**Health and Wellbeing Board**
At 2.00 pm on Thursday 2nd December, 2021
Held as a East Northants Council, Cedar Drive, Thrapston, Northants

**Present:-**

Shadow Members

Officers

Also in attendance – Councillor

The Chair welcomed members and the viewing public to the meeting.

**1 Apologies for Non-attendance**

**2 Notification of requests to address teh meeting**

**3 Members' Declaration of Interests**

**4 Minutes from Meeting Held on 23 September 2021**

**5 Action Log**

**6 Director of Public Health Annual Report 2021/22**

**7 Better Care Fund Update**

**8 Disabled Facilities Grant Update**

**9 COVID19 Update - Oversight and Engagement Board**

**10 Integrated Care System Update**

**11 PA Consulting Paper (to follow)**

**12 Close of Public Meeting**

The meeting closed at Time Not Specified

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North Northamptonshire Council

**Item no:**
**To be added by Dem Services**

# North Northamptonshire Health and Wellbeing Board
# 2nd December 2021

| | | |
|---|---|---|
| **Report Title** | **Better Care Fund Q2 Performance update** | |
| **Report Author** | **Samantha Fitzgerald – Assistant Director Adult Services**<br><br>**Samantha.fitzgerald@northnorthants.gov.uk** | |
| **Contributors/Checkers/Approvers** | | |
| **Other Director/SME** | **David Watts** | **Executive Director Adults, Communities and Wellbeing** |

**List of Appendices**

**None**

## 1. Purpose of Report

1.1. To provide an update to the Health and Wellbeing Board on the Better Care Fund Q2 performance against the (BCF) policy statement for 2021 to 2022 published on 19 August 2021 and the metric proposed in the Better Care Fund plan for 2021 to 2022.

## 2. Executive Summary

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

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

2.3 The performance is generally positive overall showing a reduction in length of stays compared to Q3 and Q4 plans, and consistently high Percentage of people over 65 returning to their usual place of residence.

## 3. Recommendations

**3.1** The board is asked to Note the BCF Q2 performance update

## 4. Report Background

### 4.1 The Better Care Fund

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

4.3 The response to the COVID-19 pandemic has demonstrated how joint approaches to the wellbeing of people, between health, social care and the wider public sector can be effective even in the most difficult circumstances. With the ongoing pressures in systems, the government has confirmed there will be minimal change to the BCF in 2021 to 2022. The 2021 to 2022 Better Care Fund policy framework aims to build on progress during the COVID-19 pandemic, strengthening the integration of commissioning and delivery of services, and delivering person-centred care; as well as continuing to support system recovery from the pandemic.

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

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

This year's BCF plan is now linked to the Integrated Care Across Northamptonshire (ICAN) services and schemes. We envisage the services within our ICAN and the BCF will form the basis of a future collaborative, and integrated, service delivery. Our 2020-21 BCF plan reflects some significant changes in our system since the last plan was submitted.

There are 3 core components (or "pillars") within the BCF/ ICAN transformation programme this year, all designed to increase prevention, improve outcomes, and shift activity from acute hospitals to our community.

**Community resilience** – supporting people to age well with planned support at home as they become frailer, and care from the right team in the right setting in a crisis; underpinned by care plans for all, social prescribing, education, information, and urgent community care wrapped around the patient.

**Frailty, escalation, and front door** – ensuring people avoid hospital admissions where possible; maximising use of outpatients, the intermediate care team, same day care and short-term stays, and, if they do need to come to hospital, they are seen in the best environment by staff trained in frailty.

**Flow and grip** – ensuring no one is in hospital without a 'reason to reside', eliminating admissions for diagnostics and IV antibiotics if not otherwise necessary, improving ward discharge processes, and ensuring patients are discharged to settings that maximise their independence and wherever possible to their homes.

**TOM Programme**
Alongside the ICAN Programme, North Northants Adult Social Care continue to embed and strengthen the improvements made under the new Target Operating Model (TOM). To date we are forecasting that an additional 390 people per year will go through our reablement service, and 18% of our over 65's are having a more independent outcome compared to 2018/2020. This included a focus on reduced admissions to Residential and Nursing care.

We continue to embed the strength-based approach through our use of the 3 conversations model and we are working to strengthen our links to local communities and resources to support our people to stay independent.

4.5 Current performance for Q2

4.5.1 Admission Avoidance

| Admission Avoidance | 20 -21 Actuals | 21 – 22 Plan |
|---|---|---|
| Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i) | 2655.0 | 3321.0 |

Currently unable to obtain quarterly data due to annual publication.

4.5.2 Length of Stay

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

| Length of Stay | Q2 Actual | Q3 Plan | Q4 Plan |
|---|---|---|---|
| 14 days or more* | 15.2% | 32.0% | 30.0% |
| 21 days or more* | 8.9% | 10.0% | 8.0% |

* As a percentage of all inpatients

Length of stay has reduced since a peak at the end of the last financial year but remain slightly higher than this time last year. We've also seen a greater number of admissions compared to the period leading to Q2 last year. Comparisons to previous years are difficult owing to the Covid pandemic; Q2 reporting is also prone to catching upward trends as we leave the Summer months.

4.5.3 People 65+ Discharged to their usual place of residence

| People 65+ discharged to their usual place of residence | Plan 21 – 22 | Q2 Actuals |
|---|---|---|
| Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence | 90.0% | 95% |

This metric remains consistently high; 95% is one of the highest months on record for the area. It is higher than the equivalent Q2 position last year and is based on a greater number of discharges compared to that period.

4.5.4 Admission to Residential and Care Homes

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

This metric is high, especially when compared to the figure for all of Northamptonshire published last year; the performance of last year, however, was skewed by the Covid pandemic. Following the split into two unitary authorities the data is also still showing us how the degree of need is split across the two areas. Further, because the population is lower, a small number of people requiring admission has a greater effect on the overall indicator.

4.5.5 Effectiveness of Reablement

| Effectiveness of Reablement | 21-22 plan | Q2 |
|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | 79.2% | 56.9% |

This is below the Q1 figure, and the published figure for the whole of the county last year. Please note the metric isn't cumulative and we still have the opportunity to meet our target for this year.

## 5. Issues and Choices

None

## 6. Implications (including financial implications)

### 6.1 Resources and Financial

None

### 6.2 Legal

None

### 6.3 Risk

None

### 6.4 Consultation

6.4.1 No consultation was required

6.5 **Consideration by Scrutiny**

6.5.1 This report has not been considered by scrutiny.

6.6 **Climate Impact**

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

6.7 **Community Impact**

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

## 7. Background Papers

None

North Northamptonshire Council

**Item no: 9**

# North Northamptonshire Health and Wellbeing Board

| | | |
|---|---|---|
| **Report Title** | **COVID-19 Local Outbreak Management Plan** | |
| **Report Author** | **Dr Annapurna Sen, Northamptonshire Health Protection Lead** | |
| **Contributors/Checkers/Approvers** | | |
| **Other Director/SME** | **Lucy Wightman** | **Director of Public Health** |

**List of Appendices**

**Appendix A – Northamptonshire Local Outbreak Management Plan**

## 1. Purpose of Report

1.1. To provide political oversight of the COVID-19 Northamptonshire Local Outbreak Management Plan (LOMP).

## 2. Executive Summary

2.1 The LOMP provides details on how Northamptonshire will identify and contain any COVID-19 outbreaks and what this might mean for residents, businesses, communities, and visitors.

2.2 The plan sets out how local teams will prevent outbreaks, and where this is not possible, minimise the spread of COVID-19 infection across Northamptonshire.

## 3. Recommendations

3.1 It is recommended that the Board: Note the plan

3.2 Governance for overseeing the local COVID-19 outbreak response will become a responsibility of the North Northamptonshire Health and Wellbeing Board.

## 4. Report Background

4.1 All upper-tier local authorities were instructed to produce a COVID-19 Local Outbreak Management Plan (LOMP). The first Northamptonshire LOMP outlining our objectives as a system in preventing and controlling COVID-19 outbreaks was published in June 2020. The scope of this plan has been broadened to reflect the changes recommended in the national CONTAIN framework (published 7th October 2021) and reflecting the organisational change from Public Health England to the UK Health Security Agency (UKHSA)

4.2 The Northamptonshire COVID-19 Health Protection Board is operationally responsible for the Local Outbreak Management Plan. It will make decisions on how outbreaks are managed, informed by local information, clinical data, and scientific modelling.

4.3 In order to ensure political oversight of the LOMP, each upper tier local authority was also required to create an Oversight and Engagement Board however, as North Northamptonshire moves from a pandemic 'response' phase to a 'recovery' phase, a decision to delegate this responsibility from the Oversight and Engagement Board to each new unitary authority Health and Wellbeing Board was made. This will allow a more local focus on the delivery of the plan and authority-specific political input to future updates.

4.4 Directors of Public Health have a crucial leadership role to play ensuring that plans in place as well as ensuring the necessary capacity and capability to quickly deploy resources to the most critical areas in response to coronavirus outbreaks and to help prevent the spread of the virus. However, as a range of services contribute to the delivery of the LOMP, oversight through the Health and Wellbeing Board also means wider partner input into the delivery and amendments will be easier and require fewer meetings.

4.5 The North Northamptonshire Health and Wellbeing Board will aim to sustain the progress made through the previous county level Oversight and Engagement Board and prepare the authority for future challenges.

## 5. Issues and Choices

5.1 The Board is asked to note the COVID-19 LOMP and changes to the associated governance arrangements.

## 6. Implications (including financial implications)

### 6.1 Resources and Financial

6.1.1 The COVID-19 LOMP outlines a range of proactive and reactive actions to be taken to prevent and manage outbreaks. Specific funding has been made available for each local authority area to support these activities, namely the COVID-19 Contain Outbreak Management Fund. The use of this fund is restricted by grant conditions and is authorised by the Director of Public Health through a Joint North and West Northamptonshire board which is also attended by the CEOs and S151 Officers of both authorities.

6.2 **Legal**

6.2.1 All upper-tier local authorities were instructed to produce a COVID-19 Local Outbreak Management Plan (LOMP), and to ensure political oversight of the LOMP, each upper tier local authority was also required to create an Oversight and Engagement Board. A decision has been agreed to delegate this responsibility from the Oversight and Engagement Board to each new unitary authority Health and Wellbeing Board was made.

6.3 **Risk**

6.3.1 The COVID-19 LOMP identifies several potential high-risk settings and vulnerable populations and details support offered to the settings and communities identified to help prevent and mitigate outbreaks.

6.4 **Consultation**

6.4.1 This has been circulated to the Northamptonshire COVID-19 Health Protection Board for consultation.

6.5 **Consideration by Scrutiny**

6.5.1 The COVID-19 LOMP has not been submitted to the Scrutiny Commission.

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# Northamptonshire COVID-19 Local Outbreak Management Plan 2021



Appendix

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West Northamptonshire Council

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Northamptonshire Health and Care Partnership

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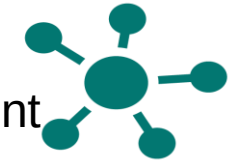
- Compliance and enforcement
- Vaccination
- Testing
- Contact tracing
- Outbreak management
- Support for self-isolation
- Key risks and issues



# Context

- The first Northamptonshire COVID-19 Local Outbreak Management Plan (LOMP) outlining our objectives as a system in preventing and controlling COVID-19 outbreaks was published in June 2020.
- The scope of this update has been broadened to reflect the changes recommended in the CONTAIN framework (published 7th October 2021), bearing in the mind the specific sets of challenges that the autumn and winter will bring in dealing with not just COVID-19 but other infectious diseases, and how the changes will be applied locally.
- Northamptonshire will aim to sustain the progress made and prepare the county for future challenges, while ensuring the local Health and Social care economy does not come under unsustainable pressure.
- COVID-19 Regional Partnership Teams (RPTs), led by UKHSA and the Office of Health Improvement and Disparities (OHID), now play a pivotal role in connecting the national and local response.

# Glossary of Terms

- **Asymptomatic Testing** - testing those without symptoms (this is usually with Lateral Flow Device LFD tests but can be with PCR tests)
- **Contact Tracing Partnership** - national, regional and local teams working together to trace contacts of positive cases
- **Community Engagement** - listening to and discussing/addressing concerns or queries of members of the community
- **Enhanced Contact Tracing** - use of intelligence gathered from contact tracing to identify early and/or prevent outbreaks
- **EHO** - Environmental Health Officer
- **High Risk Settings** - settings that have either a high risk of COVID-19 outbreaks (i.e. transmission more likely) and/or a high risk of serious consequences (i.e. hospitalisation and death more likely)
- **Non-Pharmaceutical Interventions** - any interventions to reduce impact and transmission of the virus other than medical treatment and vaccination
- **Self-Isolation** - act of staying at home during potential infectious period to protect others
- **VOC or Variants of Concern** - new genetic variants of the virus that exhibit concerning properties (e.g. increased infectiousness)

# Governance

**COVID-19 Health Protection Board**

- Provides health protection expertise
- Leads development and review of the Outbreak Prevention and Control Plan
- Seeks assurance from delivery partners and informs system of delivery of the plan
- Makes strategic decisions about the outbreak response and prevention, including vaccination and testing

**Local Oversight and Engagement Board/Health and Wellbeing Board**

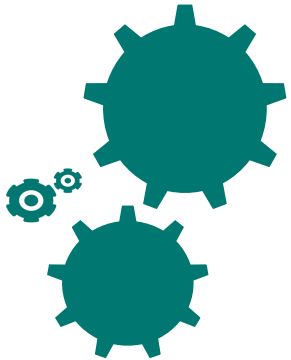
- Provides political oversight of the plan
- Engages with the public on elements of the plan

**COVID-19 Recovery Coordinating Group (RCG)**

**(Strategic Coordination Group (SCG) will be mobilised as required if there is a return to Response status)**

- Provides clear direction and oversight to the recovery activity
- Mobilises the multi-agency resources required to deliver the plan

# Governance: Regional Partnership Team (RPT)



COVID-19 Regional Partnership Teams (RPTs), led by UKHSA and the Office for Health Improvement and Disparities (OHID), now play a pivotal role in connecting the national and local response by:

- Providing ongoing oversight and assurance, escalating risks and issues as needed including via the national local action committee command structure, and providing additional support and escalating requests for surge assistance
- Working collaboratively to bring their collective capability together in support of local areas, working in partnership as necessary with Northamptonshire DPH, Chief Executives and local authority Leaders of North and West Northamptonshire and wider system partners
- Working closely with national teams to support policy and operational co-ordination across UKHSA, NHS England's regional teams, DHSC, and other key government departments

# Northamptonshire Context

- One LRF covering two new Unitary Authorities created on 1st April 2021 - North Northamptonshire and West Northamptonshire
- **Strong travel links and connectivity** M1 corridor and fast train connections from London mean that during times of free movement there is significant travel into county both from the South East and North of England
- **Logistics and distribution hub** Large proportion of workforce in employment (low unemployment) but high rates of low paid work in manufacturing and distribution
- **Large rural areas with urban centres** Northampton, Kettering, Corby and Wellingborough and smaller towns including Daventry, Towcester, Brackley, Raunds, Irthlingborough and others distributed across the county

# Intelligence and Surveillance

Routine Data – testing, cases, contact tracing and vaccination

A combination of UKHSA-prepared surveillance reports and locally tailored analysis is used to inform IMT discussion. Line lists alongside Common Exposures lists are used to inform outbreak investigations.

COVID Marshall and Police Intelligence

Following repealing of most COVID-19 regulations, police intelligence is only shared at IMT meetings in relation to self-isolation breaches or by exception. COVID-19 marshals have also been stood down.

Community Engagement

Community engagement events, 'COVID Ambassadors' and 'Northamptonshire Support Volunteers' are all useful tools to support engagement with specific communities. As a system we collaborate with community and faith leaders, to obtain information and intelligence on challenges and ways of working with the community they represent.

# High Risk Settings in Northamptonshire

| Care homes | Schools | Shared accommodation | Prisons and other detention | Health care settings | Industrial (manufacturing and distribution) settings | Public open spaces | Communities |
|---|---|---|---|---|---|---|---|
| 240 with an additional 29 supported living facilities | 326 mainstream, 15 special schools, 10 independent schools plus 5 boarding schools | Homeless shelters largely closed but a number of supported accommodation buildings supporting vulnerable individuals | 3 detention facilities at border of county | 2 district general hospitals,14 other hospital settings, 69 GP practices | 54 food processing and meat packing | 10 train stations, bus and coach stations. Local tourist attractions | Various potential community groups/ Settings across the county – known groups mapped as stakeholders |

# Understanding and Managing Risk

The plan identifies a number of potential high-risk settings and vulnerable populations. Settings are considered high risk if outbreaks are highly likely to occur or if the consequences of an outbreak in the setting would be significant.



**Why identify high risk settings?**

1. To provide support and assistance in managing an outbreak
2. To be able to deliver proactive prevention activity including testing, vaccination and Infection control advice
3. For surveillance/mapping - so that we can identify patterns early and act quickly

**What support is given to high-risk settings around prevention?**

- Assist with risk assessment and support with planning and delivery of control measures
- Offer infection control training and regular guidance updates
- Advise and support on the local Test and Trace Programme
- Advise and support the delivery of local Vaccination Programme

# Vulnerable Communities

We can consider 'vulnerability' in terms of*:

**People who are clinically at higher risk of more serious illness and poor health outcomes**

- People with long term conditions
- People with serious mental health issues
- Alcohol/substance misuse

**People from Minority Ethnic Groups**

- Black and minority ethnic communities

**People who are socially isolated or excluded and marginalised**

- Deprived communities: poor housing, low income, unemployment, crime
- People who are homeless or rough sleeping
- People for whom English is not their first language
- Gypsy, Roma, Traveller communities
- Carers
- Domestic violence victims
- Asylum seekers, refugees and unregistered migrant workers

* to note that there is significant overlap in these categories

## We want to ensure:

Strong engagement and collaborative working

Good access to testing and vaccination

Enhanced support for isolation

# Resourcing

| What we have done | What we are planning | Further enhancements |
|---|---|---|
| • Definitive resource plan aimed at identifying and utilising resource capacity effectively in line with agreed financial spending.<br>• Resource plan updated as and when required, and revisited to incorporate recommendations in CONTAIN framework to ensure it is still fit for purpose. | • Updated governance structure and supporting resource plan created to reflect move through repealed restrictions.<br>• Plans ensure future infection control in the county can be monitored and escalated as required.<br>• Planning to move management of COVID-19 into business as usual when/where possible, retaining surge capacity where spikes/waves occur. | • Continue to identify resource capacity risks and opportunities dependent on current levels of COVID-19 activity.<br>• Create new resource plan in line with new unitary council structure and national roadmap. |

# Education and Schools

| Current state | Transition |
| --- | --- |
| • Case notification form and tracker produced locally so that settings can notify system of cases or issues in advance of UKHSA or national data streams to allow a swift local response.<br>• Community IPC team delivering support to schools on request or where identified.<br>• Healthy Schools team offering wider wellbeing support.<br>• Regular COVID information sharing to settings via bespoke Head teachers letter. | Schools team is in the process of being sent daily updates from the PowerBI export to identify any cases attending school or childcare settings to monitor and ensure any potential outbreaks are identified.<br>Work has been done to identify best model of response to support both new local authorities through a single community IPC team managing incidents and outbreak management in schools.<br>New notification system being developed to monitor education settings.<br>Preparing a model of care to support educational settings from the start of the new term.<br>Standard operating procedure for managing incidents/outbreaks has been share within all schools within the county |

# Adult Social Care

**Care Home Cell**

- We have an established Care Home Cell that includes representation from Adult Social Care, Public Health, CCG IPC and Quality Teams, DIPCs, Primary Care and Analyst Support.
- The Care Home Cell meets monthly to review the care home dashboard and agree any strategic actions or operational considerations required to support care homes (and wider adult social care settings when appropriate).



**NASS Provider Hub**

- The NASS Provider Hub offers a single point of contact for all adult social care providers (including but not exclusively care homes). The hub sends out proactive communications weekly but also receives enquiries and provides support when required.

**New Unitary Authorities**

- Although the Northamptonshire Adult Social Care function has now been divided into two teams as part of LGR, the adult social care COVID-19 response remains county-wide.

# Community Engagement


An extended programme of community engagement work has been established since Summer 2020 and since then, the county has undertaken an initial large behavioural insights survey. In addition to this, it has conducted a Deep Dive session on behavioural insights, including input from community and faith leaders to increase understanding.

## Community Fora and Focus Groups

Collaboration with existing fora e.g. REACH Young Persons Collaborative and Black Communities Together Northants as well as setting up target group focus groups.

## Community Ambassadors and Northamptonshire Support Volunteers

The COVID-19 Community Ambassadors Team is made up of volunteers across West Northamptonshire, whilst the Northamptonshire Support Volunteers are based across Northamptonshire. Both groups help residents to stay up to date with how to protect themselves and others against the virus. The LA PH will keep them updated with the latest advice and guidance, so that they can help their family, friends and other community members to make sense of the latest information.

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# Communications and Engagement

## Engagement

- We will speak with, listen to and understand the concerns of local communities.
- We will ensure vulnerable groups and marginalised communities are heard.
- We will gather information from various community and faith leaders to inform our engagement plan.

## Proactive Communications

- We will build on the LRF's existing #NorthantsTogether branding.
- We will use evidence and local intelligence alongside published literature on behavioural insights to shape local messaging.

#Northants Together

## Reactive Communications

- We will work closely with the UKSHA (Health Protection) regional communications team, as well as key local stakeholders to keep residents informed.

# Community Resilience

- The Community Resilience Cell is continuing to manage the CEV list on behalf of the two unitary councils.
- Additional activities:
  - Coordinate the voluntary sector through the Northamptonshire Emergency Response Corps supporting urgent food requests
  - Volunteer Online register to be maintained through the Northamptonshire Emergency Response Corps Reservists.
  - Coordination of teams (local authority, local infrastructure organisations and communities) to give the best support and engagements.
  - Managing the COVID Local Support Scheme (until 30 September 2021).

# COVID-Safe Reopening of Economy

## COVID-secure advice and support

- Environmental Health provide businesses with advice on re-opening safely in line with current legislation and national guidance as required.

Communications colleagues also work with various business fora to coordinate business webinars for members to get updated with latest advice and to have a chance to ask questions.

- Following revoking of most regulations, the local system is to agree an approach on COVID-19 safety control measures to maintain safe delivery of business.

- Establishing tracking mechanisms for ‘business health’ and job fulfillment.

# Compliance and Enforcement

Health and Safety Executive (HSE) and both North and West Northamptonshire local authorities are the lead enforcement authorities for business related COVID-19 compliance and enforcement.

- Both Local authorities will continue to be the main enforcement authority in retail, hotel and catering, office and consumer or leisure settings while, in general, HSE inspectors lead on enforcement in more industrialised settings such as manufacturing.
- Businesses are responsible for taking precautions to protect people against COVID-19 in their health and safety risk assessments.

Under the government's COVID-19 Response: Autumn and Winter Plan, both local authorities in Northamptonshire will retain powers under the No. 3 Regulations until 24 March 2022 and will also play a role in ensuring that employers comply with their obligations under the self-isolation regulations.

# Compliance and Enforcement

| | |
|---|---|
| **Step 4 implemented** | • To continue collaborative work between the JET to observe how rules are complied with in line with the national roadmap.<br>• Workplace and health and social care setting compliance and enforcement specifically will continue to be supported by EHO teams, HSE and CQC. |
| **End of all restrictions and revoked legislation** | • To continue collaborative work between the JET to observe compliance in line with the national guidance and existing regulation.<br>• Workplace and health and social care setting compliance and enforcement specifically will continue to be supported by regulatory bodies - EHOs, HSE and CQC. |
| **Re-escalation** | • Identify clear communication channels to ensure risks are signposted to relevant partners or agencies to apply relevant existing legislation within their remit.<br>• Joint Enforcement Team will identify and enforce any breaches of current self-isolation regulations.<br>• Identify areas that become part of service and areas of continued coronavirus response enforcement. |

# Vaccination

The main line of Covid-19 defence is now vaccination rather than lockdown restrictions. NHS Northamptonshire is a lead agency in Covid and Flu vaccination programme delivery.

Local health and care partners play a key role in delivering the programme and driving uptake, as set out in the COVID-19 Vaccine Delivery Plan. System should continue to work in partnership with the NHS to help shape local plans to tackle disparities in vaccine uptake, as well as ensuring uptake of second dose and boosters.

Increasing vaccination rates overall, especially among disproportionately affected groups, will be central to the local COVID-19 response. Public Health plays a decisive role in understanding the population.
NHS England has published guidance to LA's on 'surge vaccination' in response to the prevalence of the Delta Variant.

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Advice on a potential COVID-19 booster vaccination programme, published by the JCVI in June 2021, advises that boosters are offered initially to the most vulnerable (broadly cohorts 1 to 4), alongside a Flu (Influenza) vaccine since September. This is to maximise protection in the most vulnerable ahead of the winter months.

From 19 July 2021 the JCVI has also advised that children at increased risk of serious COVID disease are offered the Pfizer-BioNTech vaccine. This includes children aged 12 to 15 years with neurodisabilities, Down's syndrome, immunosuppression and multiple or severe learning disabilities. The JCVI also recommends that children and young people aged 12 to 17 who lived with an immunosuppressed person should be offered the vaccine.

All healthy children aged 12 to 15 will also be offered a vaccine this autumn.

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# Vaccination

Since the launch of the COVID-19 Vaccination Programme in Northamptonshire on 8th December 2020 to 24th November 2021:

| | |
|---|---|
| 1,186,146 | Total doses administered |
| 533,015 | Total first doses administered |
| 479,865 | Total second doses administered |
| 243,949 | Total booster doses administered |

- 97% of our 70+ population have received both doses and 60% of them have also received their booster dose
- 94.3% of our population age 50-69 have received two doses.
- 77% of our 18-49 year olds have received both doses
- 70% of our 16-17 years have received their first dose as well as 44.1% of our 12-15 year old healthy children have received their first dose. 50% of our 12-15 children who are with At Risk group or a house hold contact of Immunocompromised have also received their first dose.
- 97.6% of our care home residents are fully vaccinated and 57.5% have also received their booster dose
- 89.6% of health care workers and 86.6% of care workers are fully vaccinated.

## Static Vaccination Sites:

### 1. Local Vaccination Sites (LVS)

- 16 Primary Care Network Hubs that cover 100% of the population
- 4 Community Pharmacy Sites from 15 March 2021

### 2. Mass Vaccination Sites (MVS)

- 1 Mass Vaccination Centre offering up to ~1500 appointments per day

## Mobile Vaccination Sites:

- Home Visiting Service and GP service to Care Homes and the housebound
- Pop-up clinics in towns and villages to increase general uptake
- Outreach clinics for vulnerable populations (e.g. homeless, BAME)
- School health nursing team offering clinics at main stream schools and SEND schools to vaccinate 12-15 year old children

# Vaccination Inequalities

There is a detailed plan to address inequalities in vaccination across a number of groups. Selected interventions are described below:

| | Current and Planned Interventions |
|---|---|
| **Ethnicity** | • Engagement via community leaders/ambassadors and community events.<br>• Communications including videos in various language.<br>• Outreach clinics in mosques conducted and further planned. |
| **Socioeconomic Deprivation** | • Outreach and communications via key locations – foodbanks, job centres etc.<br>• Mobile communications (eg GOMO vans) to keep messaging visible. |
| **Disability** | • Ensuring accessible communications and communication channels/formats.<br>• Work with local charities that support those with various disabilities. |
| **Rough Sleeping** | • Outreach clinics to support uptake in targeted groups.<br>• Engagement with support groups and others that are vulnerably housed. |
| **Severe Mental Illness** | • Working with community mental health trust to offer opportunistic vaccination.<br>• Ongoing service provision to ensure cohorts are covered upon admission. |
| **Asylum Seekers/ Unregistered Migrants** | • Engagement through charity organisations and employers.<br>• Pop-up clinics at accessible locations. |
| **Domestic Violence Refuges** | • Engagement through charity organisations.<br>• Pop-up clinics at accessible locations. |

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West Northamptonshire Council

North Northamptonshire Council

Northamptonshire Health and Care Partnership

# Testing

- Symptomatic and asymptomatic testing will remain in place to help identify positive cases and reduce the risk of transmission to others, regardless of vaccination status.
- Free PCR testing for people with COVID-19 symptoms and free lateral flow testing, particularly for people working in higher risk workplaces and in education settings will continue in England as part of the government winter plan.



## Current state

- Secured LTS sites in all but one district of the county.
- Ensured appropriate access by targeting MTU to our under-represented and hard to reach groups.
- Set up 2 fixed ATS sites covering Wellingborough and Northampton.
- Directed all testing queries via a shared team inbox.
- Surge Testing Plan developed should we experience a VOC.

## Transition

- Open smaller satellite ATS and Community Collect sites to expand access to LFT testing but retain PCR capacity.
- Option for more targeted and tailored asymptomatic testing for disproportionately affected communities.
- PCR testing for symptomatic people remains a top priority.
- High-risk and vulnerable settings such as the NHS and adult social care will continue providing test.

## Re-escalation

- Options for more targeted and tailored asymptomatic testing options depending on availability of LFT kits and the contents of the National Testing Strategy.

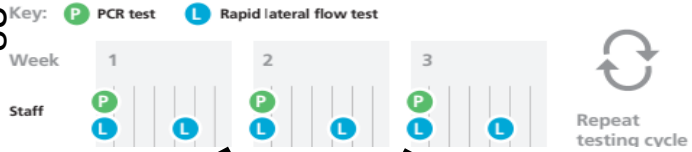
# Symptomatic Testing

| | Objectives | Tactics |
|---|---|---|
| **Step 4** (19th July onwards) | • Continue to operate a network of testing sites as well as the option to order PCR tests for self-test at home, as appropriate to the current epidemiology. | • The delivery and operation of symptomatic testing sites sits with UK HSA, however Northamptonshire Councils work closely with UK HSA to ensure good access to symptomatic testing across the county.<br>• UKHSA can provide access to additional mobile testing units to be deployed in certain outbreak scenarios. |

# Asymptomatic Testing Programmes

## Proactive

Regular systematic asymptomatic testing

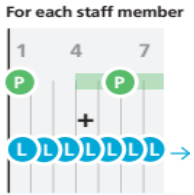



1. Community-based proactive

2. Workplace-based proactive

## Reactive

3. Outbreak setting testing




4. Community surge testing

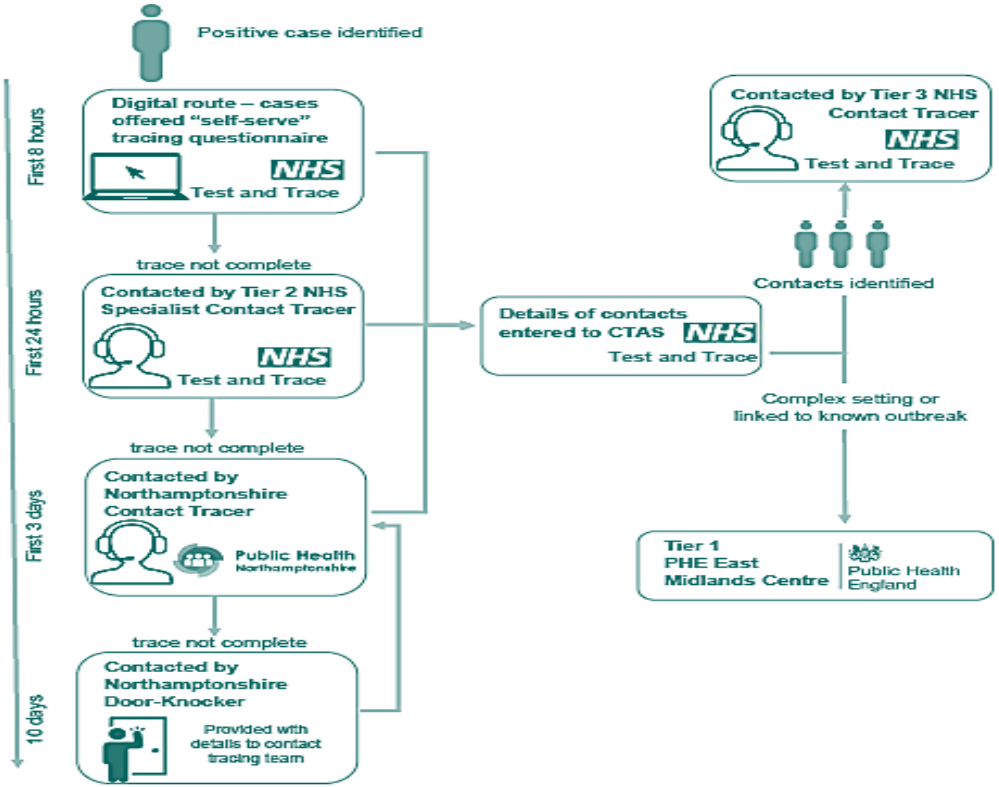
# Proactive Asymptomatic Testing

| | Objectives | Tactics |
|---|---|---|
| **Step 4** (19th July onwards) | • LAs should use a range of methods to reach disproportionately affected groups and support targeted community testing.<br>• Promoting access to LFTs available to the wider community through online ordering / community/pharmacy collect. | • Promoting access to LFTs available to the wider community through online ordering / community/pharmacy collect.<br>• Assisted testing is now targeted at communities with lower LFT uptakes and focuses on education and engagement with these communities in order to promote increased regular testing. Additional mobile unit and door to door teams due to come online in November. All businesses will be encouraged to signpost staff to continue to access free weekly testing via Gov.uk and the Pharmacy Collect service.<br>• Secondary school children will be required to complete two onsite tests on their return to school, and to continue home testing until the end of September.<br>• University students will be required to test before travelling for the autumn term, and on arrival complete two LFD tests either through self testing at home or at an Asymptomatic Testing Site. |

# Contact Tracing Partnership

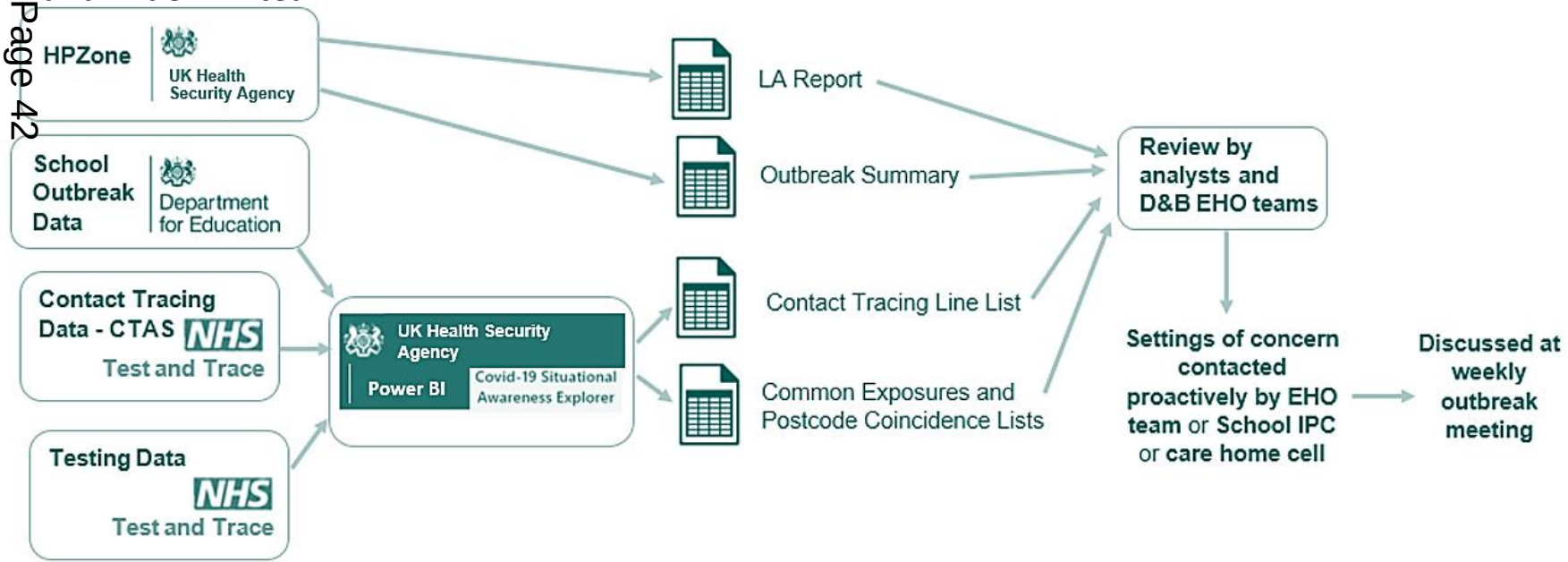
- All positive cases, regardless of age or vaccination status, will continue to be contacted.
- Local Tracing Partnerships (LTPs) work alongside the National Trace Team.
- As of March 2021 90% of cumulative cases from Northamptonshire recorded on CTAS had been successfully traced.
- This has increased from 72% in August when our Local Contact Tracing Team was established.
- We currently have an arrangement to receive cases from the National Service that fall within pre-agreed Post Codes. We use dedicated tracers to resource this function.

# Contact Tracing Partnership

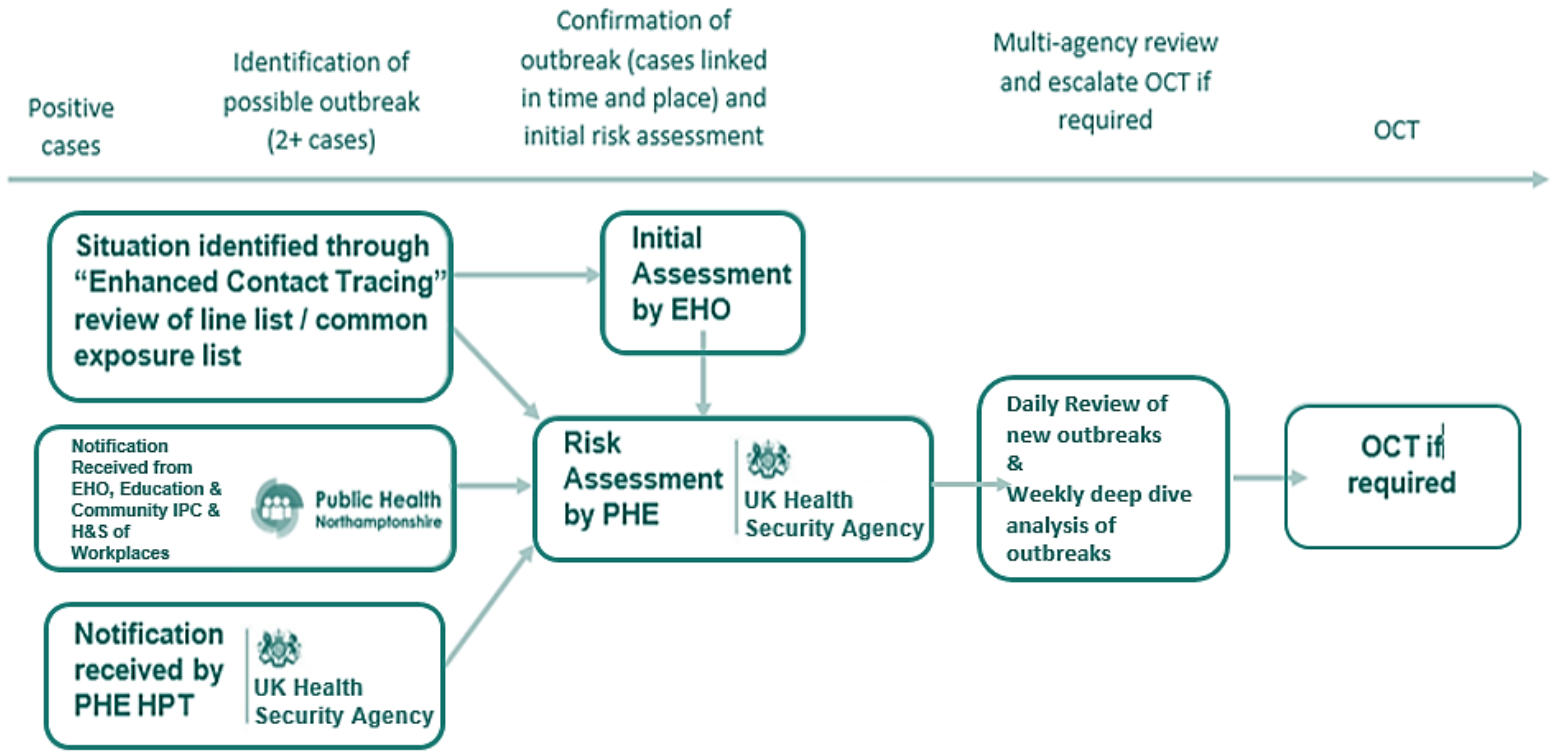


# Enhanced Contact Tracing

- Dedicated EHO analyst to review line lists and common exposure lists to identify settings requiring proactive reach-out.
- IMT functions and weekly outbreak meetings provide forum to share information with UK HSA and wider PH team.



# Outbreak Management



# Outbreak Management

## Current state

- Outbreaks are managed through working in collaboration with UK HSA, EH, Public Health Northamptonshire, local NHS trusts, CCG, Adult Social Care, HSE, CQC and the community IPC team. This is supported by specific cells established as part of the outbreak response - including the schools cell, care homes cell and IPC cell.
- Review of outbreaks:
  - Daily review of LA and HPZ reports.
  - Weekly review to evaluate status, follow up investigations and control measures, and escalate any issues or concerns – convening an OCT if required.
  - To inform care home cell to identify quality and regulatory issues.
  - To inform vaccination cell regarding care homes and other work settings with active outbreaks.

## Transition

- We will continue responding to COVID settings outbreaks as per the current arrangements but reduction in outbreak rates will allow resource for more proactive risk assessment and identification of very high risk settings.
  - Regular IPC training for workforce in all settings.
  - Supporting managing other infectious disease outbreaks.
  - Advising communication team on IPC health promotion activities.
  - Supporting vaccination, care homes and schools cells, alongside workplaces, with IPC advice to maintain COVID-safe service delivery.
  - HPT has temporarily increased capacity to support COVID and non-COVID outbreak response, as well as COVID recovery programmes.
  - To support education settings, a local surveillance system as well as reporting mechanism has been developed to manage incidents and outbreaks.

## Re-escalation

- If the proportion of highly significant (deaths involved) or significant (more than 30% of setting affected) increase substantially, we will look to escalating capacity and resourcing, and identify the duration for which additional capacity is required and therefore whether redeployment of staff is sufficient to manage a temporary re-escalation.

# Support for Self-Isolation

- The Government will continue to offer practical and financial support to those who are eligible and require assistance to self-isolate. This support has been extended until 31 March 2022.
- Both North and West Northamptonshire Local authorities will continue to play a critical role in supporting people on low incomes who are required to self-isolate by delivering financial assistance via the Test and Trace Support Payment scheme (TTSP) and Practical Support Payment (PSP) schemes and raising awareness of the support available.
- The Contain Outbreak Management Fund (COMF) is the primary source of funding to support both local authorities to deliver their outbreak management plan and implement measures to tackle transmission, and enhanced response activity in areas with particularly challenging disease situations. It is expected that all funds will be spent by the **end of March 2022**.

# Support for Self-Isolation



Contact us to request support

Advice and support for young people

Test and trace payment support

Self-isolation support pack

**Community Resilience Hub**
Connects requests for support with local council and voluntary sector offers

**Self-Isolation Payments**
Coordinated by Revenue and Benefits Teams


**Isolation Support Pack**
Provided to all cases and contacts having to isolate for 10 days

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North Northamptonshire Council

Northamptonshire Health and Care Partnership

# Key Risks and Issues

Risk management is currently coordinated by the COVID-19 Recovery Programme Team and is reviewed on a regular basis through the RCG Board. However the large overarching risks to successful delivery of the LOMP specific to Northants are identified and discussed below:

| Organisational | |
|---|---|
| **Risk** | **Mitigations** |
| Newly created unitary authorities – risk of disruption, dilution of Public Health specialist skills and loss of local focus. | Close coordination of management within and across the new councils.<br>Joint COVID response team wherein Public Health, Emergency Planning, EHO and communications and engagement teams are working in collaboration. |
| Repealing of most COVID regulations, except self-isolation requirements – risk of non-adherence to guidance due to reduced enforcement capability. | Local communications and campaigns to engage with people and communities.<br>Use of existing powers, including Public Health Act, to enforce if required. |
| Reopening of all settings with a new normal life with complacent behaviour of the workforce. | Close coordination with workplace Health and Safety leads targeted communications to strongly advise infection control measures and use of Health and Safety Act where safety of workforce is at risk. |
| NHS is likely to come under unsustainable winter pressure due to increasing case rates of COVID-19 or other respiratory viruses. | Alerting local population if the risk level changes.<br>Local decision of enforcing face coverings in settings with high risks and other control measures.<br>Stepping up vaccination campaign<br>and surge vaccination in frontline work force as well as high risk groups. |

## Geographical

| Risk | Mitigations |
|---|---|
| Key transit route – risk of increased transmission due to high levels of transit across county. | Strong EHO links with logistic businesses.<br>Transport colleagues available for IMT if any issues with M1 services, rail or coach links.<br>HPT links with cross-border colleagues. |
| Reopening of businesses and events – increased mixing and movement across the county. | Escalating any concerns via IMT, with any significant concerns discussed in Deep Dive meeting. |
| Reopening of schools, colleges and universities without any IPC restrictions. | Local IMT is working with educational set ups and children services.<br>Developed a local surveillance system and reporting mechanism to support head teachers and deans in managing incidents and outbreaks. |
| Winter may see increase in hospitalisations due to COVID-19 or other respiratory complications which may lead to increased mortality. | Targeted campaign to promote uptake of booster doses to those who are eligible and co-administering with flu vaccines.<br>Strongly advising use of control measures such as face coverings, hand hygiene, some social distancing and adequate ventilation and if necessary local authority may enforce and mandate use of face coverings in high risk settings. |

North Northamptonshire Council

**Item no:11**

# North Northamptonshire Health and Wellbeing Board

| | |
|---|---|
| **Report Title** | **NHCP Place, Communities and Neighbourhoods Proposal** |
| **Report Author** | **David Watts, Executive Director of Adults, Communities & Wellbeing (DASS)- David.watts@northnorthants.gov.uk** |

**List of Appendices**

**Appendix A – Stakeholders Engaged**
**Appendix B – Evidence base (maps, demographics, peer review, services, assets)**
**Appendix C – Outputs from HWB September and November workshops**
**Appendix D – Options appraised**
**Appendix E – Place governance proposal**

## 1. Purpose of Report

1.1. For Board members to review and formally endorse the North boundary and governance proposals for 'Place' within Northamptonshire's Integrated Care System.

## 2. Executive Summary

2.1 The report contains background and context to Place within the ICS, an outline of the approach undertaken to define Place and the evidence base used to inform decision-making. It establishes design principles for place levels, neighbourhood and community options for analysis and shares the output of stakeholder engagement to inform recommendations. Formal community and neighbourhood boundary and governance proposals are made for review and endorsement, with proposed next steps.

## 3. Recommendations

3.1 It is recommended that the Board:

a) Formally endorse the development of four communities- Corby, Kettering, Wellingborough, and East Northants- as the boundaries for communities in the North.
b) Formally endorse the plans to design neighbourhoods through clusters of wards with approximately 30-50k population size.

c) Endorse governance recommendations to widen HWBB remit and membership, establish Community Locality Wellbeing Forums, and utilise existing governance forums for neighbourhoods.

3.2 Reason for Recommendations:

- The proposed structure for communities is recognisable to local people, offers sensible planning and delivery geographies, and is broadly grouped by commonalities of need; aligning most closely with the principles agreed with system stakeholders.
- Wards are sensible and useful structures for grouping similar populations, engaging with local people at the most localised level and are recognisable to local people, aligning with the agreed design principles. However, grouping in clusters is required in order to ensure efficient planning and service delivery.
- Broadening the remit and membership of the Health and Wellbeing Boards will ensure that they are fully addressing the wider determinants of health in their activities.
- A level of governance is required at community level to ensure that there is the membership and capacity to plan in accordance with specific, targeted population needs and in line with the agreed Outcomes Framework / JSNA and Local Area Plans.
- Utilising existing governance forums for neighbourhoods will ensure that services are co-produced with local people and feedback from the most local levels are built into the approach.

## 4. Report Background

4.1 We are working towards establishing Northamptonshire as a 'thriving ICS' by April 2022, which, subject to legislation, is the point when Integrated Care Systems are expected to become established in law. This means that care between NHS, local authorities and others will be integrated, with local partners responsible for managing resources and improving health outcomes through a range of ICS organisations. In Northamptonshire we are in the process of defining plans for 'Place'. This is an important building block for developing an ICS capable of supporting meaningful service improvement to deliver on the long-term health and wellbeing outcomes agreed across the ICS. This contributes to NHCP's mission to empower positive futures; choose well, stay well and live well, empowering healthy lifestyles and ultimately preventing ill health across Northamptonshire. It is a key requirement to meet ICS statutory guidance. Outline plans must be developed by December 2021 and 'place' arrangements must be in place by April 2022. Plans will evolve and continually develop beyond April 2022.

4.2 The role and function of communities and neighbourhoods within Northamptonshire has been developing as part of ongoing ICS development work. The Partnership has already identified a number of core features and aspirations for Place.

4.3 Arrangements for integrated care at community and neighbourhood level will:

- Define boundaries in order to plan and align the commissioning of NHS and local government services around shared objectives and outcomes.

- Support our emerging ‘collaboratives’ to work at a system level, operating services which are tailored to meet needs at local ‘neighbourhood’ level. Sub-place and neighbourhood boundaries & arrangements inform where and how Collaboratives deliver – and vice versa.
- Draw on population health intelligence to support care redesign locally, e.g. Joint Strategic Needs Assessments (JSNA). Feed into: quality improvement strategy, prevention and approach to address health inequalities.
- Enable two way communication and coordinate strategy and programmes for neighbourhoods.
- Support development of more local arrangements delivering health, social care and public health services around the needs of the population and promote self-help/preventative measures.

## 5. Issues and Choices

5.1 We have engaged over 50 stakeholders to define draft proposals for communities and neighbourhoods so far, through two rounds of HWBB forum engagements in September and November, one-to-one discussions as well as review through the NHCP governance forums. Thinking will continue to evolve over the coming months.

5.2 The consensus from engagement to date is that places need to support the targeting of commonalities of need within particular populations, ensuring that services are localised to the greatest extent possible (where required) and facilitate co-production through providing forums for engagement for local people and organisations. In addition to this, places should be designed so that where economies of scale and planning and delivering efficiencies are possible, these are maximised. Existing governance forums can be utilised, and existing structures or geographical boundaries should be used where practicable so that places are recognisable to local people. There is agreement from stakeholders engaged that there should be two levels below ‘Place’ in order to support principles around ensuring economies of scale, localisation of services, effective and proportionate governance structures, equity of service delivery and widespread engagement / local voice. It is therefore recommended that ‘communities’ are a formal level of planning below place, with communities being constituted of ‘neighbourhoods’ at the lowest local level.

5.3 In both the West and North, several options of structures for both community and neighbourhood were considered. Included in this were Northamptonshire’s 16 Primary Care Networks. However, there was consensus that these are not viable structures for planning or delivery at any level of place, due to their overlapping geographies, varying population sizes and lack of recognisability to local people.

5.4 In the North, stakeholders fed back that at the community level, four localities are sensible planning and delivery geographies (based on former district boundaries) due to the commonalities of need within those populations (four distinct areas with different needs), the urban/rural mix of each of the four areas and their recognisability to local people. In the West stakeholders felt that two communities made sense as structures (based on current NHS locality boundaries) due to their broadly rural/urban split and similar population sizes, allowing for targeting of commonalities of need.

5.5 In both the North and West, ward boundaries were agreed to be useful structures for grouping similar populations and are recognisable to local people. However there was also consensus that, as individual units, wards are too small for both efficient planning and service delivery.

5.6 Therefore, in the North, 'community' recommendations are that there are four communities based around the former district boundaries - Kettering, Corby, Wellingborough, and East Northants. In the West it is recommended that the two CCG localities- Northampton, and South Northants and Daventry- should form the basis of the community structure.

5.7 At neighbourhood level in both North and West it is recommended that neighbourhoods should be comprised of 'clusters' of local government wards aligning broadly to urban and rural areas, with populations of approximately 30,000-50,000 people.

5.8 It is recommended that governance structures follow broadly the same structure in the North as in the West. Recommendations to the Board are as follows:

- Widen HWBB remit and membership to include liaison with other parts of ICS governance, clinical leadership and members from organisations to ensure that all wider determinants of health are considered
- Establishment of Community Locality Wellbeing Forums (one per locality), with responsibility for joint planning of local services across the health and care system
- Use of existing governance forums for neighbourhoods to engage with local people and ensure feedback from local service delivery

## 6. Implications (including financial implications)

### 6.1 Resources and Financial

6.1.1 There are no resources and / or financial implications arising from the proposals at this stage. More detailed plans will be determined through following stages. Resource implications may include additional system-wide resources to attend and participate in HWBBs, and development of informal forum structures at Community level (although these will likely replace existing structures).

### 6.2 Legal

6.2.1 Recommendations in the paper include some suggested changes to the remit and membership of statutory functions in the HWBB.

### 6.3 Risk

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

6.3.2 The risk of not making a decision is that the Council will not be complying with national legislation as part of the Health and Care Bill July 2021.

6.4 **Consultation**

6.4.1 Informal consultation has taken place though this process (see detailed report) and formal consultation is taking place at HWBB, through NHCP wider system governance and through sovereign organisational boards.

6.5 **Consideration by Scrutiny**

6.5.1 Not applicable

6.6 **Climate Impact**

6.6.1 Not applicable

6.7 **Community Impact**

6.7.1 Proposals within this paper support development of greater community involvement in health and care decision-making, local service planning and delivery. This is described in the detailed paper.

## 7. Background Papers

7.1 LGA/ NHS Guidance- Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

7.2 NHS Guidance- Interim guidance on the functions and governance of the integrated care board: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf

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Northamptonshire Health and Care Partnership



# ICS Northamptonshire Place and Sub-Place Proposal

## December 2 2021

Appendix

# Contents





# Appendices

1. Stakeholders engaged
2. Evidence base (maps, demographics, services, assets)
3. Outputs from HWB September and November workshops
4. ICB proposed membership and functions



# Executive summary - background

We are working towards establishing Northamptonshire as a ‘thriving ICS’ by April 2022, which, subject to legislation, is the point when Integrated Care Systems (ICS) are expected to become established in law. As part of this, we have developed plans for ‘places’, an important building block for developing an ICS capable of supporting meaningful service improvement to deliver on the long-term health and wellbeing outcomes agreed across the ICS. This will support NHCP’s mission to empower positive futures; choose well, stay well and live well, empowering healthy lifestyles and ultimately preventing ill health across Northamptonshire.

Within Northants, we have already agreed that ‘Places’ will be aligned to the two unitary councils. The rest of this paper makes recommendations for other tiers of ‘sub-place’, through communities and neighbourhoods.

The purpose of places is to define sensible boundaries to plan and align commissioning of NHS and local government services around shared objectives and outcomes. These places will support emerging ‘collaboratives’ to work locally, enabling them to tailor and deliver services at a variety of different levels. Each place will be required to draw on population health intelligence to support care redesign locally, e.g. Joint Strategic Needs Assessments (JSNA) and Local Area Plans. This will ensure that services are designed based on addressing health inequalities across Northamptonshire in the agreed ICS Outcomes Framework. Finally, places will help to ensure that local engagement takes place at all levels, providing all communities with a voice and ensuring that people are at the centre of designing our local services.



# Executive summary – outcome of engagement

We have engaged over 50 stakeholders to define draft proposals for communities and neighbourhoods so far, through two rounds of HWBB forum engagements in September and November, one-to-one discussions as well as review through the NHCP governance forums. Thinking will continue to evolve over the coming months.

The consensus from engagement to date is that places need to support the targeting of commonalities of need within particular populations, ensuring that services are localised to the greatest extent possible (where required) and facilitate co-production through providing forums for engagement for local people and organisations. In addition to this, places should be designed so that where economies of scale and planning and delivering efficiencies are possible, these are maximised. Existing governance forums can be utilised, and existing structures or geographical boundaries should be used where practicable so that places are recognisable to local people. There is agreement from stakeholders engaged that there should be two levels below 'Place' in order to support principles around ensuring economies of scale, localisation of services, effective and proportionate governance structures, equity of service delivery and widespread engagement / local voice. **It is therefore recommended that 'communities' are a formal level of planning below place, with communities being constituted of 'neighbourhoods' at the lowest local level.**



In both the West and North, several options of structures for both community and neighbourhood were considered. Included in this were Northamptonshire's 16 Primary Care Networks. However, there was consensus that these are not viable structures for planning or delivery at any level of place, due to their overlapping geographies, varying population sizes and lack of recognisability to local people.

**In the North, stakeholders fed back that at the community level, four localities are sensible planning and delivery geographies** (based on former district boundaries) due to the commonalities of need within those populations (four distinct areas with different needs), the urban/rural mix of each of the four areas and their recognisability to local people. **In the West stakeholders felt that two communities made sense as structures** (based on current NHS locality boundaries) due to their broadly rural/urban split and similar population sizes, allowing for targeting of commonalities of need.

In both the North and West, **ward boundaries were agreed to be useful structures for grouping similar populations** and are recognisable to local people. However there was also consensus that, as individual units, wards are too small for both efficient planning and service delivery.

# Executive summary – recommendations

Therefore, in the **North**, 'community' recommendations are that **there are four communities based around the former district boundaries - Kettering, Corby, Wellingborough, and East Northants.**

In the **West** it is recommended that **the two CCG localities- Northampton, and South Northants and Daventry- should form the basis of the community structure.**

At **neighbourhood level in both North and West it is recommended that neighbourhoods should be comprised of 'clusters' of wards** aligning broadly to urban and rural areas, with populations of approximately 30,000-50,000 people.

It is recommended that governance structures follow broadly the same structure in the North as in the West.
Recommendations to the Board are as follows:

- **Widen HWBB remit and membership** to include liaison with other parts of ICS governance, clinical leadership and members from organisations to ensure that all wider determinants of health are considered
- **Establishment of Community Locality Wellbeing Forums** (one per locality), with informal responsibility for joint planning of localised services across the health and care system, feeding into the HWBB
- **Use of existing governance forums for neighbourhoods** to engage with local people and ensure feedback from local service delivery



The Health and Wellbeing Board is therefore asked to review and endorse the boundary and governance recommendations above, and as outlined and detailed in this paper, to the NHCP Board.

# 1. Background and Context

Outlines where Northamptonshire is in the ICS development process, an overview of the national context, what places are and why they are needed in Northamptonshire

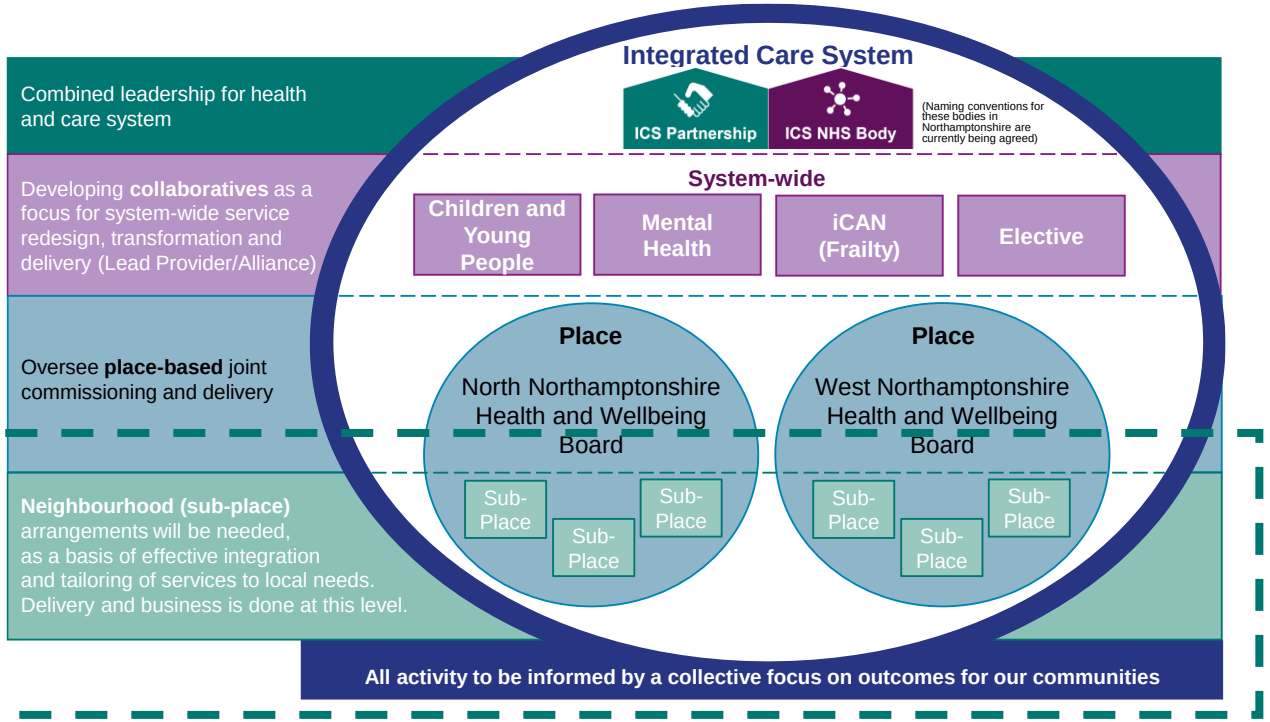
# Where we are in the development of our ICS in Northamptonshire

We are working towards establishing Northamptonshire as a ‘thriving ICS’ by April 2022, which, subject to legislation, is the point when Integrated Care Systems are expected to become established in law. This means that care between NHS, local authorities and others will be integrated, with local partners responsible for managing resources and improving health outcomes through a range of ICS organisations.

In Northamptonshire we are in the process of defining plans for ‘Place’. This is an important building block for developing an ICS capable of supporting meaningful service improvement to deliver on the long-term health and wellbeing outcomes agreed across the ICS.

This contributes to NHCP’s mission to empower positive futures; choose well, stay well and live well, empowering healthy lifestyles and ultimately preventing ill health across Northamptonshire.

It is a key requirement to meet ICS statutory guidance. Outline plans must be developed by December 2021 and ‘place’ arrangements must be in place by April 2022. Plans will evolve and continually develop beyond April 2022.




Within Northants, ‘Places’ will be aligned to the two unitary councils. The rest of this paper makes recommendations for other tiers of ‘sub-place’, through communities and neighbourhoods.

# The national and local context

Northamptonshire Health and Care Partnership

**National and NHS published guidance provides guidelines, with local areas being asked to identify their own plans.**

- **NHS England discuss a three-tiered model of systems, places and neighbourhoods** – Systems being through which a whole area's health and care partners come together; places serving 250,000 to 500,000 people being served by a set of health and care providers in an area; and neighbourhoods serving 30,000-50,000 people in local areas.
- **Different activities sit at different levels of the system**; this division of roles and responsibilities should be determined locally. However, decisions should be based on the principle of subsidiarity whereby responsibility is escalated only where there is a need to work at scale.
- **A breadth of contextual factors need to be taken into account when defining the levels of the ICS,** including: geographical or infrastructure features, existing partnership and governance structures, and the footprints of local authorities and Health and Wellbeing Boards. PCNs can be a useful structure around which to align neighbourhoods, however they may not have practical geographical catchment to form the basis of neighbourhoods.
- **Population sizes, service delivery arrangements, community identities and governance structures can vary** and systems can and will adapt the model to suit their local contexts e.g. larger systems operating additional intermediate tiers.

***Source: LGA/ NHS Guidance- Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems***



**What we have agreed locally so far:**

- **Our ICS will have two 'Places'** – aligning with the footprints for the new Unitary Authorities.
- **Our two HWBBs will maintain their roles and responsibilities** around needs analysis, strategic planning and scrutiny – and may expand their Terms of Reference and membership.
- **ICSs will require an overall system strategy to be developed by the ICS Partnership.** It will incorporate our two (planned) Joint Health and Wellbeing Strategies – producing a single, system-wide strategic plan for meeting health, care and wider wellbeing needs.

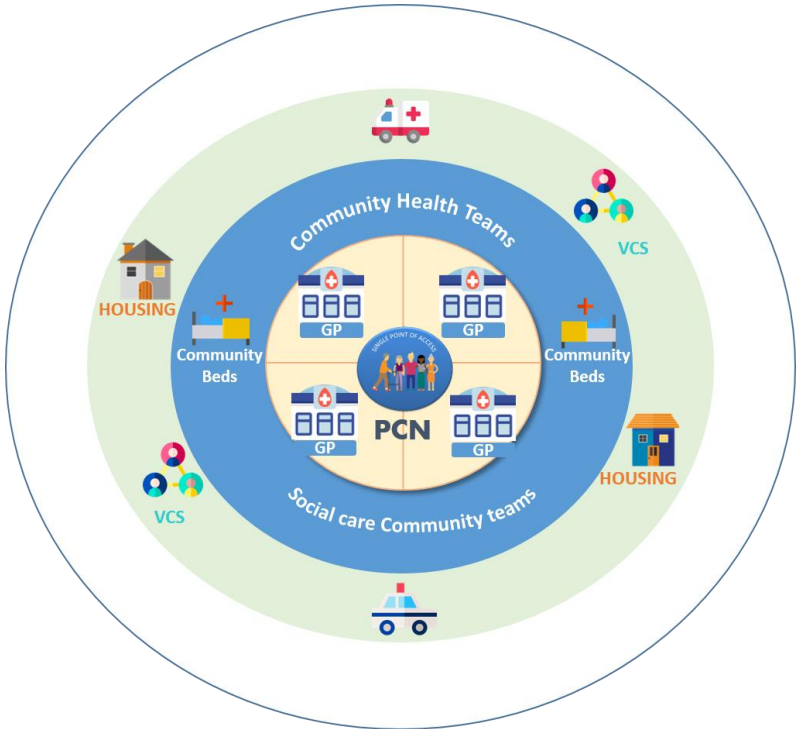
# What ‘communities and neighbourhoods’ are and why we need them

The role and function of communities and neighbourhoods within Northamptonshire has been developing as part of ongoing ICS development work. The Partnership has already identified a number of core features and aspirations for Place.

**Arrangements for integrated care at community and neighbourhood level will:**

- **Define boundaries** in order to **plan and align the commissioning of NHS and local government services** around shared objectives and outcomes
- **Support our emerging ‘collaboratives’ to work at a system level**, operating services which are tailored to meet needs at local ‘neighbourhood’ level. Sub-place and neighbourhood boundaries & arrangements inform where and how Collaboratives deliver – and vice versa
- **Draw on population health intelligence to support care redesign locally**, e.g. Joint Strategic Needs Assessments (JSNA). Feed into: quality improvement strategy, prevention and approach to address health inequalities
- **Enable two way communication** and coordinate strategy and programmes for neighbourhoods
- **Support development of more local arrangements** delivering health, social care and public health services around the needs of the population and promote self-help/preventative measures

Source: NHCP Partnership Board Paper, October 2021. LGA Thriving Places Guidance, September 2021




At a neighbourhood level we want to create **integrated hubs** delivering a range of services that meet local needs and outcomes set out in place based Health and Wellbeing Strategies

**Discussed at Partnership board in May 2019**

# 2. Place Workstream Approach

Scope, objectives and approach employed; progress to date and stakeholders engaged

# Scope and objectives and approach

## Objectives and Scope

**The objectives of the Place workstream are to work with Local Authority, health and place stakeholders to:**

1. Build on the operating model blueprint to further develop the role of Place to describe the interlink with other system components – particularly place boards, the ICP and Collaboratives.
2. Define a common approach to ICS sub-place boundaries – geographical building blocks for place-based delivery and contribution to the Outcomes Framework that can be recognised and where possible shared across the system. This must empower local communities and be set up to address agreed public health outcomes around addressing the health inequalities in the system.
3. Develop a proposal for place and sub-place governance requirements that incorporates the role of HWBs and individual parts of the system (social care, primary care, acute care, community and mental health, CVS), ensuring that all local voices co-produce the approach.
4. Agree the role of HWBs with regards to ICP governance (consistent with the blueprint and NHS guidance).
5. Provide an initial conduit from place into collaborative development programmes – ensuring that views on place role and boundaries align.



## Approach

- Develop hypotheses around:
    a) Place definition and principles
    b) Developing a more detailed articulation of the role of place in the ICS system
    c) Outlining how places will meet that role and deliver on the agreed Outcomes Framework
    d) Geography – facilitating development of sub-place boundaries which represent local characteristics / delivery
    e) Governance – Place Boards and sub-boards for health and care system – membership, ToR
    f) Develop an articulation of the role of place in Collaborative planning and design
- Provide supporting analysis of key delivery organisations current service planning boundaries (Primary Care, Local Government, Trusts, CVS, Community)
- Engagement sessions with place and community stakeholders to test and further develop thinking, moving from hypotheses / options to recommendation / proposal
- Draft proposal for new place and sub-place arrangements, covering a) – g) above, reviewed at HWBBs
- Review at ICS System Executive Group and NHCP Partnership Board

# Approach and progress to date

Northamptonshire Health and Care Partnership

## Complete

**Workstream Mobilisation and 1-1 Engagements**

Stakeholders from the Place workstream were mobilised, we established what had been agreed in terms of 'Place' and 'sub-Place', and identified key stakeholders from health, social care and the voluntary and care sectors to engage through a series of 1-1 semi-structured interviews.

**Mapping Activities and Information Gathering**

In conjunction with information gathering through the stakeholder interviews, an exercise was carried out to map the key geographical and administrative boundaries within Northants, how services are delivered, and provide an overview of the infrastructure supporting health and social care delivery.

**Health and Wellbeing Board and Forum Workshops**

Following on from the Health and Wellbeing Board workshops held in September, additional North and West workshops were held with stakeholders from the HWB Boards and Forums to test underpinning principles and long- and short-listed options for 'sub-Place'.

**Recommendations and Findings**

The hypothesis document containing Place definition and principles and the proposed option for sub-Place and governance developed and approval gained amongst participants of the Place workstream group.

## Next Steps

**Approval at North and West Health and Wellbeing Boards**

Recommendations will be reviewed at North and West Health and Wellbeing Boards on 2nd and 9th December.

**Approval at System Executive Group, Partnership Board and Sovereign Boards**

Place proposal review at ICS System Executive Group and Partnership Board in December 2021.

Subsequent sign-off through Sovereign Boards within Northants ICS organisations.

# Stakeholders engaged

*'Place-based systems should be established or amended following local discussion and considering the role of all the partners who contribute to health and care in a place, including housing, employment and training, and emergency services'.*
Source: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

The stakeholders engaged as part of this workstream were agreed amongst the workstream group as providing a good representation of stakeholders from across the health and care landscape within Northants. A full list of stakeholders engaged can be found in the appendix.

- Northants Children's Trust
- West Northamptonshire Council (executives and and members)
- North Northamptonshire Council (executives and members)
- Northamptonshire Healthcare Foundation Trust
- Public Health Northamptonshire
- Northamptonshire CCG
- UHN NHS Group
- GP Locality Chairs
- GPs- including Clinical Director leads of Primary Care Networks
- Voluntary Impact Northamptonshire
- Northamptonshire Fire and Rescue Service
- Northampton General Hospital
- Kettering General Hospital
- Town and Parish Councils (West engaged, North planned to engage)
- Police and Ambulance Service (planned to engage for both N/W)

Engaged

Planned for Engagement at Next Available Opportunity

# 3. Current Situation and Evidence Base

Current places, neighbourhoods, assets, services and boundaries. What we can learn from peers.

# Introduction to the evidence base

This section is the output of an exercise undertaken to map the key administrative and geographical boundaries, health and care service delivery arrangements, population demographics and needs / outcomes. In addition to this, a peer review was undertaken to understand how developing ICSs across the country are drawing and defining the boundaries of their Places and neighbourhoods. The analysis in and purpose of the following slides is outlined below, and the full evidence base can be found in the appendix.

**Current Geographical Boundaries across Northamptonshire-** Administrative and service delivery boundaries and areas, including former district councils, wards, parishes, PCNs and localities, were mapped. This exercise was undertaken to understand the structures that are already in place that may form the foundation for community and neighbourhood boundaries, in order to utilise existing service delivery and governance arrangements where possible.

**Population Outcomes and Demographics-** Mapped to gain a greater understanding of the geographical alignment of Northamptonshire's population demographics, as well as the population outcomes across the county. This was undertaken to understand where the commonalities of need lie, to form the basis of how community and neighbourhood structures are constructed to best meet need.

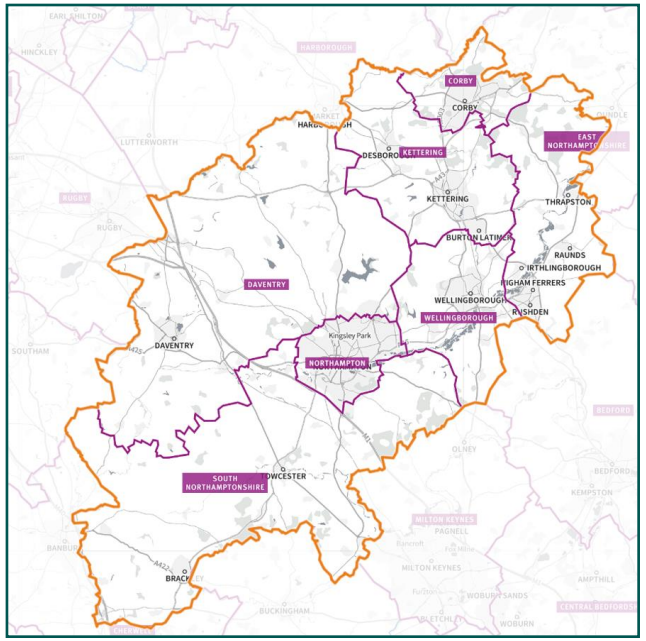
**Summary Overview of Health and Care Services-** Across Northants this has been outlined to show how services are delivered and delivery locations are spread across the county. Through ascertaining an overview of current service delivery, this helped to inform how services would be delivered in the future community and neighbourhood model.

**A Peer Review** of other mature and developing integrated care systems was undertaken, particularly focussing on where ICSs have outlined the structure and arrangements for their neighbourhoods, and how integrated care will be delivered within these. This exercise was undertaken to understand further the boundaries that may be used in forming neighbourhoods and communities, and how other systems are adapting the model to suit their specific needs.

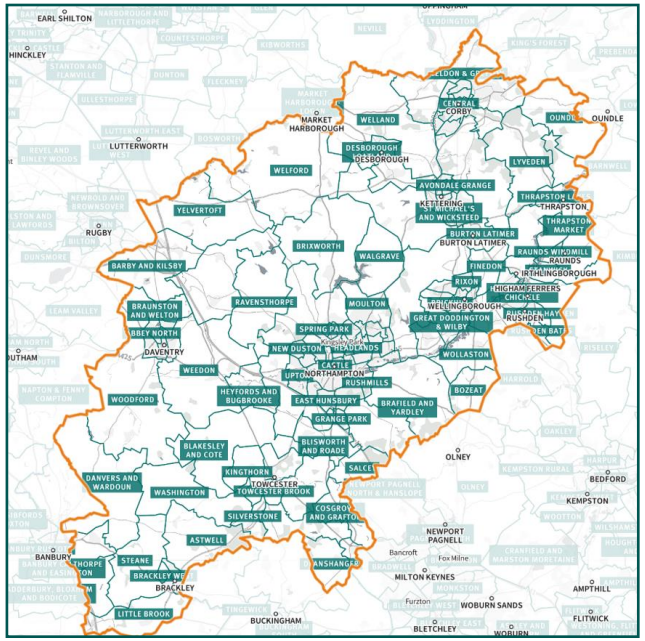
# Current geographical boundaries across Northamptonshire

Northamptonshire Health and Care Partnership

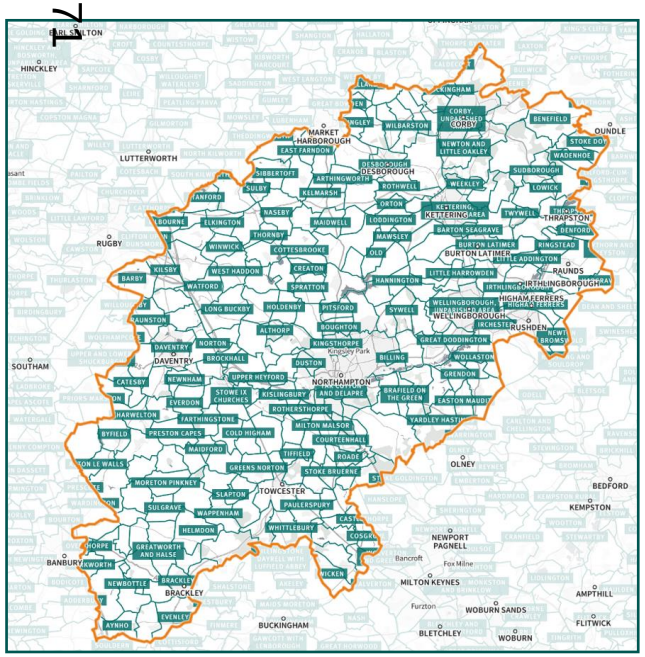
This slide shows current / former geographic and democratic boundaries, including former district councils, existing wards, existing NHS Primary Care Networks, Parishes and Towns and NHS GP localities.



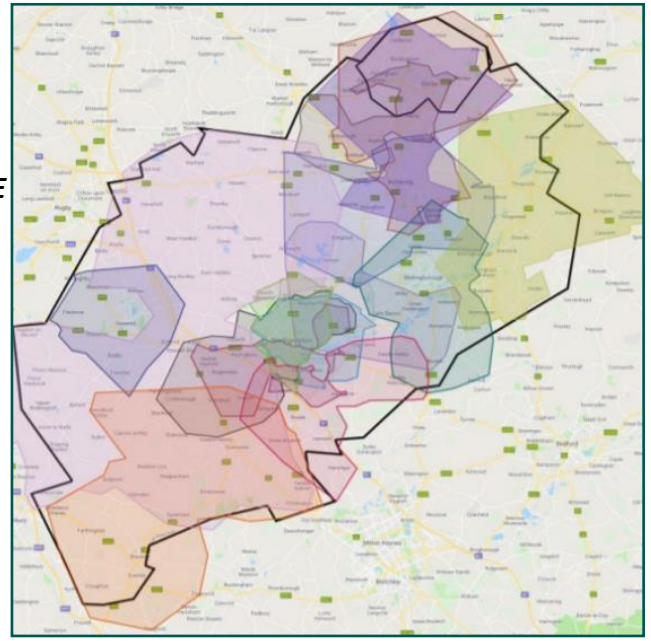

***7 Former district Councils Source: SHAPE Place Atlas***
*Popn range between 72k-225k*



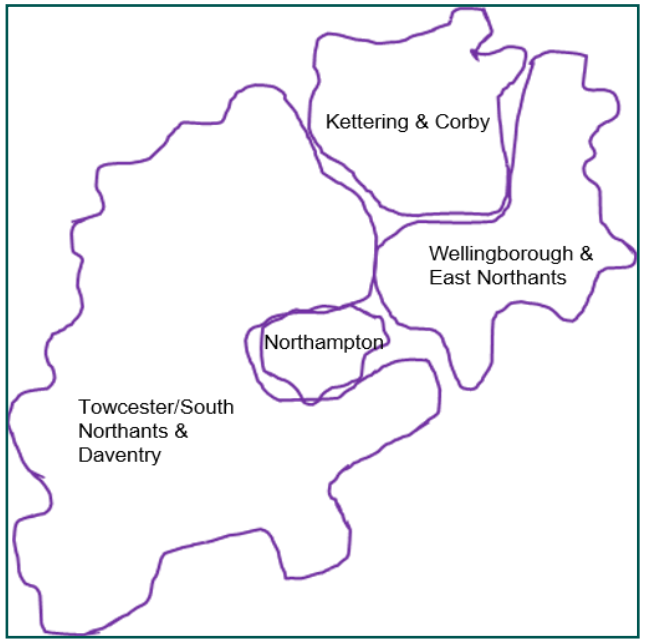
***57 Ward Boundaries Source: SHAPE Place Atlas***
*Approx. popn 4-10k*



***Over 250 parishes plus non-parished areas Source: SHAPE Place Atlas***
*Popn varies hugely- up to 130k*



***16 Primary Care Networks Source: NHCP Website***
*Approx. popn 30-78k*




***Localities: Approximate Boundaries***
*Approx. average populations 174k-225k*

***The full evidence base can be found in the appendix***

# Population outcomes and demographics

## Population Outcomes

Population outcomes across Northants show that worse population outcomes such as deprivation and homelessness are more highly associated with urban areas, while higher projected population growth is associated more with rural areas. The most notable outcomes are reported below:

- **Projected population growth by 2026, against a 2021 baseline**: Higher in Daventry, Corby, East Northants and South Northants (+7.1%, +6.6%, +5.2%, +5.1% respectively). All of which are largely rural- suggesting greatest growth in areas with the lowest current population- except for Corby which is currently widely urban. The most urban area, Northampton, had the lowest projected population growth at +1%.
- **(Internal) Index of Multiple Deprivation:** Found that higher deprivation is associated with more urban areas, and is higher in the North areas of East Northants, Wellingborough, Corby and Kettering
- **Statutory Homelessness (Reported by formed districts):** Statutory homelessness was found to be more prevalent in Wellingborough, Northampton, Kettering and Corby (at 6.4, 5.8, 4.9 and 3.8 per 1,000 households respectively).
- **Level of rurality/urbanity, reported by classification (i.e. urban rural and town; rural village and dispersed):** Northampton, Wellingborough, Corby and Kettering are more urban, with the more rural areas in South Northants and Daventry.
- **Employment Deprivation: measures the proportion of the working-age population in an area involuntarily excluded from the labour market:** More highly concentrated in Northampton, Daventry, Corby and Kettering



## Population Demographics

Several population demographics were researched in order to understand commonalities of need, with the below two demographics being mapped geographically. This shows that urban populations tend to have a higher proportion of younger and non-white ethnicities, with higher proportions of older people and white ethnicities in rural areas:

- **Ethnicity:** Asian/Asian British, Black, African, Caribbean and Black British, and Mixed Multiple Ethnic Groups populations are concentrated more highly in and around the urban areas; while rural areas tend to be largely White Ethnic groups.
- **Age**: a mapping of age groups aged 0-19 demonstrates distribution is largely equal, with slightly higher concentration in urban areas. Groups 75+, when mapped, tended to reside more in the rural areas.

***The full evidence base, including maps of boundaries, demographics, assets and service delivery can be found in the appendix***

# Summary view of Northamptonshire health and care services

Northamptonshire Health and Care Partnership

The below diagram provides and overview of key health and care services and locations and the level at which they are delivered. Pharmacies, a range of NHFT services, care-home/home and children's services are delivered county-wide; Community hubs, ASC Teams and acute hospitals sit at place level in North and West Northants; and Age-Well Teams, GPs, police and fire are based around neighbourhoods.

~130 **pharmacies** countywide

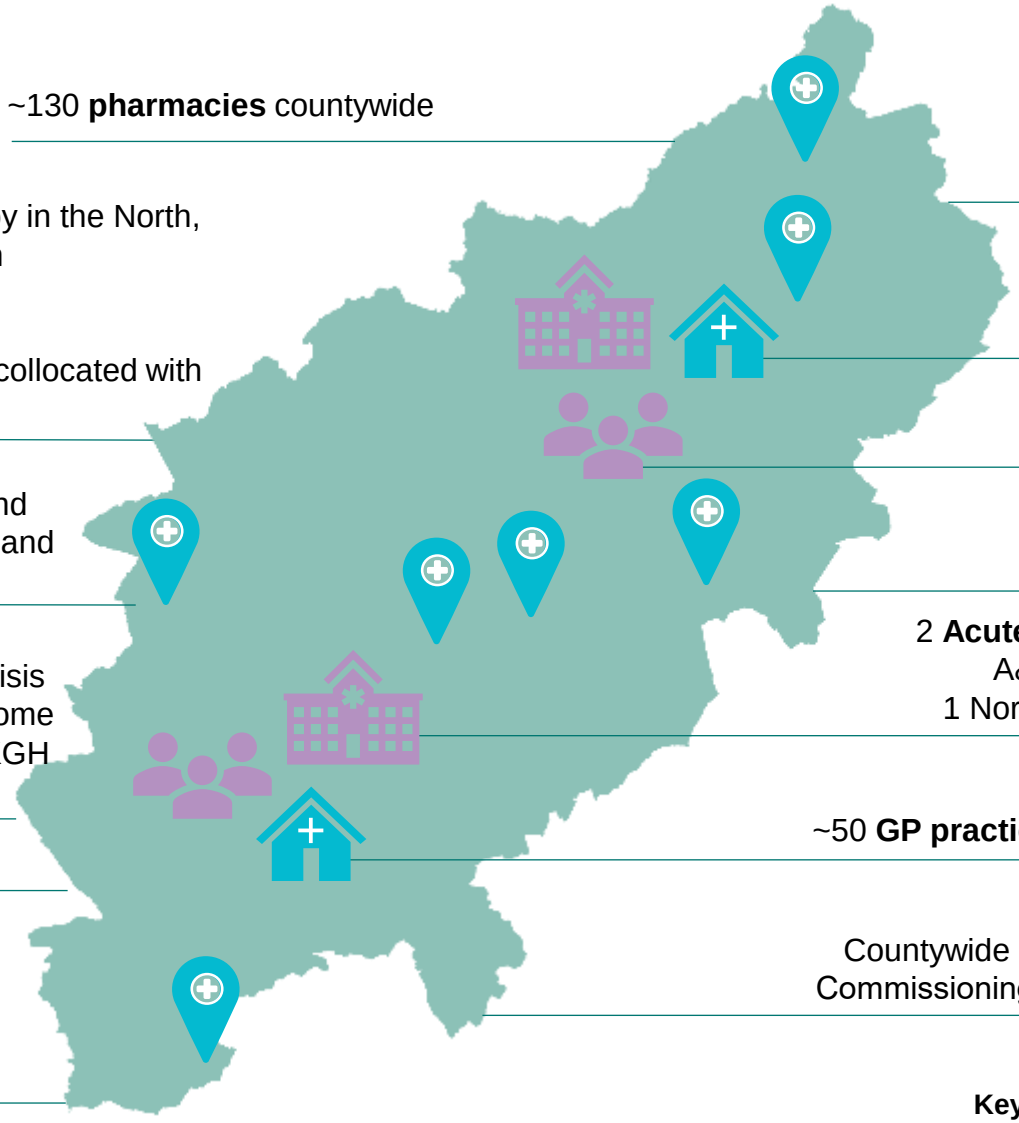
**ASC Community Hubs**
Wellingborough, Raunds, Kettering and Corby in the North,
Towcester, Daventry and two in Northampton
in the West
4 community adult social care teams in West
Community adult social care teams in North collocated with hubs – LD team and Inclusion team

**3 main NHFT sites** offering a variety of services and inpatient beds; plus some with integrated GP hubs and community nursing bases

NHFT offers a wide range of additional services across the county, including crisis cafes, care respite homes and in-the-home services- as well as some services at KGH and NGH.

~250 **care homes** countywide

**In the Home**; Domiciliary care, assistive technology, family interventions, community services



11 **Age-Well** Teams- aligned around PCNs, providing wrap around support for older people

~40 **GP practices** in North

**Reablement, short-term service and hospital assessment teams**

**Police and Fire** Services delivered at neighbourhood level

2 **Acute Hospitals at Place level** including; A&E, specialist/ diagnosis and elective
1 North (Kettering), 1 West (Northampton)

~50 **GP practices** in West

Countywide **Children's Services-** Commissioning and Children's Trust

**Key:** Neighbourhood / Community; Place; County-Wide

# How other places are organising

In many parts of the country, and across Integrated Care Systems at various levels of maturity, partnerships at a 'Place' level have been developing naturally over a number of years; the majority of which will be based on local authority boundaries and other clear geographical footprints. At neighbourhood level, Integrated Care Systems across the country are still developing in response to the latest ICS guidance. The majority of mature and developing ICSs are basing their neighbourhood structure on their Locality / PCN structures, linked to existing NHS structures, where these structures align to existing geographies. However, many places are still developing plans in response to the latest ICS guidance.

**Manchester LCO**

Will provide some services across their 3 localities and a small number of services across the North and South of the city. They are also creating 'integrated neighbourhood teams', across 12 neighbourhoods of 30,000-50,000 people. Each team works across 2-4 council ward areas.

**Dorset**

The county of Dorset is one of the first wave of emergent Integrated Care Systems. In an effort to create resilient and sustainable GPs as a strong foundation of the system, Dorset GPs have been working together in 12 locality groups focussing on transformation within their localities.

**North East London and North West London ICS**

Both ICSs in development have additional geographical levels of organisation in 'local systems' and 'clusters' due to the size and complexity of their systems, and the strength and identity of relationships at borough level.

**West Yorkshire and Harrogate**

Have 6 local places with partnerships in each making decisions on how they use their collective resources, including buildings and staff. They are supporting the development of 56 PCNs which are localised partnerships serving neighbourhoods of 30,000-50,000 people.

**North Central London CCG**

Borough partnerships have been formed to support working at 'place' level towards a strategic approach to commissioning, through continued work on population health, health inequalities and strategic reviews of services. Their neighbourhoods are 32 thriving PCNs.

**Nottinghamshire**

Is a mature ICS, with three Places, split into PCNs at neighbourhood level, of which there are twenty, aligned to ward structures. These PCNs support groups of GP practices to come together locally, in partnership with community services, social care, mental health and other health and social care providers.

**Lancashire and South Cumbria**

Has primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver services to populations of 30,000 to 50,000, driven by data, mobilising prevention and anticipatory care.

Source: Publicly available data and ICS Strategies. Full source list in appendix.

# 4. Design Principles for Communities and Neighbourhood Development



Design principles discussed through stakeholder engagement, to prioritise options for communities and neighbourhoods

# Proposed design principles for communities and neighbourhoods

Northamptonshire Health and Care Partnership

The following guiding principles emerged from stakeholder engagement sessions. They are proposed as a high-level framework against which options for how 'communities and neighbourhoods' can be appraised.

**1. Localisation**

Services should be tailored to local levels to the greatest extent possible where there is benefit, within the bounds of what budgets allow.

**2. Efficiency**

Duplication of efforts or inefficiency in the delivery of services across broader geographies should be minimised, with services being delivered at an 'appropriate' place level.

**3. Population size**

Neighbourhood boundaries take into account demographic determinants of geographies, whilst maintaining sensible population sizes to support strategic commissioning and efficient service delivery.



**4. Equity**

Neighbourhoods have a set of core services, increasing equity for all. Tailored services are delivered where needed, according to specific needs (in line with the Outcomes Framework set and Joint Strategic Needs Assessment).

**5. Recognisable**

Neighbourhoods are recognisable to local people, being drawn as closely as possible to geographical and administrative boundaries as possible, within the bounds of what makes sense to service providers.

**6. Governance**

Governance should ensure that input is sought from community and neighbourhood levels, whilst retaining responsibility for strategic decision-making at system and place levels. Use established forums where possible to streamline governance.

**7. Engagement and involvement**

Individuals, community groups, and parishes will be able to engage through a range of forums. Opportunity presented by digital technologies is taken advantage of, and there is effort to ensure that unnecessary time is not spent in meetings.

# 5. Community and Neighbourhood Options and Analysis



Long-list and shortlisted options for community and neighbourhood boundaries. Recommendations for both North and West.

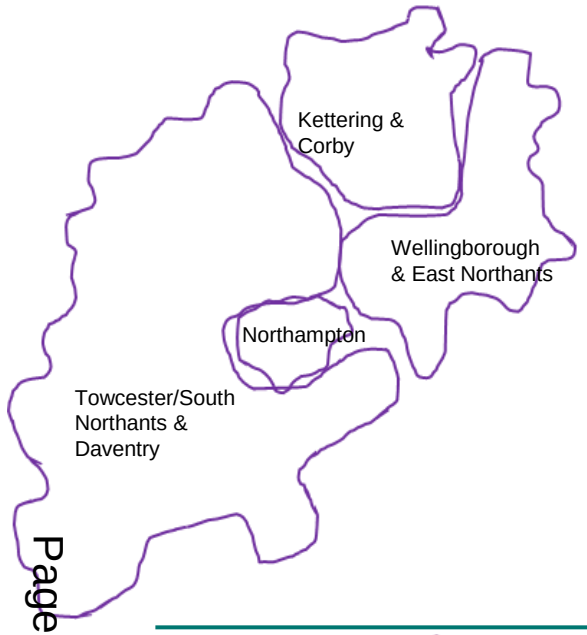
Detailed pros and cons of each option at an appendix.

# Long-list of community and neighbourhood options

The following long-list of community and neighbourhood options was presented and discussed at two workshops, one for each ICS Place - one in the North and one in the West in November 2021. Four possible boundary options were reviewed further with two discounted.

| | Long-List of Options | Based On: | Decision | Rationale |
|---|---|---|---|---|
| 1 | **4 Localities** | NHS (GP) boundaries | **Review Further** | Localities are similar sizes and exist as planning and service delivery units for NHS primary care already, although the boundaries would not be recognisable to local people. |
| 2 | **7 former districts / boroughs** | LG boundaries | | Former districts and boroughs are recognisable by most local people, nearly all of them have similar population sizes, and there is a significant amount of service delivery already happening on this level. However, these are no longer an existing structure in local government. |
| 3 | **10 areas grouped by urbanity / rurality index** | ONS Statistics | | Although not established in current arrangements, this option allows for the creation of structures that have similar population sizes and demographics, enabling service providers to identify commonality of needs within particular areas. |
| 4 | **57 Electoral Wards** | LG boundaries | | Wards offer small and recognisable structures, with strong commonality of need within them. However they are comparatively small as service delivery structures. |
| 5 | **16 Primary Care Networks** | NHS (GP) boundaries | **Discounted:** Large overlaps in geography and not recognised by local people | Primary care networks in Northamptonshire were not deemed suitable structures to be used as the basis for Place or sub-Place. They vary widely in size; both population and geographical. In addition, their formation is not based on any pre-existing geographies or commonalities of need, they are not recognisable to local people and many of their borders overlap. Whilst PCNs will be utilised in the future ICS to support the NHS neighbourhood delivery model, they are not recommended as a suitable basis for the creation of ICS neighbourhoods and communities. |
| 6 | **8-10 areas grouped by Multiple Deprivation Index** | ONS / JSNA Statistics | **Discounted:** Not a meaningful geographical unit; similar to Option 5 as many outcomes follow rural / urban lines | This option allows for the creation of structures that have similar needs. It is very similar to Option 3 as deprivation in Northamptonshire follows urban / rural areas and therefore was deemed duplicative. Basing Place geographies on population outcomes alone also creates boundaries which are not recognisable to local people, commissioners, or service providers. |

# Short-listed community and neighbourhood options

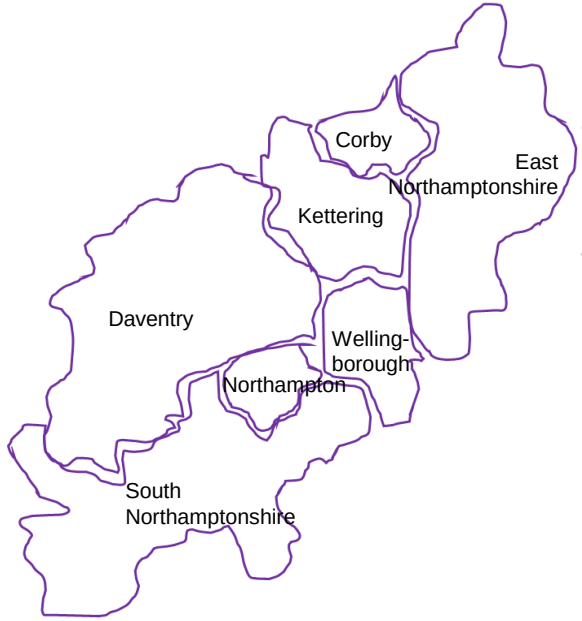



## Shortlisted Option 1 – Four Localities

This option is defined by the Local Medical Committee GP provision and four elected GP chairs

### Population

- *Northampton*- 225k
- *Towcester/ South Northants & Daventry*- 180k
- *Kettering and Corby*- 174k
- *Wellingborough & East Northants*- 175k

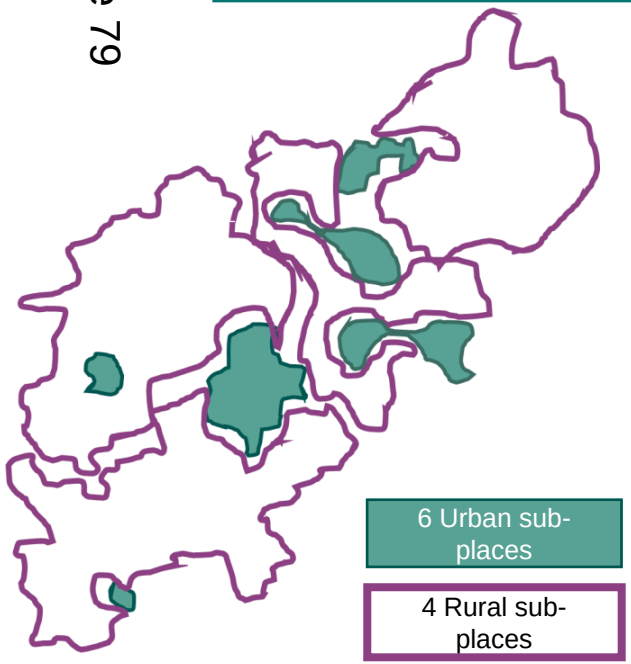



## Shortlisted Option 2 – Seven Former Districts

This option is based on the former seven districts and boroughs before local government reorganisation into two unitary councils

### Population

- *Northampton*- 225k
- *South Northants*- 95k
- *Daventry*- 86k
- *Wellingborough*- 80k
- *Kettering*- 102k
- *Corby*- 72k
- *East Northants*- 94k




## Shortlisted Option 3 – Six Urban and Four Rural Areas

This option is based on population density and need and has six urban (including towns) and four rural sub-places

### Population Classification

**West**

- *Urban*: Brackley, Daventry, Northampton
- *Rural:* South, West

**North**

- *Urban*: Wellingborough & Rushden, Kettering, Corby
- *Rural:* East, North

## Shortlisted Option 4 – 57 Local Electoral Wards

This option is based on Northamptonshire's 57 local electoral wards

### Population

Each ward has a population of circa. 4,000-10,000 (with some outliers and variation)

# Neighbourhoods and Communities: drawing conclusions

Northamptonshire Health and Care Partnership

| Appraisal Against Agreed Principles | Option: | Option 1: Localities | | Option 2: Former District Boundaries | |
|---|---|---|---|---|---|
| | | North Output | West Output | North Output | West Output |
| | Localisation | Broad population sizes and geographies limit the extent to which there can be tailoring to local needs. Not deemed suitable for the lowest level of 'place' | | Scale of former districts limits the extent to which particular locations can received tailored services. Not deemed suitable for the lowest level of 'place' | As per North. Larger areas of Daventry and South Northants, and Northampton's large population limit opportunities for localisation |
| | Efficiency | Large locality structures allow for the high-level delivery of services, and greater economies of scale within service delivery | | Broadly, services can be delivered efficiently to populations | Efficiency of services may be difficult to achieve due to highly dense populations in Northampton and geographically large rural areas |
| | Population Size | Localities have similar population sizes, but do not group similar demographics | Localities have similar population sizes and broadly follow a rural/urban split to a limited extent | Former district boundaries group broadly similar demographics and have similar population sizes | Broadly similar demographics grouped, but Northampton has a significantly higher population than the other districts |
| | Equity | Areas with differing needs are grouped together (Kettering / Corby), which could promote planning and delivery inequality | Localities align broadly with an urban/rural divide so there are similar commonalities of need, however significant deprivation in rural areas needs to be considered | Districts fall along distinct demographic boundaries, broadly aligning needs, although with some mix of urban and rural areas | Districts fall broadly along an urban rural divide, although significant variation in need within both urban and rural areas needs to be taken into account |
| | Recognisable | There is low recognisability of the localities, with some grouped areas seeing themselves as significantly different from each other | There is low recognisability of the localities, although some acknowledgement of the difference between urban and rural areas | There is significant recognisability of the former district boundaries, however these structures are no longer in use and misalign with current local authority commissioning and delivery structures | |
| | Governance | While there are currently locality leads, they're NHS structures, aren't formal and cannot currently support commissioning and delivery of other services | | Former HWB Forums offer opportunity for engagement upwards, however these are not statutory groups and do not formally feed into the system | |
| | Engagement | Areas are too large for local organisations and people to engage with and feed upwards into localities in a meaningful way | | There is no longer a formal route for engagement with the system, through the structure of the former districts | |
| | **Conclusion** | Offer some opportunities, but areas are deemed too broad as-is, with varying needs within each locality ✗ | Localities offer sensible structures for governance, commissioning and service delivery in the West ✓ | Former district boundaries, whilst not ideal for defining governance and delivery by, offer opportunity for greater localisation in the North ✓ | Former district boundaries do not align to current structures and would be unhelpful planning units given recent reorganisation ✗ |

✓ Carried forward as a recommendation in hybrid/modified form ✓ Carried forward as a recommendation ✗ Discounted as an option

# Neighbourhoods and Communities: drawing conclusions

Northamptonshire Health and Care Partnership

Appraisal Against Agreed Principles

| Option: | Urban/ Rural Geographies | | Wards | |
|---|---|---|---|---|
| | North Output | West Output | North Output | West Output |
| **Localisation** | Division into 5 areas offers potential opportunity for localisation, however rural areas are still large | Localisation can occur to an extent, although rural geography and urban population are large- limiting this | The size of wards, both in terms of population and geography, allows for high levels of localisation and targeting of specific services | |
| **Efficiency** | Services can be provided at scale for populations within urban areas, however rural geographies are so wide that economies of scale may not be achievable | | Wards are a very small structure, individually, through which to deliver services, which would lead to service delivery inefficiencies | |
| **Population Size** | Urban and rural communities have different population sizes | The urban area of Northampton would have a significantly greater population size than other areas | Wards tend to have similar geographic and demographic determinants, but there can be hugely significant variation of population on ward level | |
| **Equity** | Urban/rural divides align broadly with specific outcomes and needs, allowing for specific targeting of services | There are similar needs in urban/rural groupings, although deprivation in rural areas does need to be taken into account | Broadly, wards have strong commonalities of need, allowing for highly targeted outcomes-based delivery | Adjacent wards in Northampton have vastly differing needs, so delivery would need to be well-targeted in line with these |
| **Recognisable** | There is low recognisability of these boundaries, with some urban areas not naturally falling together | There is not significant recognisability along the urban/ rural divide, with rural areas being quite geographically broad | There is likely to be high recognisability of ward boundaries, although a limitation to the extent to which people identify with activities within their local ward | |
| **Governance** | There are currently no governance structures in place to align to these boundaries | | There are low level governance structures in place for wards, however these are on such a low level that, individually, they cannot support the planning, commissioning or delivering of services | |
| **Engagement** | There are no formal routes for engagement through urban/rural divides, however broadly similar geographies offer the opportunity to engage at broadly local levels | | There are wide opportunities for engagement at this level to ensure that there is a significant amount of local input | |
| **Conclusion** | Urban and rural geographies in the North offer high commonality of need supporting outcomes-based delivery. However for planning purposes have little recognisability or governance structures ✓ | In the West, urban and rural geographies have little to no recognisability, current governance or engagement structures, and large rural geographies do not provide wide commonality of needs or opportunities to localise services ✗ | Across both North and West Northants, ward boundaries offer strong opportunities to localise services, have strong commonalities of need, are highly recognisable and offer wide engagement opportunities. However ward boundaries are far too small to be efficient and, individually are far too small units for effective service delivery. Instead, some configuration of ward clusters should be used a the basis for neighbourhood structure ✓ | |

✓ Carried forward as a recommendation in hybrid/modified form ✓ Carried forward as a recommendation ✗ Discounted as an option

# Communities: drawing conclusions

The consensus from both North and West HWB Board and Forum workshops was that there should be two levels below 'Place' in order to support principles around ensuring economies of scale, localisation of services, effective and proportionate governance structures, equity of service delivery and widespread engagement / local voice. It is therefore recommended that 'communities' are a formal level of planning below place, with communities being constituted of 'neighbourhoods' at the lowest local level. North/West 'community' recommendations are below:

| | | | |
|---|---|---|---|
| **Community Level – North Recommendation** | A hybrid of locality and former district boundaries recommended as options for community, creating a structure with four distinct communities (and populations): Corby (72k); Kettering (102k); and Wellingborough (80k) & East Northants (94k). |  | This allows for distinct features of Kettering and Corby to be taken account of, supports a sensible distribution of urban/rural neighbourhoods within each community and provides efficiency of service delivery through some economies of scale.<br><br>Although boundaries are aligned to former structures (former districts) which no longer exist, the places themselves are recognisable to local people. |
| **Community Level – West Recommendation** |  | | Localities are carried forward as the chosen boundaries for community, with two distinct communities (and populations) as: Northampton (225k) and Towcester, South Northants & Daventry (180k).<br><br>This recognises the urban/rural split and maximises economies of scale. Places are recognisable and populations are broadly similar. Governance structures already exist to support these boundaries. |

# Neighbourhoods: drawing conclusions

Northamptonshire Health and Care Partnership

North/West ‘neighbourhood’ recommendations are below:

| | |
|---|---|
| **Neighbourhood Level – North and West Recommendation** |  Recommendation for a lower level of place, below community level, in clusters of wards at populations of ~30-50k. This ensures appropriate engagement at a local level and more localised service delivery than at community level.<br><br>These clusters of wards could be organised by recognisability and commonalities of need. For North, this will allow for the alignment of places along urban / rural lines as well, deemed a determinant of health outcomes in those areas. |

The following section defines how these communities and neighbourhoods would work in practice.

# 6. Communities and Neighbourhoods Proposal

Proposal for how places, communities and neighbourhoods will work in practice

# Place, Communities and Neighbourhoods proposals: how places will work in practice

Northamptonshire Health and Care Partnership

| ICS Place layer | Main function of place layer | What happens at each level |
|---|---|---|
| **Neighbourhood**<br>Clusters of wards, likely ~30-50k population clusters, reflecting particular needs | **Local service delivery, local engagement and voice** | • **Providers** across the system work together to deliver services at a local level, targeting specific needs through locally integrated teams and using shared neighbourhood assets.<br>• **People** receive more integrated and targeted services, supporting them to remain well for longer.<br>• **Local engagement** through existing forums (e.g. patient participation groups, councillor feedback, community groups) feeds upwards through community governance levels to inform strategic priorities and commissioning plans. |
| **Community**<br>West: 2 Localities in Northampton and Towcester/ South Northants & Daventry<br>North: 4 Localities in Kettering, Corby, Wellingborough, East Northants (former districts) | **Community / neighbourhood level commissioning , service design and delivery** | • **Health and care providers** across the system (social care, primary care, community care, acute care, voluntary sector) work together to plan and deliver services, optimising shared assets and resources at a lower level than place.<br>• **Commissioners** make resourcing decisions based on Outcomes Framework / JSNA, tailored to communities and neighbourhoods through 'Local Area Profiles'.<br>• **Governance** within each community feeds priorities from community and neighbourhood delivery into HWBBs to inform strategy. Stakeholders within governance at this level action specific service delivery plans within their own organisations. |
| **Place**<br>Two places – one in each Unitary | **Place level strategy and ICS overall scrutiny** | • **Health and care providers** across the system set strategy within each Place and provide scrutiny and review to overall ICS strategy.<br>• **Governance** is already established through HWBB, however membership may need changing to align to ICS system (see later section). |

*"I will be able to access more services, closer to my home. I don't need to contact so many different organisations to manage my care needs. I know that I can speak to someone locally to feed back on local services."*

# Case study example: adult mental health

Peter is a young adult who has been struggling with his mental health during the pandemic. Peter is in full time employment at the moment, but has been reliant on benefits in the past. At the moment his needs are being met through regular reviews with his social worker and GP. Peter loves playing football with other people from a local community centre and also sometimes attends a crisis café to keep in touch with others. Should his needs escalate, his family know what services are available for more intensive inpatient support.

## Home

Peter is stable and happy. His needs are being kept under review through regular meetings through a multi-disciplinary community team across social care, primary care and community mental health.


## Neighbourhood

Peter plays football through his local community group.

Peter has attended a 'crisis café' at times when he has felt able.
Run by an NHFT mental health professional and a MIND peer support worker, they provide support and safety by offering coping mechanisms and management techniques to help reduce the risk of crisis.

Peter will also see information posted in community buildings that may focus on some of the known challenges that are more prevalent and impact on mental health to show him where he may get support from.

## Community

Attending regular Cognitive Behaviour Therapy clinics at a local health centre in Kettering has also helped Peter keep his condition under control.

He knows that if he has money concerns or problems with his job, there is someone to talk to at one of the community hubs which include support with housing, employment and benefits, amongst other council services.

## Place

If Peter's condition deteriorates, Peter and his family know that there are modern, inpatient facilities in the county. This also provides some respite for Peter's family at times of crisis.

Some patients with mental health problems need intensive treatment and support as an inpatient. This care is provided at a psychiatric intensive care units e.g. the Marina Ward based at Berrywood Hospital in Northampton.

# 7. Communities and Neighbourhoods Governance Proposal

Proposal for how places, communities and neighbourhoods governance will work

# Overview of ICS governance

Northamptonshire Health and Care Partnership

This section defines the recommended role of governance in supporting places, communities and neighbourhoods.

Detailed proposals are currently being developed for an NHS Statutory Integrated Care Board (ICB) and Integrated Care Partnership (ICP) Board. Below that, the NHCP has already agreed that Health and Wellbeing Boards (HWBBs) will be the governance forums at a 'Place' level.

This section of this paper outlines:

- Recommended changes to HWBBs membership and terms of reference
- What functions are delivered at each level of governance, including communities and neighbourhoods
- How governance is expected to function alongside other existing governance forums already in existence

**Figure:** Emerging Integrated Care System Governance Map

# Communities and Neighbourhoods governance proposal recommendations

Northamptonshire Health and Care Partnership

The following recommendations are made, to ensure that there is proportionate, appropriate governance and decision-making in place to support the ICP, HWBBs and the principles outlined earlier.

1. **Widen the remit and membership of HWBBs at 'Place' level**
   - Wider the remit to include a role in reviewing and inputting to the ICS Strategy as developed by the ICP Board
   - Widen HWBB participation to include:
     - A representative from ICB (replacing the CCG member)
     - A representative from the Integrated Care Partnership Board (responsible for liaison with the ICP Board)
     - A clinical lead (representing the medical profession, ensuring that clinical leadership is built into all ICS governance layers)
     - Ensure appropriate representation to reflect wider determinants of health i.e. housing, employment, education and justice / probation
2. **Develop new ICS Community Locality Wellbeing Forums (one per locality)**
   - Responsible for joint planning of community / neighbourhood services, including new transformed pathways; integrated oversight of local services across collaboratives / other providers
   - Development of 'Local Area Plans' to support service planning / delivery below JSNA (HWBB) level
   - No statutory responsibility for decision-making and not constituted as a formal HWBB committee, but responsible for feeding back on strategy and commissioning to HWBB (including from lower neighbourhood level, possibly via appointed councillor neighbourhood leads)
   - Encompasses the role of HWBB Forums and GP Locality Boards currently, with additional members to include 'neighbourhood' councillor representatives, providers of local services (including collaboratives and social care), voluntary sector, parishes and towns
3. **Utilise existing neighbourhood structure to ensure local voice and engagement**
   - Multiple existing structures exist to engage with local people e.g. ward councillor structures, Parish and Town councils and other local voluntary sector forums
   - All would have a responsibility to feedback to Community Locality Boards in the structure
   - Possible appointed ward councillor 'neighbourhood leads' to act as a conduit between neighbourhood and community

# 8. Next steps

# Decision-making and next steps

HWBB is asked to review and endorse the Boundary and Governance recommendations in this paper up to NHCP Partnership Board. Those are:

1. Boundary proposal North:
    - Development of four localities in Corby, Kettering, Wellingborough and East Northants
    - Progress with plans to design neighbourhoods through clusters of wards at a ~30-50k population size
2. Governance proposal North: Endorse governance recommendations to
    - Widen HWBB remit and membership
    - Establishment of Community Locality Wellbeing Forums (one per locality)
    - Use of existing governance forums for neighbourhoods



## Next steps: formal 'Place' proposal development

| Board / Approval step | Type | Timing |
|---|---|---|
| HWBB – North and West | Review and endorse recommendations | North – today<br>West – 9th December |
| NHCP System Executive | Review and endorse recommendations | 24th November (complete); 8th December |
| NHCP Partnership Board | Review and endorse recommendations | 16th December |
| Submission to NHS England | For information | February 2022 |
| Sovereign Boards for all NHCP organisations (Councils, CCG, NHS Trusts) | For sign-off and approval | By March 2022 |

# APPENDICES

A. Stakeholders engaged
B. Evidence base (maps, demographics, peer review, services, assets)
C. Outputs from HWB September and November workshops
D. Options appraised
E. Place governance proposal

# Appendix A

## Stakeholders engaged

# Stakeholders Engaged

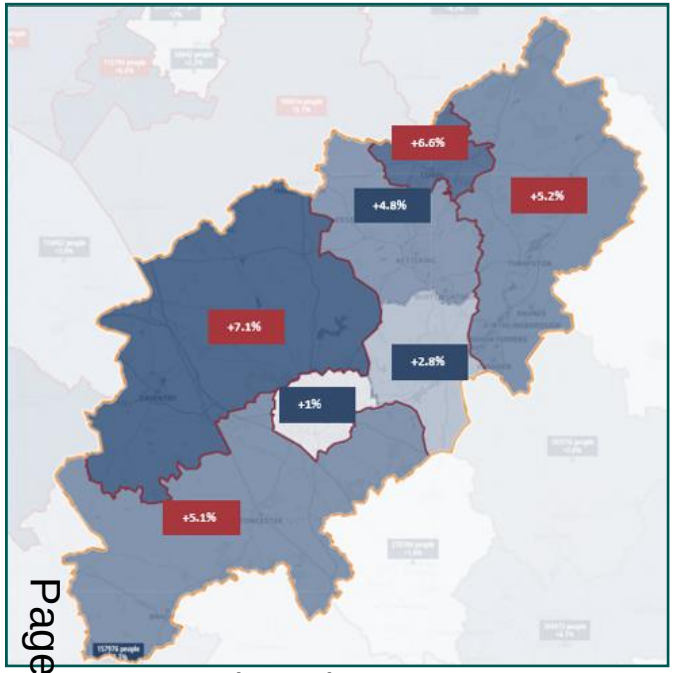
| Stakeholder | Organisation/ Role |
|---|---|
| Naomi Eisenstadt | NHCP Independent Chair |
| David Watts | DASS- North Northants |
| Stuart Lackenby | DASS- West Northants |
| Karen Spellman | Director of Integration and Partnerships, University Hospitals of Northants NHS Group |
| Ali Gilbert | Director of Transformation Delivery, Northamptonshire CCG |
| Jonathan Cox | Chair of Northants GP Board |
| Katie Brown | Assistant Director, West Northants Council |
| David Williams | Director of Strategy & Business Development, NHFT |
| Cllr Jon-Paul Carr | Chair, North Northants HWB Board |
| Cllr Matt Golby | Portfolio Holder Adults, Public Health Wellbeing, Chair of West Northants HWBB |
| Colin Foster | Chief Executive, Northamptonshire Children's Trust |
| Lucy Wightman | Joint Director of Public Health - North and West Northants Councils, Director of Population Health Strategy - Northamptonshire CCG |
| Julie Lemmy | Deputy Director of Primary Care, Northamptonshire CCG |
| Dr Chris Ellis | GP Locality Chair, Wellingborough HWB Forum |
| Dr Ammar Ghouri | GP Locality Chair |
| Dr Darin Seiger | GP Locality Chair |
| Dr Philip Stevens | GP Locality Chair |
| Russell Rolph | CEO, Voluntary Impact Northamptonshire |
| Cllr Macaulay Nichol | Vice Chair, North Northants HWBB |
| Cllr Helen Harrison | Portfolio Holder for Adults/Public Health, North Northants Council |
| Cllr John McGhee | North Northants Council, Corby HWB Forum |

| Stakeholder | Organisation/ Role |
|---|---|
| Samantha Fitzgerald | Assistant Director of Adult Social Services, North Northants |
| Dr Raf Poggi | PCN Clinical Director |
| Shaun Sannerude | Community Development Officer, North Northants |
| Hazel Webb | Kettering HWB Forum and North Northants Council |
| David Maher | Deputy Chief Executive, Northamptonshire Healthcare Foundation Trust |
| Lisa Byran | Northamptonshire Fire and Rescue Service |
| Ellie Hall | Northamptonshire CCG |
| Julia Kainth | Northamptonshire CCG |
| Bhavna Gosia | Head of Programme Delivery, NHCP |
| Leah Lambe | Project Manager, ICS Programme, NHCP |
| Fiona Bell | Programme Manager, ICS Programme, NHCP |
| Colin Smith | Northamptonshire Local Medical Committee |
| Alan Burns | West Northants, Daventry HWB Forum |
| Becky Thornton | Voluntary Impact Northamptonshire |
| Chloe Gay | Public Health Northamptonshire |
| Ed Cooke | West Northants Council, Daventry HWB Forum |
| Eileen Doyle | Transformation Lead, NHCP/ICS |
| Jean Knight | Northamptonshire Healthcare Foundation Trust |
| Jessica Slater | SERVE |
| Kirstie Watson | Northamptonshire CCG |
| Lisa Humpage | Northampton General Hospital NHS Trust |

# Appendix B – Part 1

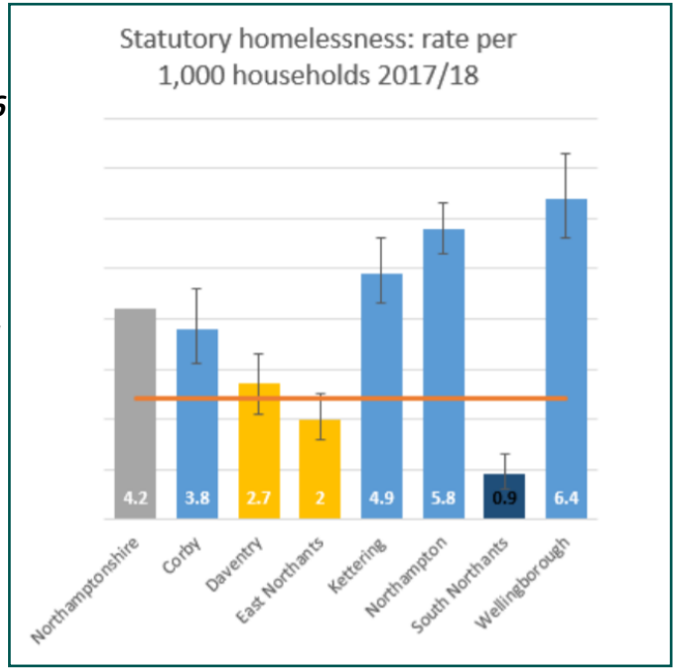
## Evidence base: demographic mapping

Northamptonshire Health and Care Partnership

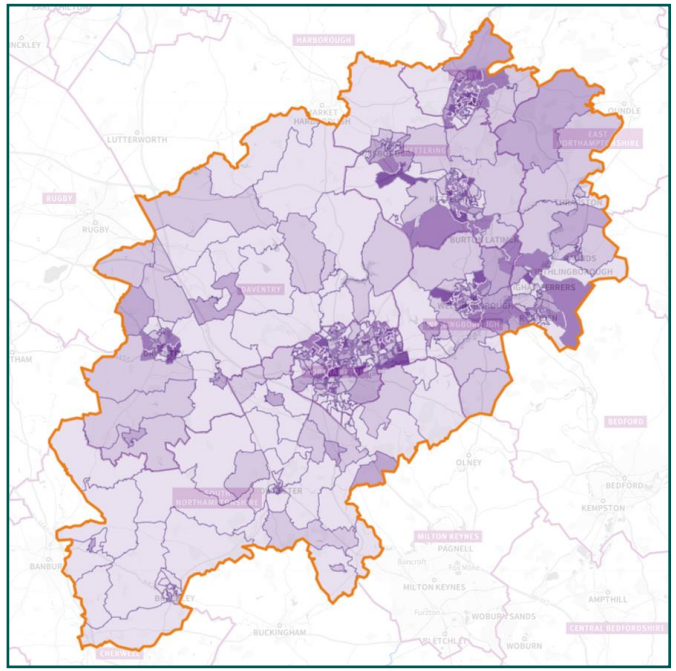



***Predicted Population Growth by 2026 Against 2021 Baseline- Dark Blue= Higher Growth***
*Demonstrates higher expected growth in Daventry and Corby, followed by South and East Northants*

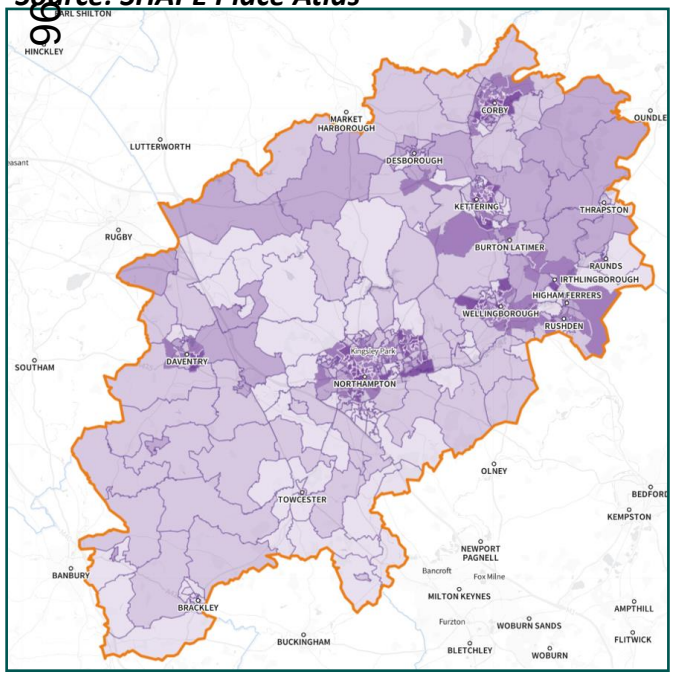
***Source: SHAPE Place Atlas***



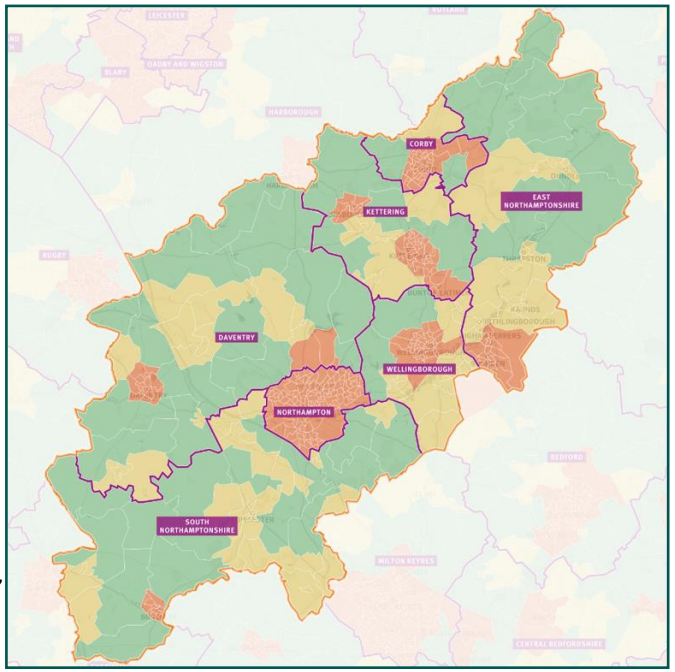

***Statutory Homelessness Broken Down by District- Orange Line= England Average***
*Statutory homelessness is more prevalent in Wellingborough, Northampton, Kettering and Corby*
***Source: PHN JSNA Insight Pack, 2019***



***Employment Deprivation: measures the proportion of the working-age population in an area involuntarily excluded from the labour market.***
*More highly concentrated in Northampton, Daventry, Corby and Kettering*
***Source: SHAPE Place Atlas***




***Index of multiple deprivation (internal) Deeper purple= greater deprivation***
*Higher deprivation is associated with more urban areas, and is higher in the North areas of East Northants, Wellingborough, Corby and Kettering*




***Level of rurality- Green= Rural and dispersed/ Orange= Urban city and town***
*Northampton, Wellingborough, Corby and Kettering are more urban, with the more rural areas in South Northants and Daventry*
***Source: SHAPE Place Atlas***

# Internal Ethnicity Distribution

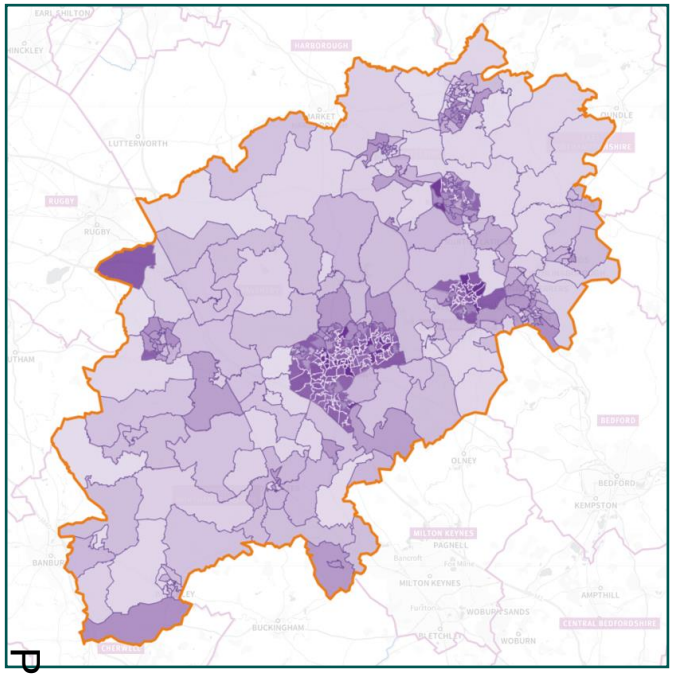


Northamptonshire Health and Care Partnership

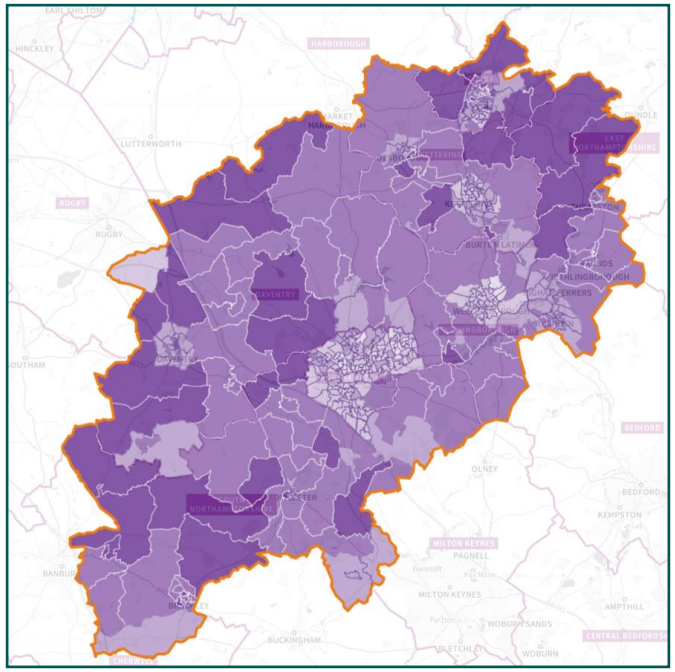
*An overview of ethnic distribution across Northamptonshire, measured as an internal indicator, demonstrates that Asian/Asian British, Black, African, Caribbean and Black British, and Mixed Multiple Ethnic Groups are concentrated more highly in and around the urban areas; while White Ethnic groups are more prevalent in the rural areas.*

***Source: SHAPE Place Atlas***

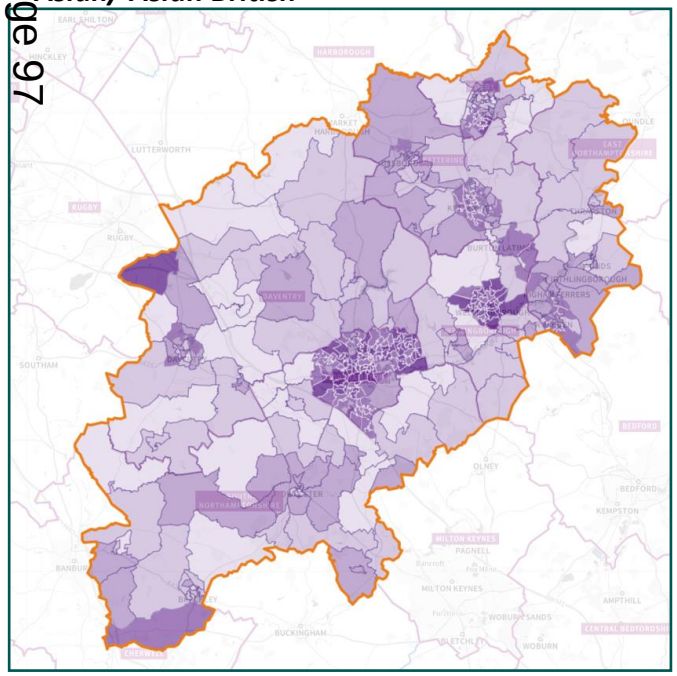
***Keys:***



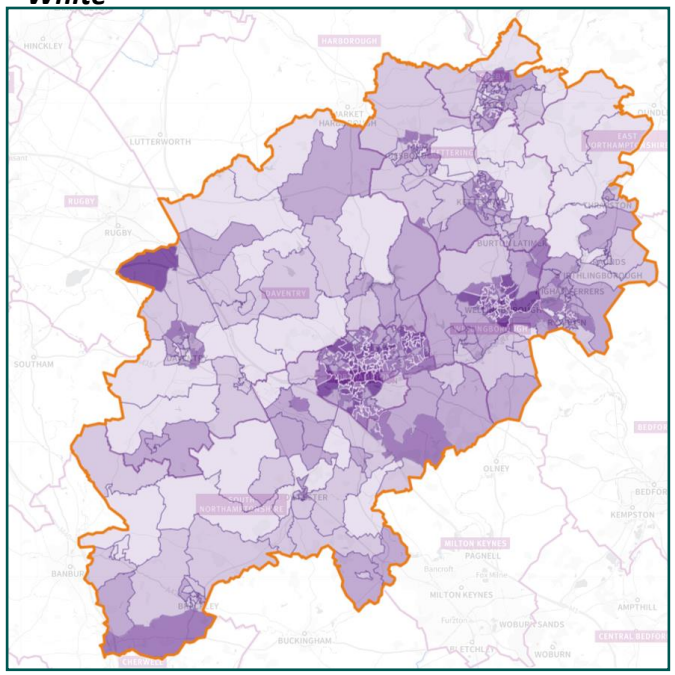
***Asian/ Asian British***



***White***



***Black, African, Caribbean and Black British***



***Mixed Multiple Ethnic Groups***

***Asian/ Asian British***

- 9.4% to 98.7%: 30 areas
- 3.44% to 9.39%: 123 areas
- 1.47% to 3.43%: 91 areas
- 0.69% to 1.46%: 99 areas
- 0% to 0.68%: 70 areas

***White***

- 98.17% to 100%: 42 areas
- 96.6% to 98.16%: 99 areas
- 92.52% to 96.59%: 107 areas
- 79.1% to 92.51%: 130 areas
- 0.72% to 79.09%: 35 areas

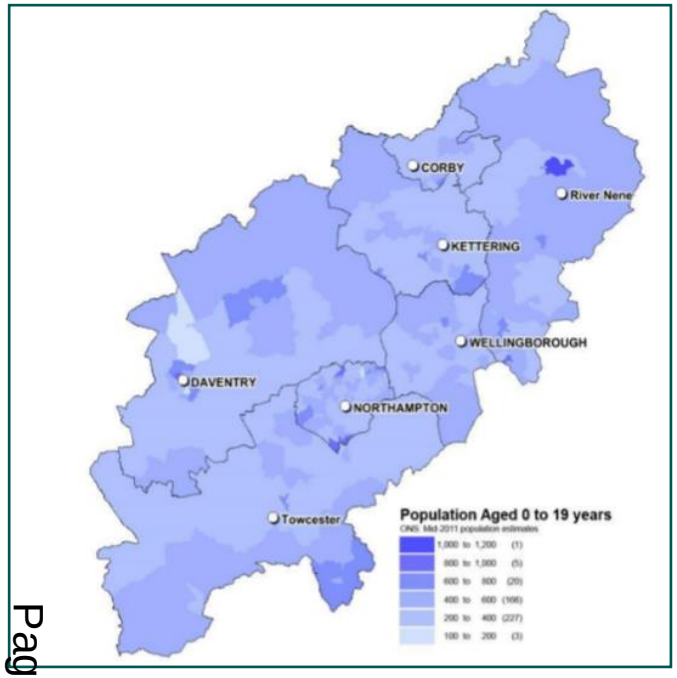
***Black, African, Caribbean and Black British***

- 3.82% to 64.96%: 98 areas
- 1.07% to 3.81%: 112 areas
- 0.41% to 1.06%: 87 areas
- 0.14% to 0.4%: 78 areas
- 0% to 0.13%: 38 areas

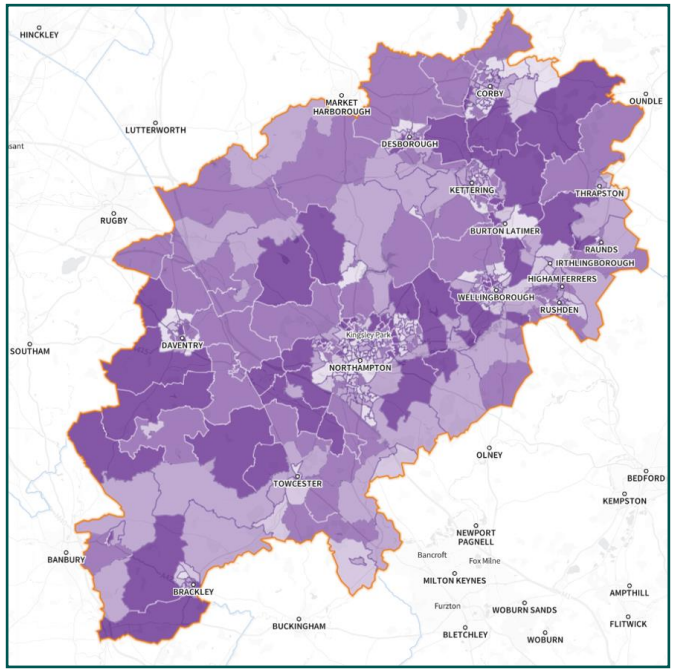
***Mixed Multiple Ethnic Groups***

- 3.35% to 14.92%: 74 areas
- 1.86% to 3.34%: 100 areas
- 1.17% to 1.85%: 112 areas
- 0.71% to 1.16%: 85 areas
- 0% to 0.7%: 42 areas

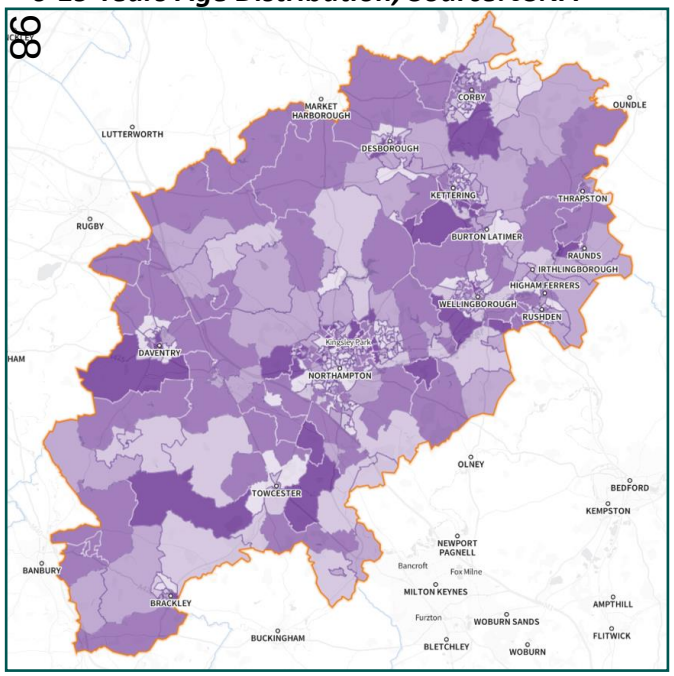
Northamptonshire Health and Care Partnership



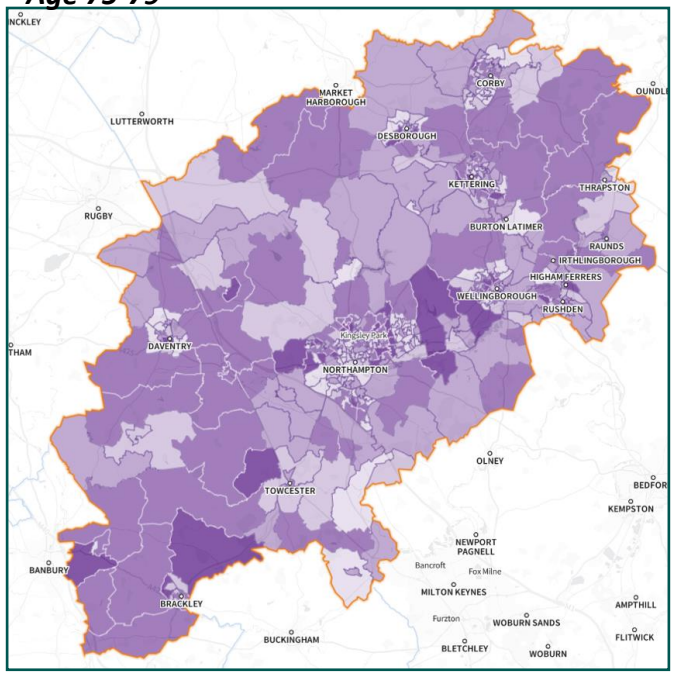

*0-19 Years Age Distribution, Source: JSNA*




*Age 75-79*




*Age 80-84*

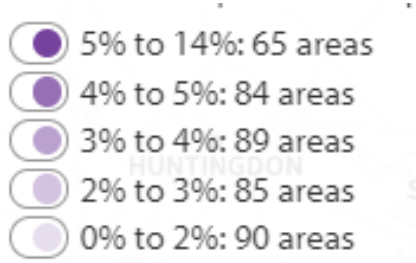



*Age 85-89*

*An overview of younger and older age distribution across Northamptonshire, demonstrates that urban areas tend to see a higher proportion of 0—19 year olds. In contrast, persons aged 75+ tend to be located in more rural areas.*

***Keys:***

***75-79:***




***80-84:***


***85-89:***


***Source: SHAPE Place Atlas***

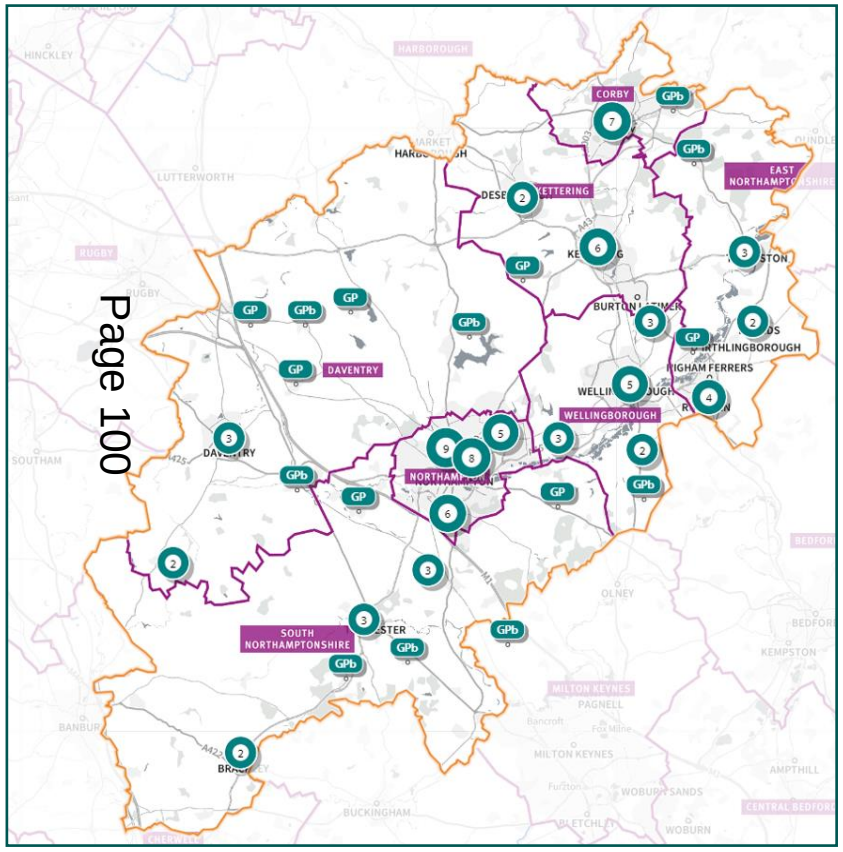
# Appendix B – Part 2

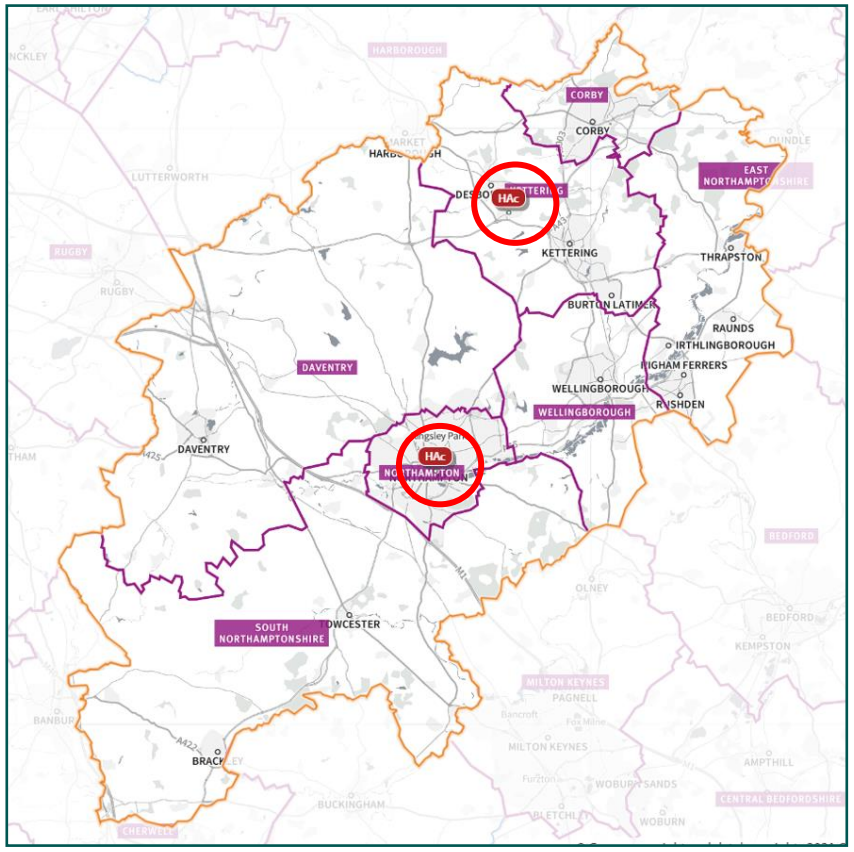
Evidence base: services, assets

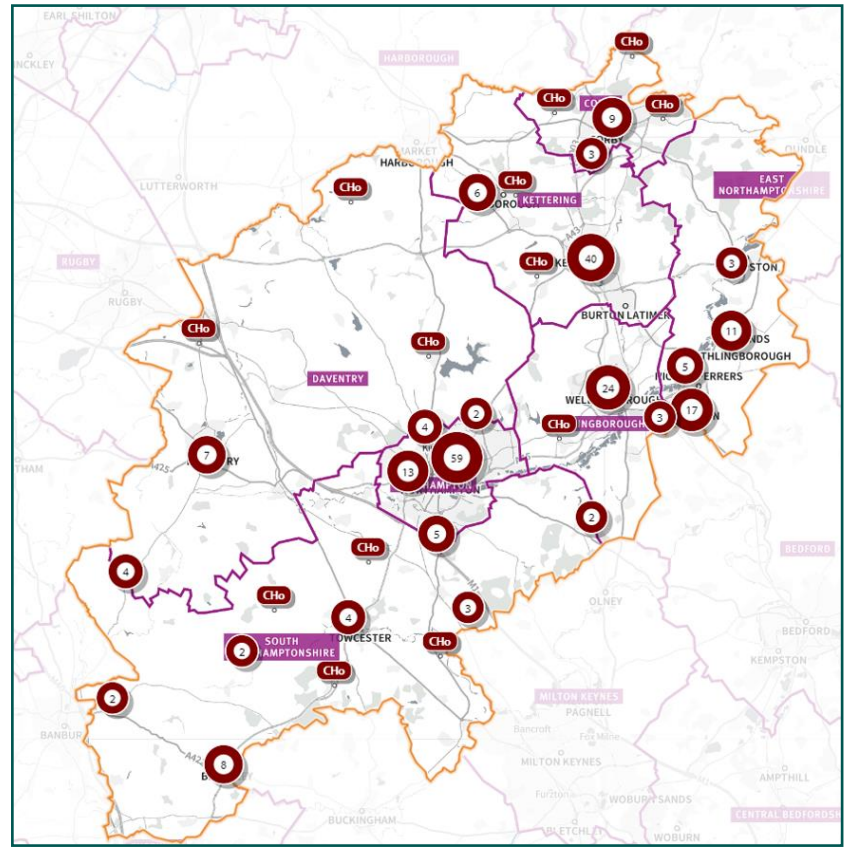
# NHS assets across primary care and acute, and care home distribution

Northamptonshire Health and Care Partnership

*Assets are distributed predominantly in the East and North urban areas and in Northampton; there is limited access to NHS assets and a sparser distribution of care homes in the West, more rural areas.*






***GP Practices and Branch Practices***

*There are 94 GP practices and branch practices across Northamptonshire. Nearly 80 GP Practices are each aligned to one of 16 Primary Care Networks.*

***Northampton General Hospital & Kettering General Hospital***

*Northamptonshire has two General Hospitals offering acute care, alongside other services: Northampton General Hospital in West Northants and Kettering General Hospital in North Northants.*

***Care Homes***

# Social care assets and high-level services

Northamptonshire Health and Care Partnership

## Northamptonshire-Wide

Children's Services – Commissioning & Children's Trust; Pharmacy Services

## Unitary Councils (North and West)

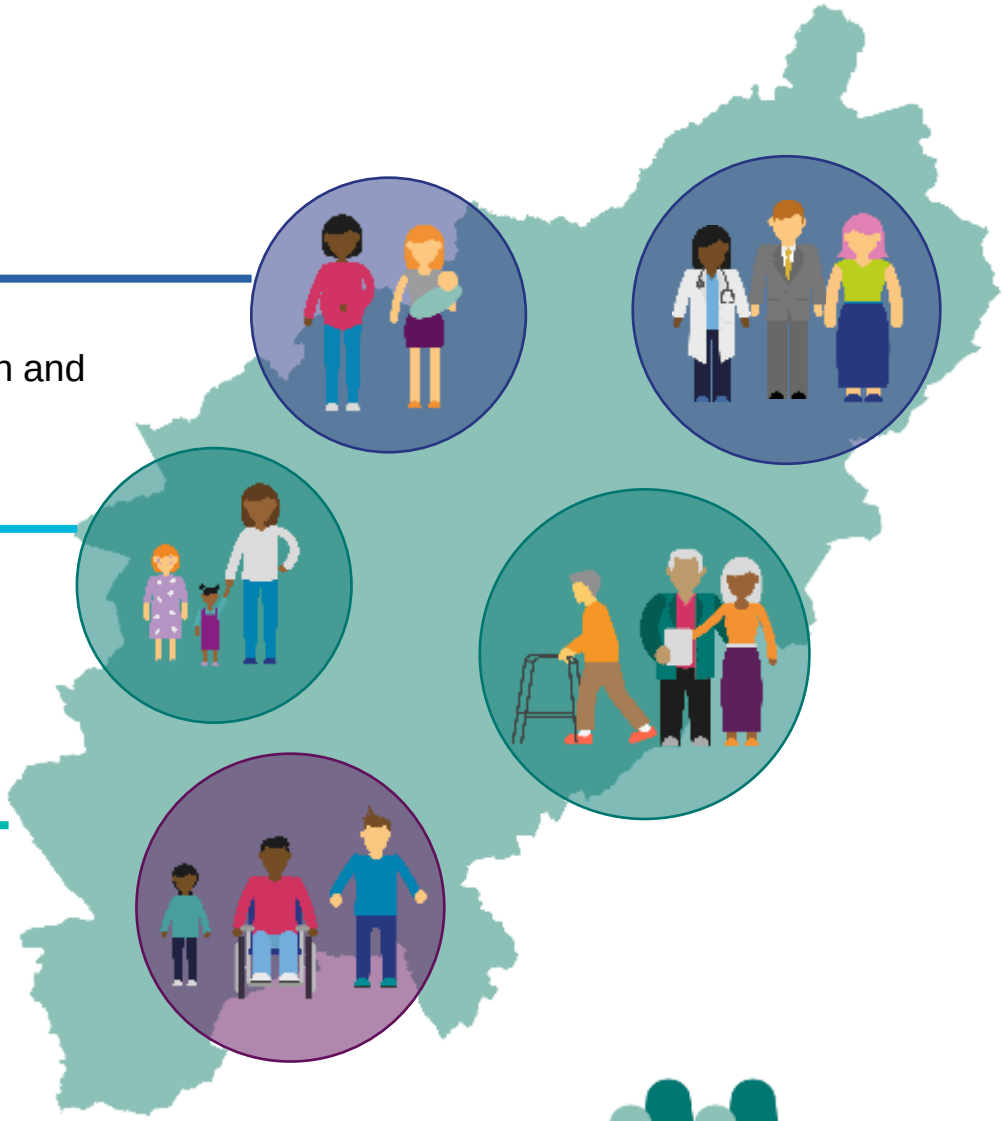
Adult Social Care Teams- 2 in the North and 2 in the West

## Community / Neighbourhood Model

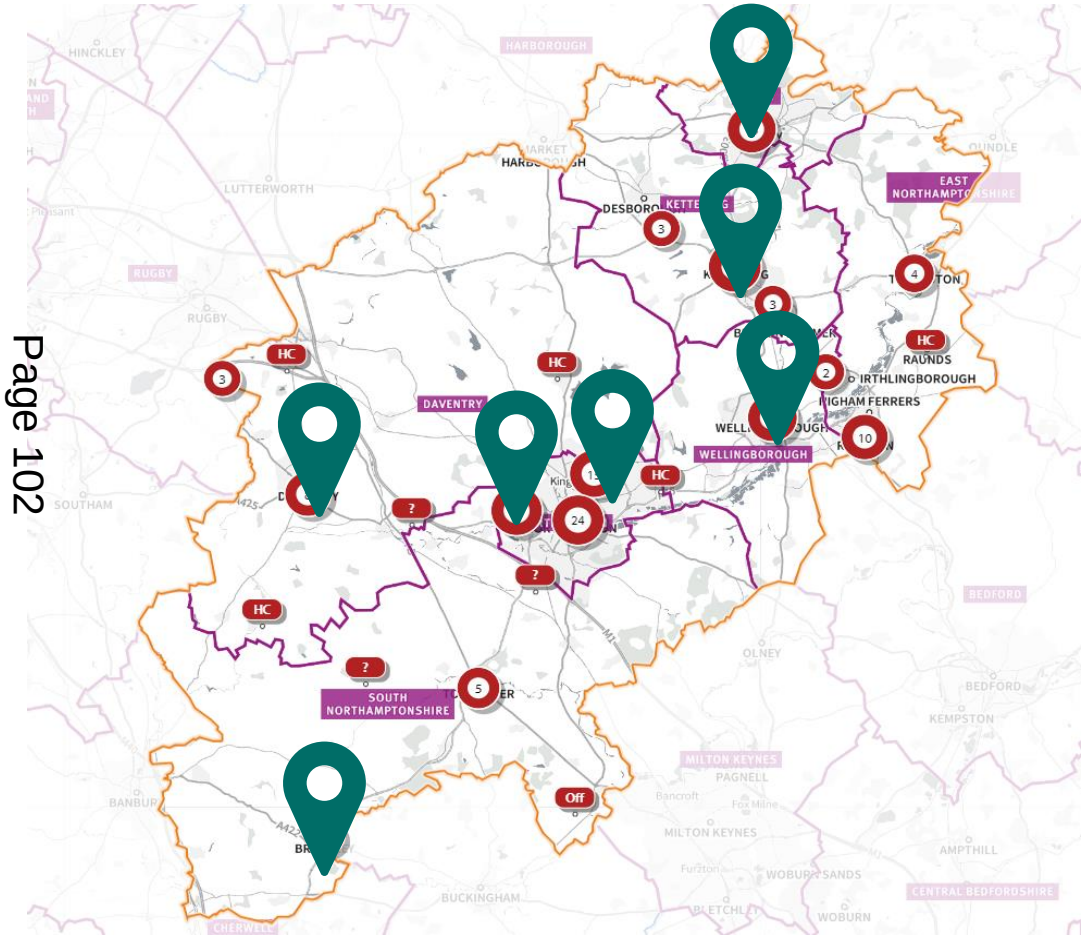
Community hubs, beds and health services, fire, police and ambulance and housing and DFGs; NHFT services e.g. Crisis Cafes, Age Well Teams (via PCNs), and 7 key delivery sites

## In the Home and Care Homes

Domiciliary care and Technology Enabled Care, Family Interventions, District Nursing, Health Visitors etc.



# Community and mental health service assets (NHFT)




***Source: SHAPE and NHFT Website***

NHFT has 7 main sites across Northamptonshire: Brackley Medical Centre and Community hospital, Berrywood Hospital, Campbell House and Newland House, Corby Community Hospital and Willowbrook Health Centre, Danetre Hospital, Isebrook Hospital and St Mary's Hospital.

These sites offer a variety of services, including mental health inpatient beds, psychiatric intensive care, dementia care, functional illness beds, a range of mental health team services, 0-19 services, disability hubs and hospice hubs. Some are also bases for community nursing and some e.g. Brackley, have integrated hubs with GPs.

In addition to this, NHFT provides services from a wide range of locations across the county, including ~170 physical locations, ranging from the above community hospital and healthcare facilities, to crisis cafes, clinics, respite homes and in-the-home services. Some services are also offered at acute sites such as Kettering General Hospital and Northampton General Hospital.

# Appendix C

Outputs from HWB September and November workshops

# North September HWBB discussions

Northamptonshire Health and Care Partnership

We need to involve the population through co-production

We need to ensure people feel represented on the HWBB

Communities need to be engaged in order to effectively deliver solutions

It's key to understand where one policy to deliver a service works across a geography and where different approaches are needed

Services can be shaped around communities and neighbourhoods by connecting with the natural leaders of the community

The most appropriate community depends on the outcomes we're trying to achieve

It's important to have a two-way flow of information, and create links between the HWB boards and forums

ICS design principles need to be reflected across the whole system

Some outputs of HWB Board & Forum workshops in September

# West September HWBB discussions

Northamptonshire Health and Care Partnership

We need to consider characteristics e.g. rural vs. urban areas

Considerations include already existing geographies, such as old council boundaries

Resource allocation may not be identical in every area

There can't be the same restrictions placed across all places- it must be dependent on the service being delivered/ problem being solved

We need to have a solid thread through to communities i.e. Champions for those areas

It's important to consider co-production of strategy

We need to clearly consider the role of the HWBB in the wider Integrated Care system

Overlapping responsibilities need to be clearly defined

Some outputs of HWB Board & Forums Workshop in September

# North November HWBB Workshop: Principles Discussion

Northamptonshire Health and Care Partnership

| Principle | Feedback from Workshop Discussion |
|---|---|
| **Efficiency** | • Increasing the tailoring of services to a local level is highly favourable as it allows for specific targeting of commonality of needs and particular outcomes.<br>• We need to take into account where services can be tailored and where they can be more universal, as well as the practicalities of managing services on a small scale.<br>• There is a need to consider the extent to which we can localise services, whilst taking into account what budgets allow and the ongoing ASC and GP profession issues. |
| **Equality** | • It's important to target demographics who have similar needs; allowing for targeted service delivery.<br>• Community and neighbourhood means different things to different people and we have to ensure we are taking into account local opinions in our construction of Place.<br>• Geographical locations are an important consideration: access to services is as important as where you draw delivery boundaries.<br>• Population sizes matter significantly from a commissioning and delivery point of view- particularly where funding is often based on per capita calculations. |
| **Equity** | • There should be a basic and core level of service for everyone; with specific services being targeted in specific populations.<br>• Living in a particular location should not preclude you from accessing a particular service.<br>• Engagement with communities is important, in order to understand their specific needs. |
| **Recognisability** | • Boundaries should be drawn on what works in terms of service delivery, not just what is recognisable to local people.<br>• The extent to which people access services based on whether they recognise their local area varies hugely; for some people they will only access services in their community whereas to others it matters less.<br>• The benefit of services being close to local people is that it allows them to take control of their own health outcomes and focusses on prevention-based healthcare. |
| **Governance** | • Higher levels of governance have the greatest capacity to consider and set strategy.<br>• It's important that lower levels of governance are able to feed upwards, but there is a need to consider the capacity that lower levels have to take on additional responsibility. |
| **Engagement and Involvement** | • Local forums should be used to the greatest extent possible for engagement.<br>• Engagement doesn't necessarily have to be through meetings, there are alternative channels that can be used to engage with local people.<br>• Co-production is important – we need to ensure that there is a mechanism for feedback. |

# North November HWBB Workshop: Feedback on Options

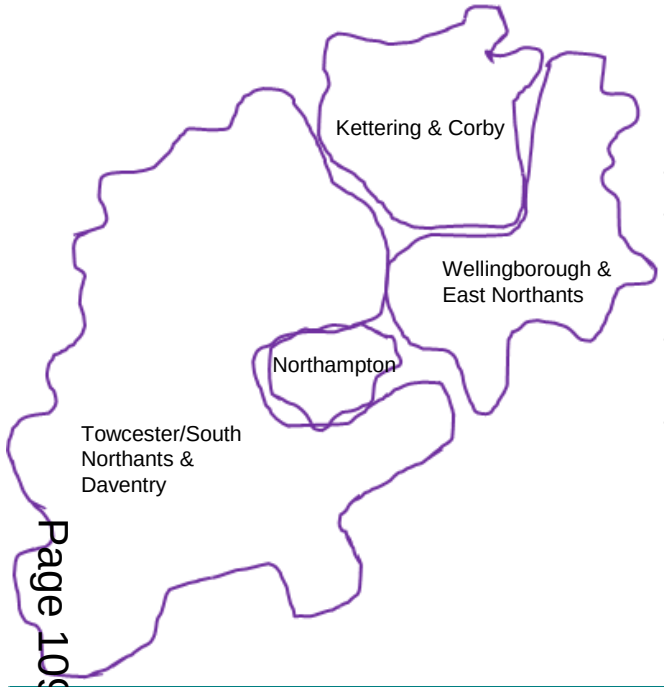
Northamptonshire Health and Care Partnership

| | Options | Pros | Cons | Other Feedback |
|---|---|---|---|---|
| 1 | **4 Localities** | • There would be no change for GPs in terms of delivering healthcare structures.<br>• Localities make sense from a commissioning and delivery point of view. | • There is the possibility that this would promote inequality across Kettering and Corby.<br>• Localities tend to group very different populations in the North. | • The broad structures of localities work in the North, however there are vastly different populations contained in them. Drilling down into these geographies and populations would better support place-based planning and delivery. |
| 2 | **7 former districts / boroughs** | • Very recognisable to local people.<br>• Includes towns and rural areas in each district, allowing for focus on commonalities of need. | • A big geographical unit – needs to work with a lower layer of structure to ensure local engagement. | • The geographies of these places make sense, but former districts will not be used in governance and planning. |
| 3 | **16 Primary Care Networks** | | | • There was agreement that this option should be excluded due to large, overlapping geographies which are not recognisable to local people. |
| 4 | **57 Electoral Wards** | • Wards allow for local levels of planning. | • Wards are very small units for delivery so would not be efficient or in any way provide economies of scale. | • The option should be considered; as it is recognisable and allows for low-levels of planning. However the units are too small individually to be practicable and wards would have to be combined or used to feed into some other structure. |
| 5 | **10 areas grouped by urbanity / rurality index** | • This would allow commissioners and service delivery to target commonality of needs; and force them to think differently about what different populations need. | • Splitting between urban and rural populations could create inequity.<br>• Rural areas are larger and less identifiable as communities. | • This structure may be more suitable for the West were there is more of a disparity of need between Northampton and the vast rural area. |
| 6 | **8-10 areas grouped by Multiple Deprivation Index** | | • This structure is not recognisable.<br>• This structure does not make sense as either a planning or commissioning unit.<br>• It duplicates with option 5. | • There was agreement to exclude this option from further review. |

# Appendix D

Detailed appraisal of shortlisted options for community and neighbourhood boundaries

# Shortlisted Option 1 – Four localities




**Summary**- This option is defined by the Local Medical Committee GP provision and four elected GP chairs

## Population

- *Northampton*- 225k
- *Towcester/ South Northants & Daventry*- 180k
- *Kettering and Corby*- 174k
- *Wellingborough & East Northants*- 175k

* ONS Mid 2019 estimate

## Geography

Four areas which are similar in population size but are geographically unequal in terms of physical size

## Recognisability

- Three of the areas are recognisable by local people because they are (combinations of) former districts
- Locality structures per se are not recognised by local people

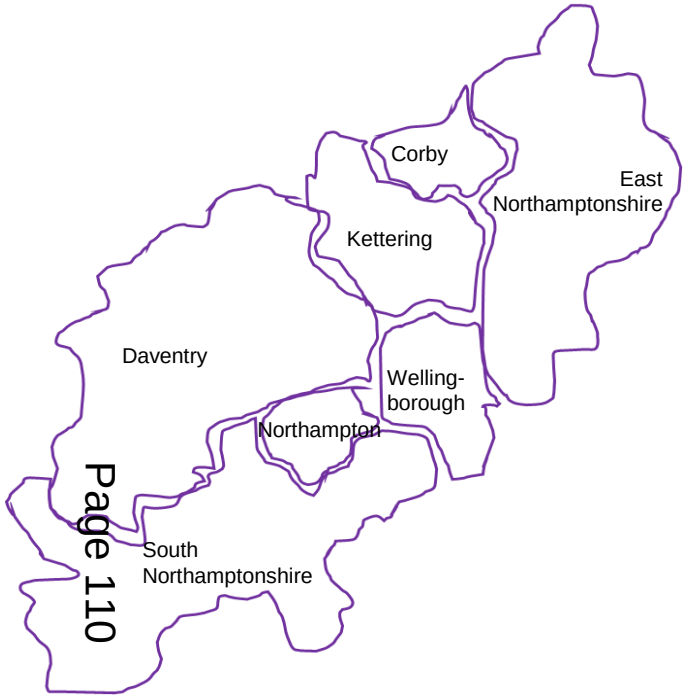
## Governance

- 4 GP chairs currently elected by GPs and represented on CCG Governing Body
- In plans for future ICB Board however, Localities are not formally represented
- LG current structures are not aligned

| PROS | CONS |
|---|---|
| • Locality boundaries align broadly with PCN boundaries meaning that there is a GP governance model in place and align to NHS primary care delivery<br>• In the West, the localities align, largely, with the urban rural divide- meaning that delivery along locality structure lines could focus on commonalities of need in those areas (which also align to a rural / urban correlation)<br>• There are already examples of integrated care in the West operating within locality boundaries- e.g. 'Healthy Young Daventry' is chaired by the locality lead | • South-West locality is geographically considerably larger than others and localities have large populations, so are not suitable as neighbourhoods<br>• Structure is not recognisable to local communities and Locality governance will not be part of the future ICB in line with current plans<br>• In the West, Towcester, South Northants and Daventry is a vast area that isn't suitable for a very local model due to varying demographics and geographies<br>• In the North, localities could promote further inequalities for Kettering and Corby (both areas of high need) as by placing them together, there is a risk of lack of sufficient focus on both high need areas |

*The above option appraisal has been undertaken by key stakeholders from within the Place workstream, and attendees of the Health and Wellbeing Board and Forum workshops*

# Shortlisted Option 2 – Seven Former Districts




**Summary**- This option is based on the former seven districts and boroughs before local government reorganisation into two unitary councils

## Population

- *Northampton*- 225k
- *South Northants*- 95k
- *Daventry*- 86k
- *Wellingborough*- 80k
- *Kettering*- 102k
- *Corby*- 72k
- *East Northants*- 94k

* ONS Mid 2019 estimate

## Geography

- Some areas may be too geographically large for local service delivery
- Good geographical links due to previous structures

## Recognisability

- Areas are recognisable by local people
- Neighbourhood services and community-hub-centres could easily dock into or co-locate with former district facilities

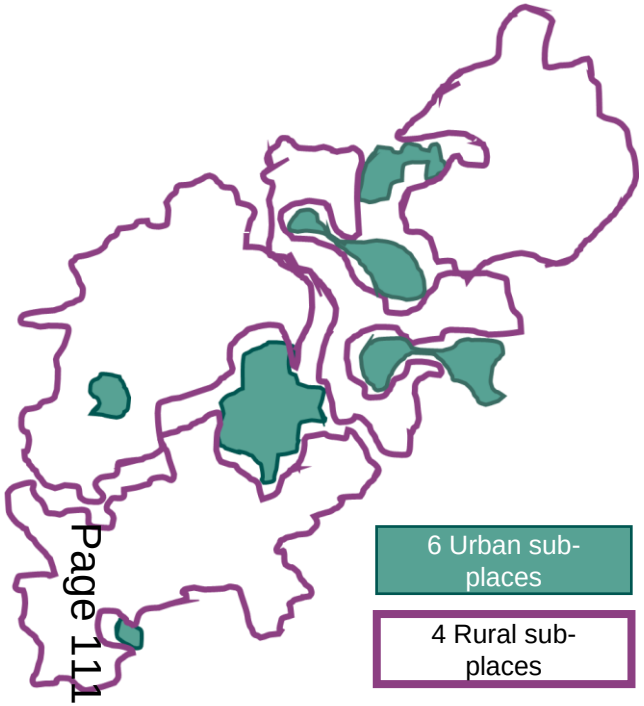
## Governance

- GP / primary care governance does not align
- Seven former Health & Wellbeing Forums already exist

| PROS | CONS |
|---|---|
| • These areas are recognisable to local people and have been used to draw the boundaries between services in the past<br>• Boundaries broadly align to the urban/rural divide so could be used to address commonality of need<br>• Each area is distinct, with its own demographics and own needs- e.g. in the North, Kettering and Corby are separate, so each areas' specific needs can be taken into account for planning and service delivery | • Across the county, structures have moved to two unitary councils; district boundaries are no longer relevant to commissioning or service delivery<br>• The former districts do not align with either social care service delivery or healthcare service delivery, leading to a requirement for more reorganisation at service delivery level |

*The above option appraisal has been undertaken by key stakeholders from within the Place workstream, and attendees of the Health and Wellbeing Board and Forum workshops*

# Shortlisted Option 3 – Six urban and four rural sub-places




**Summary**- This option is based on population density and need and has six urban (including towns) and four rural sub-places

## Population Classification

**West**
- *Urban*: Brackley, Daventry, Northampton
- *Rural:* South, West

**North**
- *Urban*: Wellingborough & Rushden, Kettering, Corby
- *Rural:* East, North

## Geography

- The four rural sub-places are geographically large
- Allow for different focus on needs for urban and rural populations

## Recognisability

- Not recognisable as service planning units, but are recognisable as places
- There would be several neighbourhood services in one area due to large areas

## Governance

- GP / primary care governance would not align
- LG governance below unitaries would not neatly align

| PROS | CONS |
|---|---|
| • Urbanity/rurality mostly coincides with other key indicators such as deprivation and multi ethnicities<br>• Encourages providers and commissioners to think differently for urban and rural areas<br>• Provision of services can be tailored by commonality of need e.g. community hubs in urban areas, outreach and transport in rural areas | • Division along urban and rural lines in both North and West could further ingrain inequalities as places would be divided along higher need and lower need areas, thus creating divisions in the community rather than promoting a sense of community cohesion<br>• The split between urban and rural areas does not take into account the nuances of population outcomes within communities; e.g. urban deprivation may be targeted, while large pockets of rural deprivation are overlooked<br>• In the North, urban communities do not fall naturally together; e.g. Wellingborough and Rushden don't see themselves as one community |

*The above option appraisal has been undertaken by key stakeholders from within the Place workstream, and attendees of the Health and Wellbeing Board and Forum workshops*

# Shortlisted Option 4 – 57 Local Electoral Wards


**Summary**- This option is based on Northamptonshire's 57 local electoral wards

## Population

Each ward has a population of circa. 4,000-10,000 (with some outliers and variation)

## Geography

- The 57 places are geographically small and low in population size

## Recognisability

- Ward boundaries are not easily recognisable for local people but offer a low-level, bottom-up route of engagement
- Wards are small to deliver differentiated services through

## Governance

- No formal governance exists
- Councillor responsibility alignment to wards
- GP / primary care governance would not align

| PROS | CONS |
|---|---|
| • High levels of engagement due to small population segmentation and providing strong commonalities of need<br>• Identifiable to council and social services across both North and West Northants<br>• Local informal governance groups are already in place and in some areas working as the link between local people, council and VCS<br>• Allows wider representation as there are clear champions for each area i.e. members | • Too small segmentation for effective service delivery and governance<br>• Electoral boundary review planned which may change ward structures<br>• Requires clear and considered thinking and planning as there are additional dividing lines - both demographic and identity based, and geographical |

*The above option appraisal has been undertaken by key stakeholders from within the Place workstream, and attendees of the Health and Wellbeing Board and Forum workshops*

# Appendix E

Place governance proposal

# ICB and ICP governance – NHS guidance on functions

Northamptonshire Health and Care Partnership

| Board | Governance Function | Membership overview |
|---|---|---|
| NHS Statutory Integrated Care Board (ICB) | • Develop a plan to meet the health and healthcare needs of the population<br>• Allocate resources<br>• Establish joint working arrangements with partners, embed collaboration<br>• Establish governance arrangements to support collective accountability for whole system delivery and performance<br>• Arrange for the provision of health services in line with allocated resources<br>• Lead system implementation of people priorities<br>• Lead system wide action on data and digital<br>• Use joined up data and digital capabilities<br>• Ensure NHS plays full part in achieving wider goals of social and economic development and environmental sustainability<br>• Drive joint work on estates, procurement, supply chain and commercial strategies<br>• Lead for Emergency Preparedness, Resilience and Response<br>• Deliver functions delegated by NHSE/I. | Membership is currently being determined |
| Integrated Care Partnership Board | • Develop an 'integrated care strategy' for the whole population, covering health and social care (both children's and adult's social care), and addressing health inequalities and wider determinants<br>• The strategy must set out how the needs assessed in the Joint Strategic Needs Assessment(s) for the ICB area are to be met by the exercise of NHS and local authority functions. Each ICP should champion inclusion and transparency and challenge all partners to demonstrate progress in reducing inequalities and improving outcomes. It should support place- and neighbourhood-level engagement, ensuring the system is connected to the needs of every community it covers. | Membership to be determined – all NHCP partners, including NHS bodies as part of the ICB and Local Authorities |

Source: Interim guidance on the functions and governance of the integrated care board, NHS England, August 2021

# Place Health and Wellbeing Boards – current arrangements and recommended changes

Northamptonshire Health and Care Partnership

| Status | Governance Function | Membership overview |
|---|---|---|
| Current functions and membership | • Develop a Health and Wellbeing Strategy<br>• Preparation of Joint Strategic Needs Assessment (JSNAs)<br>• Encourage the integration of health and social care services<br>• Encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services<br>• Oversee the publication of the Directors of Public Health Annual Report<br>• To endorse and oversee the successful implementation of Better Care Fund (BCF), Improved Better Care Fund (IBCF) and Disabled Facilities Grant (DFG) arrangements locally<br>• Review NHS Northamptonshire Clinical Commissioning Group and Unitary Council commissioning plans<br>• Advise the Care Quality Commission, NHS England, Trust Development Authority or NHS Improvement (as appropriate), where the Board has concerns about standards of service delivery or financial probity<br>• Publication of a Pharmaceutical Needs Assessment | Elected LA members<br>Local Authority Chief Executive<br>Director of Adults Services<br>Director of Children's Services<br>Director of Public Health<br>Representative of Healthwatch<br>Representative of CCG<br>Northamptonshire Police<br>Northamptonshire Healthcare Foundation Trust<br>Northampton General Hospital and Kettering General Hospital Group<br>Northamptonshire Local Medical Committee<br>NHS England<br>Voluntary and Community Sector<br>University of Northampton<br>Office of Police Fire Crime Commissioner<br>Northamptonshire Health and Care Partnership<br>Northamptonshire Fire and Rescue Service East Midlands Ambulance Service |
| ***Proposed changes to meet future requirements*** | ***Recommended changes to functions:***<br>• *Review ICB commissioning plans (replaces CCG commissioning plan due to new ICB organisation)*<br>• *Input to, and review ICS Strategy, providing HWBBs with an interface to the new ICP* | ***Recommended changes to membership:***<br>• *A representative from the Integrated Care Board (ICB) (replaces CCG)*<br>• *A representative from the Integrated Care Partnership Board*<br>• *A representative system clinical lead*<br>• *Appropriate representation to reflect wider determinants of health i.e. housing, employment, education and justice / probation* |

# Communities and neighbourhoods - current arrangements and recommended changes

Northamptonshire Health and Care Partnership

## Current governance arrangements – community / neighbourhood level

| Board | Governance Function | Membership overview |
|---|---|---|
| GP Locality Boards | CCG officers are elected by GP practices and represent their localities, meeting regularly and are present on the CCG Governing body. | LMC Locality GP members and Chairs |
| HWB Forums | Each former district has a HWB Forum. They are no longer formal, statutory arrangements but still meet regularly. | Elected councillors |
| PCNs | Independent consortia of GPs, each represented by a Clinical Director. Meet as an informal group at county level. | GP members |
| Parish and Town Council Forums | Regular formal meetings with responsibility for decision making for specific statutory responsibilities. | Elected councillors and voluntary sector |



## Recommended future governance arrangements – community / neighbourhood level

| Board | Governance Function | Membership overview |
|---|---|---|
| *ICS Community Locality Boards*<br><br>*(incorporates legacy GP Locality Boards HWBB Forums)* | *ICS Community Locality Boards brought together from existing governance at this level (HWBB forums and GP localities) with the purpose of:*<br>• *Joint planning of community / neighbourhood services, including new transformed pathways, aligned to 'Local Area Plans'*<br>• *Integrated oversight of local services across collaboratives / other providers*<br>• *No statutory responsibility for decision-making. Responsible for feeding back on strategy and commissioning to HWBB (including from lower neighbourhood level)* | *Selected locality GPs from GP Locality Board*<br>*Councillors from HWBB forums, including 'neighbourhood' councillor representatives*<br>*Community and MH provider*<br>*Collaborative providers*<br>*Social care representatives (children's and adults)*<br>*Voluntary sector representative*<br>*Chair should be a member of HWBB*<br>*Parish and Towns representative* |
| *ICS Neighbourhoods* | *It is not proposed that any new formal governance is put in place for neighbourhoods. Existing ward councillor structures, Parish and Town councils and other local voluntary sector forums have a responsibility to feedback to Community Locality Boards. This may be through appointed ward councillor neighbourhood representatives.* | |
| *PCNs* | *N/A No formal role in new ICS place structure. As per current role* | |
| *Parish and Town Council Forums* | *N/A No formal role in new ICS place structure. As current role, although with a responsibility to feed into new Community Locality Boards* | |