Street, Corby, Northants, NN17 9SA.

Present:-

Councillor Jon-Paul Carr (Chair)	North Northamptonshire Council
Councillor Scott Edwards	North Northamptonshire Council
Councillor Helen Harrison	North Northamptonshire Council
Councillor Macaulay Nichol	North Northamptonshire Council
John Ashton (via Teams)	Interim Director of Public Health, North Northants Council
Sally Burns	Director of Public Health, West Northamptonshire Council
Lisa Bryan (via Teams)	Northants Fire and Rescue
Dr Jonathan Cox	Chair, Local Medical Council
Louise de Chiara	Assistant Director Quality Assurance and Safeguarding, Northamptonshire Children's Trust
Michael Jones	Divisional Director, EMAS
David Maher	Deputy Chief Executive Northamptonshire Healthcare Foundation Trust
Professor Steve O'Brien	University of Northampton
Dr Raf Poggi	Primary Care Network
Toby Sanders	Chief Executive, NHS, Northamptonshire Integrated Care Board
Chief Superintendent Ashley Tuckley (via Teams)	Northamptonshire Police
David Watts	Director of Adults, Communities and Wellbeing, North Northants Council
Sheila White	Northamptonshire Healthwatch

Officers

Cheryl Bird	Health and Wellbeing Board Business Manager
Jenny Daniels	Democracy Officer (Democratic Services) (Minutes)
Alison Gilbert	Director of PLACE, North Northamptonshire Council
Polly Grimmitt	Director of Strategy, University Group Hospitals
Victoria Ononeze (via Teams)	Consultant in Public Health, North Northants Council
Henna Parmar	Public Health Officer – Suicide Prevention, North Northants Council
Amy Plank	Environmental Protection and Private Sector Housing Manager

25. Apologies for non-attendance

Apologies were received from Alan Burns (Chairman of KGH and NGH Group), Colin Foster (Chief Executive, Northamptonshire Childrens Trust) Ann, Marie Dodds (Director for Education), and Naomi Eisenstadt, (Chairman of the Integrated Care Board).

26. Notification of requests to address the meeting

None had been received.

27. Members' Declaration of Interests

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

No declarations were made.

28. Minutes of the Meeting Held on 10 March 2022

RESOLVED that: the Health and Wellbeing Board approved the minutes of the meeting held on 10 March 2022.

29. Action Log

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

- The Assistant Director of Adult Social Services would bring data on the unplanned admissions metric to the next meeting as this information was not currently available nationally.
- The Director of Public Health had asked for a media campaign to be included in Head Teachers newsletters.
- The Director of Adults, Communities and Wellbeing at North Northants Council would follow up with Samantha Fitzgerald regarding a conversation with Dr Steve O'Brien about possibilities for PhD students.
- The Director of Adults, Communities and Wellbeing at North Northants Council would continue to discuss neighbourhood policing and Local Area Partnerships with Assistant Chief Constable Ashley Tuckley.

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

30. Disabled Facilities Grant Annual Report 2021/2022

At the Chairman's invitation the Environmental Protection and Private Sector Housing Manager introduced this item highlighting the following:

- Work had been going on to clear the backlog of cases resulting from the pandemic over the last 18 months.
- The grant from central government for 2022/2023 was £2.5 million, with a carry forward sum of £1.5million from 2021/2022 and additional allocation 311k agreed by the Strategic Capital Board giving a total budget of £4.4 million. They had managed to spend £1.6 million including salaries so they had an underspend of £2.8million. There was £2.5million worth of cases in progress that would be allocated in the current year.
- These were mandatory grants that they were required to provide adaptions for disabled and vulnerable people to enable them to live independently in their own homes. This could mean they provided anything from grab rails to shower rails. The costs ranged between £3k and £30k. North Northants Private Sector Housing Policy allowed a spend of up to £40k for more complex schemes.

Timescales to deliver adaptions could range from 3-9 months depending on the scheme of works.

- There was an issue with recruitment; currently there were 2 vacant full-time posts for surveyors, with three unsuccessful recruitment cycles over the past 18 months. They would therefore undertake the agency routes and would get someone on a fixed term contract hoping this could lead to a permanent recruitment.
- There were also vacancies in the occupational therapy department which they were aiming to fill
- They had managed to spend £285,000 in the first quarter of the year.
- The service was advertised on the council website, they also reached out to social landlords, community occupational health teams and had recently advertised on a stall in the Cornmarket at Kettering.
- There were significant legal challenges. Cases must be reviewed within 6 months.
- Nationally there was a shortage of planned surveyors and builders to undertake the work. The Private Sector Housing Policy would be reviewed to create a broader housing policy which would do more future proofing of homes.
- Currently there were 578 people on the waiting list for an assessment: 90 cases were awaiting a survey and 63 cases needed to be fast tracked and 17 temporarily on hold.
- Once the backlog was dealt with, there could be an option to create a home improvement agency.

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

- The statutory element had not been reviewed for 20 years but the discretionary element had been reviewed in 2007/2008. The department was also considering providing emergency heating grants.
- They were still awaiting the new pay structure, so it was difficult to evaluate the post of surveyor. It had not been a well-paid post in the past so they were looking to advertise with market supplements in the short-term.
- The discretionary element needed to be increased from the current amount of £40,000 because those applying for it were means tested. Some residents were not eligible but remained on low incomes so would benefit from a review.
- They had two good contracts in the home improvement agency who had worked well in other areas of the country.
- The time residents waiting for an occupational therapist assessment had reduced from 25 to 14 weeks. Locums were currently assisting with this. They were confident that they would clear a lot of the backlog. Once a surveying contract was in post, they would be able to provide 12-14 surveys a month which would clear the backlog.
- There was no legal limit in relation for how long someone had to wait for an occupational therapist assessment to be completed.
- Occupational therapists could see a client in their own home or in hospital. Clients were risk assessed at the point of hospital discharge. They were classed as critical, urgent or standard. Clients classed as critical were always processed first and contact was made with organisations who wished for patients to be fast tracked and had checked on whether someone was at the end of life care.
- They did not liaise with the Fire Service in terms of visits. Their only requirement was to ensure safety access in the home. They would take into

consideration whether they required wheelchair users' safe access to get out of the home.

- The waiting list would include children. Cases were prioritised based on the critical need. Often children received their help quicker as they would get it free because they didn't need a means test. The figures relating to children would be provided following the meeting.
- Collaborative working with the Northants Fire and Rescue Service could be explored around completing risk assessments. When a surveyor completed a risk assessment and designed a scheme a fire escape was taken into consideration.
- The waiting list was for children, young people and adults and prioritisation on the waiting list was based on needs, Grants for children were not means tested.

RESOLVED that:

1) further information would be circulated relating to the numbers of children on the Disabled Facilities Grant waiting list following the meeting: and
2) the Health and Wellbeing Board notes the DFG spend to date for 2021/2022

31. Director of Public Health Annual Report

At the Chairman's invitation the Director of Public Health introduced the report stating it had been refreshed and covered the period from March 2020 until March 2022. It focussed mainly on the pandemic and should not be ignored as there were many things in it that the Council and its partners could learn from, particularly as COVID19 had not gone away.

The Chair gave thanks to the previous Director of Public Health for her hard work on putting the report together.

RESOLVED that:

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

32. Health Inequalities Plan

At the Chairman's invitation the Director of Public Health introduced the report stating it had been difficult to undertake the work within the timescales and formed part of the wider requirements of the Integrated Care Systems. The plan would be linked to the emerging Integrated Care Partnership Strategy and contained a set of actions . There had been strong national and regional guidance on how the report was to be approached. There was a need to be clear about how they would work in the 20% most deprived areas and how they aimed to work with travellers and consider 5 specific conditions.

A cross partnership working group had been created and reports of its first meeting had been good. Councillor Lawman had been appointed as the North Northamptonshire representative on this group.

The Health Inequalities Plan would be reviewed annually. There was also a toolkit to help them with their learning as they moved forward. Census information was received the previous week and would feed into the data.

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

- The lead for dealing with tobacco control would be the Chief Executive of NGH.
- As they progressed further into delivering the plan, they would need to have conversations with partners to ensure all the actions were covered and there was no duplication in the system.
- The Integrated Care Board 5-year plan would be able to move this work forward. Leadership and capacity was vital in being able to target communities rather than a universal approach.
- The GP contract was set nationally. General Practice might need some additional resource to help focus on an activity.

RESOLVED that: the Health and Wellbeing Board

1) Noted the Northamptonshire Integrated Care System Health Inequalities Plan and next steps for implementation; and
2) Board members would identify executive health inequalities leads in their organisations to join the Health Inequalities Oversight Board and oversee implementation of the plan.

33. Integrated Care System

At the Chairman's invitation the Chief Executive of NHS, Northamptonshire Integrated Care Board introduced the report stating they had now completed all the planning items like constitutions and agreeing terms of reference so now the work could begin.

The Director of Adults, Communities and Wellbeing at North Northants Council stated the first shadow Integrated Care Partnership Board had met and considered and supported proposals around place development. The papers included the Health and Wellbeing Board terms of reference as they needed to be agreed considering the Integrated Care System. In the North there would be four Community Wellbeing Forums, who would jointly have one representative at this Board. They may not necessarily be fully representative of black and ethnic minority groups so they had asked for a space should that be the case.

A PLACE Delivery Board would be mobilised to ensure development of the Community Wellbeing Forums and Local Area Partnerships, using existing budgets. A lot of delivery was expected from now on and they would bring forward any proposals from any learning.

The following was also confirmed:

- The democracy and standards committee had reviewed it and it would be going for approval at the end of the month.
- There was a larger volume of Integrated Care Board representation on it.
- It was noted there was a need not to lose the most important thing which was delivery of care to Northamptonshire residents.
- It was felt the local area partnerships did not adequately represent the population and it was down to the Integrated Care System to balance this between the north and west of the county.

RESOLVED that:

1) The Northamptonshire Children's Trust to be added to the Terms of Reference Board membership

2) Review the North Health and Wellbeing Board Terms of Reference for the Integrated Care System from 1 July 2022. These will be put forward for consideration to the Democracy and Standards Committee on 11 July 2022 and then to Full Council for approval on 28 July 2022;
3) Notes the progress of the Integrated Care Partnership North Place development since the North Place presentation to the Health and Wellbeing Board on 10 March 2022; and
4) Supports the proposed establishment of the North Northamptonshire Place Delivery Board to progress the mobilisation of the North Place development.

34. COVID 19 Update

At the Chairman's invitation the Director of Public Health introduced the report highlighting the following:

- COVID19 variants were now circulating widely in the community. In the last 2 weeks North Northants had seen a 50-60% increase in positive case rates. The data was received from national information on outbreaks and from the small number of PCR tests being completed.
- North Northants was slightly higher than the East Midlands average but lower than the national situation.
- There are currently 6 outbreaks in North Northamptonshire all in care homes.
- There had been a slight increase in the number of admissions to hospital; 40 in Northampton General Hospital and 58 in Kettering General Hospital, but the symptoms had been very less severe than in the past.
- The number of communications had been increased. The Health Protection team had worked hard to ensure the best advice was given.
- The advice was to stay at home and isolate if you felt ill, if going into crowded areas wear a mask and ensure vaccinations were up to date.
- The vaccination spring booster programme had been a particular success. The focus currently was ensuring all children received a second inoculation. Planning was taking place for the autumn vaccination programme.
- They expected to see a big rush in late summer/early autumn and the vaccination centre at Moulton Park would continue to be offered for the next 12 months.

The following was also noted:

- Members were asked if they had any influence with central government to request the flu and COVID vaccinations be advertised and provided at the same time. By doing this it was expected to significantly increase the amount of people being inoculated.
- The Health Protection Team had worked with colleagues in health to review vaccination levels with small communities. There was a huge disparity between the areas on what was undertaken, and they were working in different ways to encourage vaccinations.
- The correct community leaders to influence people needed to be found as many people did not take the vaccination for various reasons that they felt were good but needed to be overcome. The Local Area Partnerships were expected to be of help here. The information on where there had been difficulties would be shared.
- It was noted that national advice since April had been to invite more people in to visit care homes particularly during the jubilee celebrations. However, if the severity of illness returned there would be changes in the advice given.

RESOLVED that: The Director of Public Health West Northants Council will share information on communities with vaccine hesitancy with the Primary Care Networks the Health and Wellbeing Board notes the updates and the Northamptonshire Joint Health Protection Plan 2022-2024.

35. Health Protection Plan

The Director of Public Health introduced this item which looked ahead over the next 2 years. Health protection was about environmental disease and hazards. There were programmes to diagnose diseases such as Tuberculosis which were easy to pass on. The plan provided details of achievements and challenges. Because of the COVID pandemic many of the targets had fallen behind so the plan aimed to catch up on that. The plan had 9 themes around things such as Tuberculosis immunisations. The document also referred to some of the emergency planning arrangements which were now formally under the responsibility of the Integrated Care Board.

It was noted that an additional column where named individuals from the Integrated Care Board could be noted would be helpful.

RESOLVED that: the Board noted the Northamptonshire Health Protection 2022-2024.

36. Kettering General Hospital Re-Development

At the Chairman's invitation the Director of Strategy, University Group Hospitals provided an update highlighting the following:

- KGH had been announced as part of the government's plans to upgrade particular hospitals in 2014.
- KGH had several buildings on site only 2 of which were under 10 years old. The remainder of the buildings were very old. The boilers were 50 years old, and they were frequently without hot water and energy in the wards for long periods of time.
- The new buildings were designed to bring services from all the disparate services into one building. This would enable staff to move around the building and therefore assist people quicker.
- Car parking would also be improved.
- The Strategic Case was due to be submitted that week. Part of this reviewed 6 options from doing nothing to moving to a new site. This was narrowed down to 3 options based on the money available.
- The buildings required for the next 30 years was reviewed in line with population assumptions. These had been adjusted in line the with the iCAN programme which aimed to keep people out of hospital.
- They would move from having 634 beds to 671.
- The plan reviewed all the benefits of building the new builds. Workforce efficiencies for the staff and patients was compared with the capital costs. The preferred option would be to have a 2 phased build. It would cost approximately £600million and the first phase would be a 6-storey building. It would include a brand new A&E department for adults and children on the ground floor followed by wards and frailty units on the additional storeys.

- There would also be a new energy centre and new electrical infrastructures. Enabling works would include moving more services offsite whilst work was ongoing.
- They were hopeful the plans would bring them to constructing the first building early in 2024. In all nationally 40 hospitals were required to be built by 2030.

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

- Some public events had already taken place and further events were planned. They were very tightly controlled by the national communications team on what they could do but once the public board had met, they could build on it.
- The energy centre would lower the carbon footprint by 50%. They were keen to move as much into communities which lowered the carbon footprint for patients.
- Central Government were keen to control all building work for the 40 hospitals because they needed to control the trade in each area but as far as possible, they were keen to use local suppliers.

RESOLVED that: the Health and Wellbeing Board notes the update on the Kettering General Hospital re-development.

37. Better Care Fund End of Year Performance 2021/2022

At the Chairman's invitation the Director of Adults, Communities and Wellbeing, North Northants Council introduced this item stating they were required to monitor the matrix through the Better Care Fund. It was concerned with avoidable admissions, lengths of stay in hospital, people discharged to their place of residence, care homes and reablement. They hadn't yet received the information nationally so had not been able to publish information on avoidable admissions. There were 2 matrix for lengths of hospital stays. One was 14 days or more and one was 21 days or more. For June they had performed better in both indicators although the average was 8.3%.

Those discharged to their usual place of residence was 95.3% against a target of 95.1%

On admission to Care homes there was a rate of 624.3 per hundred thousand of population which was an under performance in relation to the 2021/2022 of 604 per hundred thousand of population.

The final month's performance in relation to people still at home over 90 days of discharge from hospital showed them performing at 72% with the monthly average for the year being 57.8%. Much of the challenge had been in supporting people to get back into their own homes as part of Integrated Care across Northamptonshire (iCAN). As part of this they were focussing on improving pathway 1 which was getting people back to their own homes and then a knock on improvement to pathway 2 which was going back to care homes for a period until they were safe to go home.

In relation to a query on the report it was confirmed that there was a very small portion of people staying in hospital or having periods of time in a care home because of waiting for adaptions to their property so they could return home safely. These people would meet critical requirements and would be prioritised..

RESOLVED that: the Health and Wellbeing Board:

1) Approves the performance template for the Better Care Fund schemes (2021/22); and
2) Notes the proposed timelines for the Better Care Fund Plan for 2022/23.

38. Group Clinical Strategy

At the Chairman's invitation the Director of Strategy, University Group Hospitals introduced this report stating the following:

- The group was formed by Northampton and Kettering General Hospitals joining together with the aim to improve the hospital experience of patients. In some areas there were very unreliable resources.
- Acute care in the county had a variation in outcomes and waiting times. Some parts of the county had a variation in access to services.
- 87% of the staff felt working together on a strategy would provide improved outcomes for patients. A series of areas were identified that staff felt they should be working on.
- A clinical ambition document had been agreed in November 2021 and they had spent the winter going out to stakeholders. Details of their responses were included in the pack and the document had been amended in line with the comments.
- They would work on 4 areas. The first was working with all partners and the Integrated Care Board and their role within it would lead on that. Acute and primary care would put the seamless pathways in place.
- They were ringfencing elective capacity. They were dedicated to protecting this so patients would get planned operations when they were told they would.
- Centres of excellence. Cardiology and North Northants already undertook some good areas in cardiology. They wished to bring treatments people travelled to Leicester or London for to the county.
- Cancer Care. They wished to develop a centre of excellence and would bring in specialist staff to really improve their cancer carer over the next 4 years.
- They would not change where services were provided. Co-locating services could drive up patient outcomes. They would continue their engagement with this and local communities as they moved forward.

In answer to comments on the strategy the following was noted:

- It was noted the strategy set the benchmark for partners and it provided the opportunity to consider how to generate the desire to come, work, live and stay in the county. The links would be created between health inequalities and the emerging Integrated Care Partnership Strategy and Outcomes Framework.
- They could meet and discuss some areas of development so that in a couple of months standardisation of the work would be achieved.
- The opportunity to link up with primary care was there and those in primary care would be keen to promote job shares.
- Links with the university would strengthen the search for staff. It was suggested the health and wellbeing board could receive an update from the Northamptonshire People's Board on staff recruitment and retention. .

RESOLVED that: the Health and Wellbeing Board:

1) Notes the significant engagement that has taken place with staff, patients, the public and local stakeholders in developing this Group Clinical Strategy; and
2) Approve the document as a strategic direction of travel for acute hospital care in the county.

(The Chief Executive of the NHS, Northamptonshire Integrated Care Board left the meeting at 3.30pm.

39. Mental Health Prevention Concordat

At the Chairman's invitation, a Consultant in Public Health reported on the support of things that had been undertaken within the Population Health and Prevention pillar within the Mental Health Learning Disability and Autism Collaborative. (MHLDA) Across Northamptonshire the impact the Pandemic had had on the mental health and wellbeing of residents was clear to see. It was presented in services but also at a community level. Signing up to the Mental Health Prevention Concordat gave a real signal that they had were meeting the need. This was previously managed by Public Health England but was now managed by the Department for Health and been amended to include the emerging Integrated Care Systems.

RESOLVED that: the Board agrees to sign up to the Prevention Concordat.

40. Northamptonshire Suicide Prevention Strategy

At the Chairman's invitation, the Public Health Officer for Suicide Prevention introduced the item stating there were a range of representations from the Suicide Prevention Steering Group from a wide variety of agencies. The local picture was like that of the national one except for the number of Children and Young People self harming being slightly higher. This was an all age strategy and the strategy was being refreshed to represent 2022-2025.

The Suicide Prevention Steering Group lead on the implementation of actions, the MHLDA collaborative will provide strategic oversight and monitoring progress would be reported through the MHLDA collaborative and the two Health and Wellbeing Boards.

Included in the Strategy was countywide data and key areas achieved from the previous strategy. Work was also taking place with Northants Police to provide real time data on suicides coming across Northamptonshire. The priority areas in the refreshed strategy were in line with national priorities and included:

- Reduce risk of suicide on key high-risk groups, these had not been identified yet, and were waiting for the deep dive audit, looking at 270 cases, collecting data on ethnicity, education, sexual orientation and address.
- Completing mapping to ensure there was no cross over with the work being completed, to identify gaps and develop areas.
- Take approaches to improve mental health in specific groups and what can be done for specific groups at risk.
- Reduce access to means of suicide, working with partners, transport and highways agencies to locate areas of risk and ensure necessary safety measures were in place.
- Provide information and support to those suffering from bereavement from suicide, working with these agencies to ensure they were supported in the right place at the right time, reaching people and analysis of these services for future development areas.
- Working with the media to develop sensitive approaches to suicide and suicide behaviour.

- Supporting research and data monitoring working with steering group partners to ensure they had the right level of data and monitoring data.
- Reducing rates of self-harm, which was a key indicator of suicide risk, develop a self-harm surveillance system.
- Looking to develop a support package for education establishments, to support staff, parents and students.

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

- Northants Fire and Rescue were emergency responders to suicide incidents and already completed some prevention work with adults and children at risk from suicide.
- Could a support task force be in place, to mobilise quickly to families and communities affected by suicide and stay with them until they recover. Northamptonshire Healthcare Foundation Trust offered to support this.
- There were some high-risk groups within the children and young people cohort who had experienced adverse childhood experiences or child sexual exploitation. The strategy could be used to help deliver the action plan for these groups.
- Part of the action plan was to have a different approach to support people who were known to many agencies within the county on an individual level.

RESOLVED that the Board:

1) Endorsed the Northamptonshire Suicide Prevention Strategy 2022-2025 and Action Plan
2) Endorsed the recommendation that the Suicide Prevention Steering Group lead the implementation of strategy, working closely with local partners and communities
3) Endorsed the recommendation that the Mental Health Learning Disability Autism (adults), and Healthy Minds and Healthy Brains (children and young people) Collaboratives maintain strategic oversight of the implementation of strategy
4) Endorsed the recommendation that the Mental Health Learning Disability Autism Executive Board signs of strategy

41 Recovery from the pandemic and way ahead

At the Chairman's invitation the Director of Public Health introduced the item highlighting there had been a lot of learning from the pandemic, with a rapid need for collaborative working across statutory bodies which must be treated as a legacy and built on. Derek Wandsworth had identified 3 scenarios for the NHS which was the basis for reviewing funding levels:

- Carry on doing things the way they had always been done: the NHS would fail.
- If we used best practice as an evidence base to bring the weakest up to the level of the best then the NHS still fell over but more slowly,
- Do things differently, using full engagement with the public to re-orient our health service to be more based in public health prevention and primary care.

There was a desire n Northamptonshire to connect public health across the councils, and to make sure public organisations were created that recognised most health was gained and lost outside of local authorities and health services but in everyday life. Full engagement was needed in communities and neighbourhoods and the mechanisms for this were being developed through the Local Area Partnerships and Community Hubs.

The Board discussed this, and the following was noted:

- There was a need to make strong links with agencies supporting the wider determinants of health, and strengthen relationships built during across the pandemic.
- Health was at home and hospital was for repair, and there was a need to focus on this.
- Teams would be dealing with latent problems occurring in communities suppressed by the pandemic which needed to be articulated in strategies.

There being no further business the meeting closed at 4.43pm.

North Northamptonshire Health and Wellbeing Board Action Log

Action No	Action point	Allocated to	Progress	Status
100322/03	Steve O'Brien and Sam Fitzgerald to discuss opportunities for a PhD student.	David Watts	David Watts to follow up with Sam Fitzgerald	

Actions completed since the 5th July 2022

Action No	Action point		Progress	Status
050722/01	Further information would be circulated relating to the numbers of children on the Disabled Facilities Grant waiting list following the meeting to Louise De Chiara	Amy Plank	Completed. Circulated on the 14th July	**Completed**
050722/02	Northamptonshire Children's Trust to be added to the Terms of Reference Board membership	Cheryl Bird	Completed. 6th July	**Completed**
050722/03	The Director of Public Health West Northants Council will share information on communities with vaccine hesitancy with the Primary Care Networks.	Sally Burns	Health Protection Team are providing information to the Primary Care Networks	**Completed**
050722/04	Louise De Chiara and Henna Parmar to discuss how the Strategy can help deliver the Children and Young People Action Plan	Louise De Chiara/Henna Parmar	Completed.	**Completed**

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North Northamptonshire Council

North Northamptonshire Health and Wellbeing Board
6 September 2022

Report Title	**Integrated Care Partnership (ICP) Strategy and North Place Development**
Report Authors	David Watts - Executive Director of Adults, Communities and Wellbeing (DASS) Ali Gilbert - ICS Place Director

List of Appendices

Appendix A – DHSC ICP strategy statutory guidance
Appendix B – ICP strategy development board terms of reference
Appendix C – North Place delivery Group terms of reference

1. Purpose of Report

1.1 To provide an overview of the development of the Northamptonshire Integrated Care Partnership (ICP) strategy.

1.2 To provide an update on the progression of the Northamptonshire Integrated Care System development of 'the North place' as outlined in the last North Health and Wellbeing Board meeting.

2. Executive Summary

2.1 Since the last HWB meeting, the DHSC have published statutory guidance for the Integrated Care Partnerships' (ICP) central role in the development of a strategy to support the planning and improvement of health and care.

It proposes that 2022/23 will be a 'Transition Year' recognising the time available will limit the breadth and depth of the initial integrated care strategy. It is expected that the integrated care strategy will mature and develop over time. The guidance includes statutory requirements which need to be included in the strategy content.

2.2 Since the last North Northamptonshire Health and Wellbeing Board ,a North system stakeholder event has been held to explore and develop the function of the LAPs and CWF. The event was led by Councillor Helen Harrison, Executive Member, Adults, Health and Wellbeing, David Watts and Ali Gilbert.

2.3 The inaugural meeting of the North Place Delivery Group was held on 22 August 2022 to progress and implement the North Place development, ensuring that the governance framework is simple, functional and enables the development and functioning of the LAPs and Community Wellbeing Forums.

3. Recommendations

3.1 It is recommended that the Board:

a) Note progress of the Integrated care Partnership Strategy development;
b) Note the progress of the Integrated Care Partnership North Place development.

3.2 Reason for Recommendations

The North Northamptonshire Health and Wellbeing Board has made a commitment:

a) To contribute to the development of the emerging ICP Integrated Care Strategy;
b) To provide oversight of the North Place development and progress made by the North Place Delivery Group.

4. Report Background

4.1 Integrated Care Partnership (ICP) Strategy

Since the last North Northamptonshire Health and Wellbeing Board meeting, the DHSC have published statutory guidance for the Integrated Care Partnerships' (ICP) central role in the development of a strategy to support the planning and improvement of health and care.

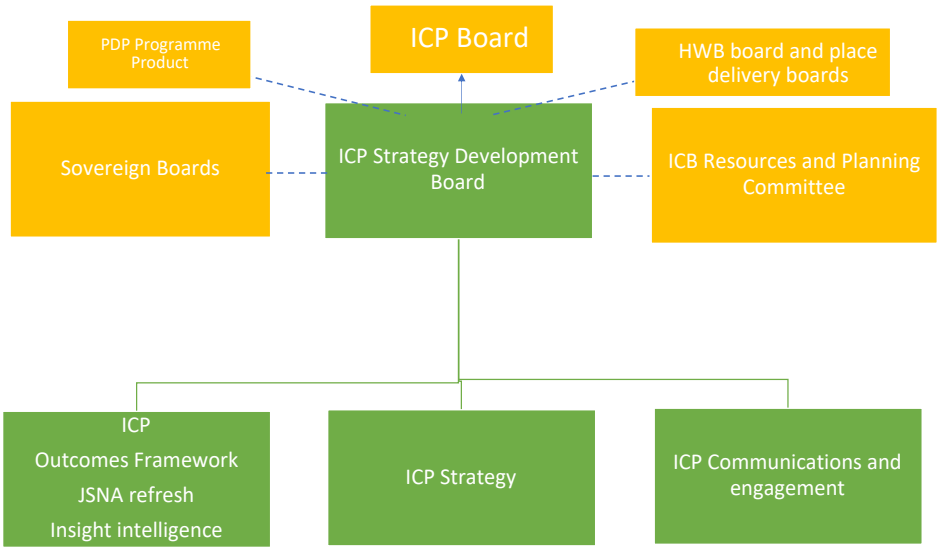
Appendix A provides a summary overview of the guidance, and it proposes that 2022/23 will be a 'transition year' recognising the time available will limit the breadth and depth of the development of the initial integrated care strategy. It is expected that the integrated care strategy will mature and develop over time.

The guidance defines statutory requirements which need to be included in the strategy content and includes:

- Strategy based on evidence and needs assessment
- To deliver system-level, evidence-based priorities in the short, medium- and long-term
- Integration of health and social care and wider determinants of health and wellbeing
- Consideration of joint working and opportunity for section 75 agreements.
- Extensive engagement and involvement
- Contents of the strategy to build on existing strategies.
- To publish by December 2022 the content of the Integrated Care Strategy.

The North Northamptonshire Health and Wellbeing Board will own and develop a Health and Wellbeing Strategy for North Northants that will underpin the Integrated Care Strategy, focused on its inequalities, health challenges and solutions that drives local service design. This is a key requirement of the ICP and will influence the ICB's 5-year Commissioning Plan.

The Northamptonshire Strategy Development Board has been established to progress the development of the strategy and are working short term with PA Consulting to produce an initial high-level framework in line with the recently published DHSA guidance. **Appendix B** covers the terms of reference of the board.



PA Consulting are currently working within the ICS Strategy Development Board to develop an outline strategy which incorporates existing strategic materials existent with the ICS to anchor the strategy. This will be aligned to the ICS ambitions and 'Live Your Best Lives' framework connected to the ICS outcomes framework and it will be compliant with the statutory guideline ask.

Engagement with wider stakeholders is being progressed as an integral component of the development.

4.2 North Place development

4.3 Since the last North Northamptonshire Health and Wellbeing Board, a North system stakeholder event has been held to explore and develop the function of the LAPs and CWF. The event was led by Councillor Helen Harrison, Executive Member, Adults, Health and Wellbeing, David Watts and Ali Gilbert with 54 attendees.

4.4 The inaugural meeting of the North Place Delivery Group was held on 22 August 2022 to progress and implement the North Place development, ensuring that the governance framework is simple, functional and enables the development and functioning of the LAPs and Community Wellbeing Forums.

The aims of the North Place Delivery Group proposed were agreed as:

- To further refine of the North Place shared vision, ambitions, and objectives based on the output of the National place development programme underway
- To develop and mobilise the North Place delivery plan
- To further develop a more coordinated, collaborative stakeholder approach of the engagement, co-production, and community activation
- To agree the population groups and development of the appropriate functions of the community wellbeing forums and LAPs
- To support the response of the PCNs to the Fuller report and their alignment with the LAPs
- To implement the insight data tool presented to the ICP on 31 May 2022
- To develop the data intelligence infrastructure to support prioritisation and decision making
- To support the opportunities of North Place transformational commissioning development opportunities with the collaboratives, eg BCF and iCAN
- To support the delivery of the ICS collaboratives where appropriate at place
- To utilise estate enablers to support the developments – asset mapping
- To oversee the emergent voluntary sector infrastructure proposals

Appendix C covers the agreed full terms of reference.

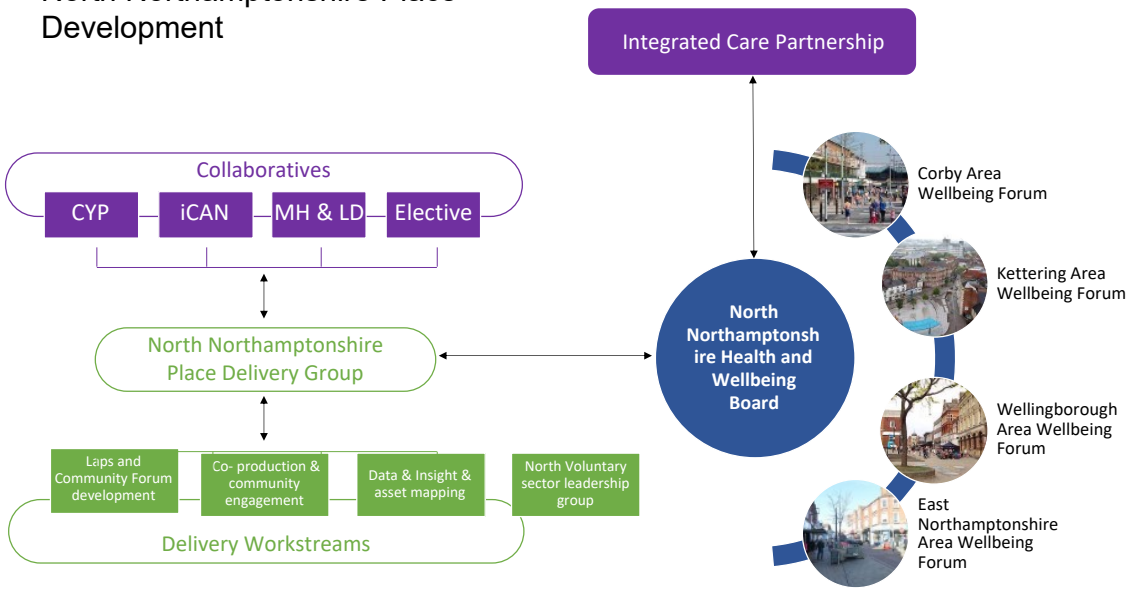
The following are the outline headlines from the inaugural North Place Delivery Board meeting held on 22 August 2022:

- The terms of reference were agreed at Appendix C
- The voluntary sector infrastructure leads, and Voluntary Impact Northamptonshire (VIN) presented a proposal on working collaboratively to support the development of the LAPs. National grants for the North VCSE development have been secured.
- The LAP overall functions were agreed as local design and ‘doing’ partnerships which will support the delivery function of the ICS collaboratives by bringing in the wider determinants of health aspects to address inequalities and support the delivery of the population outcomes, described in the ICS outcomes framework
- LAP boundaries will start as being aligned to the existing North Northamptonshire Council electoral wards
- One LAP to be agreed as the protype /pioneering LAP and will accelerate its development and lessons learnt to be applied to the other emerging LAPs
- Progress on the approach to mapping of the LAP boundaries was presented which will encompass police beat boundaries, General Practice and future LAP asset mapping
- Community Wellbeing Forums – review of the Healthwatch led review of the existing forums to be considered as the developed function of the CWF’s progresses
- ICS and local community and engagement leads will work with North Place development leadership and Healthwatch to start to explore and test the

community engagement approach for the LAPs in preparation for their development

- GP lead nominations for the new four GP locality boards has completed and four GP leads have been confirmed. North GP leadership touchpoints are being planned to ensure the North Place development work is embedded into the locality meetings routinely.
- Public Health leads have established a North business intelligence forum to progress the data and intelligence insight and tools for the LAPs, including an asset-based mapping approach
- Strengthened connectivity with the ICS Population Health Management Group is to be progressed

North Northamptonshire Place Development



5. Issues and Choices

5.1 The ICS and its requirements are requirements under the legislation laid out in the Act and therefore health and social care bodies are required to have in place the specified governance arrangements for 1 July 2022. The structure of the North Place has been developed in consultation with a wide variety of stakeholders and we have taken these views into consideration as part of the final proposal for the ICS operating model

6. Implications (including financial implications)

6.1 Resources and Financial

6.2 There are currently no identified financial implications.

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

7. Legal

7.1 There are currently no legal implications

8. Risk

8.1 The wiring of the governance of the emergent place operating model, the ICP , the ICB and the collaboratives is being addressed to ensure that the existing statutory governance and decision making of organisations is connected into ICS operating model decision making.

9. Consultation

Communications will play a key role in informing and engaging the public around the creation of the new ICS and explaining the objectives, priorities to our local communities and how these will translate into future improved outcomes to meet their health and care needs.

10. Consideration by Scrutiny

10.1 No further consideration by scrutiny has been undertaken since the last HWB meeting

11. Climate Impact

There is currently no identified climate or environmental implications.

12. Community Impact

The development of Place will create positive impacts on communities, wellbeing and on our ability to collectively support better outcomes for residents. Key priorities at a local level underpinned by insight data and led by Local Area Partnerships will

drive the delivery of services that meet the wider determinants of health supporting people to live their best life in North Northamptonshire.

Background Papers

Appendix A - DHSC ICP strategy statutory guidance
Appendix B - ICP Strategy Development Board terms of reference
Appendix C - North Place Delivery Group terms of reference

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Integrated Care Northamptonshire

DHSC Statutory Guidance for the Publication of the Integrated Care Strategy

Summary – 29 July 2022

Appendix

Ali Gilbert – ICS Place Director

North Northamptonshire Council

Considerations for the ICP Strategy Development Board - 3 August 2022

- In order to monitor our progress we require a consolidation of activities into a comprehensive milestone plan: Strategic Outcomes Framework, JSNA refresh, utilisation of Insights Data to inform strategy; Comms and engagement plan for now; PA strategy production.
- Decision making / approval process for the Integrated Care Strategy to be mapped and agreed (including ICB and ICP processes).
- Approach to development of Integrated Care Strategy, 5 Year Joint Future Plan and 1-2 Year Operational Plan needs socialising with decision makers in LAs, ICP and ICB to seek agreement.
- Engagement and involvement high priority in statutory guidance; what is sufficient for first draft? Comms, engagement and involvement plans are required beyond December 2022.
- Is the strategy still routed through and based on the 10 ambitions in LYBL and the Outcomes Framework?
- New statutory guidance is focused around health and social care integration – the 10 ambitions will help broaden our scope and provide focus on wider determinants of health - ‘health related’ services.
- Is the ICP set up as a joint committee?

Overview of the new statutory guidance

- **2022/23 Transition Year:** the time available will limit the breadth and depth of the initial integrated care strategy. It is expected that the integrated care strategy will mature and develop over time.
- The Health and Care Act 2022 establishes integrated care boards and requires them, with partner local authorities, **to form a joint committee: the integrated care partnership.**
- Guidance includes statutory requirements i.e. MUST do's therefore need to be included in the Strategy content
- Strategy based on evidence and needs assessment.
- Integration of health and social care and wider determinants of health and wellbeing. To deliver system-level, evidence-based priorities in the short-, medium- and long-term.
- Consideration of joint working and opportunity for section 75 agreements.
- Extensive engagement and involvement (**Annex A: people and organisations to consider involving).**
- Contents of the strategy: Building on existing strategies. Need to ensure we have narrative for each content section (see next slide) and evidence of all statutory requirements.
- Publication and review: Publish by December 2022

Content of the Integrated Care Strategy

- Shared outcomes (Strategic Outcomes Framework, JSNA refresh)
- Quality improvement
- Joint working and section 75 of the National Health Service Act 2006
- Personalised care
- Disparities in health and social care
- Population health and prevention
- Health protection
- Babies, children, young people, their families and healthy ageing
- Workforce
- Research and innovation
- ‘Health-related’ services
- Data and information sharing

Introduction (1)

- The integrated care strategy should set the direction of the system across the area of the integrated care board and integrated care partnership, **setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life.**
- The integrated care strategy presents an opportunity to do things differently to before, such as reaching beyond 'traditional' health and social care services **to consider the wider determinants of health or joining-up health, social care and wider services.**
- The development of the integrated care strategy can be used to agree the steps that partners, working closely with local people and communities, will take together to deliver system-level, evidence-based priorities in the short-, medium- and long-term.
- During this transition year, we recognise that the time available to develop initial integrated care strategies will be shorter than desired. We recognise that this may limit the breadth and depth of the initial integrated care strategy. **We expect that the integrated care strategy will mature and develop over time.**

Introduction (2)

- The Health and Care Act 2022 establishes integrated care boards and requires them, with partner local authorities, **to form a joint committee: the integrated care partnership.** The integrated care partnership may appoint additional members and determine its own procedures including the processes for agreeing the integrated care strategy.
- The integrated care strategy must set out how the assessed needs (identified in the joint strategic needs assessments) of the integrated care board and integrated care partnership's area are to be met by the exercise of functions by the integrated care board, partner local authorities, and NHSE (when commissioning in that area). These commissioners must have regard to the relevant integrated care strategy when exercising any of their functions, so far as relevant.
- This includes their commissioning functions, plans and strategies (including the integrated care board and Partner NHS trusts and NHS foundation trusts 5-year joint forward plan) and working with their system partners.

Introduction (3)

- **Transitional period:** 2022 to 2023 will be a transition period. We expect that integrated care partnerships will want to refresh and develop their integrated care strategy as they grow and mature. In order to influence the first 5-year joint forward plans which are to be published before the next financial year, the integrated care partnership would have to publish an initial strategy by December 2022.
- Once a strategy is published, integrated care partnerships should continue to consider how it is implemented. The strategy could include key strategic priorities for system-level action, to tackle the needs identified in the joint strategic needs assessments, complementing what is already being done at 'place'
- This is not about taking action on everything at once, nor should the key strategic priorities for system-level action be overly prescriptive on what is occurring locally, for example in health and wellbeing boards. It should aim to build upon previous system-level plans and strategies.
- The Care Quality Commission's reviews will assess how the integrated care strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for its population. This could include, for example, the equal partnership between the integrated care board and the integrated care partnership.

Introduction (4)

- The Care Quality Commission's reviews will assess how the integrated care strategy is used to inform the commissioning and provision of quality and safe services across all partners, within the integrated care system, and that this is a credible strategy for its population. This could include, for example, the equal partnership between the integrated care board and the integrated care partnership.
- Integrated care partnerships should ensure the full utilisation of public health expertise and leadership, centring on the local directors of public health. The strategy should include measures to improve health and wellbeing outcomes and experiences across the whole population, including addressing the wider determinants of health and wellbeing.
- Integrated care partnerships should ensure that the integrated care strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.
- The integrated care partnership should ensure that it builds the principle of subsidiarity in the system, encouraging partners to reflect on whether decisions and delivery are happening at the right level when they produce the strategy.
- Integrated care partnerships should involve chairs of health and wellbeing boards, local authority directors of children's services, adult social services, and public health and their teams in the production of the integrated care strategy.

Statutory Requirements
Legal Duties and Powers (1)

	Statutory Requirements
1)	The integrated care strategy **must** set out how the 'assessed needs' from the joint strategic needs assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.
2)	In preparing the integrated care strategy, the integrated care partnership **must**, in particular, consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006.
3)	The integrated care partnership **may*** include a statement on better integration of health or social care services with 'health-related' services in the integrated care strategy. *action could be taken, but it is not a requirement to do so

Statutory Requirements
Legal Duties and Powers (2)

	Statutory Requirements
4)	The integrated care partnership **must** have regard to the NHS mandate in preparing the integrated care strategy.
5)	The integrated care partnership **must** involve in the preparation of the integrated care strategy: local Healthwatch organisations whose areas coincide with, or fall wholly or partly within the integrated care partnership's area; and people who live and work in the area.
6)	The integrated care partnership **must** publish the integrated care strategy and give a copy to each partner local authority and each integrated care board that is a partner to one of those local authorities.
7)	Integrated care partnerships **must** consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.

Evidence, Prevention and Inclusion

North Northamptonshire Council

Evidence of Need

- Integrated care partnerships should use the JSNA assessments to explore gaps in care, unwarranted variation, and disparities in health and care outcomes and experiences between parts of the population and understand opportunities where system wide action could be effective in improving these, including addressing the wider determinants of health and wellbeing, and preventing ill-health and future care and support needs.
- However, integrated care partnerships should aim to go further, drawing on additional intelligence such as assessments of local communities and needs developed by providers; the perspectives of local communities, and evidence from research and practice to build on their understanding of health and care needs and further articulate how those needs can be met.

Evidence based prevention measures

- Integrated care partnerships should consider evidence-based **prevention measures** in the integrated care strategy to:
  - prevent and reduce mental and physical ill health and their risk factors;
  - hospitalisation and rehospitalisation;
  - the loss of independence;
  - avoidable and premature mortality;
  - long-term ill-health; and future care and support needs.
- This requires early identification of risk factors and illness and acting early to reduce their impact on individuals once identified.

Inclusion health groups

- The integrated care strategy should identify opportunities for research where there are gaps in evidence either of health and care need or gaps in how the needs of under-represented groups might be effectively met.
- Integrated care boards to have regard to the need to reduce inequalities between persons, not just patients, in respect to access to health services.
- The integrated care strategy should ensure that the needs of underserved populations are identified and met through the integrated care board, NHS England, or responsible local authorities exercising their functions.

Engagement & Involvement

Please also see Annex A: people and organisations to consider involving

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Involving people and organisations

- It will be, at times, more appropriate for the individuals or organisations to be involved directly at a local level in their neighbourhoods and communities rather than at the level of the integrated care partnership.
- The integrated care partnership should complement and champion this place-based and neighbourhood engagement and ensure that there are mechanisms for relevant local insights to inform the integrated care strategy.
- We recognise that 2022 to 2023 is a transition year, and the level of engagement might need to vary, according to the time and resource available to engage people and organisations in in the preparation of the initial integrated care strategy. However, we do expect this engagement to increase as the integrated care partnerships mature, and integrated care strategies develop.

Providers of health and social care services

- The integrated care partnership should map out the different types of providers and practitioners who should be engaged in the development of their initial strategy and then who will be involved in the further development and refresh of the strategy. This mapping should be inclusive of voluntary, community, and social enterprise (VCSE) and independent sector providers. In larger systems, it might be necessary for each place to gather this information and share it upwards with the integrated care partnership to ensure full coverage.
- Providers of adult and children's social care, primary care (including general practice, pharmacy, eye care, dental and audiology services), community health services, secondary care, and public health services will have important insights into how the needs of local people can be met due to their knowledge, experience and direct links with people who draw on health and social care.
- The integrated care partnership should engage a diversity of perspectives in the strategy, and **not assume that the commissioners are adequate proxies for the provider voice**. For example, for adult social care providers, integrated care partnerships could draw on care associations or similar local, regional or national networks, such as registered managers and individual's networks.
- When engaging with adult social care providers, the integrated care partnership should use the guidance on the expected ways of working for integrated care partnerships and adult social care providers to ensure that they are appropriately engaged in the development of the integrated care strategy.
- As well as involving providers, the integrated care partnership should involve **clinical and care professionals, including those working on the front-line in health and social care** as they will have important expertise on how services can be constructed and successfully delivered. To achieve this, they can work through the existing infrastructure that supports clinical and care leadership, to help ensure the widest possible range of clinical and social care leaders are able to contribute

VCSE

- There are a wide range of VCSE organisations that each fulfil a variety of roles including, but not limited to, organisations led by people with lived experience, service providers (including for social prescribing provision), advice and advocacy services, funders of research; tackling disparities in health and care and influencing the wider determinants of health.
- VCSE alliances, or similar entities, are present in each area, and will be important in the production of the integrated care strategy. Integrated care partnerships should also consider the different roles VCSE organisations can play and involve them when relevant, for example, when involving people and communities or providers.

Wider Organisations

The integrated care strategy **may** include a statement on integration with other services that impact upon peoples' health and wellbeing but are not health and care services. Examples will include employment support, housing and homelessness services and leisure services
Other groups such as businesses, employers, housing providers (particularly registered providers of social housing) and local planning services play a critical role in supporting the health and wellbeing of the local community. Engaging, and involving with them can identify new opportunities and innovative ways to improve population health.

Content of the Integrated Care Strategy

- Shared outcomes (Strategic Outcomes Framework, JSNA refresh)
- Quality improvement
- Joint working and section 75 of the National Health Service Act 2006
- Personalised care
- Disparities in health and social care
- Population health and prevention
- Health protection
- Babies, children, young people, their families and healthy ageing
- Workforce
- Research and innovation
- ‘Health-related’ services
- Data and information sharing

Babies, children, young people, their families

- When producing the integrated care strategy, the integrated care partnership should consider how the needs and health and wellbeing outcomes of babies, children, young people and families can be met and improved.
- These outcomes are shared by many partners, and the strategy should consider the integration of children's services and, for example, whether joint commissioning and the pooling of funding under section 75 of the NHS Act 2006 would meet their needs more effectively.
- Family hubs, where appropriate, should be considered as an opportunity to integrate with wider health-related services.
- The integrated care partnership could support local safeguarding work, but the safeguarding partners retain the statutory responsibilities for safeguarding children in their local area

Healthy ageing

- Recognise that older adults experience the largest burden of noncommunicable disease, including cancer, dementia, and cardiovascular disease.
- The integrated care partnership should consider when preparing their integrated care strategy how the needs and health and wellbeing outcomes of older adults can be prevented met and improved, including through mechanisms such as improved housing and technological solutions; and
- How unpaid carers can be supported in accessing services which will improve outcomes for those in their care and carers themselves.

Transition

- Integrated care partnerships could consider, when preparing the integrated care strategy, key transition points and continuity of care, including:
  - becoming a parent;
  - transitioning from maternity to children's services;
  - moves from primary to secondary and further/higher education;
  - transitioning from children's social care to adult social care, or from children and young people's health and mental health services to adult services;
  - entering employment;
  - leaving a secure setting and re-entering the community; and
  - receiving adult social care for the first time.
- To be included in Live Your Best Life ambitions

Workforce

- To support this ambition, integrated care strategies should consider the next steps needed to **create an integrated workforce across health and adult social care**.
- This could include
  - developing shared values and common standards;
  - developing new cross-system ways of working or
  - working with local partners to explore opportunities for system-wide recruitment and deployment informed by joined-up workforce planning; talent management, and skills development.

‘Health-related’ services

- Some services will have a substantial impact on health and wellbeing but are not provided by a health or social care provider. Health-related services are defined for the purposes of the integrated care strategy as services that could have an effect on the health of individuals, but are not health services or social care services.
- This includes those impacting on wider determinants, such as employment and housing.
- Integrated care strategies should encourage closer working between commissioners and providers of health-related services and health and social care services. The integrated care strategy **may** include a statement of its views on how ‘health-related’ services and health and social care services can be more closely integrated.

Publication and review

- **Publication:** Under the Health and Care Act 2022, the integrated care partnership must give a copy of the integrated care strategy to each responsible local authority and the integrated care board and must publish the integrated care strategy by December 2022. Each integrated care partnership will need to establish how this is done through their procedures.
- **Refreshing the integrated care strategy:** Whenever the integrated care partnership receives a new joint strategic needs assessment from a health and wellbeing board, it must consider whether the integrated care strategy needs to be revised.
- **Review and evaluation:** When refreshing the integrated care strategy and as part of its ongoing role in the system we expect the integrated care partnership to consider whether the strategy is being delivered by the integrated care board, NHS England, and local authorities. This can include, if appropriate, identifying, and evaluating the impact that the strategy has had on commissioning and delivery decisions.

(This section relates to the publication of the integrated care strategy. **This section is not statutory guidance).**

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Northamptonshire Integrated Care Partnership (ICP)
Strategy Development Board

Terms of Reference

The ICP Strategy Development Board (SDB) is a time limited group that will focus on the production of the ICP Strategy document only. In order to set out the ambitions for the next 5 to 10 years the development of the high level ICP Strategy will utilise the many strategies and plans already in existence from across the system. The members of the SDB are not responsible for any delivery elements included in the draft ICP Strategy. The SDB will oversee the production of the ICP Strategy as Part 1 of their function. Beyond that, Part 2 will build on the partnership working between Collaboratives and Places across the system to inform the ICP strategic direction of travel. At this point these Terms of Reference will be reviewed and updated accordingly.

1) Purpose

The purpose of the ICP Strategy Development Board is to:

1.1) Oversee the production of a high level ICP Long Term Strategy by 31st December 2022 based on the approach agreed by the ICP that focuses on improving outcomes for people, including improved health and wellbeing, supporting people to live more independent lives and reduce health inequalities.
1.2) Ensure the ICP Long Term Strategy is underpinned by the output from the System Outcomes Framework to include the refresh of the JSNA and the Insights data.
1.3) Oversee the development of a comprehensive systemwide communications and engagement plan for the launch of the ICP Long Term Strategy.
1.4) Oversee the delivery of the ICP Long Term Strategy Development Roadmap and associated deadlines.
1.5) Identify sufficient resources to support the ICP Long Term Strategy production deadline.
1.6) Ensure there is engagement with the development of 2 local Health and Wellbeing Strategies.
1.7) Ensure Place Delivery Plans are developed in line with the subsidiarity ambitions of the Strategy and the outcomes in the Strategic Outcomes Framework.
1.8) Ensure synergies exist between the development of the ICP Strategy and the NHSEI planning process for the two-year operational plan and the five-year strategy. The ICP Strategy should inform the development of the ICB plans.

2) Scope

2.1) It is a time limited group to run until the production of the final draft of the ICP Long Term Strategy is available (December 2022). The production of the draft should reflect the principles for writing the Strategy agreed by the System:

- Data and intelligence led
- Comprehensive and holistic
- Clear and transparent

- Inclusive (as far as possible given the timescales. Further communications and engagement with wider partners will be required at delivery stage.)
- Actionable and measurable

2.2) The group is not a decision-making forum and can only make recommendations to the ICP.

3) Membership

Organisation/Enabler	Representatives
Collaboratives / NGH / KGH	Karen Spellman
Collaboratives / NHFT (Community and mental health services) /	David Williams
Communication and Engagement	Dionne Mayhew
Community Pharmacy	Anne-Marie King
GP	Dr Naomi Caldwell/Dr Sanjay Gadhia
Healthwatch	Kate Holt
ICB	Bhavna Gosai Fiona Bell
NNC (Local Authority)	David Watts Ali Gilbert
Public Health	Sally Burns
VCSE	Russel Rolph
WNC (Local Authority)	Stuart Lackenby Katie Brown Julie Curtis

4) Meeting Arrangements

4.1) **Chairing Arrangements**

The meeting will be co-chaired by North Northamptonshire Council (David Watts) and West Northamptonshire Council (Stuart Lackenby) on a rotating basis.

4.2) **Frequency**

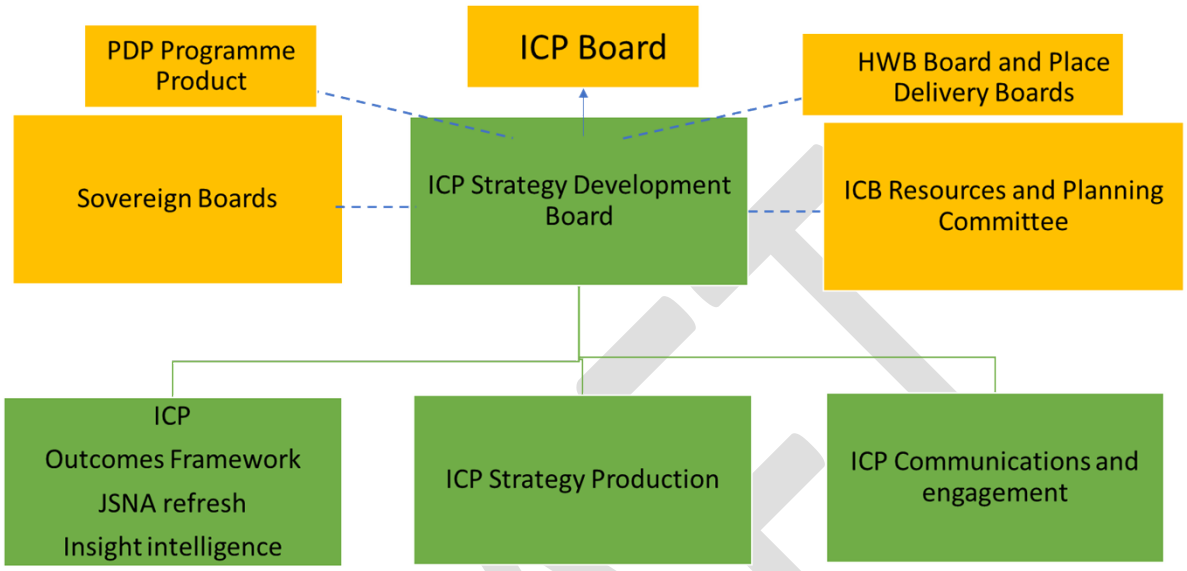
Fortnightly. Thursday 08:30 to 09:30. or any other suitable date and time.

4.3) **Administration**

Administration support for the meeting will be provided by NCC or WNC depending on the Chair. This will include keeping the action log up to date and in real time for each meeting; producing agendas; action notes; arranging meetings; extending invitations to external experts; booking rooms (when necessary); all administration tasks to support the meeting.

5) Governance and Reporting Arrangements

The following organogram sets out the governance for the ICP Strategy production and the interfaces with the wider system.



The ICP Strategy Development Board will:

5.1) Report directly to the ICP.

5.2) Seek formal approval of the final draft ICP Long Term Strategy from the ICP.

5.3) Share the final draft of the ICP Long Term Strategy with the Integrated Care Board (ICB).

5.4) During the production of the draft Strategy the two Health & Wellbeing Boards should be sighted on it at their most convenient agenda.

6) Review

These Terms of Reference will be reviewed bi-monthly to ensure they are fit for purpose.

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North Northamptonshire Place Delivery Group

Terms of Reference

August 2022

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1 Purpose

The purpose of the transitional North Northamptonshire Place Delivery Group is to oversee and support the developmental implementation of the North Northamptonshire Community Wellbeing Forums and LAPS (local area partnerships) as a key component of the North place operating model.

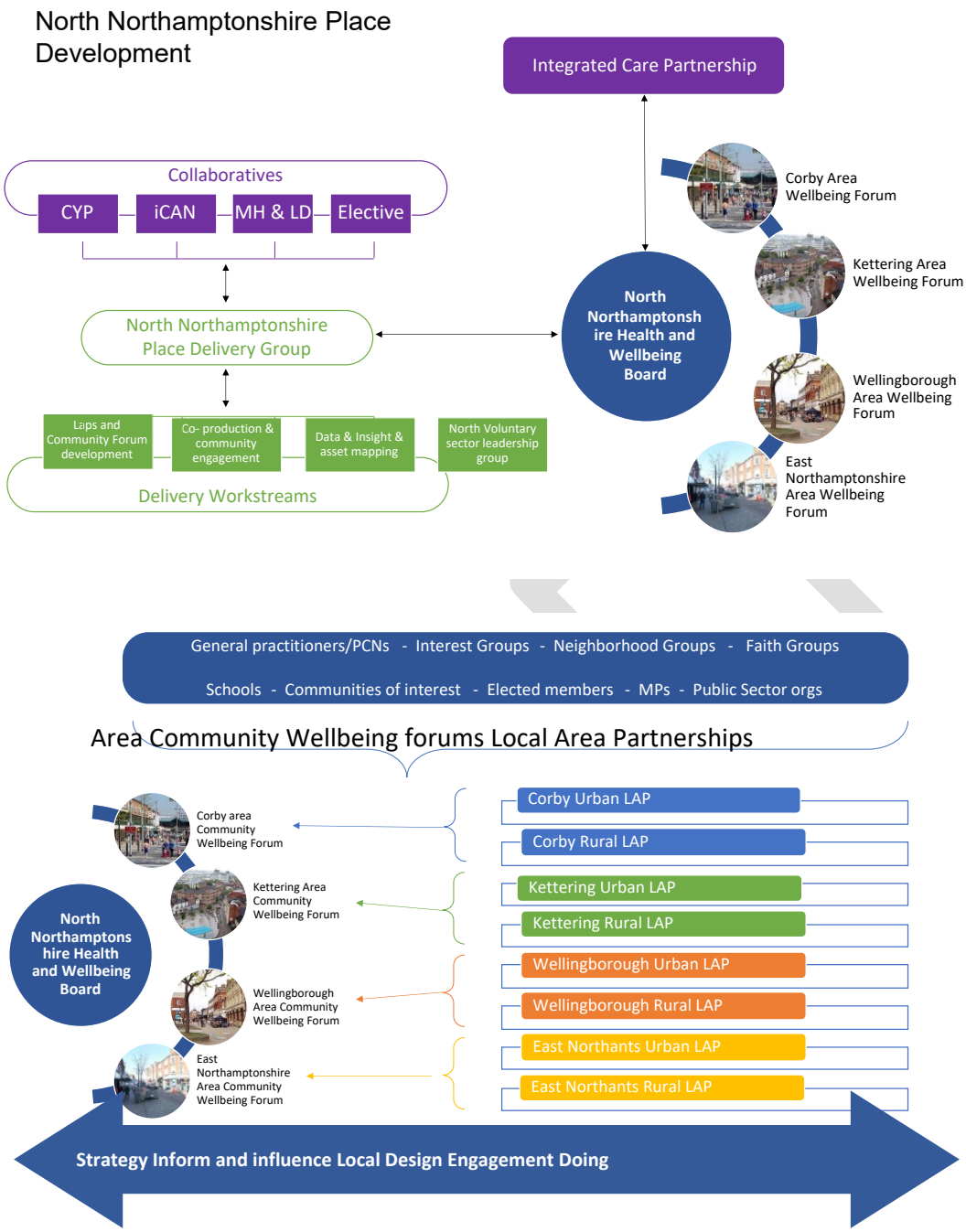
The delivery approach principles should focus on the following:

- Do with people, communities, businesses and places – their strengths and hopes
- Focus on an effective response – we come to you
- Building integrated solutions around people informed by a bottom-up approach connected to communities
- Improve through innovation
- Invest in prevention
- Measure what matters to people co-design and co-production purposeful and based on the needs of individuals

The North place includes **4 Community Wellbeing Forums** which will oversee **8 local area partnerships (LAPS)**.

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

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



2 Objectives

- development of the North place 6-month delivery plan
- mobilisation of the North place delivery plan in 6 months
- agreeing the population groups and development of the appropriate functions and relationships of the community wellbeing forums and LAP's
- to build community capacity through relationships with public services in the LAPs
- supporting the response of the PCNs to the Fuller report and their alignment with the LAPs
- further development of the engagement, co-production with partners and through community activation

- to utilise existing delivery infrastructures throughout the development
- implementation of the insight data tool
- development of data intelligence infrastructure to support prioritisation and decision making
- supporting the delivery of the ICS collaboratives where appropriate at Place
- utilising of estate enablers to support the developments
- oversee the emergent voluntary sector infrastructure proposals
- further refinement of the North Place shared vision, ambitions, and objectives based on the output of the National place development programme underway
- exploration of North Place transformational commissioning development opportunities, eg BCF
- ensuring that the governance framework is simple, functional and enables the development and functioning of the LAPs and will support:

    1. Care design and delivery function of place
    2. Collaborative relationships and leadership development
    3. Decision flows of the structure

3) Membership

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

Organisation/Enabler	**Representatives**
North Place Delivery Group Chair	Director of PLACE, North Northamptonshire Council
Communication and Engagement	Director of Communications, NHFT/ Assistant Chief Executive, North Northants Council
ICB	Chief Operating Officer/Programme Director COVID19 Vaccination
NHFT (Community and Mental Health Services)	Deputy Chief Executive/Director of Strategy and Partnerships
Collaboratives	To be invited when appropriate
NNC	Executive Director of Adults, Communities and Wellbeing and Executive Director of Place and Economy, North Northamptonshire Council
Public Health	Director of Public Health/ Consultant in Public Health
Healthwatch	Chief Executive
North Northamptonshire Fire and Rescue	Prevention, Safeguarding and Partnership Manager
North Northamptonshire Police	Chief Inspector
ICB	North GP Lead
VCSE	Chief Executive, SERVE

NBCT	Chief Executive
KGH	Deputy Chief Operating Officer
NGH	Director of Integration and Partnerships
NCT	Director of Children's Social Care/Assistant Director Quality Assurance and Commissioning

4) Meeting Arrangements

4.1) Chairing Arrangements

The meeting will be chaired by the ICS Director of Place North Northamptonshire Council.

4.2) Frequency

Fortnightly.

4.3) Administration

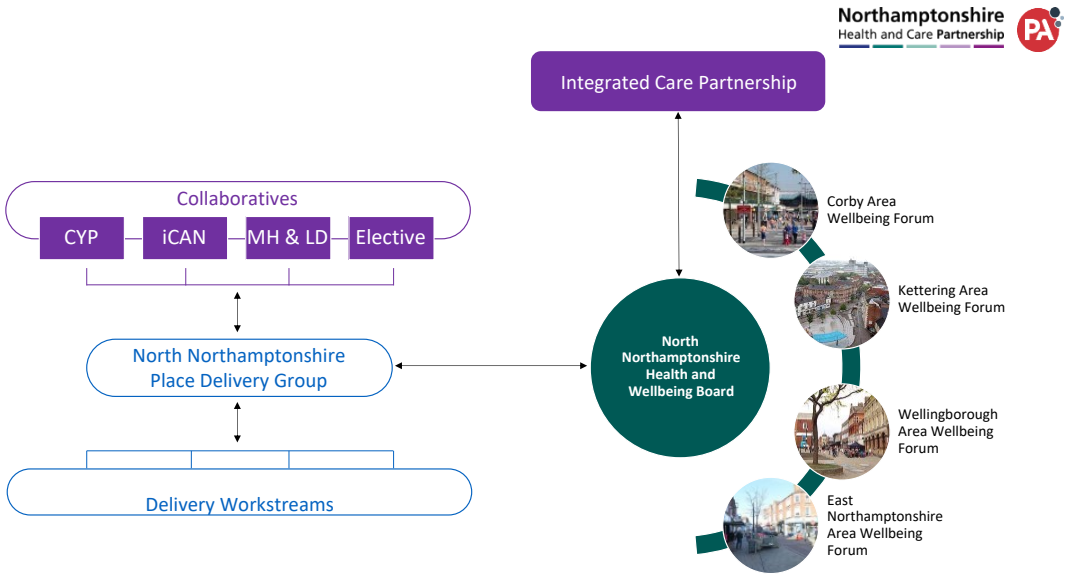
Administration support for the meeting will be provided by Cheryl Bird . This will include keeping the action log up to date and in real time for each meeting; producing agendas; action notes; arranging meetings; extending invitations to external experts; booking rooms (when necessary); all administration tasks to support the meeting.

5) Reporting Arrangements

The Place Delivery Group will report directly to the North Northamptonshire Health and Wellbeing Board.

6) Review

These Terms of Reference will be reviewed bi-monthly to ensure they are fit for purpose.



North Northamptonshire Council

North Northamptonshire Health and Wellbeing Board
6 September 2022

Report Title	Integrated Care Across Northamptonshire (iCan) Case for Change
Report Author	David Watts - Executive Director of Adults, Communities and Wellbeing (DASS) david.watts@northnorthants.gov.uk

Contributors / Checkers/ Approvers	Ali Gilbert ICS Director of Place	23 August 2022

List of Appendices

Appendix A – iCAN Case for Change

1. Purpose of Report

This report provides an overview of the case for change for the current Integrated Care Across Northamptonshire (iCAN) transformation programme to develop into an iCAN collaborative. The iCAN programme's aim is to transform and improve care for our frail and elderly population and build on initiatives and in national programmes like Age Well, the Better Care Fund, Urgent Community Response, National Discharge programme and Enhanced Care in Care Homes.

The collaborative will aim to have delegated commissioning responsibilities, including some elements of the Better Care Fund (BCF) as of April 2023.

2. Executive Summary

2.1. A summary of iCAN aims progress and next steps discussed at the Integrated Care Board (ICB) on 21st April 2022. The ICB supported the broad direction and progress of iCAN and the plans to deliver specific improvements for winter/surge activity.

2.2. Work has also progressed on shaping the iCAN collaborative and road map for the contractual development of the collaborative to move from a programme approach into a permanent way of working.

2.3. The proposed operating model and initial scope for the iCAN collaborative case for change was discussed at the ICB in August 2022 with the outcome in response to the recommendations being:

- that iCAN aims and objectives remain valid
- the scope of services to form a collaborative arrangement from April 2023 need to be defined, and that iCAN should proceed to through a collaborative framework - Gateway 4 and develop proposals in relation to delegated budgets (including alignment in part with the BCF), workforce and contractual format. It was recognised and acknowledged that the case for change proposition was being socialised with the North Northamptonshire Council Executive members and decision making was was progressing through the internal North Northamptonshire Council decision making process. It was also recognised that the accountability for the BCF oversight requires oversight within the council and national reporting requirements remain through the Health and Wellbeing Boards.
- that service user and staff engagement is progressed to inform arrangements for April 2023.

2.4 The North Northamptonshire Executive decision notice agreed on 25 August 2022 that:

Item 13	Integrated Care Across Northamptonshire (iCAN) Case for Change	**RESOLVED** KEY DECISION That the Executive: a) Supported the broad direction of travel set out in the iCAN case for change.

3. Recommendations

3.1. It is recommended that the board:

a) Support the broad direction of travel set out in the iCAN collaborative case for change and the ambitions and intentions to improve the experience of people

b) Note the decision notice of North Northamptonshire Council and support the proposed approach to continue with the direction of travel for the iCAN collaborative development, whilst the council corresponds with the ICB Chair and Chief Executive Officer (CEO) to identify mutually agreeable ways to provide assurance and political oversight satisfactory to the Executive of the council.

3.2. Reasons for Recommendations:

3.2.1. The broad direction of travel is one that fits with the overarching priorities of the ICS and Health and Wellbeing Board.

3.2.2. Whilst socialising the case for change with Executive members within the council, there have been some concerns raised regarding their involvement in the decision-making arrangements and expenditure of funds intended for the benefit of North Northamptonshire residents. Member oversight of BCF performance and expenditure for which it is responsible is a fundamental requirement in ensuring that local-authority public money is spent in accordance with national requirements alongside the priorities set out in the corporate plan.

4. Report Background

4.1 Integrated Care Across Northamptonshire (iCAN) collaborative

4.1.1 Despite this progress within the iCAN programme, there remain significant opportunities to deliver better outcomes and manage demand more effectively to ensure more people stay well at home and avoid admissions to hospital where there is the potential to design and deliver better “out of hospital” services.

4.1.2 If we are to make sustained change, we need to formally commit to work within integrated service arrangements, exploring where pooled finances and staff working across a range of services may lead to greater benefits for people and better use of collective resources. This should mean all partners are working together in a person-centred approach, across our community and hospital pathways to improve outcomes. It will also build the foundation of future wider integrated services that shift our focus to prevention and community and enabling people to choose well, live well and stay well.

4.2 Reasons for the collaborative case for change

- The ICAN programme is a five-year transformation plan, it has already achieved some early results in our hospitals and community.

- External support ends December 2022 - we need to secure existing and new ongoing benefits from our work.

- There is now a need to move from a programme to embedding those new ways of working into business-as-usual practice and processes, by developing a service delivery model that formalises/embeds what has been achieved and creates the conditions for long term integrated working and better outcomes.

- As a multi-year programme of work, any changes will be made in tranches rather than all together. In the first tranche of work, a range of out of hospital services and partners are brought together as pooled resources to develop and deliver more integrated pathways of care.

- There are already a set of pooled budgets and contracted out of hospital services within the Better Care Fund (BCF) that support much of the activities

in ICAN, which could be used as a foundation for future collaborative developments. BCF budget and monitoring is monitored by Health & Wellbeing Boards, subject to section 75 arrangements (pooling of resources) and has a national performance framework that aligns to iCAN.

- The national BCF policy for 2022/23 states two objectives:

    1. enable people to stay well, safe, and independent at home for longer
    2. provide the right care in the right place at the right time

    The alignment of these objectives with iCANs, the mandatory nature of the BCF S75 and the need for a formal agreement between commissioners working together to deliver the iCAN vision all suggest the use of the BCF S75 as a key vehicle for iCAN delivery. However, the current proposals within the iCAN case for change do not clearly set out how Health and Well-being Boards and elected members will maintain oversight and involvement within this development.

5. Issues and Choices

5.1 Collaborative outcome-based contract approaches can be utilised for both Lead Provider and Direct Contracting approaches and all organisations will need to be comfortable with governance, decision making and commissioning arrangements.

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 Whilst further work is required to explore different contracting and resourcing arrangements it is not possible to fully assess any potential financial implications. However broadly speaking, current proposals are that those services that are currently delivering on iCAN priorities could be delivered through the iCAN collaborative approach, allowing greater flexibilities in directing resources in more agile ways. This could mean a range of integrated teams or making changes to what those teams do in order to meet anticipated or un-anticipated fluctuations in demand, or potentially directing resources to other organisations to deliver targeted or universal services where appropriate.

6.1.2 Where pooling of budgets is used, the North Northamptonshire Executive and North Northamptonshire Health and Wellbeing board should have sufficient confidence in the governance arrangements to ensure that spend, such as that out in the Better Care Fund, and intended to be used for the benefit of North Northamptonshire residents has an element of protection, or ring-fencing, to ensure that the council is able to account for and evidence that those funds have been spent for the benefit of North Northamptonshire residents.

Legal and Governance

The legal context for Integrated Care Systems and the Better Care Fund are set out within various legislation. For example, the Care Act (2014), whereby closer integration and an emphasis on wellbeing and prevention run strongly throughout the legislation and guidance documentation.

The Health and Care Act (2022), led to the dis-establishment of Clinical Commissioning Groups (CCG), and led to the implementation of Integrated Care Systems and Integrated Care Boards from July 2022.

Risk

6.3.1 There are pressures within the local health and care system that increase risks around the deliverability of plans.

6.3.2 There are concerns that were raised during discussions with elected members regarding financial decision making (set out in paragraph 7.1.2) and sufficiency of governance arrangement to ensure elected members sighted on and in agreement with decisions being made that may impact on council budgets and performance or the work of Health and Wellbeing boards.

Consideration by Executive Advisory Panel

6.4.1 The Case for Change was discussed with the Health, Wellbeing and Vulnerable People EAP and comments invited to be returned by EAP members to be fed back to Executive and the Integrated Care Board.

Consideration by Scrutiny

6.5.1 Updates have been provided to Scrutiny Commission to ensure that the commission was sighted on direction of travel and any subsequent changes as they have occurred.

Equality Implications

6.6.1 There are no direct equality implications as a result of the production of the case for change document, however equality impact assessments will need to be undertaken at any point that changes are made to services in order to understand the impact on groups of people with protected characteristics.

Climate and Environment Impact

6.7.1 There are no direct impacts because of the case for change, however where changes impact on how buildings, fleet or workforce are used there will be opportunities to consider, and measure, the impact on the climate of those changes.

Community Impact

The intention of the case for change is to improve the health and wellbeing outcomes of our population. Evaluation of that impact will form a key part of how we monitor the benefits for our communities over the term of the programme.

Crime and Disorder Impact

None directly as a result of the case for change report

7.0 Background Papers

Appendix A

iCAN Collaborative

Case for Change and Story Board – Summary Proposal 3.2

Purpose of the paper

What are we asking for?

Our Case for change sets out the journey, the rationale and the detail behind the proposal ***to develop an iCAN (Integrated Care Across Northamptonshire) collaborative***.

A summary of iCAN aims, progress and next steps was presented to the Integrated Care Board (ICB) on 21st April 2022. The ICB supported the broad direction and progress of iCAN and the plans to deliver specific improvements for winter/surge activity. Work has also progressed on shaping the iCAN collaborative and road map for the contractual development of the collaborative.

This document summarises the proposed operating model and initial scope for our collaborative and steps we need to take to formalise that. **The ICB is asked to:**

- **agree that iCAN aims and objectives remain valid**
- **agree scope of tranche 1 services to form a collaborative arrangement from April 2023**
- **agree iCAN should proceed to Gateway 4 and develop proposals in relation to**
  - **delegated budgets** (including alignment of the BCF) **,**
  - **workforce and**
  - **contractual format:**
- **agree we should progress service user and staff engagement to inform arrangements for April 2023.**

Background and context

We have committed to transforming and improving care for our frail and elderly population through our ICAN programme and we've seen significant success across national priorities like Age Well, the Better Care Fund, Urgent Community Response, National Discharge programme and Enhanced Care in Care Homes.

However, despite this progress we are still not able to consistently deliver the best outcomes **and we are not managing our demand effectively to ensure more people stay well at home and we avoid unnecessary admissions**. This is impacting the quality and continuity of care people receive. **It is also significantly affecting our financial position**. Our demographic means that without action demand will outgrow our resources and reduce our ability to meet the standard of care we should aspire to deliver.

Patient experience for people aged 65+ has also been varied and sometimes unsatisfactory for too long. We know we have more stranded and super stranded patients than other areas (with many patients in acute and community beds no longer needing to be there) and we are not maximising the opportunity to return people to independence and their normal place of residence. **High Acute occupancy is also creating significant pressure at the front door when admissions are needed because of delays in getting people out.**

All these issues have been exacerbated by a previous lack of widescale community preventative and support services to help people stay well at home and not using our limited resources effectively.

But if we are to make sustained change, we need to formally commit to work within integrated service arrangements, with pooled finances and staff across a range of out of hospital services. This will mean all partners are working together in a patient-centred approach, across our community and hospital pathways to improve outcomes. It will also build the foundation of future wider integrated services that shift our focus to prevention and community and **enabling people to choose well, live well and stay well.**

This is what people, clinicians and staff tell us they want. We believe that the collaborative structure is the best route to deliver the sustained improved outcomes and make our money go further.

What are we proposing and why?

Our vision is to support more people to choose well, stay well and age well at home resulting in reduced unnecessary admissions to hospitals and better outcomes for people. Where they do experience a crisis, we will ensure that they get the right care at the right time and in the right place ensuring, where possible, they return to independence and ideal outcomes.

Outcome Focused

For too long we have measured our success on the basis of system outputs and acute performance. These are often indicators that have little meaning or relevance to the outcomes our residents wish to achieve.

Our vision starts with a shift of focus to community based care – measuring our success predominantly on the delivery of outcomes for our population and helping people age well.

From whole pathway redesign to individual Care Plans, coproduction will be the defining principle. The approach will be strengths-based, goal-oriented, and recovery-focused. Our residents will feel ownership over their own health and care process.

We believe this will produce better longer-term health outcomes, fewer escalations and admisisons, and relieve key system pressures (such as on Urgent care and Primary care)

Person Centred

To do this, we must recognise that we have been operating with a process and not person centred approach – whereby risk thresholds, strict specifications and different drivers create the conditions for duplication and gaps in our system.

Our vision continues with the development of 'person-centred' care – whereby we do more to recognise what an ideal outcome looks like as a resident. To be truly person-centred, physical health and social care needs must be factored in to holistic care plans, and we will broaden our approach to MDT working at 'Place' and 'Sub-Place' to meet service user expectations.

We believe this will support residents to manage their own care, avoid escalation, reduce admissions and help people stay well and at home for longer.

Responsive

Ensuring all care is person-centred will require a programme of transformation, during which we will consolidate system resources to achieve this within set timescales.

Our vision involves a gradual devolution of resources to a dedicated collaborative of system partners. The ultimate aim of the collaborative would be to manage a left-shift in system spend by targeting investment on the most effective initiatives at any time, as well as efficient withdrawal/ reinvestment according to changes in population need or healthcare policy (e.g. NHS Long-Term Plan).

We believe delegation of unplanned over 65 care will allow for faster transformation, and ensure the best use of system resource in the achievement of defined population health outcomes.

Integrated

The ICAN programme can demonstrate examples of partnership working for better outcomes. However, integration at pace and at scale will require partnerships to become more formalised.

Our vision includes the development of a single contract for the management of over 65 out of hospital care, and for the delivery of all Age well outcomes. The collaborative of system partners would co-design operational strategy and assure achievement of desired outcomes.

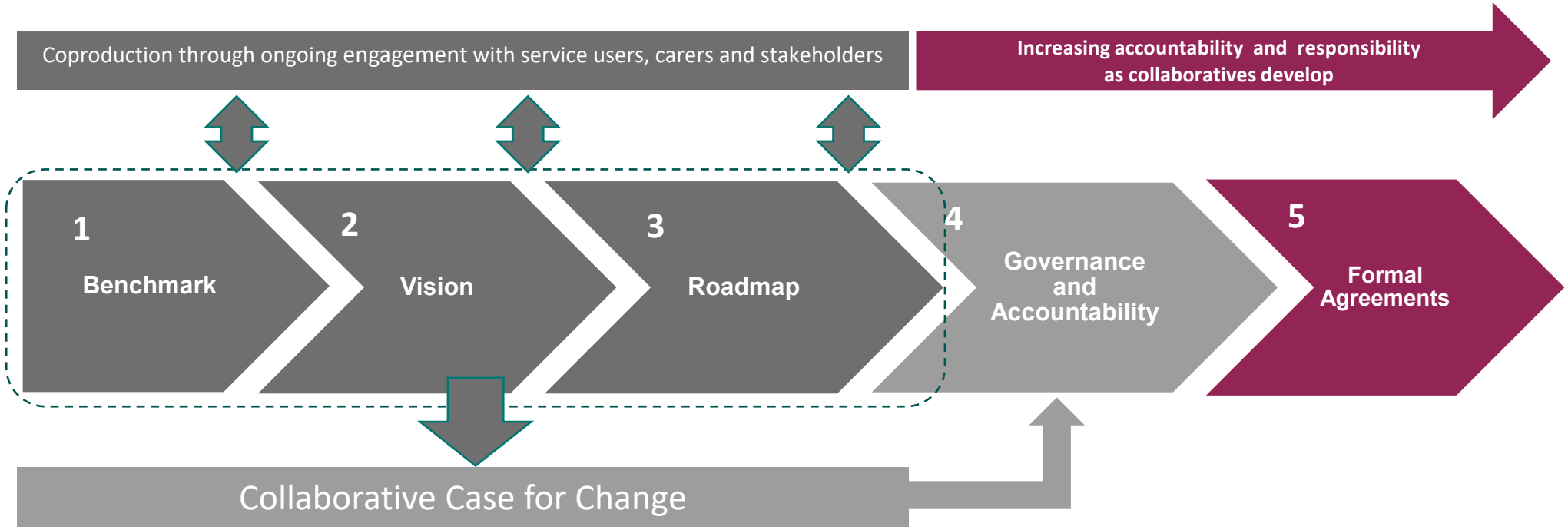
A collaborative would manage financial administration and subcontracting arrangements with all partner organisations required to deliver against the agreed Outcomes-Framework, and provide accountability to the Integrated Care Board.

What are we proposing and why?

- The ICAN programme is a five-year transformation journey, it has already achieved good results in our hospitals and community.
- ICAN Phase 1 and the external support ends December 2022 - we need to secure existing and new ongoing benefits from our work
- We now need to **move from a programme to a permanent way of working** by developing a service delivery model that formalises/embeds what's been achieved and creates the conditions for long term integrated working and better outcomes
- We are proposing that a range of out of hospital services (see next slide) and partners are brought together as pooled resources to develop and deliver more integrated pathways of care – these would form **Tranche 1 of our collaborative**
- Our focus will be helping the frail and over 65s live well, stay well and age well in their community, avoiding an escalation to acute hospitals where possible, ensuring people don't stay in hospital too long and that we return them to independence and home where possible.
- We already have a set of pooled budgets and contracted out of hospital services within the Better Care Fund (BCF) that support much of the activities in ICAN. The BCF is already the responsibility of the Health & Wellbeing Boards, subject to section 75 arrangements and has a national performance framework that aligns to ICAN.
- Using the BCF funding as a foundation for future arrangements and the pooling of resources, we can create a single contract for our ICAN Tranche 1 collaborative services that binds us to common outcomes and improved performance to meet system and national objectives
- **We believe such arrangements are required to change our focus from an organisational one to a system view.**
- We still have work to do on what this means for our workforce, budget delegations and contracting but require confirmation of our direction of travel and scope for the collaborative to commence the detailed design and engagement as set out in the next slide.

The iCAN collaborative development gateways (proposed)

We are seeking ICB support to move through Gateway 3 and commence work on Gatweays 4 and 5



Gateway milestone

Gateway Requirements

- Scope of services
- Assessment of current provision
- Problem statement
- Collaborative Partners

- Transformation Priorities
- Vision Statement
- Resource Analysis (Service provision and Collaborative support)

- Key Deliverables
- Tranches (if required)
- Strategic Overview
- Roadmap of Collaborative Development including:
  - Key Deliverable Dates
  - Tranche Dates (if required)
  - Key Decision Dates
  - Preferred Formal Agreement Type(s)

- System agreement of case for change
- Shadow governance arrangements (pending formal agreements)
- EQIA/QIA
- Evaluation methodology
- Detailed operational delivery plan including
  - Finance
  - Activity
  - Workforce
  - Outcomes

- Collaborative Agreement (if required)
- Contractual Agreement(s) or Delegation Agreement(s)

iCAN proposed operating model and scope of services

The operating model will build on our ICAN work with tranche 1 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

- The model excludes services commissioned through GP contracts – we would develop the ICAN collaborative services working with GPs and system partners to ensure we are aligned to the future CAS/Same Day/Urgent Care strategy when agreed

iCAN plan to address priority issues (1)

Our priority issues	What we have put in place or intend to implement
Too many escalations to acute care • Need to develop anticipatory care • Default to acute care and ED too often • Lack of past capacity in the community for prevention activity	✓ MDTs (Multi-disciplinary teams) for prevention and management of long-term conditions will support more patients at home ✓ Joined up strengthened primary and community care to help people make the right lifestyle choices ✓ Integrated multi-disciplinary neighbourhood teams will meet the needs of an ageing population and patients with complex conditions to provide better care locally and reduce reliance on urgent and emergency care.
Too many people admitted to hospital unnecessarily • High number of falls that lead to admission • Need to expand capacity of pathways 1 and 2	✓ integrated intermediate care offer for step up and step-down care in the community where short intervention is needed to avoid an admission or help someone return home ✓ Development of 2-hour rapid response service that can attend emergency calls in the community and where possible implement a short-term intervention to avoid an admission to hospital ✓ Pressure on emergency care reduced via same day emergency care and frailty units at the front door.
People stay too long in Hospital • Discharge processes not optimised • 40% of patients had no reason to reside • Diagnostic tests unnecessarily delay discharge • Deconditioning from long stays	✓ Integrated multi-disciplinary discharge hub works to maximise flow and optimal paths ✓ Extension of Virtual wards for patient management in the community through central monitoring hubs ✓ System dashboard and systems to manage flow effectively and target actions where they have most impact
We are not maximising independence • Lack of understanding of optimal pathways • Capacity in reablement • SCCs rehab under-utilised and community hospitals bed blocked • Over reliance on community beds	✓ Joint “Home First” approach to care for people at home or in community facilities, avoiding unnecessary hospital stays or rehabilitating them when they leave hospital as they regain their independence. ✓ Shared monitoring hub for telehealth and crisis calls linked to community and Dr support ✓ joint health, care and VCS (Voluntary Care Services) welfare teams in the community ensure people stay safe and well at home ✓ Integrated intermediate reablement service with single pathway and increased shared capacity ✓ Integrated rehabilitation service using shared bed base improved lengths of stay and outcomes

iCAN plan to address priority issues (2)

System issues	How a collaboratives will address the issues
We cannot meet demand or afford what we do • Hospitals are regularly full and overflow beds are regularly needed • Demographic will increase elderly demand • Need to build a new hospital if unchecked • Bedded solutions and staffing expensive • Onward costs rising from deconditioning	✓ Collaborative delivery model under single management administering collaborative planning and delivery ✓ Outcomes based commissioning focused on delivering end to end pathways with clear and supportive formal arrangements ✓ Potential for risk and reward incentivisation to reduce cost while improving service delivery ✓ Best allocation of available resources to deliver transformational change, reducing duplication and reinvestment in community services and prevention (left shift)
We are too tactical in commissioning • Many contracts are short term or use one off funding • The BCF is used as a means to transact funds not deliver integrated care based on common and contracted aims • We don't combine our spending power • Contracts tend to focus on single organisations not system working • The BCF has been a transactional relationship with aligned budgets not pooled resources and shared outcomes	✓ The collaborative will coproduce and support the delivery of an outcomes-based contract for out of hospital care' (initially for the frail and elderly, but with the ability to expand to unplanned care for all ages) ✓ The collaborative will work to a shared set of strategic aims, principles and behaviours, formalised through a Collaborative Agreement ✓ Longer term contracts are essential for the voluntary sector and primary care to maximise their potential and hold risks etc. A formal collaborative approach would be a key stage to achieving that goal. ✓ The BCF will be reset and aligned to iCAN collaborative governance structures to ensure the correct formal agreement are in place and that subsequent service delivery supports the strategic aims of the collaborative

iCAN plan to address priority issues (3)

System issues	How a collaboratives will address the issues
General Practice is operating under significant pressure • reducing ability to deliver preventative measures to keep patients with complex care well in their home • There is a growing crisis in this sector and without the development of new ways of working, we will see more patients escalating in to urgent care services.	✓ We will support General Practice to build on the ICAN/Age well work develop a new model for complex patients with more wraparound services to help GPs manage caseloads and prioritise their work ✓ Develop an integrated urgent / same day service supported and delivered by systemwide partners ✓ Review pathways and the role of the GP being the gatekeeper to some services ✓ We will develop our step up offer and services so that there are viable and effective services for GPs to use rather than using Acute care.
Our workforce is siloed and stretched • We compete for staff • Staff shortages or sickness mean we are not always using the most skilled and experienced staff in the best way • We struggle to attract and retain community care staff while the acutes attract more	✓ The collaborative model with draw staff together in a collaborative and more integrated manner ✓ We can explore the rotation of staff through different settings bringing us more flexibility to manage surges and gaps and creating joint ownership of issues and care ✓ We can aspire to create a new type of combined workforce for the future ✓ we will work to create terms and conditions which appropriately value all team members working within the collaborative.

How will ICAN make things better in future?

For Patients

- I am linked in to the wider voluntary and community support networks in my area
- I am supported to remain at home and in the community
- I am involved in my care and understand my condition
- my care is reviewed regularly with me and shared across partner agencies.
- I can access crisis response services in a timely way day or night
- I understand alternative options to the Emergency Department
- If admission is necessary, I will have a comprehensive plan for my discharge in place and I will not be in hospital for longer than is necessary.
- I will be returned home as the first and preferred option.

For GPs

- I can find and access a range of services to support my work and help patients make choices about their care
- Co-ordinated care supported by a frailty MDT including the voluntary sector working with health and care staff enables people to look after their own health and facilitate professional communication
- I can access hospital and social care records to understand my patients journey better.
- Improved wrap around community services and telehealth solutions help me manage the workload for patients at home and in care settings
- Efficient and easy routes to diagnosis, therapies and other treatments to reduce patient, carer and staff frustrations
- I can access step up care and short term interventions as a viable alternative to hospital conveyance

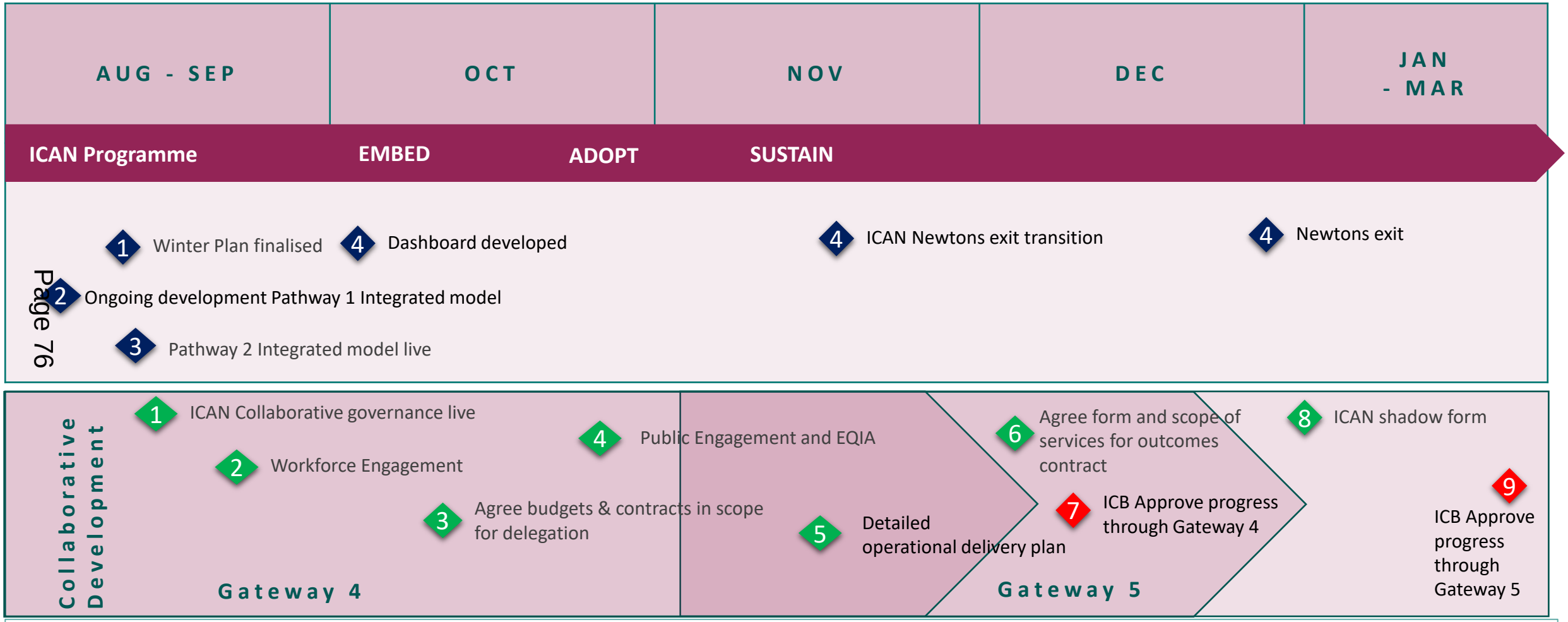
For the ICS

- We focus clinical time across the system on those that require acute or urgent interventions with more services available to help address long term conditions, monitor recovery and help people self care
- We will reduce hospital occupancy and stranded patients, so we have more capacity for electives and surge activity if required
- We will create value for money by sharing resources and estate amongst providers
- We will reduce the high costs incurred from rising unplanned care
- We will invest in preventative work and community services that also improve people's outcomes
- We will make our money go further by doing things once

For Our Staff

- I will be working in an innovative county wide collaborative offering a full range of services that delivers the best outcomes for people
- Hospitals pressures are more manageable with partners helping us manage peoples care in other settings not just acute beds
- There are more opportunities to work across settings and get more experiences that would be available in a single provider.
- I will have excellent training and development that will support me to work across the collaborative to develop my career.
- People doing the same job as me will be paid the same rates no matter where they work.

The iCAN collaborative timescales and stages



Commentary:

The timelines above represents initial thinking for the development of the collaborative and key steps in engagement, agreement on financials and delegated budgets and agreement on the contract construct as well as completion of the final two gateways of ICB approval before the collaborative could go live. They allow for the final scope of services to flex and change.

iCAN Collaborative

Case for Change and Full Story Board – version 3.2

Contents

1. **Gateway one - Baseline**
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5. **Gateway five – Formal Agreements**
   I. Collaborative Agreement (if required)
   II. Contractual Agreement(s) or Delegation Agreement(s)

6. **Next steps**

Do last, once all content and Gateway content is agreed, and reflect slide titles here (and on Gateway slide in Exec Summary

Gateway One

Baseline

Problem statement

Too many older people get admitted to hospital stay too long resulting in poor outcomes and unsustainable pressure on staff and resources.

*How do we reduce the unnecessary admissions to the acutes, improve flow and outcomes **at the same time** as increasing and transforming our community services so that we can support more people to stay out of hospital and stay well in their own communities and homes?*

"Health is made at home, hospitals are for repair"

Nigel Crisp, 2021

Do we understand the nature of the problem?

The pressure on our acutes is a symptom of the problem we face, we still rely on too much unplanned care. We needed to be clear if this was just a result of our demographic demand or if not and where we could make changes to permanently improve performance, cost and outcomes for people. Our 2020 diagnostic findings showed a clear focus for change:

Home or Community?

Are we preventing escalations from occurring in the community?

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

First Response

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

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

Front Door Services

Are we ensuring the right people are admitted?

25% of admissions reviewed could have been avoided

In Hospital

Are people discharged as soon as possible?

37% of patients reviewed had no reason to reside

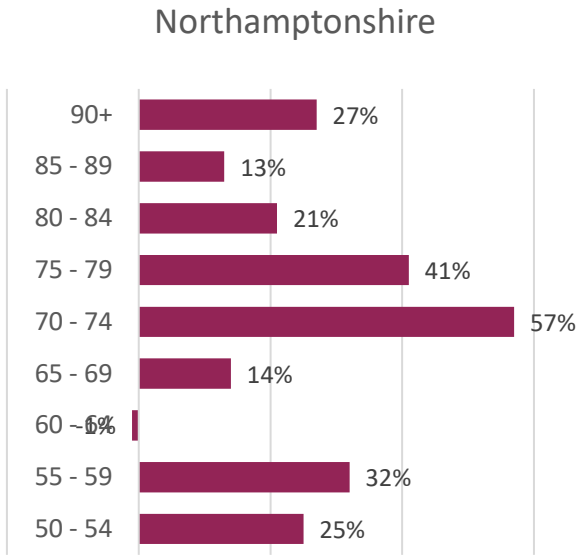
Home or Community

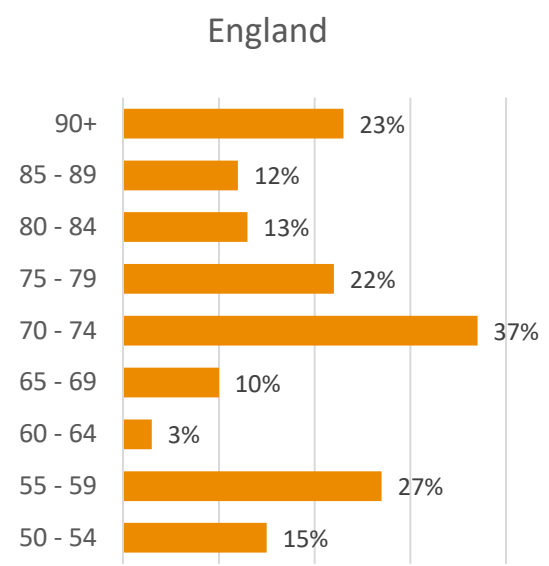
Are people discharged to the optimum setting?

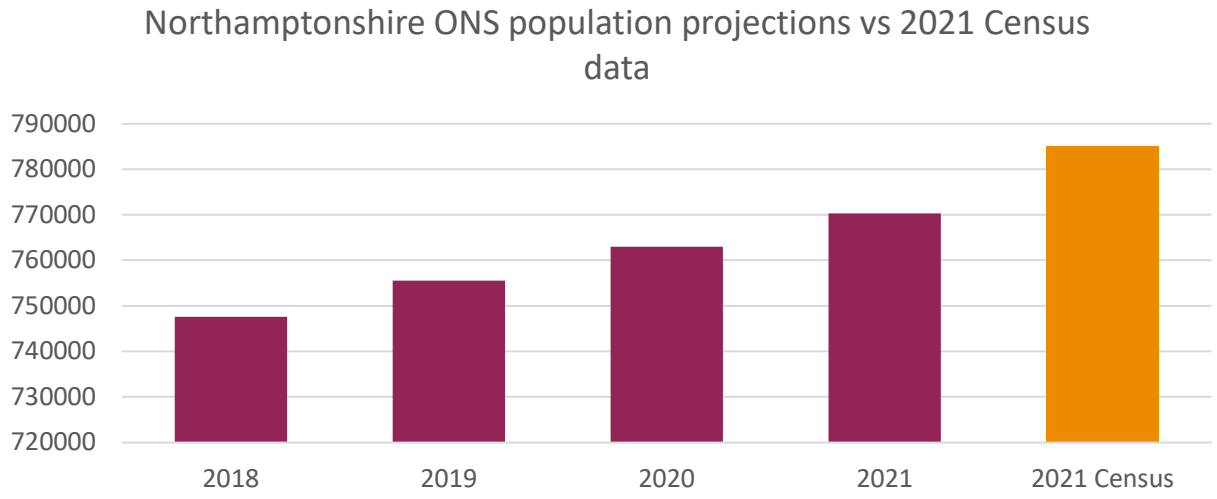
40% of patients could have received a more independent outcome

iCAN business case: the demographic challenge

- Our challenges were set to get worse if we did nothing.
- The NHSE business case for iCAN originally set out to mitigate an expected 2% increase in over 65s demand with increased numbers and increased complexity of needs
- The programme targeted an annualised £13.3million of operational savings, all of which was cost avoidance
- In the 2021 census (figures opposite), the most notable increase is in the over 70s. Frailty increases with age, therefore having more people over 75 creates a disproportionate demand for support services.
- We need to continue the ICAN work to mitigate the potential impacts of this growth on both cost and quality
- Across the county, the overall population increase according to the 2021 census data was 13.5% - over twice the England rate of 6.6%.







Progress against ICS comparators

At the start of our transformation journey, we admitted more older people to hospital, who stayed longer and were more likely to exit hospital into 24 hour care settings.

Our first improvement in 2018 was to go from the second worst nationally for discharge from hospital to residential or nursing homes to one of the top twenty authority areas in the country.

Our second improvement was to decrease our super stranded patients from almost 400 to just above 200 achieved in 2019.

The third and more recent positive change was to admit fewer older people.

We are going further with integrated community bed pathways in 2022/23.

We still have a lot to do but with our demographic growth above the average for England (particularly in the over 75s) we need to build on this and go further just to stem the effects of this growth on health and care.

STP / ICS	Unplanned Hospital Admissions May 2022	Population	NEL as % Rate of pop	Change from 2021 same three month period
Northamptonshire	**5,559**	**736,219**	**0.755**	**-8.90%**
Nottingham and Nottinghamshire	11,192	1,043,665	1.072	-6.60%
Peterborough and Cambridgeshire	8,082	892,627	0.905	-5.70%
Coventry and Warwickshire	9,829	949,454	1.035	-3.80%
Dorset	8,116	773,839	1.049	-3.70%
Beds, Luton and Milton Keynes	8,328	950,874	0.876	-0.70%
Joined up Derbyshire	9,331	1,026,426	0.909	-0.40%
Hereford and Worcestershire	6,421	788,587	0.814	0.10%
Leicester, Rutland and Leicestershire	7,797	1,100,306	0.709	1.50%

GP practice demand and priorities

Primary care sits at the heart of our communities with a multitude of dedicated staff delivering care around the clock in every neighbourhood. Our GPs are the first front door to health with 17,000 consultations a day in general practice across the county.

Despite record numbers of appointments patient satisfaction is low due to challenges in accessing care …. At the same time, primary care teams are stretched beyond capacity, with staff morale at a record low. There are also significant workforce gaps with many GPs retiring and no one to replace them

The recently published Fuller Report states "***Left as it is, primary care as we know it will become unsustainable in a relatively short period of time".***

The Fuller report goes on to propose a new vision for integrating primary care, improving the access, experience and outcomes for our communities, which centres around three essential offers:

- **Streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community **when they need it**
- **Providing more proactive, personalised care with support from a multidisciplinary team** of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- **Helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

ICAN is helping GPs build these services for over 65s but we have more to do together to develop a health and care offer that's sustainable longer term.

Supporting GP practices

- To optimise opportunities in the iCAN programme, we need general practice to be at the heart of neighbourhood teams supported by and working with community MDTs, social care and voluntary care services.
- The current model of care and the significant demands placed on general practice for ‘same day demand’ services, does not currently enable general practice to fully engage in this ICAN programme.
- We know that patients with complex health needs benefit most from continuity of care and therefore we need to empower general practice to design a new model of integrated care to keep patients well, in their home and supported by local communities.
- Significant progress has been made with the development of remote monitoring, caseload management and virtual wards, all of which could be integral to a new model which is focused on delivering preventive interventions for people with complex care needs
- We need to build on the national specification for *'Enhanced Health in Care Homes'* but equally ensure patients that are able to live independently in their own home are well connected to a support network.
- GPs could play a significant role in supporting patients in community beds (step up) and collaborate with other partners such as ICT and EMAS to avoid admissions and in facilitating early discharges on a supported package.
- We have over 700 (350 WTE) GPs working in the county, if we could protect their time to deliver continuity to complex patients, then we can transform care to patients that most need it in a way that previous transformation projects have not achieved.
- Our ambition is to keep patients with complex health needs out of our urgent care system by providing an integrated proactive service.

Developing an integrated model

- To support a new model of care, **we collectively need to redesign our urgent / same day demand services**.
- There is an opportunity to radically change the way the ICS partners deliver these primary care services in an integrated model with the potential of a single front door, centred around a clinical assessment service with a co-ordinated network of services to meet patient demand.
- **General practice is a critical partner in this model** and any changes to ways of working and approaches needs to be in a controlled way to enable our complex care model to be fully realised.
- Equally there is an important role for primary care - pharmacists, opticians and dentists to work with GPs and other system partners to support the management of complex patients and ensure effective health and care integration
- We need to think differently about how patients access some services and potentially move away from the GP being the gatekeeper to some pathways, this will require redesign across the ICS.
- To achieve this, the ICS needs to develop a different relationship with general practice: built on trust and recognition of the central role and impact that general practice has at a neighbourhood, locality, place and system level.
- The ICS needs to facilitate an environment for a sustainable, resilient and flourishing general practice sector.

- **A key next step in progressing our ICAN collaborative will therefore be working with our GPs (and wider primary care) to ensure that the design and development of Tranche 1 ICAN collaborative services works for them we connect in the additional services and offers to help manage community demand**

Public Co-production and development of “I” statements

At the heart of ICAN sits people. So we asked them what they wanted from health and care of the future. They said **“I want…..”**

Time to be listened to by health professionals who consider all of my needs not just a single medical presenting issue

Services to be available locally to me, timely access to my GP and less time spent travelling to hospital for appointments.

To have a support person to help me through my Ageing journey who I can go to and can help me to navigate where needed

To tell my story once and it be heard by all those who are supporting me

For me to gain skills and confidence to help me manage my long term conditions rather than my long term conditions managing me

To have the same choice and opportunities whether I am living alone, whether I have a carer or whether I am in 24 hour supported accommodation

When I am in a crisis I want to receive timely and coordinated care in the best place for me at the time

For me and those supporting me to make use of technology but not to the exclusion of actual personal contact – the choice is important for me

Outcomes: Resident "I" Statements – iCAN in 2025

If we get it right, what would ICAN mean for people in 2025 and what would their care look like?

Self care and prevention	Timely access to primary and community care	Enhanced care and support in the community	Rapid and coordinated urgent care and crisis response	Emergency and acute care
I am able to look after my physical and mental well being day to day. I am able to access self-care advice when needed. I know where to get guidance on the resources I can use from the health and social care system. I will be able to access patient education courses. I feel supported to manage my own condition. I know who to call if I want more information	If I need an appointment on the same day I can get one with a member of the community health and social care team who knows what care I have been receiving elsewhere. I am referred promptly to other services when needed. I am linked in to the wider voluntary and community support networks in my area. My mental health needs are given equal priority to my physical needs.	I am central to creating my care plan – no decisions about me without me - I have a named key worker who helps me to navigate the system. My care plan is based on what matters to me and is shared across partner agencies. I can access short or long term care depending on my needs. My care is reviewed regularly with me.	I can access the same level of treatment at any community care facility. I can access crisis response services in a timely way day or night. I have rapid access to community services when needed. I understand alternative options to the Emergency Department and am given support to access them where needed.	I will be seen promptly if I need to attend ED. Decisions about my diagnosis and care will be made quickly. If admission is necessary, I will have a comprehensive plan for my discharge in place I will not be in hospital for longer than is necessary. I will be returned home as the first and preferred option.

Engaging patients – the People Advisory Group (PAG)

It was important at the outset of the ICAN transformation that we engaged the view of patients and voluntary sector partners in our design and the development of our offer..

The PAG gives the people group (including those who will benefit from the use of services or who care for people who use them) oversight of the developments that occur within the iCAN programme. Meeting monthly, the PAG also promotes, aids and helps to develop co-production of services.

Membership is formed of patients, carers and service users, and includes key professionals and service leads will also on occasion be invited to present to, or update the group on key issues.

Key features of the PAG

- Experts by experience collective
- Oversight and advisory function for iCAN from patients, carers and service users
- Co-production promotion
- Specific brick and workstream co-production work
- Meets monthly and produces key messages that are shared within iCAN
- Supports specific case study learning
- Action log working method

Who else is involved in iCAN – the collaborative partners

The iCAN programme has engaged a number of organisations and system partners in the design and delivery of services. The voice of the patient and VCS is also represented by the People Advisory Group (APG), the chair of which sits on the Executive Board and Delivery Board.

NHS Northamptonshire Integrated Care Board

Primary Care

NHS Northamptonshire Healthcare NHS Foundation Trust

NHS Northampton General Hospital NHS Trust

NHS Kettering General Hospital NHS Foundation Trust

Northamptonshire Carers

Public Health Northamptonshire

West Northamptonshire Council

North Northamptonshire Council

The iCAN programme continues to build its partnership to include a wide alliance of partners including:

VOLUNTARY IMPACT NORTHAMPTONSHIRE

Community Pharmacy

Northamptonshire Police

People with Lived Experience

NHS East Midlands Ambulance Service NHS Trust

PCNs and GP Confederations

healthwatch North Northamptonshire and West Northamptonshire

What will iCAN mean for professional care staff and clinicians

iCAN care will be personalised for the frail person who needs support, with coordination of health and care professionals who will have access to a menu of responsive and available services to preserve independence and autonomy.

Co-production and coordination of care with people and their carers, connecting with the community in the place where they live.

Range of services available to choose from and support for people to make choices about their care

Co-ordinated care supported by a frailty **MDT** including the voluntary sector working with health and care staff enables people to look after their own health and facilitate professional communication

Proactive care and plans to reduce the reliance on reactive care currently provided in the hospitals in our system

Shared digital information to support efficient working and adherence to individual choices and to avoid people having to tell their storey multiple times

Efficient and easy routes to diagnosis, therapies and other treatments to reduce patient, carer and staff frustrations

Support for independence in the person's own home and community as much as possible, with focussed and brief contact with inpatient services when necessary

Patients leaving hospital as soon as they have no reason to reside via a timely and efficient discharge and returning **home as soon as possible**, avoids long term deconditioning and loss of function

What care staff and clinicians say about iCAN

The iCAN programme has engaged staff and they see their feedback being listened to and acted on improving staff satisfaction

Working across the system has allowed staff to cross fertilise ideas and learn about people and service delivery they had no knowledge of before

The ability to improve quality outcomes supports the clinical staff and engages them in transformation

Staff feel part of something bigger and believe they can effect positive change

iCAN gives staff across the system a single vision and purpose focussed on patients and outcomes rather than organisation which they feedback is highly motivating

iCAN benefits and outcomes for people

What difference could we make if we embed ICAN ways of working permanently across our over 65 pathways?

The latest ONS data shows there are **138,200** people over 65 live in Northamptonshire

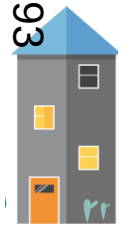
Every day, on average, **26.5** over-65s access urgent community intermediate care

Every day, **149** over-65s come to ED, **93** are admitted into hospital as an emergency admission, with **711** in a hospital bed at any time *

Some people will still have a need that must be addressed, but we could support more people with a mix of urgent and routine **community based** services

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**

By supporting people differently in our community, some of those people could remain healthy and well at home, their **needs not escalating**



Some people will still have a need that must be addressed at the Emergency Department but we could help more of them, potentially with short term support, to **go home, rather than be admitted**

We could support more people who have had a need that must be addressed by admission to hospital to be **discharged home** on Pathways 0 or 1 rather than Pathways 2 or 3

75-79 people a day will still have a need that requires them to be admitted to hospital, but we could help them **return home quicker**

By 2025

HOME

At any one time, **170** more people every day would be at home, not in hospital

* June 2022 snapshot data

What our plan means in practice for our residents

Stanley's story – a case study of the lack of preventative additional planned care

Stanley

Stanley was living with and being cared for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

Escalation

One day, Stanley's daughter called the ambulance when she found that her father was unable to mobilise due to the swelling in his legs.

He ended up remaining in hospital until his oedema had been brought under control. By this stage he had to be put on the complex discharge list and was facing a long wait.

Before the Escalation

Hospital

Formal Support

He was receiving support from the community nursing team to dress diabetic ulcers on his leg twice a week.

Since it was not the same community nurse dressing Stanley's leg each time, the nursing team did not flag Stanley's oedema worsening.

Admitted to Hospital

Stanley was conveyed to the ED at Kettering General Hospital and admitted.
Because Stanley was unable to mobilise he could not be assessed by the therapists within 72 hours.

"Everyone is looking at a part of a patients care and assuming someone else is doing the rest...surely the therapist will do this.. surely the oncologist will do this....there are a lot of assumptions...which is my frustration with the system and leads to patients missing out"

General Practitioner

Stanley's story
How would our practitioners could have done things differently

Stanley

Stanley was living with and being cared for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

If Stanley had received a **structured medication review** to better understand his non-compliance and with access to a **step-up bed,** the workshop think that his oedema could have been brought under control and the escalation to A and E averted.

Before the Escalation

Hospital

A holistic assessment of Stanley's needs had the potential to avoid this decline altogether.
Had the underlying cause of Stanley's non-compliance been addressed: accessing a carers assessment for his daughter, access to respite care, carer support, a wellbeing assessment for Stanley.
Intervening early and planning for Stanley's needs could have helped avoid the decline.

With **greater continuity** of the practitioners involved, the declining condition may have been flagged before it reached crisis point.
This could be achieved through more comprehensive **care planning** to look out for certain signs, or a **digital solution** to share images between the practitioners involved in Stanley's care.

All changes are vital to supporting Stanley to live well in the community

Stanley

Stanley was living with and being care for by his daughter.
His daughter was struggling to cope with supporting her father's complex care needs.

Non-Compliance

Stanley actively stopped taking the medication prescribed for his increasing oedema as he felt a burden to his daughter and wanted access to respite care.

Sometimes Stanley and other frail residents will experience a crisis. Ensuring our escalation and community teams have the knowledge and support to make the best **escalation decision** will ensure that Stanley can access any of the urgent community care provisions in the county that would benefit him.

Support our community and escalation teams to have an accurate **perception of the urgent community care** provisions will help break down and blockers that exist to access these services.

Before the Escalation

Hospital

A holistic assessment of Stanley's needs will ensure that we have the **right plan** for when he escalates. It will set his baseline so practitioners know when his needs are increasing.

It will also mean that he can access the **right people** so that he receives the planned services in a timely manner to enable him to live independently in the community.

Having a baseline and a plan will enable practitioners to have the **right support** to fully appraise whether someone's needs are increasing.

However, without better communication between services, we won't be able to meet Stanley's increasing needs. Ensuring the **right people** are available to our community practitioners to enable Stanley to stay in his home.

What will iCAN mean for - Mavis Ageing Well in 2025… "I will have…"

Ageing Well is a national programme that recognises people **can now** expect to live for far longer than ever before.

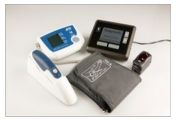
But these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life.

Our Age well plans with ICAN working with GPs aims to help older people manage these long-term conditions, making sure they receive the right kind of support to help them live as well as possible and have greater control over the care they receive, with more care and support being offered in or close to people's homes, rather than in hospital.

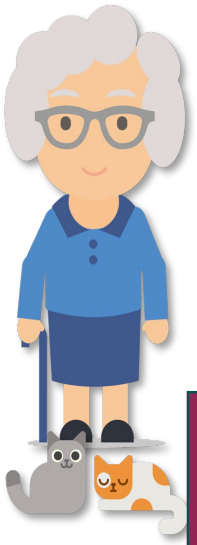
Befriending if I want this

Assistive Technology to maintain my independence

Personalised Equipment to help me self manage my health



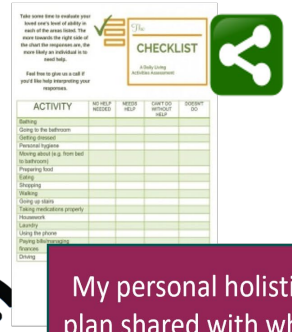
Access to range of local community activities and support groups (in person or virtual)



Mavis

Free Wi-Fi and digital platforms

Proactive remote monitoring and reassurance that support is quickly available if I need it



My personal holistic plan shared with who I choose and reviewed regularly with me.

Backed up with timely access to specialists as my needs change

My go to named person from my local integrated team

What happens if we do nothing?

Without iCAN Improvements:

Outdated ways of providing care with an over reliance on bedded care, in the face of escalating demand and elderly population, increasing emergency hospitalisations and long stays,

Elective backlogs remain and duplication of services result in a struggling workforce, high running costs, inefficiency and overspending.

With iCAN Improvements:

Shift care into the community relieving pressure on hospitals and reducing the cost of unplanned care;

Undertake major reorganisation of care to remove waste and duplication;

Improve efficiency by reducing demand supporting a reduction in escalation beds and remodelling of hospitals.

Without iCAN Improvements:

Health outcomes decline as GP/ community based care struggles to cope with increasing demand; more patients suffer health crises and require emergency hospitalisation and long stays;

Planned care cancelled as emergencies rise and beds are blocked; duplication of services undermines timeliness, quality and safety of care.

With iCAN Improvements:

Health outcomes improve by strengthening primary, integrated and urgent care to support Home First approach for patients with long term conditions;

Reduce unplanned care and shift services out of hospitals into the community; reorganise hospitals to focus on acute care and support elective recovery

Gateway Two

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Vision

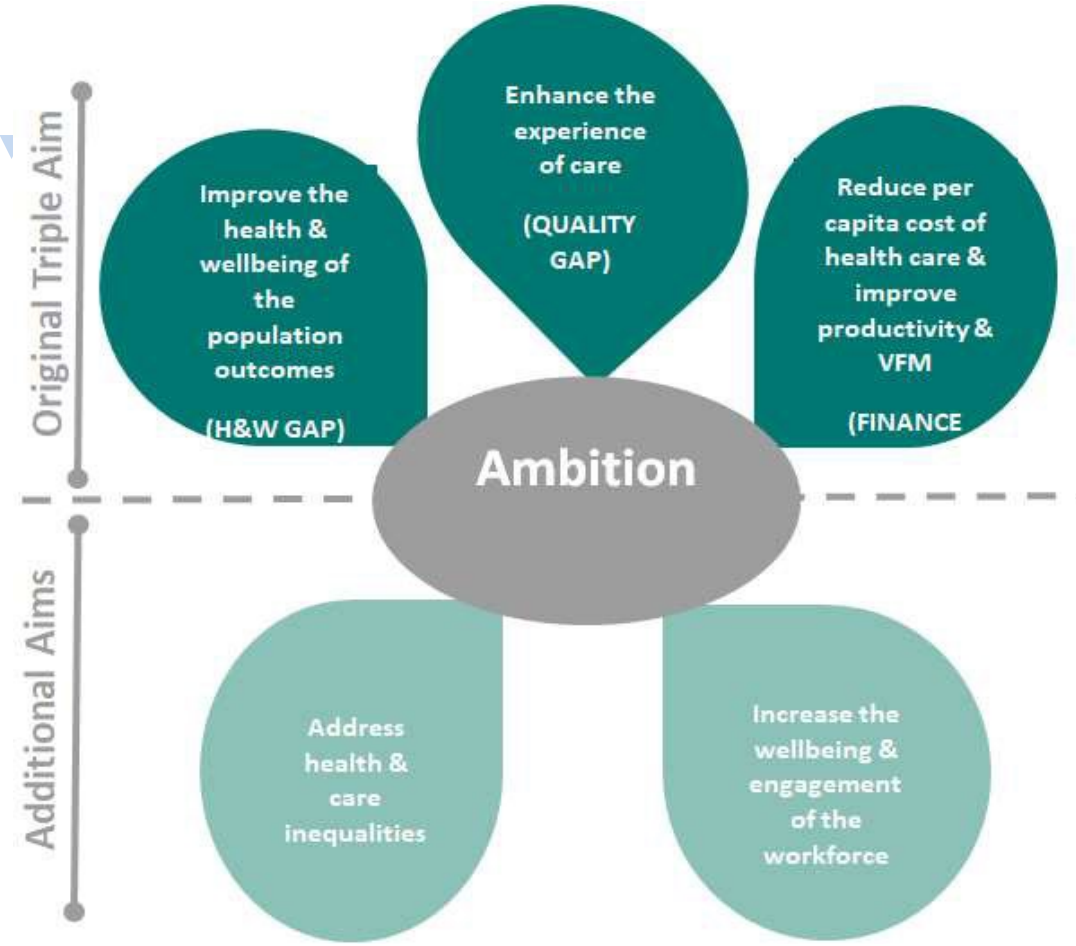
iCAN strategic alignment to our ICS

There is a strong alignment between iCAN and our ICS core objectives and ambitions

Our ICS vision	Through joined-up effort and shared resources we create a positive lifetime for all, of health, wellbeing and care in our communities
Our iCAN ambition	Greater integration across health, care and the voluntary sector will allow people to tell their story once, navigate between organisations and experience greater continuity of care

A strong sense of purpose

"Our plan is ambitious and aims to address the long-term population health needs and sustainability of our health and care system. Not only will we work in a more joined-up way in the future by delivering the health and care services people really need, but we will also transform the way we work with and provide care to the people of Northamptonshire." NHCP December 2020 Paper



iCAN collaborative aspirations

The collaborative is committed to transforming services for our patients, simplifying pathways for our stakeholders and tackling health inequalities for our residents. To this end, the collaborative is aligned to **five system goals**, the **10 ICP ambitions** and is underpinned by a framework of measures that demonstrate our progress towards them

Five System Goals

Improve outcomes for patients, service users, carers and residents of Northamptonshire who have are frail and have both planned and crisis care needs

Delivery of both **known and emerging requirements** – including NHS Long-Term Plan, Public Health Outcome Frameworks, Care Act and local Service User 'I' Statements.

Make the **best use of limited resources**, by addressing duplication and gaps within pathways and reinvesting in preventative initiatives (left-shift of system spend).

Through Neighbourhoods and place-based working enable longer-term transformation, via cross-system partnerships and integrated commissioning approaches

Reframe system relationships in **support of the Integrated Care System** aspirations, to drive sustainability, transparency and accountability.

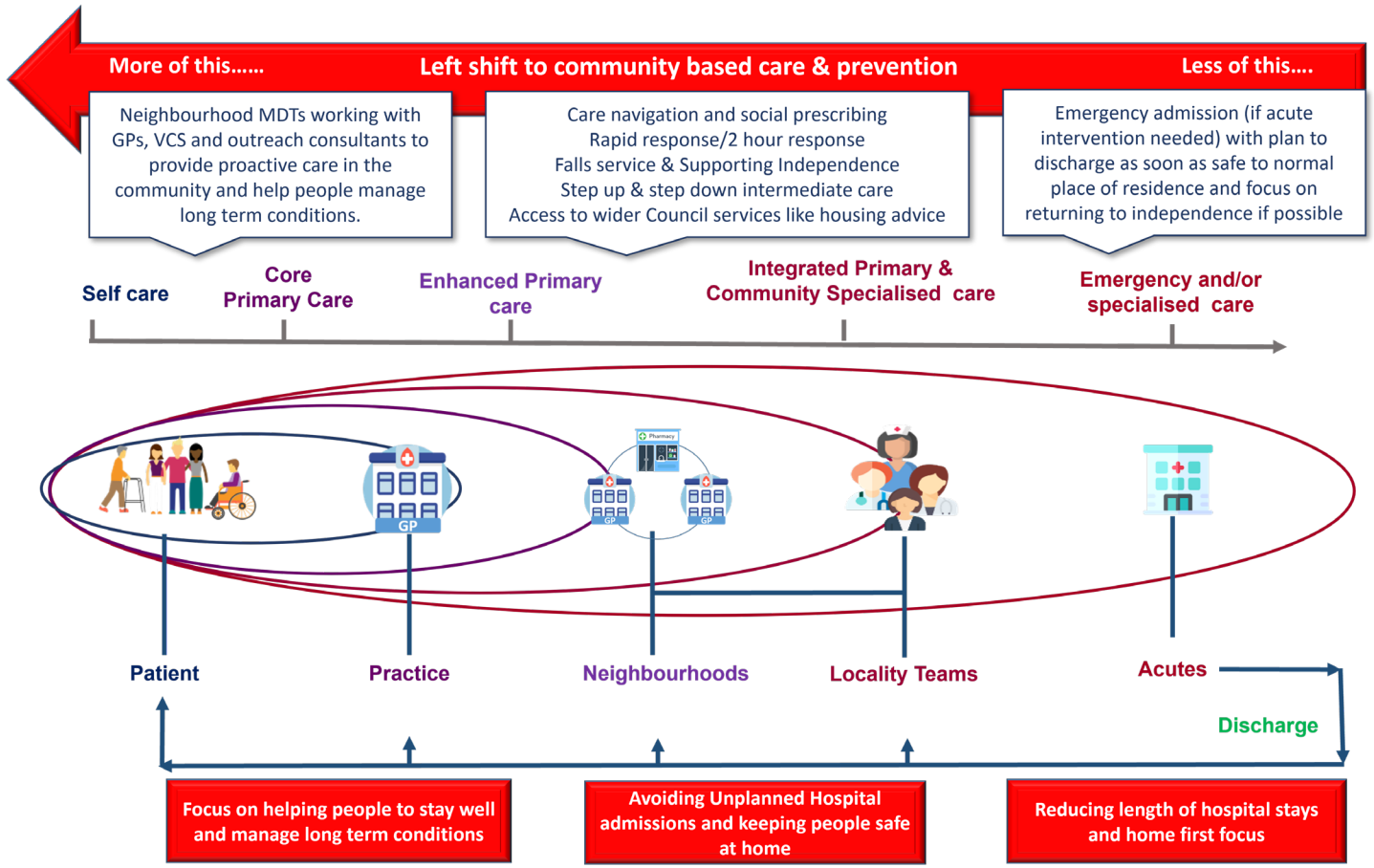
Meeting the 5 goals through ICAN – A left shift

We propose to move to a **new model of integrated proactive neighbourhood care** and away from unplanned care with a default of acute based care.

This means we will be keeping more people well or supported at home for longer, avoiding escalations and ensuring that when people do go to hospital they do not stay longer than necessary and are supported to recover in the best setting for them.

This is better for people, better for our finances and our system sustainability.

Funding might need to be refocused to the community and prevention with more delegated budgets and resources targeted based on local area profiles and health needs and less spent on unplanned care.



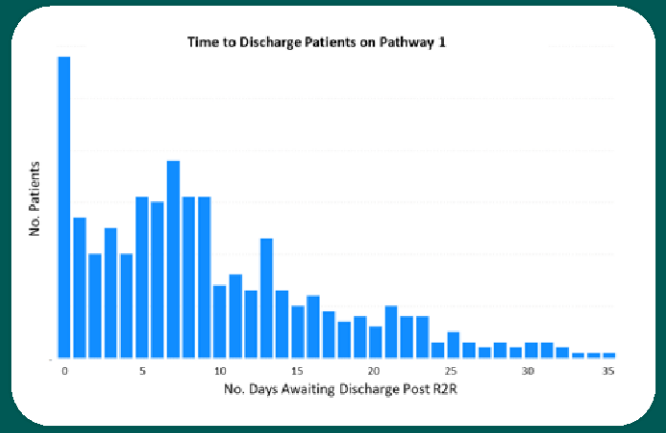
To be as effective as possible neighbourhood health and care teams need to be plugged into the wider determinants of health and a wide range of local authority and other partner services that connect to health and wellbeing including for e.g. housing, debt advice, leisure and community groups. These wider offers would be part of Local Area Partnerships put in place by the local authorities to facilitate links, access and a comprehensive community offer.

Pathways improvement: an example of collaboration

The challenge facing intermediate care pathways

- Patients who require intermediate care pathways* upon discharge from hospital are frequently waiting several days to be discharged
- This is not ideal for patients with increased deconditioning, which will increase their rehabilitation requirements and may impact their ultimate outcomes
- This is also a major contributor to long length of stay patients, leading to bed pressure in the acute hospitals
- This is caused by a combination of capacity constraints in the community, and process delays
- Through improving capacity and flow we will make the system more resilient to Winter surge pressures

The graph shown to the right shows how many people were discharged to Home-based intermediate care (P1), and how long it took from the point they were first able to be discharged. This shows while some people are discharged same-day, the majority of people take much longer.

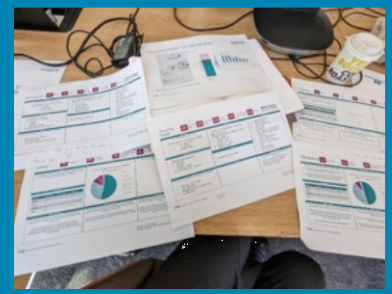


Working together collaboratively to tackle this

Working on the discharge pathway improvement sees acute, community and social care colleagues collaborating extensively:

- Improved visibility and transparency of queues and delays – working with both the Transfer of Care Hubs and the Out of Hospital services
- Referral processes – where process delays are impacting length of stay, working together to resolve root causes of delays
- Pathway 1 services working to improve their capacity via scheduling and length of stay improvements
- Pathway 2 services to improve their length of stay and therefore bed availability
- Transformation of our out of hospital beds, working in a more integrated way to maximise the community resources and deliver better outcomes for people

Colleagues from across Community Health and Social Care sharing data on Pathway 2, and collaborating on opportunities and redesigns to improve flow and outcomes for patients.



*Home-based = Pathway 1, Bed-based = Pathway 2

What success looks like: “At a glance” future benefits from ICAN

Gateway Three

Roadmap

National priorities, 'Age Well' and improved discharge

ICAN seeks to address a number of national and system priorities

- Promote a **multidisciplinary team approach** where partners work together in an integrated way to provide tailored support that helps people live well and independently at home for longer and **Give people more say about the care and support they receive**, particularly towards the end of their lives
- Offer **more support for people who look after family members, partners or friends** because of their illness, frailty or disability
- Develop more **rapid community response teams**, to support older people with health issues before they need hospital treatment (in line with the Community Service 2 hour Community urgent care response guidelines of March 22) and help those leaving hospital to return and recover at home
- Offer **more NHS support in care homes** including making sure there are strong links between care homes, local general practices and community services including the Enhanced Care in Care Homes model.
- Create a sustainable **primary care** model addressing the recommendations of the Fuller Report and building community services capacity to deliver more a robust neighbourhood model that supports care at home
- Sustained improvement in delayed discharges from health working with local authority partners and supported by the **Better Care Fund and the investment in Virtual Wards** in line with national direction
- Improve the responsiveness of urgent and emergency care and **build community care capacity**– keeping patients safe and offering the right care, at the right time, in the right setting

An underpinning objective for all will be ensuring inequalities are not created and existing ones addressed

Urgent and emergency care

The system is working to **six goals for urgent and emergency care**. These goals, in synergy with and complementary to the aims and ambitions of the iCAN programme are:

- Coordination, planning and support for people at greater risk of needing urgent or emergency care,
- Signposting to the right place, first time,
- Access to clinically safe alternatives to hospital admission,
- Rapid response in a physical or mental health crisis,
- Optimal hospital care following admission, and
- Home-first approach and reduce risk of readmission.

Why a collaborative ?

As a system we agreed in November 2020 to focus our energies on changing the way we help our older population to age well. This has been reinforced through subsequent national publications, such as The Health and Social Care White paper, ageing well programme, the Fuller report and now the national refocus of the 2022-23 Better Care Fund on two themes, "***stay well, stay safe and stay at home longer***" and "***right care, right place, right time***". These two key themes couldn't be better aligned to iCAN and what we aim to achieve.

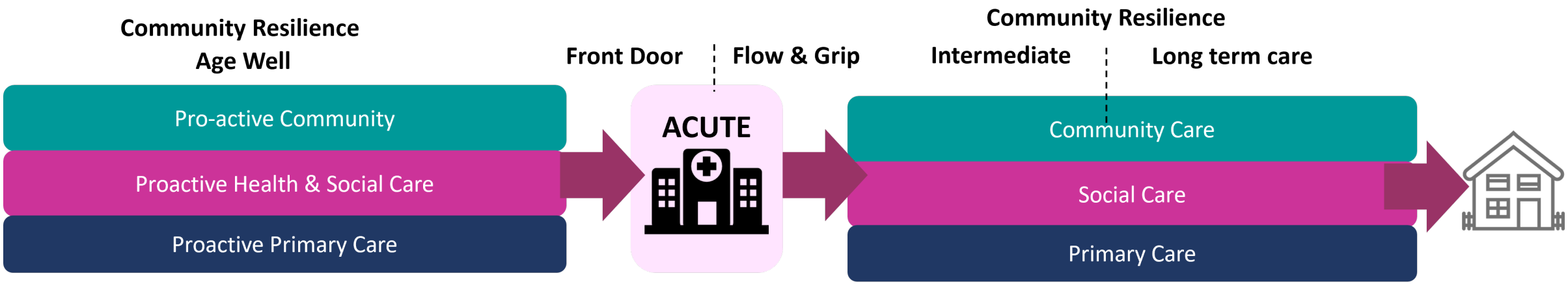
We have made fantastic progress in building a platform for the new ways of working in the community. We are already seeing signs that we are making a real difference for the people we have supported, who report feeling far more engaged in their care planning, and for professionals across the system who can see that improved practice and more joined up working is helping us deliver better services for the residents we serve. We want to consolidate these gains into a first stage collaborative structure (Age Well Service Development Funding elements) in 2023/24 to protect and ensure the new approaches are sustained.

We will continue to test new approaches to deliver a sustainable primary care-based model. We will then build onto these an extended range of services, agreed through full coproduction, to strengthen place and neighbourhood delivery in a phased sequence of additions in line with our stated five-year vision **to enable patients to choose well, live well and stay well.**

In parallel, we will continue to tackle the symptoms of an urgent care system under strain as a result of demographics and past failure to build our community resilience and offer. This has led to too much focus on urgent care and our investment has been in reactive approaches with an over reliance on bedded care and missed opportunities to return people to independence and their normal place of residence.

We have made good progress in stopping unnecessary admissions by working at the front door and implementing good practice in effective, timely discharges and step-down intermediate care and the quality of care and safety of patients. **Outcomes will continue to improve if we commit to a collaborative construct that commits us to maintaining and building on the results so far.**

Where is iCAN focusing its work?



Prevention & Avoidance
- **(1) Pro-active community health and social care: How** are community services working together to support and maintain people in their homes
- **(2) Primary care**: Primary services actively pre-empting and preventing escalation to urgent care and supporting people in their homes
- **(3) Acute admissions**: The right services in the community and at the front door to prevent unnecessary acute admissions

Hospital Flow Discharge
- **(4) Acute length of stay:** Ensuring people only in acute beds for as long as they need to be and leave when no reason to reside
- **(5) Acute discharge**: Making the best possible decisions regarding onwards care to maximise independent outcomes and flow

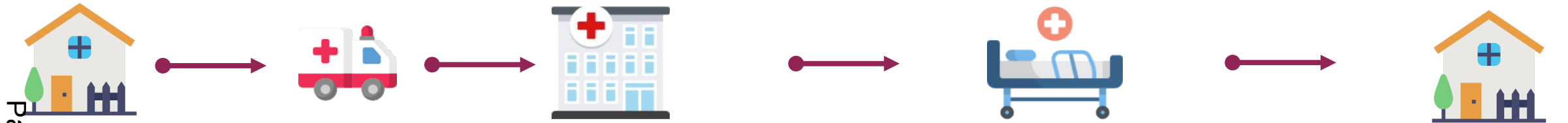
Integrated Intermediate Care
- **(6) Community health care short term**: Rehabilitation and reabling services maximising people's potential to remain independent
- **(7) Social care provision short term:** Giving reabling care to the right people, in the right setting, and achieving the best possible outcomes for them

Ongoing support
- **(8) Community & Social care long term:** Are people receiving the right services, meeting all their needs and achieving the best outcomes
- **(9) Primary Care Long term**: supporting people with long term conditions management and required interventions

(10) Foundations: Single dashboard version of demand, flow and capacity and command centre oversight

How are we targeting improvement ?

From the analysis of the issues we identified key areas of opportunity and improvement to relieve system pressure and improve performance against national metrics and policy, while in parallel investing on long term community change.



Are we preventing escalations from occurring in the community?	Are we ensuring people go to the right place upon escalation?	Are we ensuring the right people are admitted?	Are people discharged as soon as possible?			Are people discharged to the optimum setting?
5% reductions in over-65 escalations that would have resulted in admission	**5%** reduction of over-65 attendances that would have resulted in admission	**5%** reduction in over-65 admissions from ED	**7%** reduction of over-65 bed-days through reducing the Length of Stay	A reduction in the number of 'Stranded' and 'Super Stranded' patients *	An improvement in the number of patients with a 'Reason to Reside' recorded **	**5%** reduction in the cost of care for over-65s upon discharge

These targets were set for the first two years of iCAN while we were supported by externally contracted partners

* Against a baseline of 660 patients per month
** As measured against October 2021's baseline data

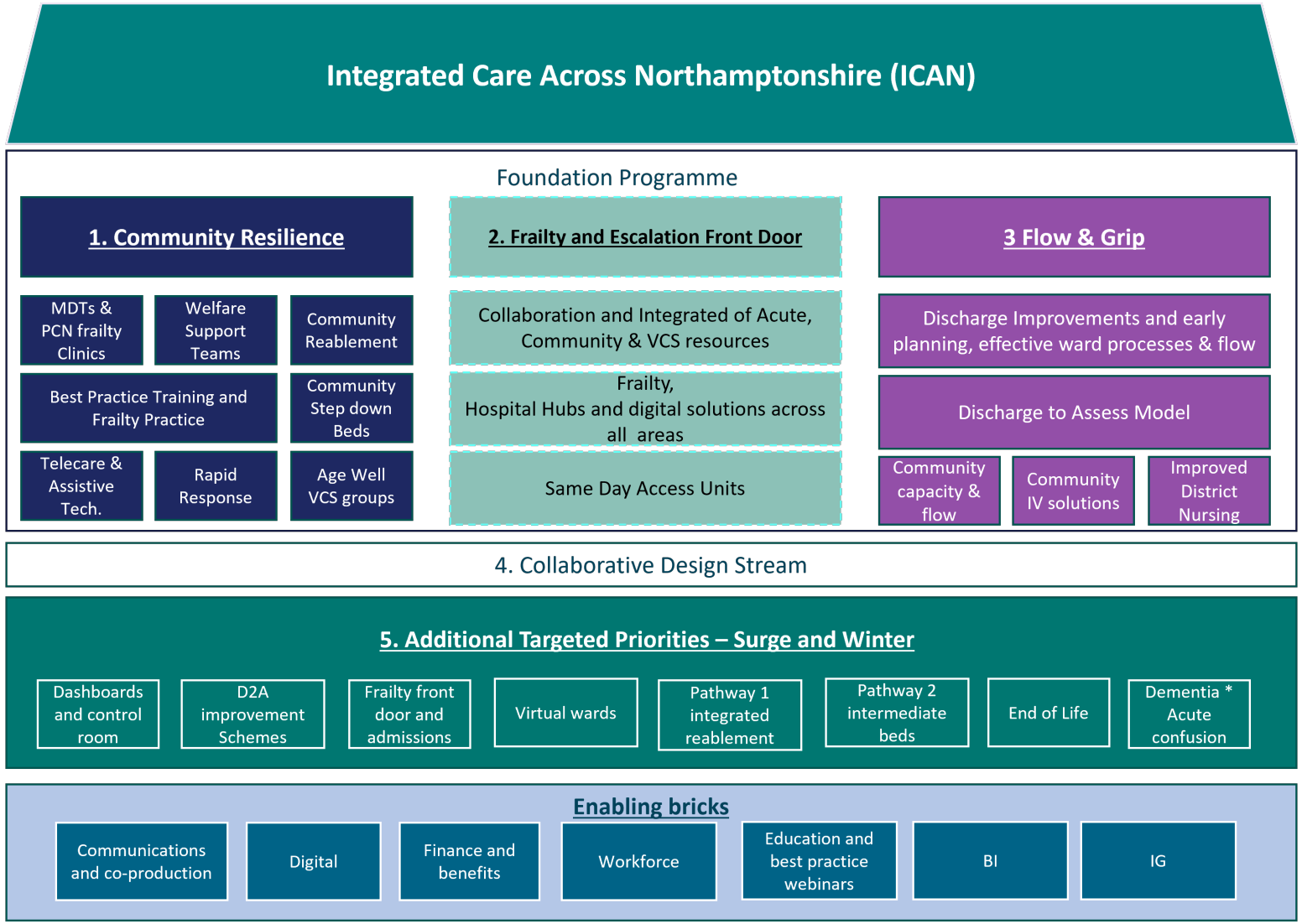
How will iCAN deliver it objectives

Partners across the system worked together to define how the programme would target these areas for improvement.

The programme began with three core streams or ‘pillars’, one for each of our focus areas and the delivery of improvements across our settings of care and all partners (‘foundation programme’).

A fourth stream of work is focused on the development of our collaborative (our collaborative Design Stream) and building on our programme learning and success to gain system agreement on the shape and scope of a formal collaborative for future delivery.

Given the repeated challenges of COVID surges and winter in 2022, we created a fifth short term focused stream to accelerate key activities and improvements needed for Winter 2022 and to stop future winters and surges leading to Tactical actions that undermine our goals (‘Winter and Surge Stream’)



Community Resilience Summary

Our Community Resilience mission is to...

Maximise independence and long term happiness by helping more people remain at home and thriving in their community

Provide holistic planned care in the community which reduces avoidable escalations

Reduce unplanned primary and community care demand

through...

Taking a strengths based approach to independence

Providing linked community services of the right size and quality to meet demand

Making appropriate interventions to reduce escalation

To achieve this we will...

Forge a strong network of community links, volunteer, health and social care services

Put the person at the centre of their care, leveraging remote monitoring and anticipatory care as appropriate

Provide urgent community response and deliver the aging well vision

Proactively support the hospital discharge and recovery programme

Use data and technology to inform people's needs and give us live visibility of what actions we need to take

What the Frailty, Escalation and Front Door work is targeting?

Our frailty, escalation and front door mission is to...

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

through...

Providing easy access to the information required for decision making

Listening to what our population wants and needs

Co-production between acute, community, and voluntary sector services

To achieve this we will...

Use data to guide improvement processes and ensure positive change

Increase knowledge of frailty system-wide through training

Connect ED staff to community and specialist services

Keep people informed and involved in care decisions

Support EMAS to utilise the appropriate pathways

Promote connections between primary care (GPs) and ICT

What our Flow and Grip work is targeting?

Our flow and grip mission is to...

Reduce unnecessary time in hospital beds

Maximise independence by helping more people return home

Improve the experience of people in our care

through...

Improving ward flow and control

Embedding true discharge to assess

Putting the person at the centre of their care

To achieve this we will...

Use data to give us live visibility of what actions we need to take

Connect hospital teams to community services

Keep people informed and involved in care decisions

Optimise tests and procedures both in hospital and in the community

Stop long-term care assessments in hospital

Commissioning the right services to meet peoples needs

The iCAN five year transformation programme

Clinical leadership team established

Year 1

New ways of working designed

Year 2

iCAN focus on

- Design
- Build
- Adopt

We are here

Focus shifted from hospital to community to enable appropriate use of acute capacity

Year 5

Sustained new ways of working

Maturing ICS

Northamptonshire Care Record trial begins

Build capacity for demand e.g. Neighbourhood Place based care, MDTs in each PCN, Frailty front door

Year 0

iCAN begins

Year 4

iCAN focus on sustaining new ways of working

Next 5 year vision for Northamptonshire

2025 VISION!

Developing ICS

TOM: getting NASS house in order and laying the foundations for Unitaries

Commissioning and completing iCAN diagnostic

Year 3

Community hubs and rapid response

iCAN focus on embedding new ways of working through a collaborative

Thriving ICS

Clearing the decks for increased community capacity

Full integrated pathway in place

Digital tools in place to support long term vision e.g. remote monitoring, NCR rollout

Building the collaborative in phases

We believe the collaborative will need to be built in phases or Tranches as our ICS strategic plans develop. The proposed Tranche 1 collaborative services for iCAN reflect the work in the iCAN transformation Programme and include the out-of-hospital services that we think will achieve our aims. This will mean a continued focus on building community resilience, reduced admissions and ensuring timely discharges but also building integrated Health and Care teams around key pathways like pathway 1 and 2 services.
The model excludes services commissioned through GP contracts – we would develop the iCAN collaborative services working with GPs and system partners to ensure we are aligned to the future CAS **(Clinical assessment services)** /Same Day/Urgent Care strategy agreed

Tranche One:
collaborative live April 2023 includes all services

Tranches Two onwards:
Commence as/when additional partners are ready to align activity with iCAN Outcomes Contract structure and/or the urgent care strategy is developed

ICAN Collaborative Tranches

Tranche One:
Most services set out in slide 7 including: 1) Shared Access points 2) Integrated MDT Approach to Community Health & Care 3) Integrated Discharge / intermediate Care Service (including P1 & P2 services) and 4) Winter and Surge Planning & Response

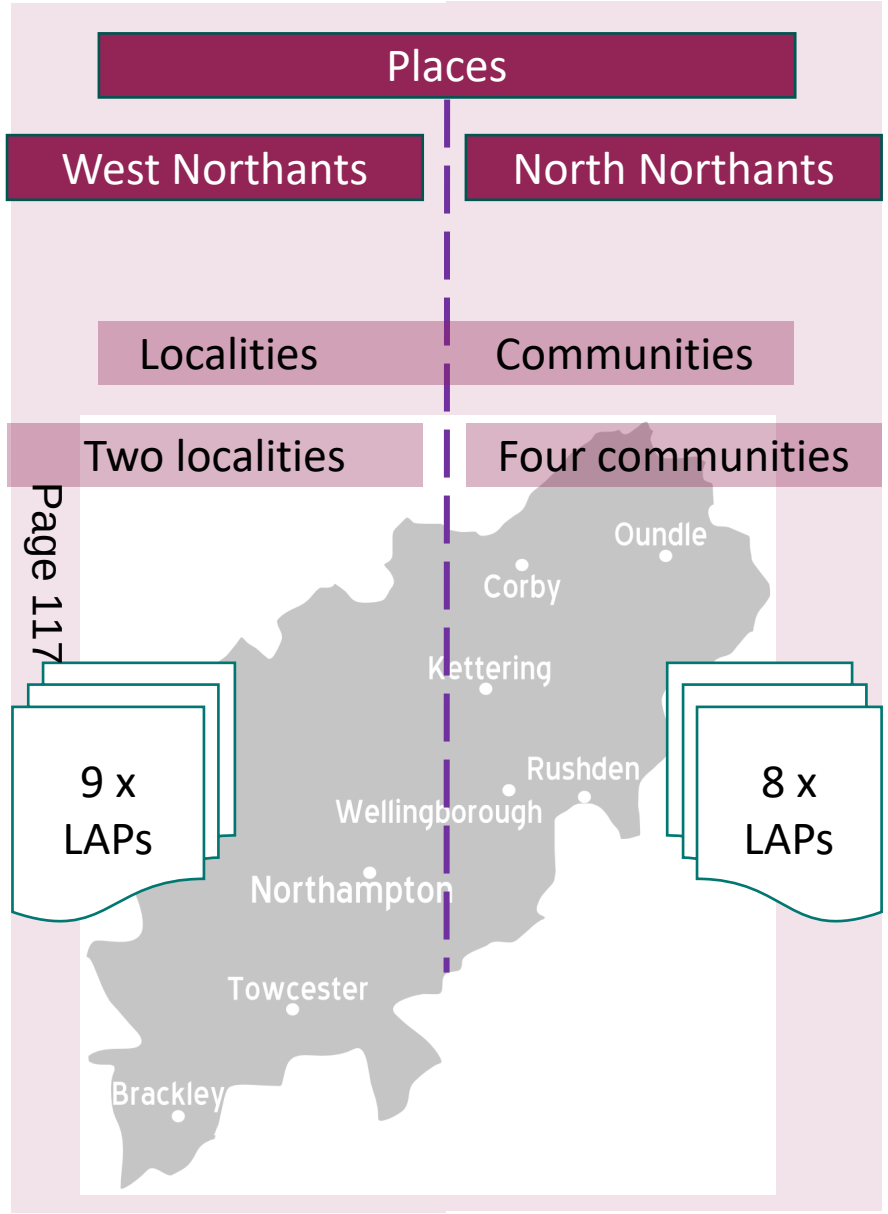
Tranche Two:
Tranche 1 services plus wraparound services required for CAS and agreed health and Care neighbourhood model for Same Day Services

Tranche Three:
Tranches 1 and 2 plus acute services (outreach), unplanned care for extended age range

iCAN Programme - Foundation Services

- Prevention and avoidance
- Hospital flow and discharge
- Community Resilience

Northamptonshire's approach to place development



Place: Understanding and working with communities; Joining up and coordinating services around people's needs; Addressing wider determinants that influence health and wellbeing; Supporting quality and sustainability of local services

Localities/Communities: Consolidating the views of residents, local providers and local area partnerships, oversight and co-ordination of care, unblock challenges, support local area planning.

Local Area Partnerships (LAPs): Represent local areas and give a voice to residents, translating strategy into local action by delivering the outcomes framework. They contribute to system-wide priorities as the delivery vehicle, providing a strong evidence base through quantitative data (digital footprint) and deep local insight from frontline partners, empowering local leaders to take accountability for local action. **For health and care specifically, neighbourhood teams service delivery will support LAP approaches**

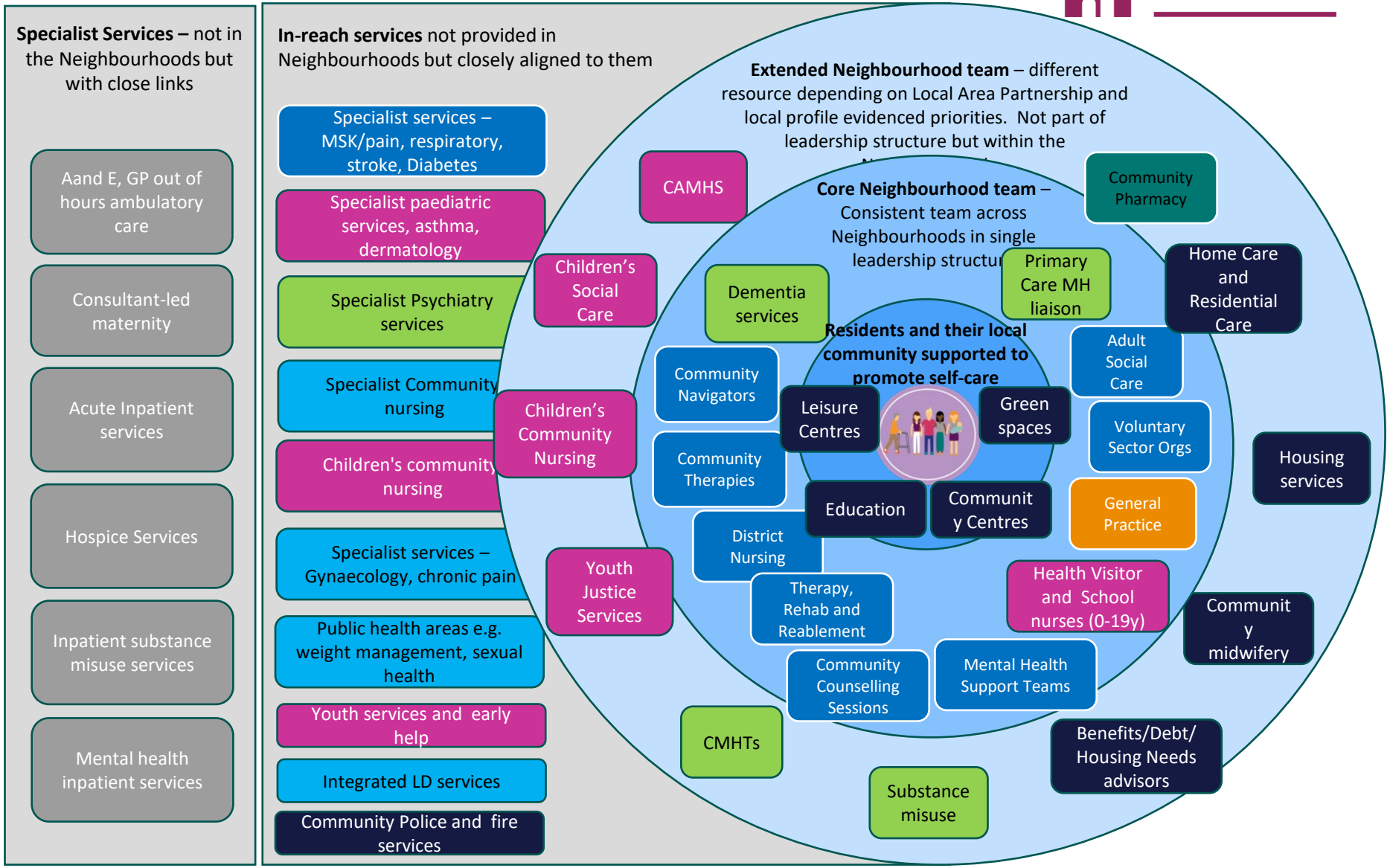
How might the future model of integrated community care look?

A new comprehensive Neighbour model of integrated Health and Care will take time to develop. We will need to engage with stakeholders and communities to design it.

A range of services will operate based on locally identified need as part of wider Local Area Partnerships (LAPs) with health and care and GPs, police, community safety, housing, leisure, voluntary sector services working as collaborative services.

More specialised services will be delivered on a different footprint as appropriate for the usage, cost and location requirements.

Health and Care will operate on a neighbourhood model aligned to GPs to help



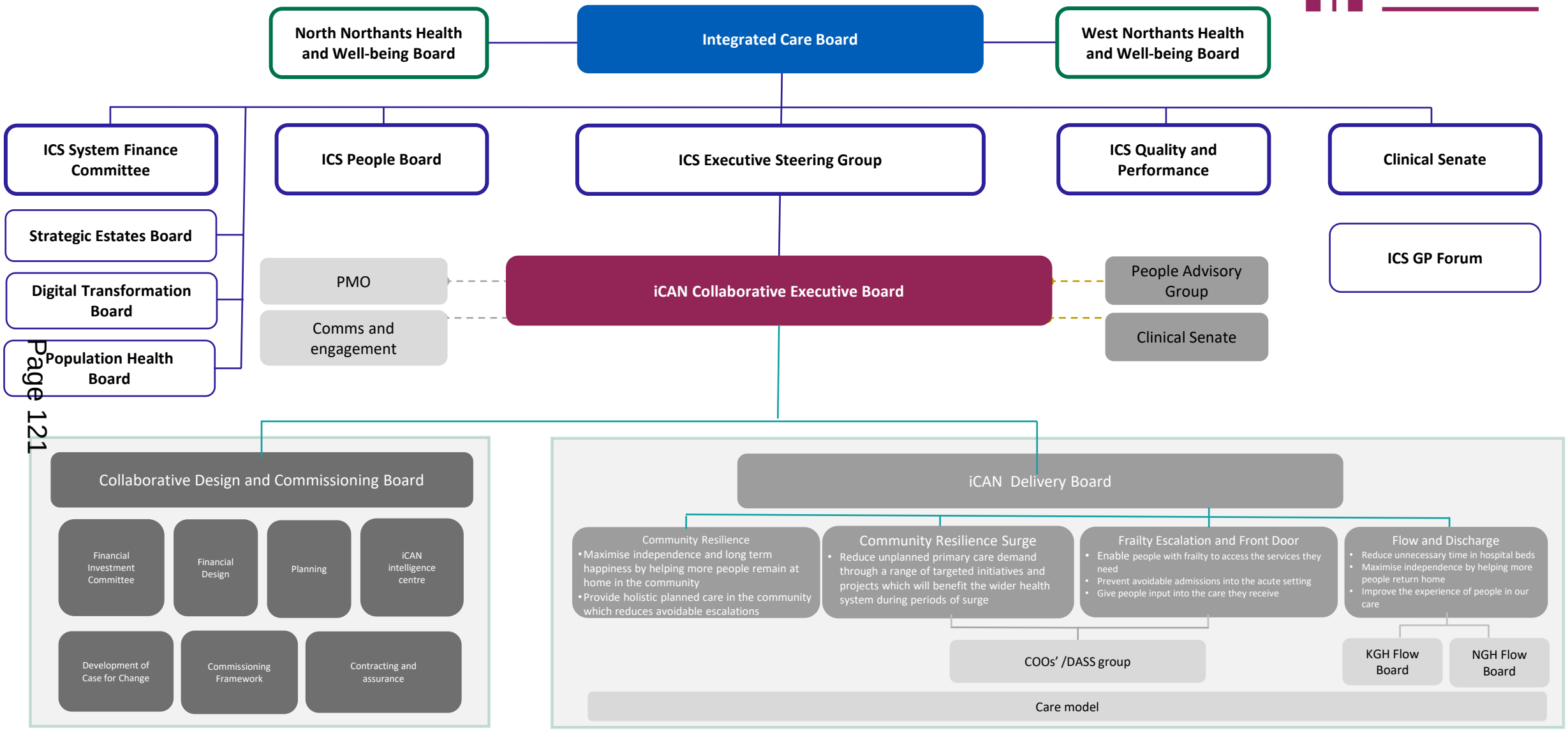
Gateway Four

Governance and accountability

Developing our new delivery vehicle

- In order to deliver our ambitions, we have developed a proposed governance structure that will help transition us from a transformation programme to a service delivery model. This new governance arrangement would take effect from September 2022.
- Between September 2022 and the end of the year, we would need to enter discussions on the scope of services we have proposed and what resources and delegated Budgets would be aligned under an ICAN collaborative and contract or delegation agreement.
- We would also need to develop an iCAN collaborative outcomes-based contract and performance framework to support the commissioning, planning and delivery of iCAN services.
- If we have agreed the scope, notional budgets and contracting arrangements then in 2023 we would propose the iCAN Executive Board would exercise functions jointly with the ICB in shadow delegation with the ambition of full delegation from April 2023, subject to appropriate assurance processes and ICB approval.
- Discussions with stakeholders to date have been high level, we would therefore seek to progress co-design work with service users on the proposed outcomes contract as well as engagement sessions involving clinical and non-clinical staff from across the acute providers, primary care, community and mental health services to make sure we had a defines set of services for Tranche 1 and understanding on how they would be accessed and operated.
- The final detailed model, scope of services and phasing will be developed with stakeholders over time as the collaborative matures and as new system models for things like the CAS and urgent care are developed and agreed by partners.
- We believe working together in a collaborative way will help us get the best from our workforce, creating opportunity and learning for them and ensuring we recruit and retain staff who work together for common aims.
- There are no plans at this stage to make any Transfer of Undertakings (Protection of Employment), also known as 'TUPE transfers' for Tranche 1 services but we want to explore how colocation and secondment models might work to ensure the collaborative functions as a single organisation.

Transitional collaborative governance structure

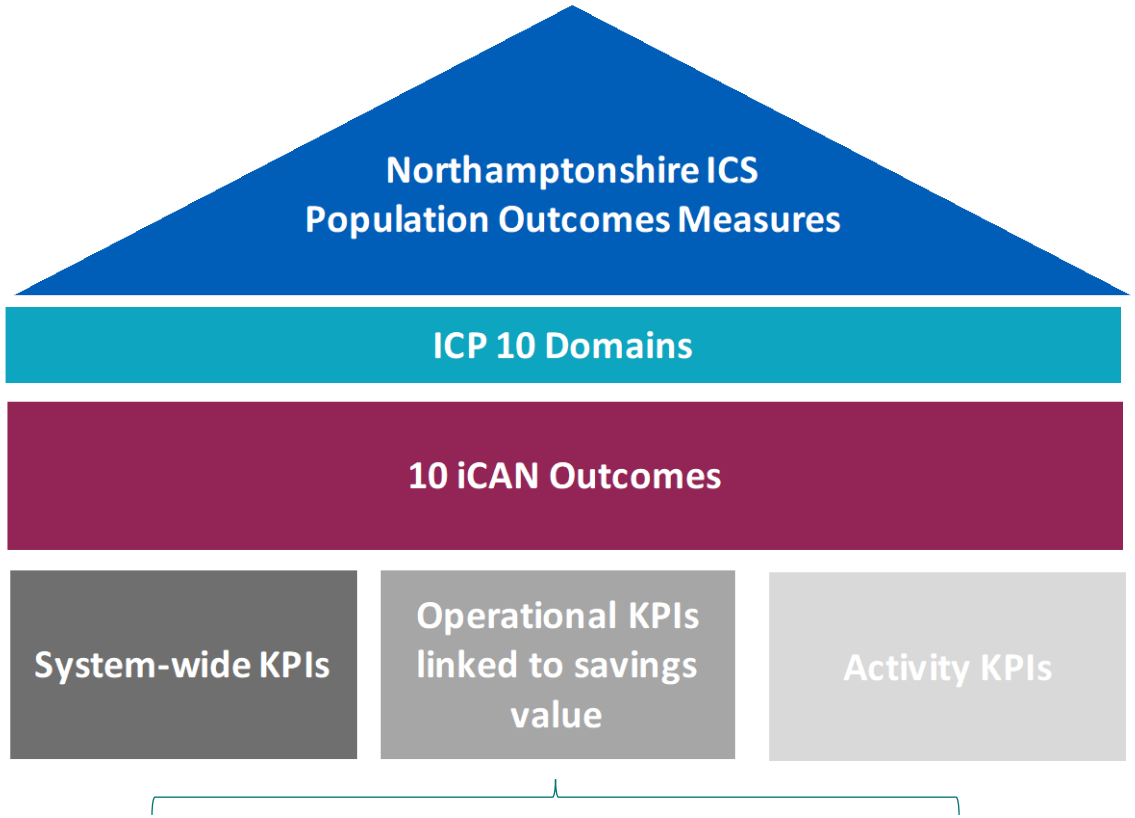


iCAN accountable decision making

Governance	Duties
Collaborative Executive Board	• Chaired by the Executive Sponsor, Chief Executive, West Northamptonshire Council • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders, Integrated Care Board, community and voluntary sector and Healthwatch • Responsible for ensuring a collaborative approach to the planning and delivery of integrated care in Northamptonshire and achieve a fully integrated model of care based on the needs of the population • Responsibility for ensuring the vision and strategic direction for the future of iCAN services in Northamptonshire is delivered, addressing the challenges of the long-term plan and population health needs • Work collaboratively and in accordance with the governance of the Integrated Care System
Delivery Board	• Reports to the iCAN Collaborative Executive Board, chaired by the Executive SRO, Director of Transformation and Quality, University Hospitals Northamptonshire • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders and the community and voluntary sector • Deliver the iCAN ambition through a series of projects that not only contribute to the longer-term development of the collaborative, but also to the shorter-term surge challenges of the system • Deliver the improvements and savings identified in the iCAN business case and move from transformational to operational activity • Define how programmes are delivered, including risks, costs, timeframes and outcomes
Collaborative and Commissioning Design Board	• Reports to the iCAN Collaborative Executive Board, chaired by the Deputy SRO, Deputy Chief Executive, Northamptonshire Healthcare NHS Foundation Trust • Representatives from West Northamptonshire and North Northamptonshire Councils, University Hospitals Northamptonshire, Northampton Healthcare NHS Foundation Trust, primary care, clinical leaders, Integrated Care Board and the community and voluntary sector • Responsible for ensuring the vision and strategic direction for integrated care services in Northamptonshire is delivered through a collaborative model which is evidence and outcome based and co-produced • Support the design and development of the iCAN collaborative model, the scope and the phasing of services therein and support the transition from transformation programme to collaborative delivery Agree and oversee commissioning activity, propose contracting and service improvements, support the development and oversight of formal arrangements

ICS outcomes framework

The following draft outcomes framework could be used for management of outcomes within the iCAN contract and Collaborative



These ICAN outcomes describe what we are trying to achieve. i.e. what service will look like when we make the changes and transform

These are the system measures and national metrics that demonstrate improvements in key areas that lead to the savings of £13m after 3 years

The 10 ICP domains have been adopted by both North and West as the key wider population wellbeing outcomes to be addressed at place level through Local Area Partnerships and neighbourhood delivery

These measures may not be directly linked to financial value but will indicate a real on the ground change happening across the system. There should be a measure for each brick

These are the KPIs which have been agreed by the BRG as the controllable measures which demonstrate real impact of the programme. These could be linked to bricks, pillars or a combination depending on the impact of the work

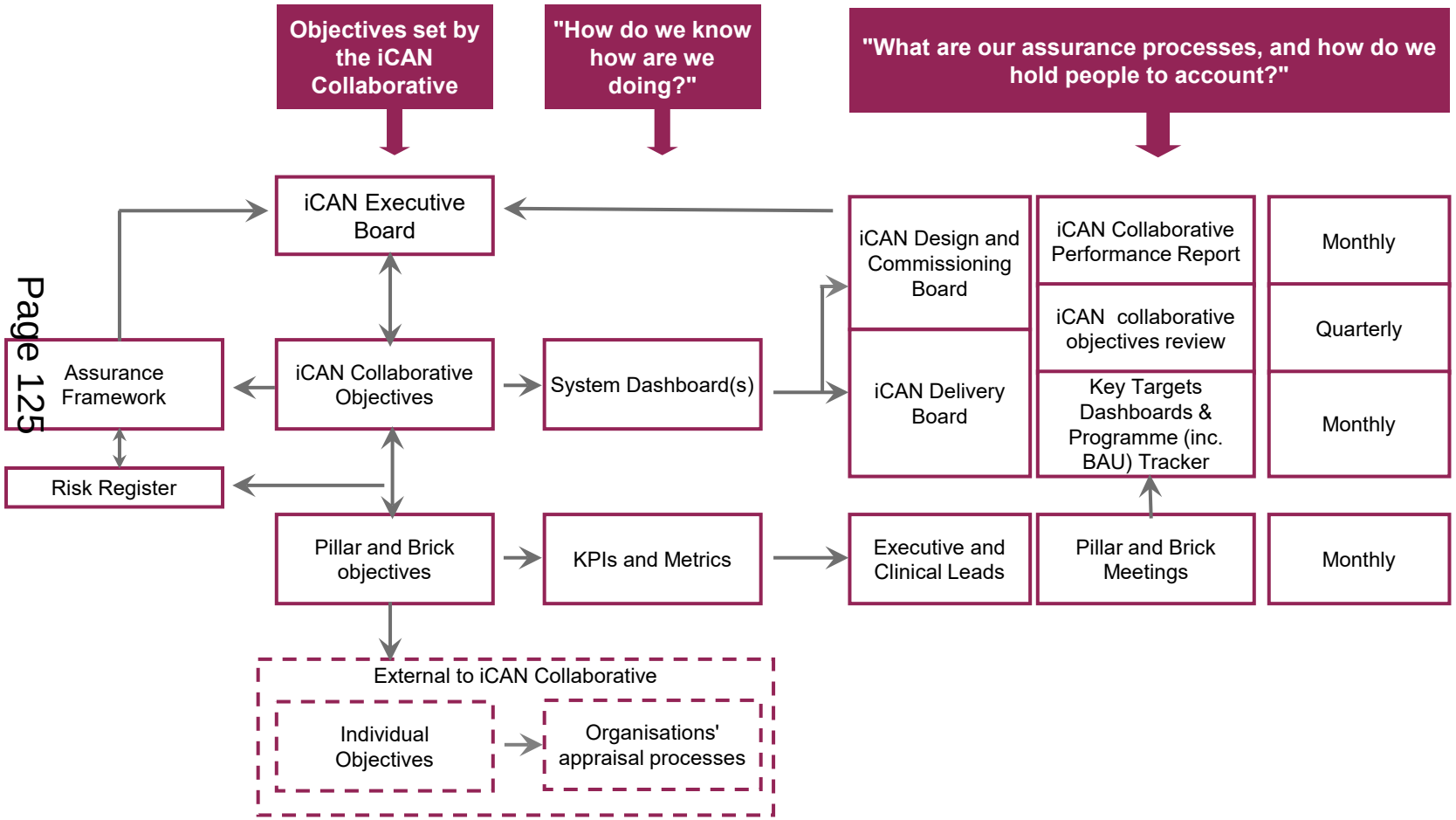
10 iCAN outcomes

1 More people remain at home in the community	6 People have input into the care they receive
2 Holistic planned care provided in the community	7 Prevented avoidable admissions into the acute setting
3 Reduced avoidable escalations	8 Reduced unnecessary time in hospital beds
4 Reduced unplanned primary care demand	9 Maximised independence by helping more people return home
5 People with frailty access the services they need	10 Improved the experience of people in our care

iCANs Three core Pillars of work have 10 outcomes related to care outcomes and peoples experiences

iCAN outcomes overview

Within a programme as complex and ambitious as iCAN it is important that we are rigorous with how we are monitoring the effectiveness and value for money the programme is delivering

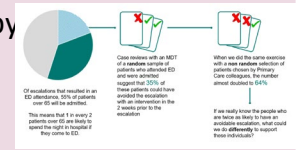
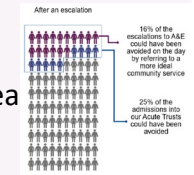
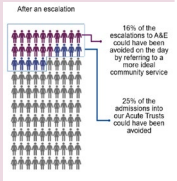
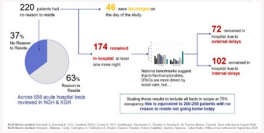


The iCAN Executive Board needs to have a simple and digestible method for regularly reviewing the progress against the objectives set by the iCAN collaborative. It will also be necessary to communicate this clearly to the ICB.

The majority of the measures relating to these objectives are monitored somewhere in the system or programme but not in one single location. The slides below set out a summary structure which could be used to link the objectives of the programme and help to easily navigate existing reporting.

It will also be necessary to understand the sustainability of our progress against these objectives, especially given the planned roll-off of the Newton team by November

iCAN is targeting specific operational benefits

What activities were carried out?	What was the "perfect world" opportunity	What would need to change?	What is the "real world" target?	What will the impact be for people?
Case reviews of a random selection of cases of people who attended ED	Randomly selected cases reviewed by an MDT of practitioners from the Northamptonshire system showed that **35%** of older adults who attended ED could have had avoided an escalation with a different intervention in the 2 weeks immediately prior to their admission. 	The majority of individuals were already in receipt of some form of care; we need to ensure that professional are aware of the range of services available, simplify and speed up referral processes and ensure appropriate community-based capacity	A **5%** reduction in the total number of escalations	People will have escalating needs addressed before they escalate to the point of an intervention, allowing them to safely remain at home
Case reviews of a random selection of people who attended ED	Case reviews showed that **16%** of the older adults who attended ED could have avoided attending ED by being referred to a more idea community-based service that would have met their needs 	People would need to access community services instead of coming to ED; the biggest opportunity was the use of ICT. We need to increase awareness of the needs that ICT can meet, ensure the capacity is used, and review OOH services.	A **5%** reduction in the total number of attendances	People will have urgent support in their home, or in a community hub to avoid attending ED
Case reviews of a random selection of people who were admitted to hospital	Case reviews showed that **25%** of the admissions into the acute trusts could have been avoided by discharging someone home from ED, either with or without additional community-based support. 	People would need to access community services instead of coming to ED; the biggest opportunity was the use of ICT, then people needing an outpatient referral.	A **5%** reduction in the total number of admissions	People will go home where appropriate, or go home with support to avoid an unnecessary admission and the associated decompensation in hospital
A review of the next steps for the patient in 658 Acute beds	**37%** of the patients in the Acute Hospital beds had no reason to reside, and yet 174 of the 220 remained in hospital at least one more night. 72 due to external delays, 102 due to internal delays. Scaling to the full number of beds means over 200 people who should have gone home today will still be in hospital tomorrow. 	The specific changes would be reducing diagnostic delays (1 in 7 patients waiting for a diagnostic test, but ¾ of these were actually waiting for communication between teams, not the test), increasing the use of community based IVs (1 in 12)	A **7%** reduction in the length of stay	More people will be able to go home rather than to a community based bed, and people will also be able to go home sooner

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iCAN outcomes framework example scorecard

Each KPI Links up to a population or system ambition and back to an I-statement to ensure we have a golden thread between them and can see the difference we are making at each level

ICS Population Outcome	ICP Ambition	iCAN Outcome	iCAN Lead KPI	iCAN Operational or activity KPI	iCAN I-statements
Stay Well	Opportunity to be fit, well and independent	Prevented avoidable admissions into the acute setting	Reduced escalations to Acute Hospitals	Avoided attendances due to Community Resilience Intervention	I understand and can access alternative options to the Emergency Department
Stay Well	Access to health and social care when they need it	Reduced avoidable escalations	Reduced ED attendances	Projected additional packages per day to Rapid Response	I understand and can access alternative options to the Emergency Department
Age Well	Opportunity to be fit, well and independent	People with frailty access the services they need	Reduced escalations to Acute Hospitals	Number of people discussed in GP Reviews	I am involved in my care and understand my condition.

Financial benefits – the ICAN Programme

- ICAN is a five year programme. The initial 18 month transformation programme (ending December 22) is designed to embed change and ways of working that secure £6m of savings across a range of interventions that they accumulate over the 5 years as shown opposite .
- By 2025, the iCAN programme was anticipated to be delivering a recurrent gross saving of £13.3m per year (stretch target of £18m)
- The baseline for comparison and savings calculations is 2019/20 as 2020/21 was such an abnormal year with COVID.

	YR1 (2021/22) £'000	YR2 (2022/23) £'000	YR3 (2023/34) £'000	YR4 (2024/25) £'000	YR5 (2025/26) £'000	Over 5 year period
BENEFITS						
Reduce A&E attendances (including associated admission & LoS)	1,078	2,695	5,390	5,390	5,390	19,943
Reduce Admissions (including associated LoS)	512	1,280	2,560	2,560	2,560	9,472
Reduce admissions avoidance packages	224	560	1,120	1,120	1,120	4,144
Reduce bed days	734	1,835	3,670	3,670	3,670	13,579
Reduction in cost of CHC packages	120	300	600	600	600	2,220
Total Benefits	**2,668**	**6,670**	**13,340**	**13,340**	**13,340**	**49,358**

- All savings and costs were translated from operational targets (signed off by operational teams) and modelled through by the finance community using a series of equations.
- The costs and benefits were been split by organisation and built into the financial plans for the system from 2022-23.
- The benefits are being tracked via a benefits realisation group/process with operational sign off that improvements have been made.
- Benefits could be avoided cost (e.g. reduced demand), operational cost reductions (e.g. reduced staff and bed closure) or reduced ongoing spend (e.g. long term care costs). The decision to realise them remains an operational one along with decisions to "cash the benefits" or not. But the targets remain with the organisation is which the benefits are identified.

Investments

- The Business case assumed additional costs and investment as follows
  - £2.74m for additional community health resource
  - Internal programme costs to run the programme and support the enablers at £1.85m for year 1 and 2 and reducing over five years
  - a maximum contingency envelope for any other potential costs that emerge

COSTS						
Non-recurrent						
Internal costs (PMO & Backfill)	1,850	1,850	1,000	1,000	500	6,200
Newton	8,000	0	0	0	0	8,000
Total	**9,850**	**1,850**	**1,000**	**1,000**	**500**	**14,200**
Recurrent						
ICT & DN Pay Costs	462	2,740	2,740	2,740	2,740	11,422
Additional IV Costs	-	TBC	TBC	TBC	TBC	-
Additional resource within maximum resource envelope	*958*	*4,360*	*4,360*	*4,360*	*4,360*	*18,398*
Total	**1,420**	**7,100**	**7,100**	**7,100**	**7,100**	**29,820**
Total Costs	**11,270**	**8,950**	**8,100**	**8,100**	**7,600**	**44,020**

The programme and External consultant investment was secured. But the recurring assumed operational investment costs shown above were not found.

- To date the main additional spend in the community has been via the Age Well programme investment into primary care provided by the CCG/ICB and one off Discharge to Assess funding.
- We are currently piloting a new model of Pathway 2 Intermediate Care following system agreement. One off Pilot funding of £2.7m has been secured and ongoing funding will be subject to the pilot proving successful and showing a return on investment for the system.
- The future capacity and cost for the left shift to a community offer will need to form part a new business case and system financial planning once the collaborative is agreed and final pathways and services are confirmed.

Budgets for a collaborative delivery model (1)

- Between now and the end of 2022 ICAN would need to work with system partners and finance to confirm the final scope of services and to agree;
  - the associated budgets that might be delegated or pooled,
  - any new investment needed for pathway 2 services (if the pilot is successful),
  - any contracts that might be transferred, and
  - any programme surplus budgets that would transfer to the collaborative
- It is suggested the Better Care Fund (BCF) services (with some changes) becomes the budgetary foundation and mechanism for pooling the resources that will sit in the iCAN collaborative.
- The national 2022/23 BCF guidance and metrics align well to all the ICAN aims with National Condition 4 setting out two national objectives as
  - **Keeping more people safe and well at home and independent for longer, and**
  - **providing the right care, in the right place at the right time.**

Existing BCF Schemes Potentially aligned to ICAN	
Carers Support	£1,488,437
Integrated Discharge teams	£1,915,164
Telecare and Assistive technology	£648,000
Community Equipment	£4,342,031
pathway 1	£17,060,586
Pathway 2	£2,818,457
Council Occupational therapy	£1,882,029
Disabled facility grant	£5,120,697
Safeguarding (Assurance) Teams	£909,164
	£36,184,566

- The majority of services effected by the ICAN vision and plan already sit in the BCF and the table above shows the value of the relevant services for the proposed ICAN tranche 1 collaborative. further complimentary services could be added. See next slide. Further information about the BCF is shown in the next slide.

Budgets for collaborative delivery model (2) The Better Care Fund?

The Better Care Fund (BCF) is one of the government's national vehicles for driving health and social care integration. It requires ICBs and local government to agree a joint plan, owned by the Health and Wellbeing Board. At a local level, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

These joint plans are for using pooled budgets to support integration, which are governed by an agreement under Section 75 of the NHS Act (2006).

Launched in 2015, the aim of the BCF is to reduce the barriers often created by separate funding streams. The minimum contributions to the BCF in 2022 to 2023 are detailed in the table (right):

The flexibility of local areas to pool more funding than the mandatory amount will remain.

The iBCF (Improved Better Care Fund) Grant determination was issued on 22 April 2022, with a condition that the grant is pooled into the area's BCF plan albeit that funds are paid directly to Local Authorities. This funding is excluded from our proposed ICAN tranche 1 service budgets as the majority of the funding is used to directly meet social care placements cost from rising demographic pressure and maintain the care market .

The DFG (Disabled Facilities Grant) is paid to local government through a Section 31 grant. This capital grant is used to implement property adaptions and minor works that help people remain at home but can be used more creatively around accommodation to help with step up0 and step down care. At this stage we are proposing that some elements of minor works or care and repair services could be part of the ICAN collaborative pooled budgets but not the whole grant which is fully committed with requests made to Council housing services for property changes.

Further information can be found here:
https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023

Budgets for a collaborative delivery model (3)

- There will need to be a discussion on the current BCF schemes that do not align to ICAN (for example Learning Disability domiciliary care) as they may be better placed in other collaboratives like mental health.
- If we remove any existing schemes by agreement, we will need to agree what schemes that do align to ICAN aims should be substituted into the BCF to maintain the statutory requirements for a minim CCG contribution and investment in out-of-hospital services for e.g., District Nursing.
- It is also suggested that we explore other services and budgets which, if integrated into ICAN may help us create true end to end community to hospital pathways and services that support our outcomes, for example Occupational Therapy in the Acutes, minor adaptions and care and repair and other voluntary sector contracts.
- We would propose the revised BCF would be subject to a new Section 75 agreement to recognise the partners whose services make up the collaborative delivery, the contributions and responsibilities of each partner and the common SLAs that we would work to.
- Having all ICAN services in one funding stream will make it easier to deliver a single contract, set of outcomes and meet national aims and to construct s75 arrangements to oversee the budget and contract.

Budgets for a collaborative delivery model (4)

- The mismatch between iCAN, which will measure outcomes for 65+ population, and the BCF which contains funding for service provision for persons under 65 is understood and will be managed as part of the collaborative design.
- Services included in the BCF which provide additional reach to under 65's will not be expected to separate out functioning and budget where to do would result in an inability to maintain safe and effective service delivery
- There are elements of primary care funding which, whilst not formally part of the BCF, are planned to be aligned to the Collaborative to ensure integrated delivery solutions e.g. Collaborative Care Team funding, PCN investment into Age Well Teams etc
- Decisions around scale of appropriate delivery would be through the iCAN Collaborative Delivery Group eg 2 Hr Rapid Response to be a single countywide model delivered through two place based teams.
- Delivery of Enhanced care in care home programme will be within the remit of the collaborative even though the funding is separate to primary care recognising that majority of care home residents will be 65+
- we will need to also ensure that the full three year of NHSE Ageing Well SDF allocation is correctly assigned to the BCF.

Workforce opportunities

Working as a collaborative we will be able to think differently across key aspects of the workforce to address challenges posed by and following the pandemic. Building upon the opportunities already seized to work more closely together, the iCAN collaborative will change and improve how we deliver services. This includes:

- Creative answers to workforce challenges in the system, such as rotating staff through settings,
- Sustainable and good value staffing models such as those established in dementia hubs and community asset groups,
- Partnership working, collaborative ethos and culture,
- One-stop-shops for patients and carers,
- High-level induction, training and learning for staff,
- Staff empowerment with staff as equals, and able to access key systems and in MDTs, take basic health measurements and prescribe low level equipment, and
- Learning partnerships with the Open University, the University of Northampton and the East Midlands research fund

Gateway Five

Formal Agreements

Integrated Care Across Northamptonshire

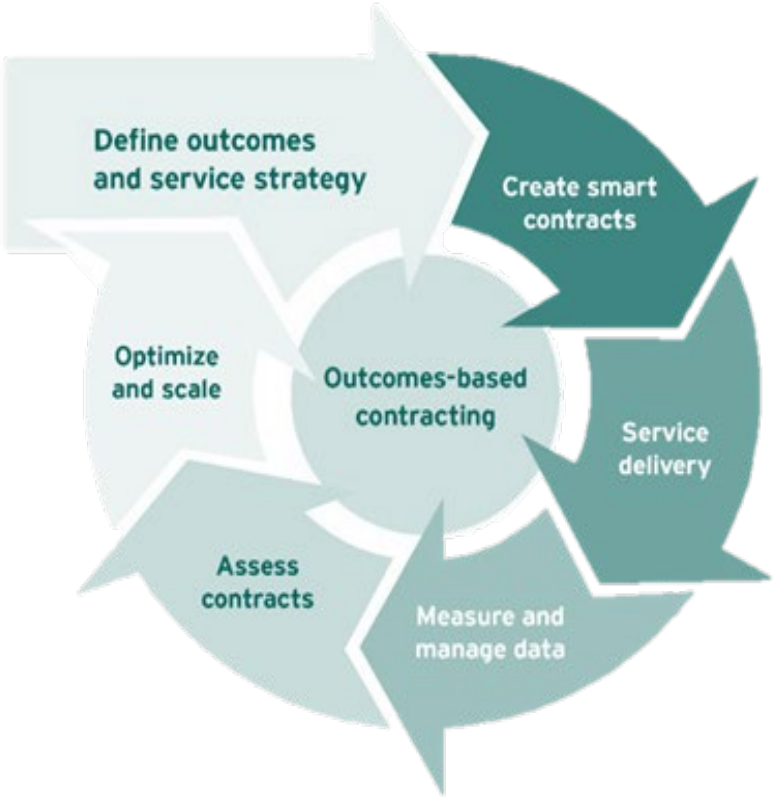
Contracts that enable transformation

The iCAN Collaborative

1. **Collaborative Contracting Arrangements** offer the most effective way of enabling desired population health outcomes and transformation goals, and give scope for wider heath and care outcomes (e.g. Public Health and Social Care) to be considered as part of a whole-pathway approach to improving outcomes for our people. This could include bold approaches for bringing health and social care workforce, contracts and packages of care under one integrated model
2. **Lead Provider** models can allow clear lines of accountability to the Integrated Care Board, but a Collaborative Agreement offers additional assurance that strategic planning is being system-led and system-owned
3. The addition of a **Collaborative Agreement** provides support to the all providers ensuring that all partners have an equal voice and decisions/ activities are assured to be system-led

The Collaborative aims to be live with the first tranche of the iCAN Collaborative Contract from 1 April 2023, with initial delegation and budget pooling for service using the BCF funding mechanisms .

Proposed contracting cycle for an Outcome-Based Collaborative Contract



Contract types that enable transformation

Creating the right environment for the positive change

Contracts do not, in themselves, produce good outcomes for our residents. However, the right contractual/collaborative framework can be an enabler for systems to work differently. Conversely, a poor contracting approach can be a barrier to achieving desired outcomes. In short, we should choose the contract to fit the vision, not the other way around.

Most, but not all of the services that are within the iCAN scope, are part of the BCF arrangements and Age Well SDF. Whilst the BCF is intended to encourage pooled budgets and integration it misses some of the key components for integration success because:

- Budgets are aligned and not pooled with the exception of community equipment
- The BCF is used as a means to transact not integrate services or share ownership
- There are no associated contracts based on population or system outcomes,
- There are no risk and reward or incentive measures, and
- Services operate within silos as there have been no overarching service design or integrated pathways

Various contracting options have been looked at, which are:

Historical contract approaches
Status quo with growing likelihood of barriers as collaboration increases

Alliance contracting
Published NHSEI approach generally considered as non-compliant with NHS standard contracts

Lead provider arrangements
Delegative approach in which a lead provider sub-contracts with other system partners on behalf of the ICB

Collaborative outcome-based contract arrangements
An approach (which may include a lead provider) which shares responsibility between commissioners & provider partners operating in the context of a collaborative agreement

Potential delegation of commissioning functions?

Discussions will be needed to agree what functions might be delegated to the iCAN collaborative alongside budgets and services. The table below illustrates the potential functions we might consider for delegation working on the basis that the collaborative will have responsibility for all aspects of delivery and the "how" and the ICB would retain the ownership of defining the "what" (outcomes & performance) and assurance that statutory duties are being met.

The aspiration would be for the iCAN to take on full delegation of commissioning functions from April 2023, subject to national guidance and final ICB approval. But the exact range of day 1 services in scope might start small and grow over time based on good performance.

	Commissioning / Provider Contracting		Potential Collaborative contracting arrangements		Potential delegation of commissioning functions	
Functions and Operations	CCG/ICB	Providers	CCG/ICB	Providers	CCG/ICB	Providers
Better Care Fund services	●	●	●	●	●	●
Age Well SDF	●		●			●
Surge and Escalation	●	●	●	●		●
Urgent Care Schemes	●	●	●	●		●
Discharge to Assess	●		●	●		●
Transformation Delivery	●	●	●	●		●
National Returns	●		●		●	●
Strategic Planning/Procuring services	●		●			
Assessing needs	●	●	●	●	●	●
Service quality and monitoring	●		●	●		●
System performance	●		●	●	●	●
Risk sharing	●	●	●	●		●
Investment / Disinvestment	●		●	●	●	●

Commissioner agreements that enable transformation

The submission of a Better Care Fund (BCF) Plan and its local formalisation through a Section 75 (S75) Agreement remains a national expectation in 2022/23. The minimum combined value of the schemes included in the 2022/23 BCF is circa £53.4 million (although the final value is to be confirmed.

In previous years, the potential for the pooling of these funds under joint commissioning arrangements has not been fully utilised with 4.8% of the value of the schemes included in the 2021/22 agreement being commissioned in this way. Although the majority of schemes have related closely to iCAN scope, previous year agreements have also included schemes that are associated with other Northants collaboratives, particularly MHLDA.

The national BCF policy for 2022/23 states two objectives:

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

The alignment of these objectives with iCAN's, the mandatory nature of the BCF S75 and the need for a formal agreement between commissioners working together to deliver the iCAN vision all suggest the use of the BCF S75 as a key vehicle for iCAN delivery.

To become the key vehicle for health & social care commissioning bodies supporting iCAN, the following incremental actions are required:

1. Alignment of the scheme content within the BCF plan to the scope of iCAN (through removal of schemes associated with other collaboratives and the addition of those associated with tranche 1 of iCAN)
2. The creation of further collaborative commissioning arrangements and their formalisation through Individual Partnership Agreements (IPAs) within Schedule 2 of the BCF S75. Over time, this may lead to the establishment of a Lead Commissioner for iCAN delivery through delegation of commissioning responsibilities to one commissioning organisation.

The iCAN outcome-based collaborative contract

If we progress to formalise iCAN collaborative arrangements, a Section 75 agreement would be used to capture the arrangements between health and the Councils to be commissioned by the ICB. To ensure the contract is based around outcomes, the following specific content needs to be considered for inclusion.

Outcome-Based Payment Mechanism

This mechanism builds on the incentivised risk and reward model for the iCAN transformation and would function in a similar manner to the established CQUIN mechanism, with a percentage of total core contract value dependent upon the evidenced improvement of iCAN outcomes and KPIs.

The KPIs and pathways are based upon national best practice for Age Well, community discharge and the extensive i-Statement coproduction work undertaken with service users and carers between 2017 and 2019.

The majority of the desired outcomes expressed through these i-Statements can be measured and aggregated via service user feedback or specific purpose focus groups.

While the acute service delivery is not considered for inclusion in the formal iCAN collaborative for Tranche 1, it will be essential that from the outset the dependencies on the acute trusts and their responsibilities in terms of maintaining the good practice from the Frailty Escalation and Front Door (FEFD) and Flow and Grip (F&G) transformation streams are clearly set out in a Memorandum of Understanding (MOU) or other service level agreement. This is because the iCAN collaborative does not control the clinical admission and discharge decisions identified in the iCAN diagnostic as contributing to the high hospital occupancy and length of stay.

Assuring this operational performance

In a programme as broad and complex as iCAN, it is important to have robust and agreed methods of tracking progress against targets and return on investment

KPIs across the programme

How will these be produced and used to provide assurance

System-wide KPIs

Attendances, admissions, LoS, Bed days and CHC spend

These measures will be used in two ways

1. External factors mean they can be significantly impacted by things other than the programme so while they may not be individually used to indicate programme benefit, any discrepancies should be explainable
2. Operational KPIs will be translated into a net impact on these measures to demonstrate system wide benefit (i.e. if our LoS has dropped by 3 days and our operational indicators show a process improvement of 2 days, 2 days of impact will be reported against the programme and 1 to other impacts i.e. Covid)

Operational KPIs linked to financial value

These are the KPIs which have been agreed by the BRG as the controllable measures which demonstrate real impact of the programme. These could be linked to bricks, pillars or a combination depending on the impact of the work

These measures will go through a rigorous process alongside the BRG and then reported at Delivery Boards:

Current opportunity and future state outlined	Level of measurement agreed (i.e. Do we measure the impact of a single brick or multiple)	Agreement on the operational KPI	Reporting set up	Baseline and target agreed by BRG and operational owner	Formula to translate into system-wide impact agreed	Realisation plan and owner agreed with BRG	Operational owners and BRG sign of value when workstream at sustainable target

Activity KPIs

These measures may not be directly linked to financial value but will indicate a real on the ground change happening across the system. There should be a measure for each brick

All bricks will have an activity measure, regardless off their independence or link to value. These will be regularly reported by brick leads to ensure real change is being adopted on the ground at the required pace

NB: Within each brick there are likely to be many other measures which will support the management of individual bricks and services. Many of these will likely not be needed to assure programme financial delivery unless they highlight specific opportunities / challenges which impact the measures above

Options for measuring and agreeing delivered performance

There are five principal methods that we could monitor as a Benefits Realisation Group to become confident in programme delivery. In all likelihood, the most rigorous method for tracking financial performance will be a pre-agreed combination of all of the below

Tracked changes to ways of working

Methodology:

Judge successful delivery based on a series of criteria which demonstrate that new ways of working are happening on the ground. These would come alongside a trusted operational owner confirming the sustainability of the new ways of working and the fact that they were having a positive impact

Positives:

- Easy and agile to measure
- Can be tracked back to real patient experience on the ground
- Allow practitioner judgement to account for external factors

Limitations:

- Not robustly linked to financial delivery
- May not indicate scale of delivery

Measurable activity KPIs against new ways of working

Methodology:

Judge successful delivery based on a series of criteria which demonstrate that new ways of working are happening on the ground and to a scale which would lead to the level of system wide impact initially targeted by this brick / pillar

Positives:

- Easy and agile to measure
- Can be tracked back to real patient experience on the ground
- Allow practitioner judgement to account for external factors

Limitations:

- Not robustly linked to financial delivery

Scaling local trials / analysis to demonstrated impact

Methodology:

Using an isolated trial or robust cause and effect analysis to demonstrate the system-wide impact of a given change. Benefit is then scaled based upon the adherence to the proven process across the system

Positives:

- Proven link to financial value
- Not impacted by external factors
- Low level of effort required to track ongoing after initial agreement of methodology

Limitations:

- May be directionally correct but may not specifically show the exact impact when scaled up across the system

Bottom Up Operational Indicators

Methodology:

Using a controlled operational KPI which is isolated and not impacted by external factors and measuring our performance against a baseline

Positives:

- Proven link to financial value
- True demonstration of operational impact across the system accounting for any external impact

Limitations:

- Requires time and collaboration to agree and set up

Top Down System Wide Measures

Methodology:

Judge the successful delivery of the programme based on the system-wide measures

Positives:

- Proven and direct link to value
- Easy to measure

Limitations:

- Extremely difficult to isolate the impact of the programme from external factors such as Covid

Proposed process to identify bottom-up delivery

Current opportunity and future state outlined	Defining what will actually be different on the ground as a result of this work and linking this back to the opportunity that was originally identified
Identification of whether this brick drives financial value	Identifying whether we need a fully rigorous benefits process for this brick or whether we can leave the measurement and management for other forums
Identification of whether this brick drives value independently	Identifying whether the bottom up measures we are looking at should be used to evaluate a single brick or a series of bricks together which cannot be broken down into their own individual impact
Agreement on operational KPI	Singling out the individual measure which will both demonstrate the impact of the programme, be relatively isolated from external factors (or at least have external factors understood) and can be linked up to our programme measures
Financial benefit formula and fixed variables agreed	Identifying the calculation that needs to be completed alongside the fixed variables required to turn a bottom up operational measure into a comparative impact on the top level financial measures
Approach to measurement agreed	Agreeing how the measurement will be completed, when impact would be expected to be seen, and clarifying the evidence that demonstrates how the potential impact has been calculated or estimated
Reporting set up, with baseline and target agreed	Agreeing with a technical owner that the data we are using to assess performance is the right information and is being used in the right way. Setting up visibility of this agreed performance /KPI, including the level against which we will measure our impact. This may be a static performance target or may build in some element of natural growth /shrinkage depending on recent trends
Realisation plan and owner agreed	The written and agreed plan and owner which will support the system to do the most appropriate thing when realising the impact of the improved performance. This may be as direct savings, reinvested or used in another way
Overall signoff	The step taken by BRG to confirm the value delivered by any performance improvement, recognise the financial value to the system using the mechanism set out in the business case (whether or not this is how the system has chosen to best realise the value)

Next steps

The iCAN outcome-based collaborative contract next steps

We will need to:

- Agree the scope of services for inclusion in the collaborative
- Agree the associated budgets for the services and that can be delegated to collaborative delivery
- Agree what commissioning and contract resources would sit within the collaborative from the partners to help manage performance and supply
- Finalise the outcomes contract and incentive mechanisms
- Develop the post Newton Europe/transformation programme running costs
- Agree the management structure for the delivery of services (as opposed to the programme structure)

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North Northamptonshire Council

Item no: 10

North Northamptonshire Health and Wellbeing Board

Report Title	MOU – Integrated Care System and the Voluntary, Community and Social Enterprise Sector (collectively known as the VCSE)
Report Author	Russell Rolph, Chief Executive, Voluntary Impact Northamptonshire

List of Appendices

Appendix A – MOU between the ICS and the VCSE
Appendix B – NHS Guidance on the Role of the VCSE in the ICS

1. Purpose of Report

1.1. This report tables an MOU between the ICS and the VCSE, an important element of NHS Guidance for all ICSs across the UK.

2. Executive Summary

1.2. There is a requirement for all ICSs to embed the VCSE into their system, both at a strategic and Placed Based level. As part of this process each ICS should adopt an MOU (Memorandum of Understanding) between the system in all its component parts and the VCSE sector. The MOU is a set of high-level principles which both the system and the VCSE should adhere to. It does not prevent any other Terms of Reference which may be required in any other specific part of the system. The MOU should be reviewed annually by the Health and Wellbeing Board.

3. Recommendations

3.1 It is recommended that the Health and Wellbeing Board ratify and endorse this MOU.

3.2 Ratifying this MOU sets the relationship between the system and the VCSE. It ensures a set of shared principles and undertakings from both parties which cements better and more effective working relationships. The ICS is about delivering different results for communities around the wider determinants of health, particularly at a local or Neighbourhood level through Area Partnerships. As the VCSE is a conduit into differing communities and cohorts

these shared principles and undertakings are vital to the effective throughput of ICS outcomes.

4. Report Background

4.1 The Integrated Care System went live in Northamptonshire on the 1st of July 2022. As part of the ICS framework there is a requirement (laid down by NHS Guidance) that the system embeds the VCSE into its work. NHS England believe that the VCSE is vital to ensuring that the ICS delivers effective and economic services into communities and in that regard is an equal partner. Voluntary Impact Northamptonshire is the systems appointed choice as NHS VCSE Broker into the ICS and is the recipient of Health Equality Grant Funding (known as Connect Northamptonshire) which amounts to £448K over the next three years. As NHS VCSE Broker, VIN is bringing the system wide MOU with the VCSE for consideration and endorsement.

5. Issues and Choices

5.1 The MOU establishes a set of high-level principles which the system and the VCSE should work to. The success of the ICS in respect of the wider determinants of health will require new and intuitive ways of working to deliver different results for communities, and the VCSE has a role in supporting this as engagers, brokers and in the delivery of services. The VCSE is already represented in three of the four clinical collaboratives (Mental Health, ICAN and CYP) and has a VCSE Assembly populated with 380 members and 11 Thematic Groups. Over and above this, other networks can access a further 1600 VCSE organisations and our value to Northamptonshire is considerable. By adopting the MOU, the Health and Wellbeing Board ratifies a commitment to working with the VCSE around a set of shared principles and undertakings. The board has several choices:

- To adopt the MOU.
- To adopt the MOU with amendments.
- To reject the MOU.

Rejection of the MOU will have implications on the relationship between the system and the VCSE, on which it might, could or should rely to deliver services, engage with communities, provide intelligence, assess impact, and support development and growth programmes.

6. Implications (including financial implications)

6.1 Resources and Financial

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

6.2 Legal

There are no legal implications arising from the proposals.

6.3 Risk

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

6.4 **Consultation**

6.4.1 This MOU has been circulated to the ICB Chair and ICS CEO, the Directors of Place, and the Directors and Deputy Directors of Adult Social Services. It has also been circulated to all partners engaged in the Health Equalities Grant Phase 2 submission with the Lottery, in addition to the wider VCSE which includes the VCSE Assembly Board and the Assembly Thematic Groups.

6.5 **Consideration by Scrutiny**

6.5.1 None.

6.6 **Climate Impact**

6.6.1 None.

6.7 **Community Impact**

6.7.1 The MOU will help the community engagement process within the Local Area Partnerships as it sets the tone for relationship between statutory partners and the VCSE.

7. Background Papers

7.1 PAR905 NHS Guidance on **Building Strong Integrated Systems Everywhere (or Appendix B).**

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Northamptonshire Integrated Care System (ICS) Memorandum of Understanding

Appendix A

This document is a written understanding between the Statutory, Voluntary and Community Sectors and other partners about how they will co-operate within the ICS construct and at point of place delivery through Local Area Partnerships. It has been compiled by Voluntary Impact Northamptonshire, VCSE NHS Broker for the ICS and Recipient of the Health Equality Grant Phase 2 on behalf of Northamptonshire community organisations (known as Connect Northamptonshire) and those members involved in the VCSE Assembly. This document is dated **12.07.2022** and should be **reviewed annually** by respective Health and Wellbeing Boards who are expected to endorse these aspirations and undertakings. The Health and Wellbeing Boards in both the West and the North will endorse this MOU, and all statutory partners and VCSE organisations should show commitment to it.

The Vision of an Integrated Care System:

To put local people at the heart of the services we design and deliver, helping local people to realise their potential; to live healthier, happier lives; and to stay well and independent in their families, homes, and communities for as long as possible. Voluntary and Community organisations make a major and literally incalculable contribution to the social, cultural, and economic life of Northamptonshire. They act as pathfinders for the involvement of our population in the design and delivery of services and often act as advocates for those who otherwise have no voice. In doing so, they promote both equality and diversity. They help to alleviate poverty, reduce health inequalities, improve the quality of life, and empower socially excluded people. The Voluntary and Community sector also makes an important direct economic contribution to the area. The Voluntary and Community sector in Northampton shire can operate most effectively if it has the understanding and support of the statutory sector, and vice versa.

The purpose of an MOU:

A 'Local Memorandum of Understanding' is a written understanding between the Statutory, Voluntary and Community Sectors and other partners within any given locality about how they will co-operate. It should recognise the contribution that Voluntary and Community groups make and acknowledge their independence, and the moves in central government and wider society towards empowering the voluntary sector and communities. It is crucial to the governance and wellbeing of communities in Northamptonshire, as elsewhere, working through engagement of volunteers, to promote an active population, promotion of debate, questioning and new ideas, and providing services. If the Memorandum of Understanding is effective, it will support the development of Voluntary and Community sector capacity to increase and improve the impact of the sector and benefit the population of Northamptonshire: Community health resilience is the ability of a community to use its assets to strengthen public health and healthcare systems and to improve the community's physical, behavioural, and social health to withstand, adapt to, and recover from adversity and reduce inequalities. The Voluntary and Community sector in Northamptonshire is wide-ranging, richly diverse, and resilient. There is continued recognition of the Voluntary and Community sectors independence, skill, and professionalism. Statutory organisations and the Voluntary and Community sector share many aspirations. These include the pursuit of inclusiveness, dedication to public life, and support for the development of healthy and safe communities. VCSE

organisations often provide unique solutions to difficult issues and have a reach into communities and cohorts that others do not. If the sectors work well together, the population of Northamptonshire will benefit as they will be empowered and will receive better services.

Shared Principles:

Some principles are fundamental to the relationship which exists between the Statutory sector and other partners such as the VCSE. All sectors need to:

- Ensure that we are transparent in all we do and remain committed to the principles of co-production. Co-production is an essential element of any ICS.
- Ensure that we are both solution- focused and bold in our decision making, and that all conflicts or potential conflicts are declared and resolved accordingly.
- That we respect each other's views and allow partners the courtesy of being listened to and heard.
- That voluntary or social action is an essential component of a democratic society.
- That an independent and diverse Voluntary and Community sector enriches society and is fundamental to its well-being.
- Accept that in the development and delivery of public policy and services, statutory organisations and the Voluntary and Community sector have distinct but complementary roles but in coming together they have collective strength for the good of communities.
- Strive to work with partners to ensure excellent services.
- Accept that partnership is effective if it works towards common goals and achieves benefits for service users and communities.
- Accept that Statutory organisations and the Voluntary and Community sector have different forms of accountability and are answerable to different stakeholders: But common to both is the need for integrity, objectivity, accountability, openness, honesty, leadership, and inclusivity.
- Accept that Voluntary and Community organisations are entitled to campaign within the law to advance their aims with or without support from statutory bodies, and to promote equality of opportunity for all people regardless of race, age, disability, gender, sexual orientation, religion or any other discriminatory or oppressive criteria and elimination discriminatory or oppressive practice.

Undertakings by the VCSE and the Statutory sectors:

- To advance a positive relationship with Voluntary and Community bodies, Statutory organisations signing up to the Northamptonshire ICS MOU will adopt these undertakings:
- Recognise and support the independence of Voluntary and Community bodies as equal partners, including their right within the law to campaign, to comment on and to challenge policy within the law, irrespective of any resource focus relationship that might exist, and to determine and manage their own affairs.
- Take account of the need for greater proportionality, targeting, consistency and transparency in frameworks and to promote strategic resource focus, enhancing the capacity of Voluntary and Community organisations.
- Recognise the importance of infrastructure to the voluntary sector and volunteering and, where appropriate, to support its development at a unitary and place level.

- Seek to appraise new policies and procedures, particularly at the developmental stage, to identify as far as possible potentially damaging implications for the sector.
- Consult and ensure shared decision making is carried out with the voluntary sector, subject to considerations of urgency, sensitivity, or confidentiality, or on issues that are likely to affect it. Such consultation should be timely and allow reasonable timescales for response, considering the need of organisations to consult their users, beneficiaries, and stakeholders.
- Consult and co-design a fluid engagement strategy that can respond to the needs of the communities impacted by change.
- Take account positively of the specific needs, interests and contributions of those Voluntary and Community bodies which represent women, minority groups and socially excluded people.
- Ensure that statutory sector staff are informed on the nature and importance of the Voluntary and Community sector.
- Recognise and acknowledge the skills and knowledge the voluntary sector retain.
- Undertake regular mapping exercises with the Voluntary and Community Sector to identify gaps and overlaps in service provision and areas of potential support.
- Promote effective working relationships, consistency of approach and good practice between Statutory partners and the VCSE.
- Work to develop a shared data asset register to support local needs assessments to target approaches in reducing inequalities.

Undertakings by the Voluntary and Community Sector:

In developing their relationship with the statutory sector, Voluntary and Community sector organisations agree the following undertakings: Voluntary and Community organisations will:

- Maintain high standards of governance and conduct and meet reporting and accountability obligations to funding bodies and users.
- Respect and be accountable to the law, and in the case of charities observe the appropriate guidance from the Charity Commission, including that on political activities and campaigning.
- Acknowledge responsibilities and constraints placed on the statutory sector, including the democratic responsibility and legitimacy of elected representatives.
- Develop quality standards appropriate to the organisations.
- Ensure that service users, volunteers, members, and supporters are informed and consulted, where appropriate, about activities and policy positions.
- Promote effective working relationships with other agencies and across the Voluntary and Community sector.
- Involve users, wherever possible, in the development and management of activities and services.
- Put in place policies for promoting best practice and equality of opportunity, including employment, the involvement of volunteers and users, and in building service provision.
- Work to develop a shared data asset register to support local needs assessments to target approaches in reducing inequalities.
- Build positive, effective, and lasting relationships with Statutory partners and communities.

Next steps:

The publication and endorsement of this Northamptonshire ICS MOU will not, in isolation, change or alter exponentially the relationships which exist between sectors for the benefit of communities. Whilst there are some excellent examples of co-production, engagement and joint working, positive and lasting change will depend on several essential and critical factors agreed on and committed to by all partners. These are:

- Ensuring that the priorities agreed upon for both the wider ICS and the LAPS are consistent and make sense to all, not least the communities that they intend to benefit.
- Ensuring that the wider determinants of health remain as important as the agreed clinical priorities.
- Ensuring that the Population Health Data is used wisely and consistently well as a mechanism for change in communities.
- Ensuring that community assets (VCSE organisations, buildings, people, services, and skills) remain an important conduit for the ICS and for preventing health inequality.
- Ensure that the VCSE is properly represented within the structures of the ICS.
- That solutions are truly tailored to community need.
- That reporting mechanisms focus not only on statistics but socially account for changes in people's lives.
- That Public Outcome Frameworks possess an element of Social Return on Investment.
- That feedback and engagement loops are inclusive.
- That this MOU is treated with respect and is reviewed annually in line with changing circumstances at both the West and North Health and Wellbeing Boards.

Classification: Official

Publications approval reference: PAR905

Building strong integrated care systems everywhere

ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector

NHS England and NHS Improvement may update or supplement this document during 2021/22. Elements of this guidance are subject to change until the legislation passes through Parliament and receives Royal Assent. We also welcome feedback from system and stakeholders to help us continually improve our guidance and learn from implementation. The latest versions of all NHS England and NHS Improvement guidance relating to the development of ICSs can be found at ICS Guidance.

Version 1, 2 September 2021

ICS implementation guidance

Integrated care systems (ICSs) are partnerships of health and care organisations that come together to plan and deliver joined up services and to improve the health of people who live and work in their area.

They exist to achieve four aims:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- enhance **productivity and value for money**
- help the NHS support broader **social and economic development**.

Following several years of locally-led development, and based on the recommendations of NHS England and NHS Improvement, the government has set out plans to put ICSs on a statutory footing.

To support this transition, NHS England and NHS Improvement are publishing guidance and resources, drawing on learning from all over the country.

Our aim is to enable local health and care leaders to build strong and effective ICSs in every part of England.

Collaborating as ICSs will help health and care organisations tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

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About this document

This guidance is for health and care leaders from all organisations in ICSs that are developing partnerships across local government, health, housing, social care and the voluntary, community and social enterprise (VCSE) sector. The ICS design framework sets the expectation that integrated care board (ICB) governance and decision-making arrangements support close working with the VCSE sector as a strategic partner in shaping, improving and delivering services, and developing and delivering plans to tackle the wider determinants of health. This guidance provides more detail on how to embed VCSE sector partnerships in ICSs.

Key points

- The VCSE sector is a key strategic partner with an important contribution to make in shaping, improving and delivering services, and developing and implementing plans to tackle the wider determinants of health
- VCSE partnership should be embedded in how the ICS operates, including through involvement in governance structures in population health management and service redesign work, and in system workforce, leadership and organisational development plans.

Action required

- By April 2022, ICBs are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.
- These arrangements should build on the involvement of VCSE partners in relevant forums at place and neighbourhood level.

Other guidance and resources

- ICS design framework
- Guidance on ICSs working with people and communities
- Guidance on the functions and governance of the ICB

Foreword: communities at the heart of health and care systems – the essential role of the VCSE

The COVID-19 pandemic has given society its biggest challenge of the past 70 years. It has shown that people need support joined up across local councils, the NHS and voluntary organisations. Initiatives to bring support to people in their communities have been most successful when partners have bridged traditional divisions between health and care and the voluntary sector. The pandemic has highlighted the value of this work.

Some of the most exciting and innovative work I have seen has been in the voluntary, community and social enterprise sector (VCSE). A strong focus on health and wellbeing, social connection and having fun!

In Wigan, we created a social contract between citizen and state – The Wigan Deal – bringing communities and local partnerships together.

As part of this, we took an 'invest to save' approach to strengthen the role of the VCSE sector in prevention and community resilience. We set up a community investment fund for VCSEs and gave council officers freedom to work with communities in an innovative way.

Council cost–benefit analysis estimates that for every £1 spent through the fund, £2 of fiscal value is created. This includes direct savings to social care, crisis savings and benefits payments.

Our approach was to join the dots around people and place, cutting through the complex proliferation of initiatives and departmental solutions.

This is what we learned:

- Find out what's important to residents and listen closely to communities. They will make the right decisions about their own lives with the right support.

- Invest in local community grassroots organisations and relationships with families to truly help people and reduce demand for expensive, ineffective and clunky state solutions.
- Give the freedom to test new approaches in integrated place-based teams, such as the self-organised Buurtzorg model in neighbourhoods. Trust public servants to work with people.
- Reduce time and money spent on passing people around the system for further assessment and referrals to another agency to deal with part of their problems.

It is important to understand that many VCSE organisations are struggling financially because fundraising has been adversely affected by the pandemic, at a time when demand for their services and support has never been greater. Positive engagement with the VCSE sector now can ensure that their knowledge, expertise and networks are protected, for the benefit of the whole community.

Frontline workers in VCSE sector organisations, together with their public sector colleagues, want to help people and improve their lives. We need to tap into their creativity and resilience and set them free to cut across the artificial organisational barriers of health, care, housing and criminal justice. If we do, the future is much more exciting!

Professor Donna Hall, CBE
Chair New Local Government Network and Bolton NHS Foundation Trust

Why do we need VCSE partnerships in ICSs?

The VCSE sector brings specialist expertise and fresh perspectives to public service delivery and is particularly well placed to support people with complex and multiple needs. It has a long track record in promoting engagement and finding creative ways to improve outcomes for groups with the poorest health, making it an essential partner in combating the inverse care law.[1]

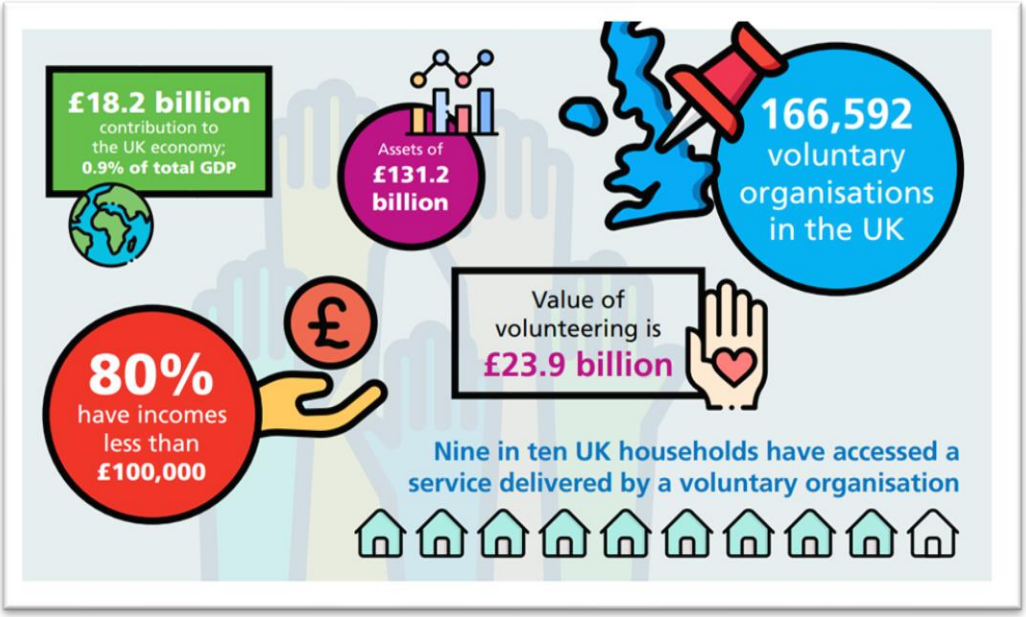
With its focus on early action, preventative services and wider social value, the sector provides good value for money. It brings insights, voice and assets into partnerships to support health and wellbeing, including expertise in service redesign and delivery, insight into inequalities, and access to volunteers and premises.

> "Voluntary and community sector organisations – from large national charities to small local ones – are involved in care pathways covering a wide variety of services, including disease-specific care, and in co-ordinating care for those with multi-morbidity across different parts of a pathway."
> (King's Fund[2])

Those working in the sector make up a significant proportion of the health and care workforce (Figure 1). Social enterprises alone employ over 100,000 staff – and have a turnover of more than £1.5 billion.[3] Around three million people volunteer in health and care, making an important contribution to people's experience of care.[4]

[1] The inverse care law highlights that disadvantaged populations need more healthcare than advantaged populations, but tend to receive less.
[2] Communities and health | The King's Fund
[3] Social enterprises: part of the NHS family – an explanatory guide for the wider NHS » Social Enterprise UK
[4] Volunteering in health and care | The King's Fund

Figure 1: The voluntary sector in numbers (Source: The UK Civil Society Almanac, 2020)



The VCSE sector has, and continues to, play an important role in keeping people connected during the COVID-19 pandemic, responding quickly to meet communities' needs. Organisations across the sector modified their services to support people and communities in the most vulnerable situations.

Table 1: Examples of some of the benefits when there is close partnership working between the VCSE sector and statutory partners

Achievement	Description
Improving outcomes in population health and healthcare	
Faster and more joined-up mental healthcare in Somerset	The Open Mental Health partnership is a new approach to mental health care designed by partners from all sectors with the involvement of people who use services at all stages. The care model includes a 24-hour helpline and has tightly linked the VCSE sector to the NHS through a shared scheme for recovery and care planning.
Better prevention and treatment of eye care problems in West Yorkshire and Harrogate	The charities Vision UK, Thomas Pocklington Trust and the Macular Society are involved in a comprehensive review of eye care services, alongside NHS commissioners, hospitals and community services, opticians and local authorities. The aim is to improve all eye care services from prevention through to rehabilitation, building in shared decision-making and personalisation. Carers Wakefield is now using

Achievement	Description
	the Eyes Right Toolkit to improve prevention of vision problems among the local unpaid carer population.
Tackling inequalities	
Improved vaccination take-up for homeless people in Brighton	Arch Healthcare Community Interest Company, the main provider of primary care for people experiencing homelessness in Brighton, built on its pre-existing relationship with and knowledge of the local homeless community. It developed a mobile vaccination service, partnering with St John Ambulance and going to temporary accommodation hostels rather than inviting patients to a surgery or a mass vaccination site. It vaccinated more than 800 people in eight weeks, with around 38 people vaccinated per day in the community.
Better support for carers in Herefordshire and Worcestershire	Statutory health and care partners worked with local VCSE carers organisations, NHS staff and unpaid carers to improve support. Work included developing a carer's CV to support employment prospects for carers; a 'Carer Assist' service to support carers in the NHS workforce; and training and development for staff across the system on awareness and support for unpaid carers.
Enhancing productivity and value for money	
Out-of-hospital support for COVID-19 patients in Hertfordshire	Local charity Communities 1st worked with hospitals to establish 'virtual wards', where patients with COVID-19 are managed at home and they use oximetry to monitor their own oxygen levels. The primary aim of some of these wards is supported early discharge, freeing up hospital staff and beds; others are referring patients directly from emergency departments and primary care.

Challenges to VCSE and ICS partnership working

There can be as many as 16,000 VCSE organisations in the largest ICSs, ranging from big social enterprises employing a large workforce to informal grassroots groups supporting people in their local community. Support may relate to a specific condition, such as mental health, disability or cancer care, or it may be organised around a geographical or virtual community or local organisation or group.

The diversity of the VCSE sector is a strength to be recognised and celebrated – but it also means it can be daunting for ICSs, particularly at system level, to engage in a systematic way. Equally, VCSEs face challenges in working in a complex landscape and overcoming funding and time constraints. Statutory partners need to carefully consider how to equitably resource the involvement of VCSE partners in a way that respects their time and resource.

However, within many ICSs, partners have already created VCSE alliances to support engagement with the diversity of the sector. In addition, at place level, VCSE infrastructure organisations (often called CVSs or Voluntary Action) usually exist and provide a co-ordinating function for the sector. NHS bodies and local government already commission VCSE organisations and work with them at different scales, and the COVID-19 response has, in many cases, accelerated collaboration and deepened relationships, providing good foundations to build on.

> "The voluntary sector can at times be competitively minded because it has needed to be. But now with collaborations in integrated care systems, we're more able to think about what unites us and how we can collaborate."
> (Beccy Wardle, Head of NHS partnerships, Rethink Mental Illness)

Case study: A VCSE Assembly in Norfolk and Waveney ICS

The Norfolk and Waveney Health and Care Partnership and its local VCSE organisations have developed a VCSE Assembly as a way to improve health and care by connecting the VCSE sector with statutory partners in the ICS. NHS, county councils and VCSE sector partners work in partnership to develop the Assembly and link it to the Health and Wellbeing Board, to ensure it represents and meets the needs of communities and the voluntary sector, and that the voices of smaller groups are heard.

Core requirement and good practice for building VCSE partnerships in ICSs

Core requirement

By April 2022 integrated care partnerships (ICPs) and the ICB[5] are expected to have developed a formal agreement for engaging and embedding the VCSE sector in system-level governance and decision-making arrangements, ideally by working through a VCSE alliance to reflect the diversity of the sector.

- The detail of partnership arrangements will depend on existing local infrastructure and approaches.
- Partnership arrangements should include agreed ways of working such as a memorandum of understanding and sets of principles.
- There is a national ICS and VCSE sector partnership programme to support this work.

> "As with all partnerships, ICSs need to invest time and money to build strategic relationships with the VCSE, creating, supporting and working with alliances. VCSE alliances are very knowledgeable about their communities, and everyone benefits from them being in the room."
> (Charlotte Augst, Chief Executive, National Voices)

The questions below, based on learning of 'what good looks like', are intended to stimulate thinking on how best to embed the VCSE sector in the ICB's governance and partnership arrangements.

[5] The ICS Design Framework referred to this organisation as the ICS NHS Body. However, since the second reading of the draft legislation in parliament we have adopted the name integrated care board (ICB).

Embedding the VCSE sector in the ICBs governance and partnership arrangements – a check list
Is there VCSE sector involvement in system-wide workstreams, service redesign, place-based partnerships, neighbourhood teams, primary care networks and provider collaboratives?
Have you mapped VCSE stakeholders and the contribution and resources brought by the VCSE sector to the ICS?
Are you working with VCSE groups relevant to the priorities you are tackling, and the population groups you are trying to support?
Are you building on existing structures and networks, such as VCSE representation on health and wellbeing boards and local VCSE infrastructure organisations?
Can data sharing agreements be made between health, care and VCSE partners?
Do you have a co-ordinated system approach to developing and sustaining effective social prescribing, developed with input from VCSE sector leaders, local authority and health commissioners, primary care networks, referral agencies and the health and wellbeing board?
Do you actively support NHS anchor institutions to work in partnership with the VCSE sector and involve the sector in networks to take joint action on the social determinants of health?
Does the ICS support a sustainable VCSE sector through market development, strategic grants and investment in VCSE infrastructure and alliances, including understanding where communities are not served or advocated for by the VCSE?
Are you being proactive in commissioning VCSE organisations to deliver services, including with innovative approaches to population health management and service transformation?

Can you develop non-financial support for VCSE organisations, such as their inclusion in leadership and quality training, workforce diversity and wellbeing initiatives, secondments and supported leadership opportunities on system workstreams?
Do you have a consistent approach to measuring the impact of VCSE partnerships as part of a wider social value approach?
Does the ICS have a strategy to support and increase volunteering in both public and VCSE sectors?

Case studies: Supporting broader economic and social development in the north west

Parts of the Lancashire coastal town Fleetwood are significantly disadvantaged Healthier Fleetwood helps residents improve their health and wellbeing. The starting point was 'connecting' all the great work going on in Fleetwood so that residents could engage with the services and support available. A strong network of partners is now providing expertise and facilities alongside the enthusiasm and energy of the residents, turning ideas into reality.

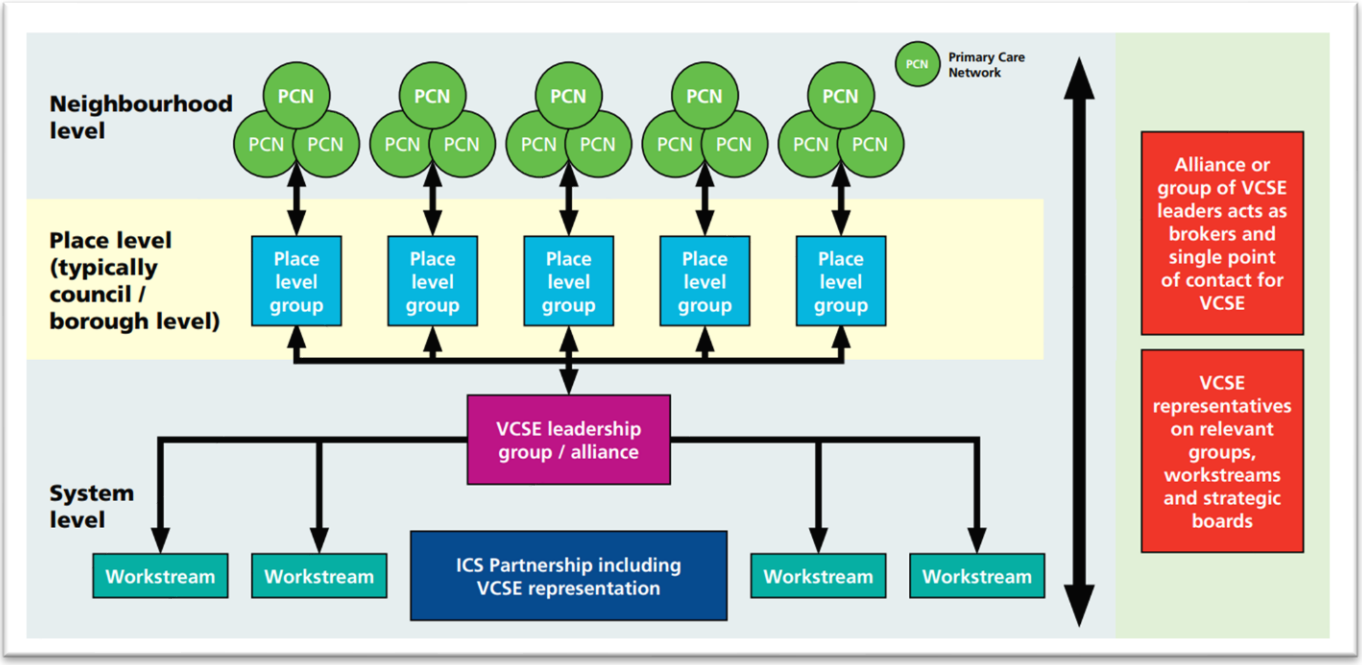
Local authorities, NHS providers, clinical commissioning groups and VCSE organisations across Cheshire and Merseyside signed up to a social value charter. They are using the shared social value approach to unlock the potential for local public sector organisations to use their purchasing power to contribute to better economic, environmental and social outcomes locally, making connections to local business and supported by a network of social value champions.

Working with the VCSE sector across the ICS

VCSE sector alliance model

Many ICSs have already developed alliance models to support the involvement of the diversity of the VCSE sector. Partnership at system level is likely to focus on strategic opportunities across the footprint and can build on existing arrangements at place. The model below (Figure 2), based on emerging work in ICSs, shows a potential approach to VCSE partnerships across the ICS that will support relationships to deliver better health and care for local people. NHS England and NHS Improvement are working with national VCSE partners on a development programme that supports systematic partnership with the VCSE sector in ICSs through an alliance model.

Figure 2: Approach to VCSE partnerships across the ICS



Case study: Building VCSE sector leadership and representation in Lancashire and South Cumbria

Lancashire and South Cumbria has strengthened its engagement processes by clarifying the lines of accountability and channels of communication. New voluntary sector leadership groups in its five integrated care partnership areas or places, each chaired by an elected representative, have jointly agreed a mechanism for transparent representation and voice. Representatives of each of the five areas and other voluntary organisations across the ICS area are also included in the Voluntary, Community and Faith Sector Leadership Alliance. This provides a single point of contact for public sector leaders and others in the VCSE sector.

VCSE partnerships at place

People access most of the health and care services they use in the 'place' in which they live, including advice and support to stay well and joined up treatment when they need it. The arrangements for partners to jointly plan and deliver health, social care and public health services alongside other services that promote health and wellbeing in a defined place have a long history. They involve the NHS, local government and providers of health and care services, including the VCSE sector, people and communities.

'Places' are also where most voluntary sector funding is allocated (usually by local council area) and where the sector can be increasingly embedded in decision-making and strategic planning. Experience shows that the greatest opportunities to improve care by redesigning services are often at place. Provider collaboratives (see below) are expected to link closely with place-based partnerships of health and social care partners, including the VCSE.

There is an expectation that the VCSE sector will be an integral part of the place-based partnerships developed in ICSs. This can build on existing structures and networks such as VCSE representation in health and wellbeing boards and local VCSE infrastructure organisations.

Case study: joined up work between all sectors to improve health and housing in Wakefield

Wakefield CCG and other NHS and local authority partners work with Wakefield District Housing, a social enterprise, to fund a number of schemes to improve housing and tenants' and community health. Mental health navigators take referrals on problems like hoarding, poor tenancy management and anti-social behaviour. In addition, a service based on local hospital wards is helping people get home from hospital sooner, by addressing barriers such as broken heating, cold homes or the need for new mobility equipment.

VCSE partnerships at neighbourhood

In neighbourhoods, local teams can work across organisational boundaries to give seamless care closer to people's homes, improve population health and prevention, and co-ordinate NHS support to those living in care homes. Primary care networks (PCNs) are a key part of this work, bringing together general practices, pharmacists and others.

ICSs are encouraged to consider how VCSE organisations can be included in multidisciplinary neighbourhood teams along with statutory partners, to improve the support to high-risk users and high-intensity service users.

An important connection for the VCSE sector in neighbourhoods is the social prescribing link worker, one of the new roles in PCNs. Link workers provide a bridge between health and community by connecting people to local activities and services for practical and emotional support. They work closely with the VCSE sector to identify and nurture local community groups and support. Much of the support that link workers refer to is provided by the VCSE, and often link workers are employed by the sector as well.

Provider collaboratives and the VCSE sector

NHS trusts and foundation trusts and provider collaboratives commission services from the VCSE sector as part of wider care pathways; for example, 'hospital at home' services, support for unpaid carers, community transport and community mental health services. This enables people and communities to benefit from the innovation that is often driven by the VCSE sector. It is expected that provider

collaboratives will continue to leverage the expertise of VCSE organisations to support co-design and delivery of health and care services.

Conclusion

The voluntary, community and social enterprise sector is key to the creation of successful integrated care systems. NHS England and Improvement are committed to supporting systems to build effective local partnerships everywhere. We hope this guidance will help local leaders to strengthen their arrangements, building on learning from around the country.

Appendix A: Further resources and information

About the VCSE sector

Local VCSE infrastructure organisations (LIOs, or Councils for Voluntary Services/Voluntary Actions) provide support and leadership for the local VCSE sector and can help statutory partners reach large numbers of charities and community groups in their area. These organisations are often aligned to local government areas such as counties or metropolitan boroughs. They facilitate networks of organisations that bring communities of interest, place and experience together, enabling them to play a key role in co-production and engagement. NAVCA's Find a member site lists LIOs for all areas.

The UK has a network of 46 accredited Community Foundations. These organisations invest in communities and people, matching donors and partners to local need. They often cover wider geographical areas that are a good match with ICSs and can support strategic grant making, capacity building and engagement.

Dedicated support from NHS England and NHS Improvement

The national voluntary partnerships and system transformation teams advise ICSs on strategic engagement with the VCSE sector. The VCSE leadership programme provides resources and facilitated support to develop or strengthen VCSE alliances in all ICSs.
england.voluntarypartnerships@nhs.net

The social prescribing team advises on best practice in working with the VCSE sector, primary care networks and partners to develop social prescribing.
england.socialprescribing@england.nhs.net

More information

Integrated care: www.england.nhs.uk/integratedcare/
ICS Design Framework

NCVO: Creating Partnerships for Success details examples and case studies from the STP/ICS VCSE Leadership programme

NHS Confederation: How health and care systems can work better with VCSE partners

The role of VCSE organisations in care and support planning: National Voices

Community organisations and primary care networks: National Voices
Inclusion health self-assessment tool for primary care networks
Social prescribing: NHS England Social Prescribing Summary Guide
National Voices, Rolling Out Social Prescribing
RSA and NCVO: Meeting as equals; Creating asset-based charities which have real impact

Appendix B: Glossary

Integrated care system (ICS): In an ICS, NHS organisations in partnership with local councils and others take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

Subject to legislation, the statutory ICS arrangements will include:

- an integrated care partnership, the broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS
- an integrated care board, bringing the NHS together locally to improve population health and care.

Within ICSs, it is expected that several place-based partnerships will be agreed. The number of 'places' will depend on the geography of individual ICSs. The footprint of places should be defined based on what is meaningful to local people, such as a town, city, borough or county.

Neighbourhood: The smallest and most local area that services are organised at.

Primary care network (PCN): Local collaboration of GP practices covering 30,000 to 50,000 people working towards integrated primary and community health services.

Provider collaborative:[6] Partnership arrangements involving two or more trusts (NHS trusts or foundation trusts) working at scale across multiple places, with shared purpose and effective decision-making arrangements, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and experience
- improve resilience (eg by providing mutual aid)
- ensure that specialisation and consolidation occur where this will provide better outcomes and value.

[6] Working together at scale: guidance on provider collaboratives

Voluntary and community sector: Made up of organisations which have a social purpose and exist not to make profit. Those with incomes of over £5,000 must register as a charity. Community organisations are generally smaller, operate in a particular community of geography or interest, and may be formally constituted with a management committee.

Social enterprise:[7] Like traditional businesses, social enterprises aim to make a profit, but reinvest or donate those profits to create positive social change.

[7] www.socialenterprise.org.uk

For more information on integrated care systems visit: www.england.nhs.uk/integratedcare/

Find us on LinkedIn: www.linkedin.com/showcase/futurehealthandcare/

Sign up to the Integrated Care bulletin: www.england.nhs.uk/email-bulletins/integrated-care-bulletin/

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North Northamptonshire Council

Item no: 12

North Northamptonshire Health and Wellbeing Board

6th September 2022

Report Title	**Community Engagement Framework and Engagement and Project One: ICP Strategy**
Report Author	**Dionne Mayhew, Director of Communications NHFT, Communications and Engagement Lead, ICB** **Simon Deacon, Assistant Director of Communications, NHFT/ICB**

List of Appendices

Appendix A – Integrated Care Northamptonshire Community Engagement Framework

1. Purpose of Report

1.1 To offer assurance regarding the development and delivery of the Integrated Care Board's (ICB) Draft Community Engagement Framework. This underlines the health and care's system's commitment to working with people and communities and how the approaches within it will assist in the creation of the Integrated Care Partnership (ICP) Strategy and ICB Forward Plan.

2. Executive Summary

2.1 Every Integrated Care System (ICS) is required to produce a strategy and approach for how it will work with people and communities.

2.2 In Northamptonshire it was agreed that this 'framework' of approach should be co-designed with key colleagues, practitioners, VSCFE and community representatives. This co-design process took place earlier this year.

2.3 The Community Engagement Framework in Appendix 1 is the result of this work, articulating the ICB's ambition, vision and values for working with people and communities, our shares themes for working together and which priority projects will take place in Y1 and 2. Critically the approaches co-designed for Project One – Listening and working together to inform our strategic plans – is being used in the creation of the ICP Strategy and ICB Forward Plan.

3. Recommendations

3.1 Note the Integrated Care Board's Draft Community Engagement Framework (Appendix 1).

3.2 Be assured that through having this shared Framework for working it, will more robustly enable the voice of people and communities to help form and shape our work together across Integrated Care Northamptonshire (ICN) and inform both the ICP Strategy and ICB Forward Plan.

3.3 Support the ongoing development of the Framework and its priority programmes to ensure they embed across health and care.

4. Report Background

4.1 As part of the ICB's obligations and its Readiness to Operate statement, each ICS needed to produce a **strategy/approach for working with people and communities.**

4.2 This approach had to take into consideration the NHS guidelines/10 principles for working with people and communities. These were published in July 2022.

4.3 These 10 principles were subject to recent additional public consultation and formed the starting point for the creation of the Framework at Appendix 1. While we are assured they align with our co-produced Draft, the outcomes of the consultation will be considered in our finalisation of the draft Framework

4.4 The draft framework, themes and projects within it were approved by the ICB in June 2022. Now in Phase 2, we are taking the draft through a 'Routes to Action' process to embed and align with emerging Collaborative and Place based ways of working. The final version of the document will be taken to ICB Board for assurance.

5. Issues and Choices

5.1 As stated in 2.2 in Northamptonshire it was agreed to co-produce the required Community Engagement Framework.

5.2 This activity was undertaken through Spring and early Summer with an independent partner – Traverse, a provider endorsed by NHSE Patient and Public Involvement Team (NHSE PPI)

5.3 Traverse is also additionally engaged by NHSE PPI to undertake a quality review of the engagement strategies for all 42 health systems in the county.

5.4 Following this process of co-production – which is outlined in the framework – the draft strategy was developed with a number of aims:

5.4.1 Set a specific ambition, vision and values for working together with people and communities as co-produced through the process.

5.4.2 Define our early priority projects to support the delivery of the national four priorities of ICSs.

5.4.3 Develop framework themes and an action plan for embedding the priorities and principles for working together.

5.4.4 Outline how we understand our impact, continue to listen and learn.

5.5 The first priority project is 'listening and working together to inform our strategy plans.' The creation of the ICP Strategy and ICB Forward Plan represent the ideal opportunities to bring the framework to life.

5.6 Key ICB colleagues and the chair have been sighted on this approach which has now commenced to ensure community engagement is embedded into the creation of our strategic plans.

5.7 Through a phased programme of collective work we are taking a three-pronged approach to bring the voice of people and communities into our strategic plans as above and we ask;

- What does the data say?
- What do people say?
- Can anything be done?

5.8 The approach recognises that communities are complex as is the scope and pace for creating our plans. It aims to acknowledge that different segments of our population may have very diverse 'wants' and 'needs' and that those who need the most may be the least likely to articulate their view on the 'hows'.

5.9 Therefore our approach takes into account what we already know and have heard, will delve deeper where we see gaps and align our focus with identified priority areas.

5.10 This work involves:

- **Phase One: Research** Developing thematic and gap analysis insights report(s) to understand what it is our patients and communities want from their health and care.
- **Phase Two: Inform** Using our research, bring together key colleagues to sight, inform further and incorporate findings into their planning e.g. LAPs, Strategic groups, key ICB Boards
- **Phase Three: Involve** Collaborate to support ICN wide 'public conversations' to inform the ICP strategy and feed into ICB plan development
- **Phase Four: Engage** On the ICB Joint Plan with H&WBBs, wider stakeholders and interested members of the public

- **Phase Five: Embed and review** Use Community Engagement Framework to work towards a longer-term goal of embedded co-production across all our activity.

6. Implications (including financial implications)

6.1 Resources and Financial

Work is underway to scope out any resource and financial implications for the delivery of this work. Where possible existing resource will be utilised to enable delivery.

6.2 Legal

N/A

6.3 Risk

N/A

6.4 Consultation

N/A

6.5 Consideration by Scrutiny

N/A

6.6 Climate Impact

N/A

6.7 Community Impact

A focus on community Impact is inherent in the Framework, particularly the vision, values and ambitions

Appendix

Integrated Care Northamptonshire

[DRAFT] Community Engagement Framework

Our strategic approach for working together with people and communities (WORKING DRAFT)

July 2022-25

Version control

Document Information	
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This document was developed in partnership by Traverse and the Northamptonshire Integrated Care System, their partners, and local people through a co-production process.

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Foreword

Our county is home to over 750,000 people, who all lead different lives, have different views of the world and have different health and care needs. It is important to recognise that as our population ages and changes, we need to listen and change together.

Of course, through the pandemic we needed to focus our efforts in a different way to help us get through it as safely as possible, concentrating on providing the best care and community support. This meant that our working together with people and communities, across all of our services didn't happen as much as we would have wanted it to. While conversations did and do still happen, we know it wasn't ideal that we couldn't continue our ongoing engagement and conversations about our wider health and care services.

We have always acknowledged that we all need to work together if we are to deliver the lasting, positive changes we would hope to see **and now we have an exciting opportunity…**

In April 2021, Northamptonshire was designated by the NHS as an Integrated Care System (ICS). **And from July 2022, as our Integrated Care Board (ICB) formally launches, together our ICS will be called Integrated Care Northamptonshire (ICN)**.

In a fundamental change to how health and care is organised, we are now one of 42 ICS areas created across England. National expectations have outlined that each area must organise their local organisational structures in a particular way so that they effectively share the powers and responsibilities to support their populations to live healthy lives and get the care and support they need when they need it.

This structure offers a great opportunity for us to work together more effectively. So building on this we have developed a **Community Engagement Framework.** Central to the new structure of the ICN and endorsed by our ICB, this framework sets out our expected ways of working, our shared vision and our highest priority projects to help us to work together with people and communities, not just in pockets or on an ad hoc basis, but across all we do in better and more authentic ways.

We have shaped this approach together through co-production, and in the true essence of co-production we will continue to shape and evolve our approach. It is ambitious, but together so are we.

So please read on to find out more about our plans, and we hope you all join us in striving for our shared vision and making a positive difference together.

Dionne Mayhew
Communications and engagement lead

Toby Sanders
ICB Chief Executive

On behalf of Integrated Care Northamptonshire

Introduction

Our Community Engagement Framework: a strategic approach for working together with people and communities

This framework and our approach was developed by and for members of Integrated Care Northamptonshire (ICN), in partnership with Traverse – an independent social purpose consultancy – and with a wide range of local partners and people through a co-production process, in support of the ICN formation in July 2022. Progress against its delivery will be monitored and owned by Northamptonshire's Integrated Care Board (ICB).

Working in partnership with people and communities forms the foundations of our strategic approach to developing integrated care for all Northamptonshire's citizens. The **objective** of our **Community Engagement Framework** is to enable ICN partners to work more effectively together, as it provides a clear expectations for working with people and communities in the design, delivery and improvement of health and care systems.

This framework also supports ICN (monitored via the ICB) to meet its obligations as set out in the NHS 'Working in Partnership with People and Communities Statutory Guidance'.

Key definitions

A key finding from our conversations with local people and organisations was the need for a shared understanding of terms used to describe different types of approaches to working with people and communities, particularly co-production.

In this document, we are using the following definitions from the NHS Working in Partnership with People and Communities Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England (Draft).[1]

Inform: Sharing accessible information so people understand changes and can have their say.

Consult: Asking for people's opinions on one or more ideas or options.

Engage: Listening to people to understand issues and discussing ideas for change.

Co-design: Designing with people and incorporating their ideas into the final approach.

Co-produce: Working together in an equal partnership with people with lived and learnt experience from start to finish.

Additionally, we refer to '**involvement**', whilst not defined in the NHS Working in Partnership with People and Communities Statutory Guidance, it is a commonly used term. We take it to mean any approach to people or community participation and as such it covers the spectrum of the above terms.

[1] https://www.engage.england.nhs.uk/consultation/working-in-partnership-with-people-and-communities/user_uploads/b1133_i---guidance-on-working-in-partnership-with-people-and-communities---consultation-draft-may-2022.pdf

Why working with people and communities is integral to our Integrated Care System

A strong and effective ICS has a deep understanding of all the people and communities it serves. Unlocking diverse experiences, insights, assets, and solutions from local people and communities will enable us as ICN to work together to improve outcomes, tackle health inequalities and the other challenges faced by our health and care systems more effectively.

Becoming ICN creates a fresh opportunity to strengthen work with local people and communities. This means building on all our of good practice, trusted relationships, effective networks, and positive activities where people and communities are involved, to ensure that at a system level this all adds up to more than the sum of its parts, for all communities in Northamptonshire.

Northamptonshire Health and Care Partnership - A history of working together with people and communities in Northamptonshire

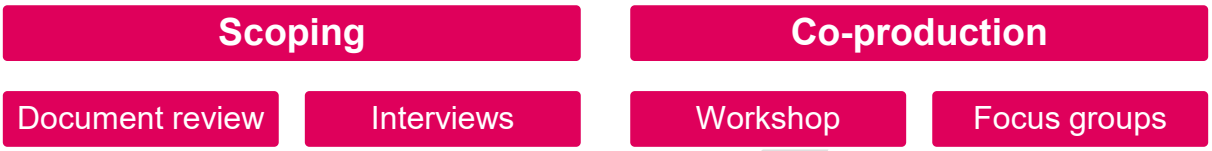
We heard and learned more about the many, varied and extensive involvement activities across providers and in the Voluntary, Community, Faith and Social Enterprise Sector (VCSFE) organisations, which have been in place for many years, and which have supported the delivery and development of many of our services and pathways of care. From the outset across NHCP we have worked together with involvement practitioners to bring the learnings and insights from this work into our system level activity. As NHCP our history is outlined below:

Figure 1: Summarised timeline of prior work done

How we went about co-producing our framework

We co-produced this system-wide strategic framework – with the commitment and buy-in from local people, senior leaders, and key partners – to build on the best of our local practice and existing relationships. Co-producing in this way means that people, communities, and partners helped define our shared vision, ambitions, and priority actions. This will ensure they are embedded in our approach and can be involved in developing key strands of work that emerge.

Figure 2: Overview of process for developing the strategic approach



The co-production process (Figure 2) began in March 2022, concluding in early June 2022. It involved 51 people from 29 organisations or community groups.

We invited a wide breadth of representatives to our conversations. We acknowledge that we could have involved more people and organisations who were missing from these conversations, but we are focused on building our capacity and capability to widen our involvement for future iterations. If you want to know more about the co-production process, see Appendix B: Co-production process.

Using the NHS England ten principles for 'Working together with people and communities' as a guide, we explored the following key questions to create our framework:

- What is the shared **vision** for working together with people and communities?
- What are our **ambitions** for working together with people and communities?
- What should be our core **values** for working together with people and communities?
- What are the **opportunities, challenges, and tensions** for implementing the approach?
- What **actions** are needed to deliver the co-produced approach?

Figure 3: Ten principles for working with people and communities[2]

Ensure people and communities have an active role in decision-making and governance	Provide clear and accessible public information
Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions	Use community-centred approaches that empower people and communities, making connections to what works already
Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working	Use co-production, insight and engagement methods so that people and communities can actively participate in health and care services
Build relationships based on trust, especially with marginalised groups and those affected by inequalities	Tackle system priorities and service reconfiguration in partnership with people and communities
Work with Healthwatch and the voluntary, community and social enterprise sector as key partners	Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places

Our community engagement framework

Our **community engagement framework** outlines our aspirations for working together with people and communities – co-produced by local people and organisations. It sets out what we want this to be like, what it should feel like for those involved, the values that will guide us and our actions – and provides themes for how we will achieve these things.

We also know that through working together as ICN **our shared priorities are to improve outcomes, tackle health inequalities, make best use of resources and enable broader socio-economic development**. So, we have considered this and developed some priority strategic projects to focus our efforts on.

Why have a framework and who is it for?

Our framework is for everyone, this document is our call to action for staff, practitioners, and people across ICN to work together to deliver the changes we have all said we want to see. Through having a strategic framework, we have clarity on our direction of travel, accountability for our actions and agreement on our priorities.

[2] Working in Partnership with People and Communities: Statutory Guidance for Integrated Care Boards, NHS Trusts, NHS Foundation Trusts and NHS England

Our shared vision for the Community Engagement Framework

Our vision, ambitions and values were developed via the interviews, refined via the workshop, finalised in the focus groups. They are developed to support us to work together and via our Integrated Care Board to deliver the ambitions of the Framework, over the next five years. In 2027, we want the vision we have co-designed together to be our reality.

"We work in partnership with people and communities in Northamptonshire, especially those affected by inequalities, on issues that are important to them. Everyone will know how their contribution has made a difference."

Our ambitions

These statements, co-produced within our activity as set out above will set the framework and basis for all our work together as we move forwards.

- We build trusting relationships and effective partnerships, by embedding a consistent approach to co-production
- We are all committed to genuinely hearing what people say, and feeding back the influence on our decisions and actions
- We have genuine diversity and inclusion at all levels in the system, involving people according to their needs and preferences
- We prioritise the needs and issues that are important to people and communities
- We evaluate what we do, share learning, and celebrate our successes

Our values

These values, directly selected from the feedback within our conversations, will be our motivation and guide for how we work together as ICN and with people and communities. They will help us prioritise **what** we do and very importantly, provide the framework for **how** we do it.

- Trusted
- Transparent
- Authentic
- Accountable
- Accessible

How we will work with people and communities

This section is about making things happen, it outlines what we need to do, and our plans to achieve the vision, ambitions, and values outlined in the previous section.

What does an Integrated Care System need to do?

In our co-production workshop, Toby Sanders, our ICB Chief Executive Designate talked about what an ICS should do and shared their four key priorities;

An ICS should:

- Build on NHS Long Term Plan priorities
- Build on COVID system response
- Focus on collaboration, not competition
- Build closer NHS and local government working

ICS priorities are to:

1. Improve outcomes
2. Tackle health inequalities
3. Make best use of resources
4. Enable broader socio-economic development

You said: Opportunities and challenges in working together in new ways

Opportunity: Learning from Covid-19

People described substantial opportunities to build on the success of working with people and communities realised over recent years, especially those that arose during the pandemic. There was increased partnership working; and much more effective information sharing with communities across Northamptonshire about COVID-19 and vaccination programme. In addition to this, work is already taking place within Northamptonshire to promote wellbeing, living healthy and happy lives and empowering people to support their own outcomes. We need to make best use of these successes and opportunities to further build and sustain relationships, particularly with seldom heard communities.

Challenge: Embedding involvement

We have heard that people, communities, and partners are unsettled by the current changes to health and care, and those working with the system feel fatigued by those that have taken place in public services over many years. Whilst we hear and appreciate this, we will still endeavour to take this opportunity to shift culture and behaviour around co-production, so it is no longer seen as a ‘nice-to-do’ but is fundamental to how we develop integrated health and care services.

Opportunity: Defining what the different types of approaches to working with people and communities mean to all of us

Those we spoke to want to create a consistent understanding of true co-production and all levels of working with people and communities. We discussed that this could be 'an equal partnership where power is shared with people and communities'. So we will examine what this could mean to us, both in our statutory responsibilities and in our business as usual practice. Our aim will be to establish a consistency in usage and understanding from Board leadership through to those who design, deliver, and improve services.

Challenge: Building capacity and maximising resources

Finally, effective partnership working is the key to delivering our ambitions. We must keep our focus on developing trusted relationships and enabling skills, capacity, and resources to be shared across partners. We recognise that we may need to review how existing resources are deployed and identify additional funding to meet the requirements set out in this document.

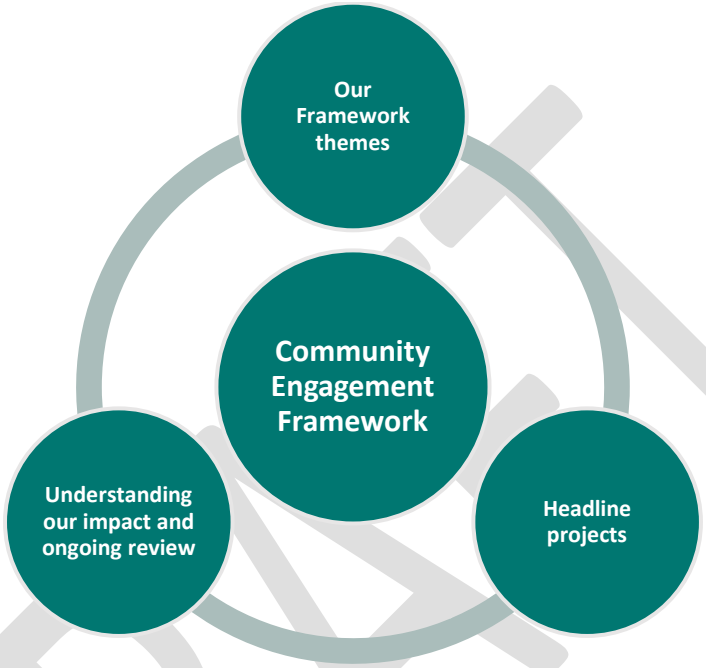
Opportunity: Building on existing excellence in practice across our county

We heard about many examples of well-established involvement activities happening across provider and VCSFE organisations. Many of our staff, volunteers and community members have worked tirelessly to ensure the voice of people and communities is heard in their work, and in the co-design and co-production of services. We are seeing this work truly influence and have a positive impact. Activity happening through our NHS providers, local authorities and our developing Collaboratives programmes is already informing their case for change approaches and priorities.

We are truly thankful to each and every one of the staff, community members, involvees and volunteers who have taken the time to make this difference and work with people and communities. We know this is something we should be proud of and we want to take the opportunity to say thank you…and use this shared Framework to realise on our ambition to work together more robustly and build on the excellence in practice that already exists.

Making it happen

Together we agree we want to support the national ICS priorities, build a Framework around how we work, and deliver improvements together. We agree we want to build strong foundations to enable this, we agree we must understand our impacts and we agree we need to keep having conversations. So we will make this happen in the following ways.



Our Framework themes and how we will embed them

We have developed key themes to ensure we embed our framework as a **way of working** through 2022 to 2025:

1. **Embedding a consistent approach to co-production**
2. **Ensuring genuine diversity and inclusion is at the core of our approach**
3. **Making best use of our insight around the health and wellbeing of all our people and communities**
4. **Evaluating what we do, sharing the learning and celebrating our successes.**

Making progress against these themes will help us achieve against our ambitions.

We will set up working groups of key people who can work together to continue to shape and embed the themes effectively.

A detailed delivery plan is presented in Appendix A: Our Themes delivery plan. It outlines what we plan to do in year one, and years two to three, for each theme. These actions were identified through the co-production process.

Headline projects to support our priorities

The strategic projects below are developed to support a clear and aligned focus on the four national ICS priorities. The projects will be the **what**, the framework themes the **how** and we will need to create collaborative working groups and examine resources and capacity to ensure the delivery of these projects:

Project 1: Listening and working together to inform our strategic plans

Working with our NHS providers, local authorities, VCSFE organisations and colleagues across the Collaborative programmes we will make the best use of resources, by developing a **thematic and gap analysis insights report** to understand what it is our patients and communities want from their health and care. These insights should then be used in the shaping and development of our ongoing activity and in particular our five-year strategic plans.

Using this insight report as a key reference point, we will **bring together colleagues at all ICN levels**, in organisations, collaboratives, population health, including aligning with the health inequalities strategy, to **engage further** where needed on what improved outcomes might mean to the people and communities involved.

Using this insight as a guiding reference, we will then work towards a **longer-term goal of embedded co-production** across all our activity.

Supports:

- ✓ **Improve outcomes – priority aim**
- ✓ Tackle health inequalities
- ✓ Make best use of resources
- ✓ Enable broader socio-economic development

Project 2: Moving from hearing to doing

Our feedback is that historically, involvement initiatives in Northamptonshire have faced challenges in moving from 'hearing' to 'doing'. Decision-making infrastructure needs to be defined such that people's involvement has a **clear scope and route-to-influence** from the start of any process.

We will design and deliver a **programme and methodology** to embed the value of working with people and communities at board and senior meeting level, to ultimately ensure that our involvement of people is meaningful and leads to tangible actions and impact.

With our system leaders support we will embrace the philosophy that better outcomes happen through co-production, rather than through informing or consulting.

This initiative will seek to embed this approach and demonstrate the impact of community frameworks and feedback into Board level objectives. Similarly, **we will seek to embed accountability for involving people and communities into standard reporting requirements** (as is seen in requirements for financial accountability or Equality Impact Assessments).

Co-production as an approach expects decision-makers and those responsible for implementing services and initiatives to be 'in the room' alongside people and communities. We believe that building better ways for that to happen more will ultimately support our vision and ambitions.

Supports:

- ✓ Improve outcomes
- ✓ Tackle health inequalities
- ✓ **Make best use of resources – priority aim**
- ✓ Enable broader socio-economic development

Project 3: Work together to embed equality through emerging Health and Wellbeing forums at Integrated Care Partnership levels

Throughout the co-production process, equality, diversity, and inclusion was identified as a priority for working with people and communities. There are existing voluntary, community, social enterprise, and faith sector organisations who are already working effectively with diverse communities and groups. They know their communities well and have existing trusted relationships. Many of these relationships were strengthened during the pandemic.

Through the structures of ICN, in particular at 'Place' level, **we will collaborate with our Health and Well-being Boards and Voluntary Assembly and VCFSE organisations to consider equality forums or core representation for structural levels as relevant**. Our aim is to have wide representation from health inclusion groups who can support and work to facilitate co-production on health and care plans and services with those they support. Through the example set by the 'Hearing to doing' model', there will be an expectation that services will respond to the specific needs and insights of the groups and people involved.

Supports:

- ✓ Improve outcomes
- ✓ **Tackle health inequalities – priority aim**
- ✓ Make best use of resources
- ✓ **Enable broader socio-economic development – priority aim**

Understanding our impact and ongoing review

Building trusted relationships with people and communities is key to the success of our framework. An essential element of this will be to review and identify the impact of the work and publicly share it – successes, but also where there continues to be more to be done.

Our Integrated Care Board will review and update this document and progress made, at least annually. They will publish their report and invite feedback on it.

To support the understanding of our impact, we will be undertaking a benchmark analysis and co-producing an outcomes framework in June 2022. The benchmark analysis will review our current practice, highlighting key gaps in our current approach alongside existing good practice, to better understand strengths and areas for improvement. This will provide us with a baseline for future evaluations of our working with people and communities.

We will also co-produce an impacts framework for monitoring and measuring the impact of our strategic approach as it gets implemented.

The development of our approach is ongoing, and we invite feedback at any stage, via the contact details at the start of this document.

Appendix A: Themes delivery plan

Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
Embedding a consistent approach to co-production	Develop a communications plan around our strategic approach to socialise and encourage cross system engagement with the vision, ambitions, and definitions of involvement with people, communities, at 'Place' levels and with and system partners	Develop an ongoing communications plan to support the activities and outcomes of our approach, with support from the Community Involvement Network
	Commission a co-production programme for the ICB to establish system leadership for our approach	Review the co-production programme approach in establishing system leadership
	Working withing the emerging structure of ICN and ICP level strategies, establish a framework for embedding a Community Involvement Network of key statutory and voluntary sector partners and local Healthwatch to take ownership of and drive forward our approach	Through the Community Involvement Network: ■ Identify and publicise examples of good practice ■ Identify priority areas for gathering additional insights (as a result of the insight gathering exercise below) ■ Identify the cultural change training and support needs for system partners to develop a collective understanding of genuine co-production ■ Clarify where co-production is not appropriate – and other forms of involvement are ■ Consider how to embed involvement as an accountability criteria in reporting
Ensuring genuine diversity and inclusion is at the core of our approach	Develop clear alignment and 'ways of working' with the Health Inequalities team, Population health board and colleagues in these areas. Establish a 'ways of working' agreement that aligns with the principles in the Health Inequalities strategy	Review our ways of working and, share insights and outcomes

Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
	Commission voluntary and community sector partners working with diverse communities to establish equality forums with wide representation from health inclusion groups for each area to facilitate co-production with those they support	Review the equality forums approach, share insights and outcomes, and consider the need to widen representation
	Establish and communicate expectations around the use of plain English; interpreting and translation; and the Accessible Information Standards to facilitate equality of access to health and care services with system partners Communications leads	Explore signing up as a system to an aligned plain, clear language approach
		Monitor the use and feedback from people and communities about interpreting and translation services
		Evaluate the implementation of the Accessible Information Standard across system partners, share good practice and identify areas for improvement
Making best use of our insight around the health and wellbeing of all our people and communities	Create a 'community insights report' gathered from existing insights and involvement activity across Northamptonshire's NHS provider and VCSFE organisations, local authorities and community groups. This will be used to inform our five year plans and key ICN strategies	Identify gaps in our knowledge and key relationships from this process; and commission further insight gathering and involvement processes for co-production priorities, especially around health inequalities
	Use the insights gathering exercise above to map existing relationships and involvement networks	Explore the development of an insights and involvement hub to gather and provide easy access and analysis of insights. This hub will be a live resource to access latest feedback, activity and projects happening in our area.
	Discuss with Public Health how to make best use of the new Census data and population health management data, alongside people's health and wellbeing insights, to inform strategic and service decisions	Review and identify any tools and priorities for more insight gathering, e.g. citizen's panel / identify priority services/ areas / places
Evaluating what we do, sharing the learning and celebrating our successes	Undertake a benchmark analysis and review the outcomes to inform our approach	Create mechanisms for communicating and feeding back the outcomes of community involvement work to those who were involved, as well as to partners and organisations across the system.

Theme	Year 1 actions (July 2022-23)	Years 2-3 actions (July 2023-2025)
	Develop an approach to evaluating progress against our vision and ambitions set out in this document. Examine the scope to build better, effective working relationships with our Research & Innovation, Business Intelligence and Patient Experience teams	Provide evidence that there is greater coordination of health and care through ongoing evaluations reporting
	Develop best practice guidance and share examples of successful community involvement across Northamptonshire	Hold 'People and Communities' networking and celebration events across different areas

Appendix B: Co-production process

For a full overview of participation refer to Appendix D: Co-production participants.

Scoping phase

The scoping phase was carried out by Traverse between March and April 2022, guided by the NHCP Communications team, to inform the design and delivery of the co-production phase.

Document review

Traverse reviewed key documentation related to existing patient, public and carer involvement from the NHCP and its key partners. This helped us understand the aims of previous and ongoing engagement, identify potential gaps and successes, understand the inclusiveness approaches, identify areas for further development, and highlight good practice and learning from elsewhere.

Interviews

Traverse ran 21 interviews alongside the document review. Overall, we hoped to:

- understand interviewees' ambitions for working with people and communities
- identify any opportunities or challenges, as well as potential tensions moving forward
- seek input into the co-production workshop
- identify any further documents for the document review.

Co-production phase

We explored several lines of inquiry through a series of co-production style events to develop the strategic approach.

- What is the shared **vision** for working together with people and communities?
- What are our **ambitions** for working together with people and communities?
- What should be our core **values** for working together with people and communities?

- What are the **opportunities, challenges, and tensions** for implementing the approach?
- What **actions** are needed to deliver the co-produced approach?

Co-production workshop

A half-day co-production workshop was delivered with 30 participants, including staff colleagues, patient and public representatives, and third sector organisations. The main aim of the workshop was to co-produce a shared vision and ambitions for working together with people and communities.

Focus groups

Four shorter focus groups were delivered following the main workshop:

- two 'test and challenge' sessions
- one session on equality, diversity, and inclusion
- one session on tools, approaches, and structures.

The aim of these sessions was to reflect on insights coming out of the workshop and start shaping and prioritising more specific approaches and next steps to support implementation and delivery.

Appendix C: Co-production insights

Scoping phase

Through the scoping, initial insights were identified around the system's approach to working with people and communities. Stakeholders described some pockets of good practice across the system, in particular the use of co-production within some collaboratives[3]. There is, however, a need for greater collaborative working across a wider range of system partners. Other ICSs, such as Dorset, Sussex, and Somerset, demonstrate more effective partnership working, with councils, local Healthwatch, and the voluntary and community sector.

Whilst there is a good understanding from individual stakeholders about their own involvement activities, there is a lack of clarity between different local players about what involvement is going more broadly. In turn, this leads to lack of understanding across the system about what local people think about their services. The NHCP documents tended to describe the engagement itself, rather than identify the impact or outcomes of working with people and communities.

NHCP articulate ambitions around empowering service-users to be involved in the decisions that affect them. Interviewees recognised that people and community involvement is challenging, particularly in acute healthcare settings, and said to do it in a meaningful way requires more funding, resourcing and support to make this ambition a reality. A lack of funding and capacity were seen as two of the primary barriers to people's involvement being prioritised at all levels of the system, and for progress on this agenda to be quick enough.

Other challenges include:

- Lack of clarity around roles and responsibilities relating to people and community involvement at all levels of the ICS.

[3] Stakeholder identified the mental health, learning disability and autism collaborative as an area which is leading the way in co-production.

- Implications of the COVID-19 pandemic.
- National issues, pressures and targets resulting in community involvement becoming a less urgent priority.
- Understanding and communicating the positive impact of community involvement between services and with the communities themselves.

Recommendations

Through the interviews, stakeholders described some initial recommendations for working with people and communities across the system:

- There needs to be a shared vision and collective commitment, from an ICB to local level, with clarity on language used, what the vision and priorities mean for each level and how this will translate into roles and responsibilities.
- There must be a shared understanding of genuine co-production to ensure that it is used effectively and consistently.
- There should be feedback mechanisms in place that allow the people involved in engagement or co-production to understand the impact that their involvement has had on health and care.
- More joined-up working is needed to make involvement more efficient and prevent 'engagement fatigue' across communities.
- There must be greater consideration of the wider determinants of health and a move towards a focus on wellbeing to address the social and economic factors which contribute to health inequalities.
- Community involvement must capture a wider range of voices and avoid the 'usual suspects' by engaging with those who might not access services and otherwise not be engaged.
    - Stakeholders were keen to understand what was meant by diversity and consider who might be missing – for example, working aged men or migrant communities.
- There should be sharing of training, skills, and resources across the system to help areas which find integrating people and community involvement more challenging – this might also include a network or repository for sharing best practice between partners.

The document review also highlighted areas that could enhance work with people and communities across the system:

- It is important to move beyond the sole involvement of only service users in future engagement, particularly when exploring health inequalities across the region.
- Most of the documents shared in relation to health inequalities were mostly focussed on addiction or disabled people. This should be expanded to investigate the breadth of people affected by health inequalities.
- The outputs generated could be co-produced with community partners before release. Some previous public documents have come across as 'cold', as if intended for an internal audience and affect how the community engage with them.
- The outputs produced should include solid conclusions, describing the outcomes of the community involvement and what that means for people and communities moving forward.

Co-production phase

Following the scoping, a workshop was held to explore ambitions and values, past successes and challenges, and potential tensions moving forward.

Draft ambitions

Workshop participants shared an extensive range of hopes and ambitions for ICN. The broadest and most significant of these were brought together into the vision in our strategic approach, a

range were clustered thematically to shape our ambitions, and the more specific action-based ones were collated into Appendix A: Our delivery framework.

Below we present a more comprehensive picture of participants' ambitions for ICN in working together with people and communities.

- Embed a consistent and fully integrated co-production approach and develop a shared understanding about the different levels and types of involvement.
- Ensure genuine diverse representation at all system levels, involving those who are traditionally excluded, as well as considering physical barriers, such as rurality.
- Prioritise the needs of people and communities ahead of the needs of the system, not making decisions about what is best for whom based on assumptions.
- Provide comprehensive and clear feedback on decisions and actions in an honest and transparent way. Outlining ambitions for involvement and what is achievable; communicating to those involved rather than in a non-targeted way to 'everyone'.
- Consider people's whole lives, going beyond health to things such as heating, food, and housing. Shift language and reframe the way that health and care is talked about by asking people what matters to them and their community.
- Share power, the same way that everyone shares in experiencing the challenges and barriers. Have difficult conversations and work together to make trade-offs. Engage people and communities in shaping priorities and co-designing bigger systems, approaches, and solutions.
- Commit to hearing what people say and doing something about it, having ownership of involvement across the whole system. Ensuring actions and decisions are informed by involvement, and that communities voices are heard across the whole system, not just those at the public-facing end.
- Provide different ways for people and communities to have a say; appreciating it is important to find a way of appropriately representing people that do not engage. Ask people how they want to receive information and designing different networks to communicate, rather than the traditional press releases.
- Move away from complicated jargon to communicating in plain and accessible language, understanding that the impact of this work is directly impacted by how it is communicated.
- Undertake ongoing evaluation of the outcomes and impact of this work. Celebrate contributions and successes, and communicate about involvement initiatives, particularly when using different approaches like co-production. Share insights and learning to build on what we know.
- Proactively go out to engage people and communities on their terms, in settings that suit them. Create more opportunities to hear people's experiences.
- Build trusting relationships and know each other. Build effective partnership approaches. Make connections, build and strengthen our networks

We refined these ambitions (Figure 4) to test through the focus groups, creating a final five.

Figure 4: First draft of ambitions for Integrated Care Northamptonshire

- We share power by embedding a consistent co-production approach
- We are all committed to hearing what people say and doing something about it
- We have genuine diversity and inclusion, at all levels in the system
- We engage and communicate in different ways, according to people's needs and preferences
- We comprehensively and clearly feedback our decisions and actions
- We put the needs of people and communities before the needs of the system
- We take a holistic approach, considering people's whole lives
- We evaluate what we do, share learning, and celebrate our successes
- We build trusting relationships and effective partnerships

Values

Workshop participants identified a range of values they felt are important for ICN when working with people and communities (Figure 5). These were refined through focus group discussions.

Figure 5: Values identified in the co-production workshop

Appendix D: Co-production participants

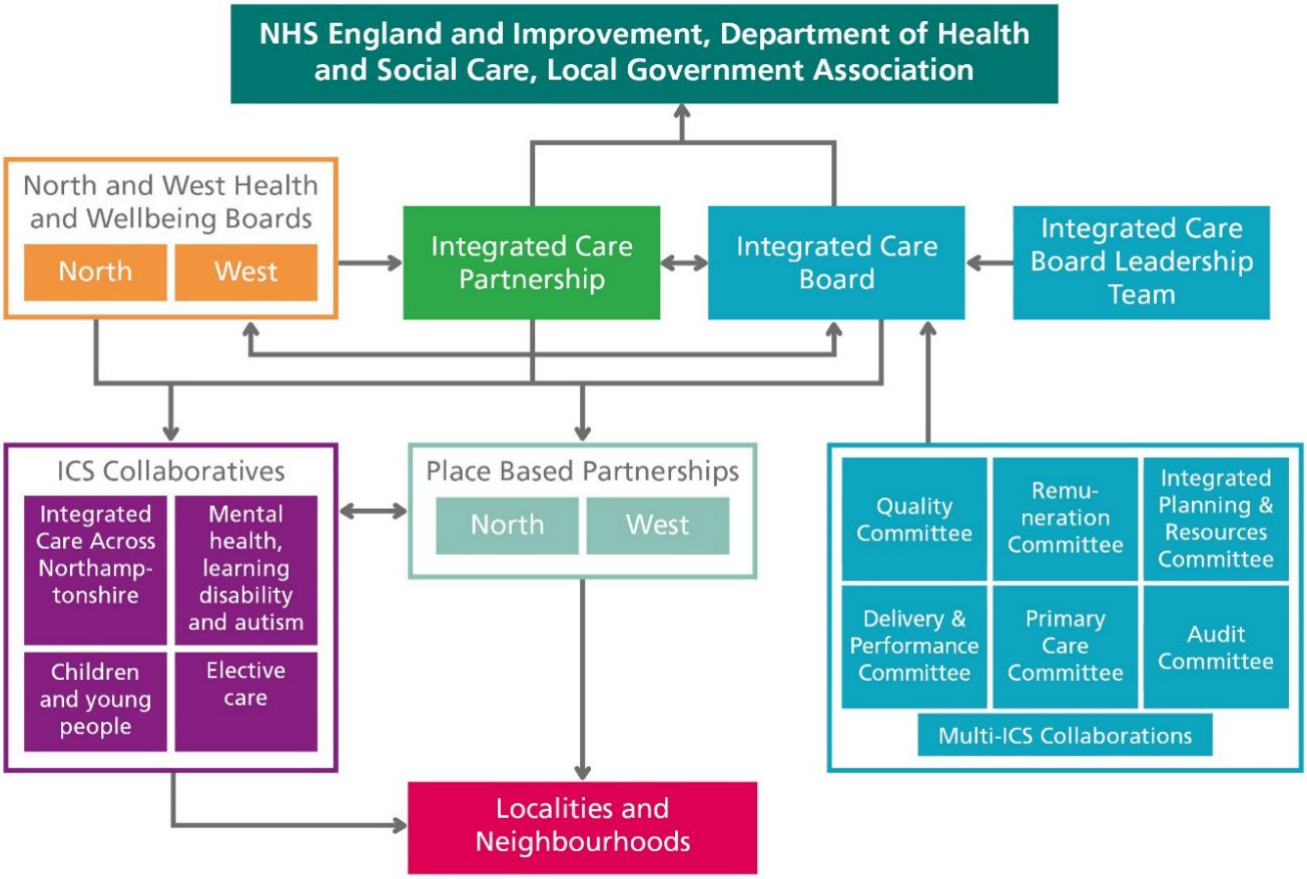
Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
ICB – Chair	✓				
ICB – Chief Executive	✓	✓			
NHFT – Children and Young People Programme Lead	✓				
Northamptonshire Carers lead / NHFT Governor	✓	✓			
iCAN – Programme lead	✓				

Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
NHS – Elective Care Programme manager	✓				
MHLDA – Programme lead	✓	✓	✓		
Healthwatch	✓				
Young Healthwatch	✓	✓			
Public health – Health inequalities lead	✓			✓	
VIN – Chief Exec (Voluntary Sector Assembly)	✓	✓			
NGH – Organisation Engagement lead	✓	✓			
NHFT – Head of Patient Experience	✓				
Acutes Group – Director of Comms and Engagement	✓				
West Northants Council – Head of Comms and Engagement	✓				
GP Chair – Primary care rep	✓				
Local Council Rep Lead North	✓				
Local Council Rep Lead West	✓				
Safeguarding and Wellbeing Services – Assistant Director	✓	✓			
NHCP – EDI Lead	✓			✓	
NHFT – Deputy Chief Exec	✓				
Chair – East Northants Patient Participation Group Association		✓			
ICB – Deputy Director Governance		✓			
CYP expert by experience		✓			
iCAN – Patient representative		✓			
NHFT – Patient representative		✓			
Northamptonshire Black Communities Together – CEO		✓		✓	
CCG – Primary Care lead		✓			
PA Consulting		✓			
Population health and social prescribing lead		✓			✓
Chair: Wootton Medical Centre and South Northamptonshire Patient Engagement Group		✓			
Queens view Medical Centre – PPG member		✓		✓	
Northampton General Hospital – Head of Communications and Engagement					
Northamptonshire Healthcare Foundation Trust – Corporate Governance		✓			✓

Organisation and role	Interview	Workshop	Focus group 1-2: Challenge	Focus group 3: EDI	Focus group 4: Tools
ICS – Head of Programme Delivery		✓			✓
NHCP – Corporate Services & Governance Manager		✓			✓
West Northamptonshire Council – Consultation, Engagement and Public Relations Manager		✓		✓	
Northamptonshire CCG – Patient experience coordinator		✓			
Northamptonshire Healthcare Foundation Trust – Expert by experience		✓			
Involvee / Service User		✓			
Northampton General Hospital – Head of Patient Experience & Engagement		✓			
NHCP – Communications Manager		✓			
Northamptonshire CCG and NHCP – Communications Lead		✓			✓
NHCP – Senior Comms Officer		✓	✓	✓	✓
Northamptonshire CCG – Primary Care Development Manager		✓		✓	
CYP lead			✓		
Public Health – Commissioning Officer			✓		
NHFT and NHCP – Interim Senior System Communications Support	✓		✓		
Arden and GEM – EDI Manager			✓	✓	
Kettering General Hospital NHS Foundation Trust – Head of EDI				✓	
Northamptonshire Carers – Ethnic Minority Carers Lead				✓	

Appendix E: The Northamptonshire Integrated Care System Functions and Decisions Map

This Functions and Decision Map is a high-level structural chart that sets out where key ICB functions are delegated and taken by which part or parts of the system. The Functions and Decision map also includes decision-making responsibilities that are delegated to the ICB (for example, from NHS England). Further details and context can be found online on the ICB constitutions NHSE pages.



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North Northamptonshire Council

Item no: 13

North Northamptonshire Health and Wellbeing Board

6th September 2022

Report Title	**Recruitment and Retention update (ICN People Board)**
Report Author	**Dr Stephen O'Brien, Visiting Professor and Executive Project Manager, University of Northampton**

List of Appendices

None

1. Purpose of Report

1.1. At the Health and Wellbeing Board on July 5th, 2022, there was a general discussion about the current state of the recruitment and retention of the workforce across Northamptonshire. Given the critical role that the Integrated Care Northamptonshire (ICN) People Board plays in workforce matters it was suggested that a report could come from the People Board outlining the latest work focussing on recruitment and retention across the system.

2. Executive Summary

2.1 The role and purpose of the ICN People Board is outlined

Recruitment challenges and current and future actions are highlighted
Retention challenges and current and future actions are highlighted

3. Recommendations

3.1 It is recommended that the Board:

a) Notes the report
b) Provides feedback to the People Board on any critical issues

3.2 (Reason for Recommendations)
The report provides a contextual update on the current recruitment, retention, and workforce position across the ICN in Northamptonshire.
The report should align with other workforce recruitment and retention plans across the wider health and social care sector of local government.

4. Report Background

4.1 The ICN People Board has a remit to:

Co-ordinate and inform a series of work programmes to develop the workforce across Northamptonshire, ensuring that organisations work together collaboratively to address the challenges and deliver the solutions.

The overarching purpose of the group is to support the development of sustainable (clinical, operational and financial) workforce and OD interventions for the benefit of the Northamptonshire patients and population served.

The main purpose of the Group is to:

•Be an expert reference group, to share experience and best practice for workforce transformation across the ICN
•Work collaboratively to support solutions in response to the workforce impact of the ICN
•Proactively encourage and drive workforce transformation through its subgroup structure.
•Initiate and monitor projects to deliver workforce transformation within budget and meeting the agreed Health Education England (HEE) investment principles and framework whilst implementing appropriate actions to mitigate identified risks.

The People Board has adopted a sub-group structure to initiate actions to meet the purposes of the Board. These are:

Health and Wellbeing
Education and Supply
Primary Care
Organisational development (OD)
People Processes
International recruitment
Equality Diversity and Inclusion (EDI)

5. Issues and Choices

5.1 This section of the report will outline in general the current recruitment and retention issues exercising the People Board.

Recruitment: It is noted that recruitment remains a challenge for the health and social care sector, however in recent meetings the scale of the challenge in adult social care has been highlighted with the presentation of the
The 'Size and structure of the adult social care workforce in England' report July 2022
Skills for Care shared the headlines from the report. This report includes current information on the number of organisations, number of workers and number of job roles.
You can find the full report on our web site
Key findings include.

- The total number of posts in adult social care in England (including filled posts and staff vacancies) was 1.79m as at 2021/22 (this was 0.3% higher than in 2020/21).
- The number of filled posts was estimated at 1.62 million and the number of vacant posts was 165,000.
- The number of filled posts has decreased by around 3% (50,000) between 2020/21 and 2021/22; the only annual decrease since records began in 2012/13.
- Over the same period the number of vacant posts has increased (by 55,000 or 52%) which shows that the decrease in filled posts is a result of recruitment and retention difficulties rather than a decrease in demand for care staff.
- The decrease in filled posts and corresponding increase in vacancies across adult social care comes as the wider economy has reopened following the height of the COVID-19 pandemic.
- The number of full-time equivalent (FTE) filled posts was estimated at 1.17 million and the number of people working in adult social care was estimated at 1.50 million.
- An estimated 17,900 organisations were involved in providing or organising adult social care in England as at 2021/22. Those services were delivered in an estimated 39,000 establishments.

This newest report comes ahead of Skills for Care's more detailed 'State of the adult social care workforce in England' report which will be released in October 2022. If you would like to know more about our data Skills for Care can provide you with a more tailored report. please contact analysis@skillsforcare.org.uk

The ICN continues to utilise a national recruitment campaign called "Best of Both Worlds" which highlights the positives in working in the sector and in Northamptonshire.

Works continues to strategically recruitment international healthcare professionals with a focussed effort now to expand this work from adult nursing into other fields of nursing practice, midwifery and the allied health professions. There is now a well-established process for shared recruitment, preparation, training, testing competence and employment across the county. The University of Northampton (UoN) continues to provide the tests of competence required for registration.

Recruitment of students at UoN remains buoyant and whilst national figures suggest a slight downturn from the initial post pandemic recruitment numbers work continues to secure enough placement opportunities to increase the numbers entering educational preparation programmes. HEE is supporting this work locally, including the development of apprenticeships and new roles such as Nursing Associate. Following the pandemic UoN have recruited record numbers of post graduate students in the field of Public Health.

The People Board funded and developed the ICN Workforce database which tracks posts, vacancies and other critical workforce data to inform its decision making. UoN data on successful completions and first destinations feeds into this database.

Retention: is an increasingly difficult challenge given the national post pandemic position in the UK and the cost of living implications. The People Board is working on the following projects/initiatives to address these challenges.

It manages an extensive nationally allocated budget for Continuing Professional Development which is shown to support retention over the longer term. The budget supports a range of workforce projects at ICN level and those aimed at practitioner development.

The ICN workforce database is examining “reasons for leaving data” as a critical indicator for retention actions going forward.

The People Board has developed a system for apprentice levy gifting to ensure the current workforce can be supported to develop where apprenticeships are seen to be part of the solution.

The Health and Wellbeing sub-group is seen as critical to ensure that the current workforce are safe, supported and well. It is noted nationally the importance of this work particularly as we emerge from the Coronavirus pandemic. They have two key areas of focus for system-wide support:

Healthy working environments – physical health, mental health, wellbeing
Health and wellbeing festival 2022
Psychological support into 2022

Bullying, harassment and abuse – psychological safety
Compassionate leadership
Civility/respect

Outputs of this group to date include:

2021
Delivery of Virtual Wellbeing Festival – to date figures show in excess of 19,500 hits
Review of the group to ensure both EDI and H&WB receive full focus across the system
Appointment of Comms Lead to Stronger Together, and further exploration with H&WB Leads to identify further promotion and development within organisations
Contributed to a NICE Consultation on Mental Wellbeing at Work
Winter Wellbeing Comms campaign across the NHS organisations

Cultural Ambassador training across the system
Early attendees on Just Culture accredited training, as a system wide pilot
Route into MH Hubs identified and fast track referrals for NHCP staff now taking place
Long Covid support group up and running with good initial feedback
System wide review against the H&WB self-assessment (part of H&WB Framework) has started. Peer group being established to support completion
Representation from the group with ‘Be Well Midlands’ and promotion across NHCP
Early conversations around a H&WB Conference in late 2022
Review of H&WB Champions

2022

Continued Delivery of Long Covid Support Group
Development of systemwide H&WB Strategy
Scoping Compassionate Leadership conference
Peer Support for launch of HWB Champions into provider organisations

Delivery of NHCP Health and Wellbeing Festival – approx. 11k hits in the week 4/7; live video views 1,703 (increase on 1,200); on demand so far in excess of 900

Future projects include

System wide H&WB Self Assessment
Potential further work following outcome of Be Well Midlands
Potential scoping of extended Long Covid pilot
Potential evaluation and further roll out of Stronger Together/Social Care Managers training days
Exploring Occupational Health Doctor contract

6. Implications (including financial implications)

6.1 Resources and Financial

6.1.1 There are no resource or financial implications that arise from this report as the report is provided for information and feedback purposes only.

6.2 Legal

There are no legal implications arising from the report.

6.3 Risk

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

6.4 Consultation

No consultation is recommended as a result of this report

6.5 Consideration by Scrutiny

None

6.6 Climate Impact

None

6.7 Community Impact

Clearly the recruitment and retention of health and social care across the ICN for Northamptonshire is a critical issue in terms of current and future community impact. Inadequate staffing levels could have a significant negative impact in terms of access to services and ongoing treatments.

7. Background Papers

None provided