Northamptonshire
Health and Care Partnership

ICS Northamptonshire
Place and Sub-Place Proposal

December 9 2021

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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 are developing 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.

We developed our case for change for integrated care in Northamptonshire through our System Development Plan in December 2020. This described how our NHS and social care system is not currently able to meet the level and complexity of demand and need within our population. Collective responsibility in managing our available resources across the entire health and care system will provide the best way of addressing health inequalities and improving the health outcomes for the population of 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 **West**, 'community' recommendations are that **the two existing GP localities- Northampton, and South Northants and Daventry- should form the basis of the community structure.**

In the **North** it is recommended that that **there are four communities based around the former district boundaries - Kettering, Corby, Wellingborough, and East Northants.**

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 West as in the North. 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 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

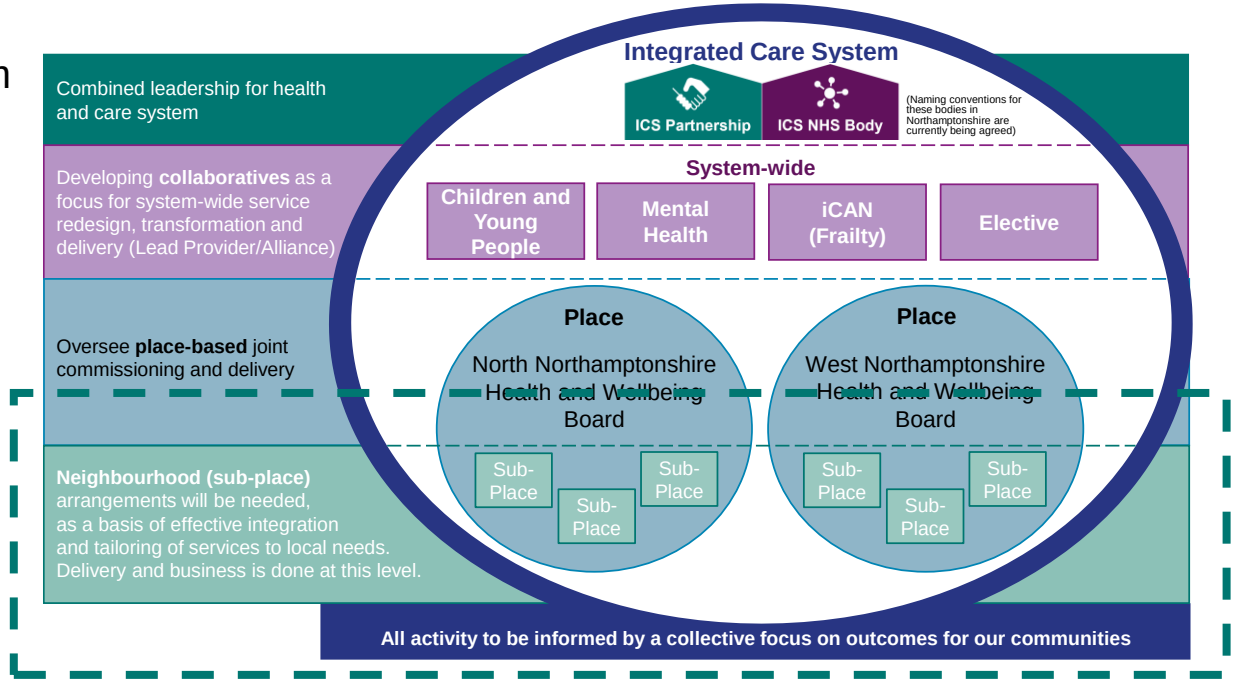
Where we are in the development of our ICS in Northamptonshire

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.

We developed our case for change for integrated care in Northamptonshire through our System Development Plan in December 2020. This described how our NHS and social care system is not currently able to meet the level and complexity of demand and need within our population. Collective responsibility in managing our available resources across the entire health and care system will provide the best way of addressing health inequalities and improving the health outcomes for the population of Northamptonshire.

We are in the process of defining our 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 that we have agreed need to improve. 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 also 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.

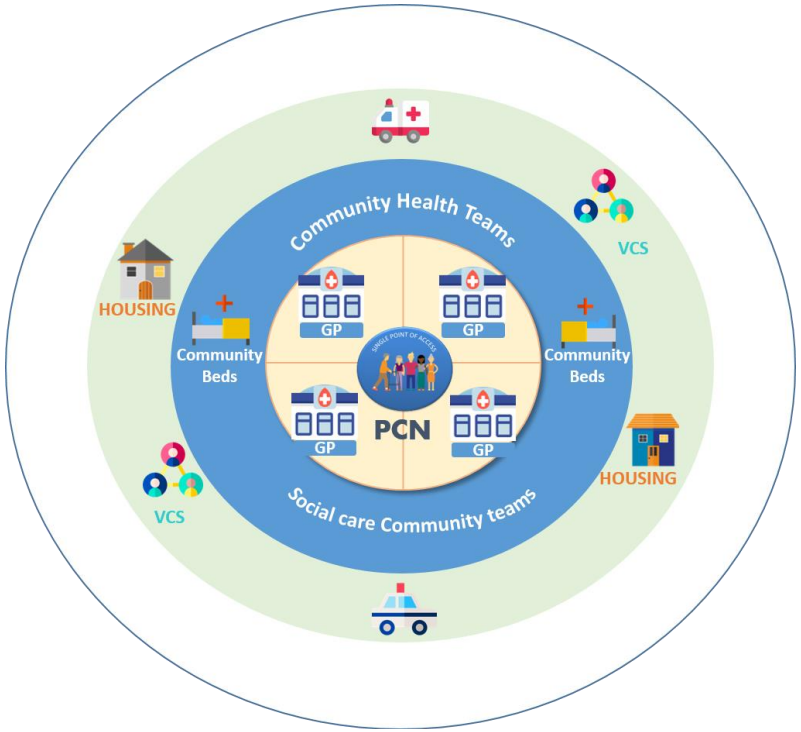
What ‘communities and neighbourhoods’ are and why we need them

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

Northamptonshire Health and Care Partnership

Phase 1 – Place Approach Definition

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

Phase 2 – Place Implementation and Delivery

Phase 1 of work has defined the principles, boundaries and governance for Place and its sub-places. Once this Phase 1 paper has been through the agreed governance routes, there will be a further phase 2 of work required to develop the details of governance arrangements, ensuring that recommendations are operational by April 2022 as well as putting in place wider steps to embed place at a local level. More details on the next steps for the implementation phase can be found in section 8 (next steps).

Approach and progress to date

Northamptonshire Health and Care Partnership

Complete

- Workstream Mobilisation and 1-1 Engagements
- Mapping Activities and Information Gathering
- Health and Wellbeing Board and Forum Workshops
- Recommendations and Findings

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.

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.

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'.

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

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

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

Subsequent sign-off through Sovereign Boards within relevant 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

Northamptonshire Health and Care Partnership

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.

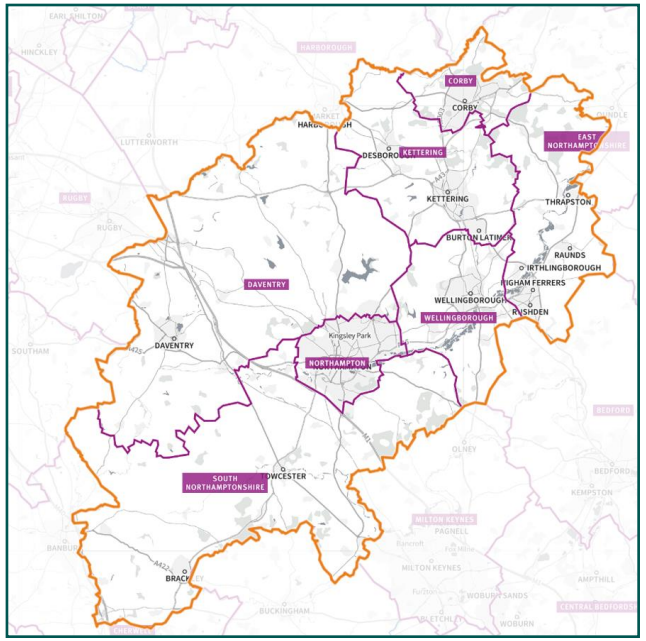
Summary Overview of Health and Care Services- Across Northants this has been outlined to show how services are delivered and delivery locations are spread across the county. Through ascertaining an overview of current service delivery, this helped to inform how services would be delivered in the future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

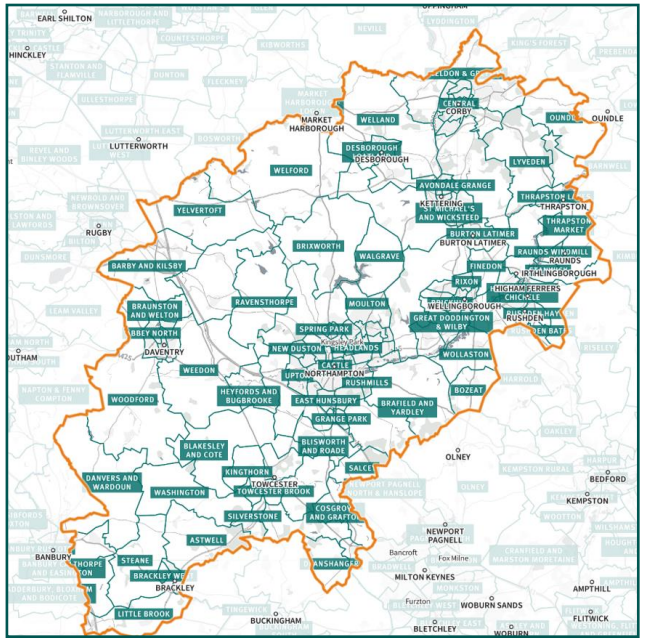
Current geographical boundaries across Northamptonshire

Northamptonshire Health and Care Partnership

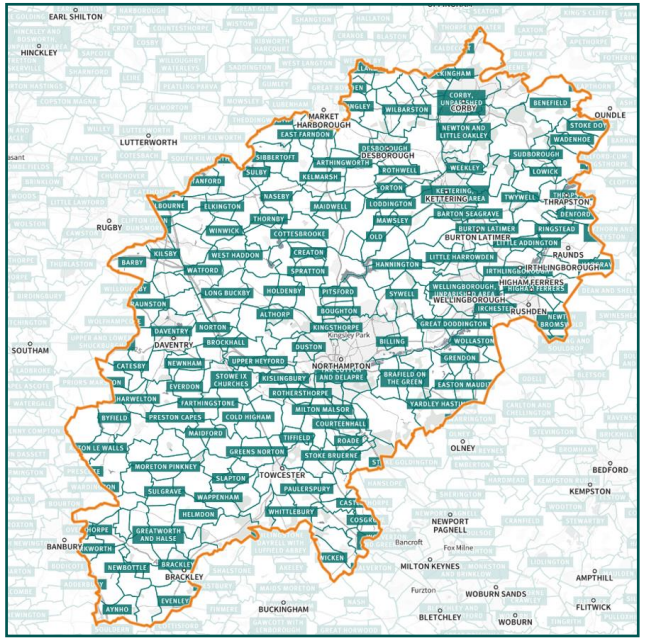
This slide shows current / former geographic and democratic boundaries, including former district councils, existing wards, existing NHS Primary Care Networks, Parishes and Towns and NHS GP localities.



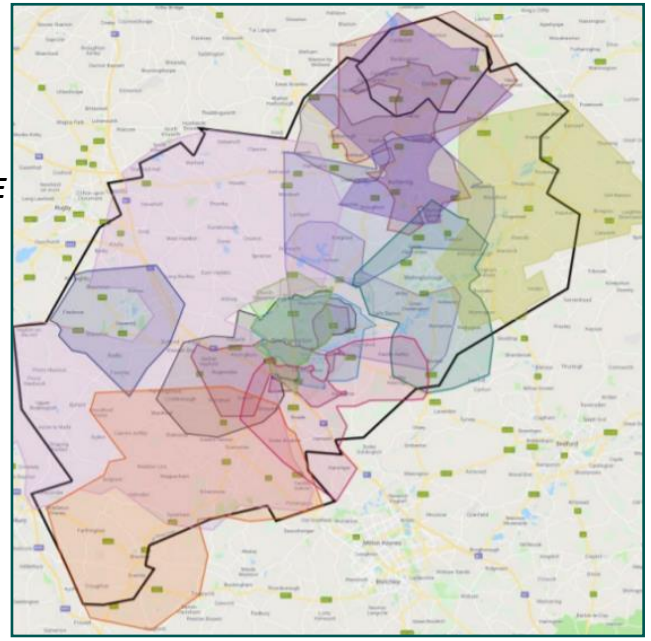
7 Former district Councils Source: SHAPE Place Atlas
Popn range between 72k-225k



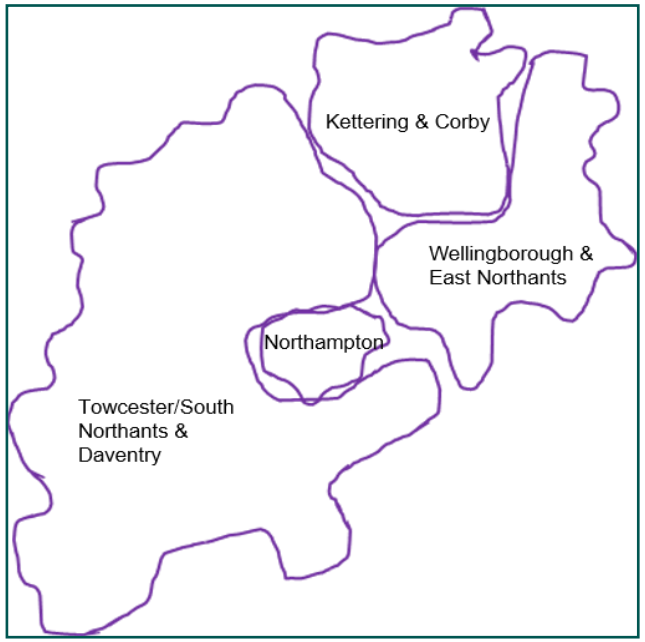
57 Ward Boundaries Source: SHAPE Place Atlas
Approx. popn 4-10k



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

Northamptonshire Health and Care Partnership

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

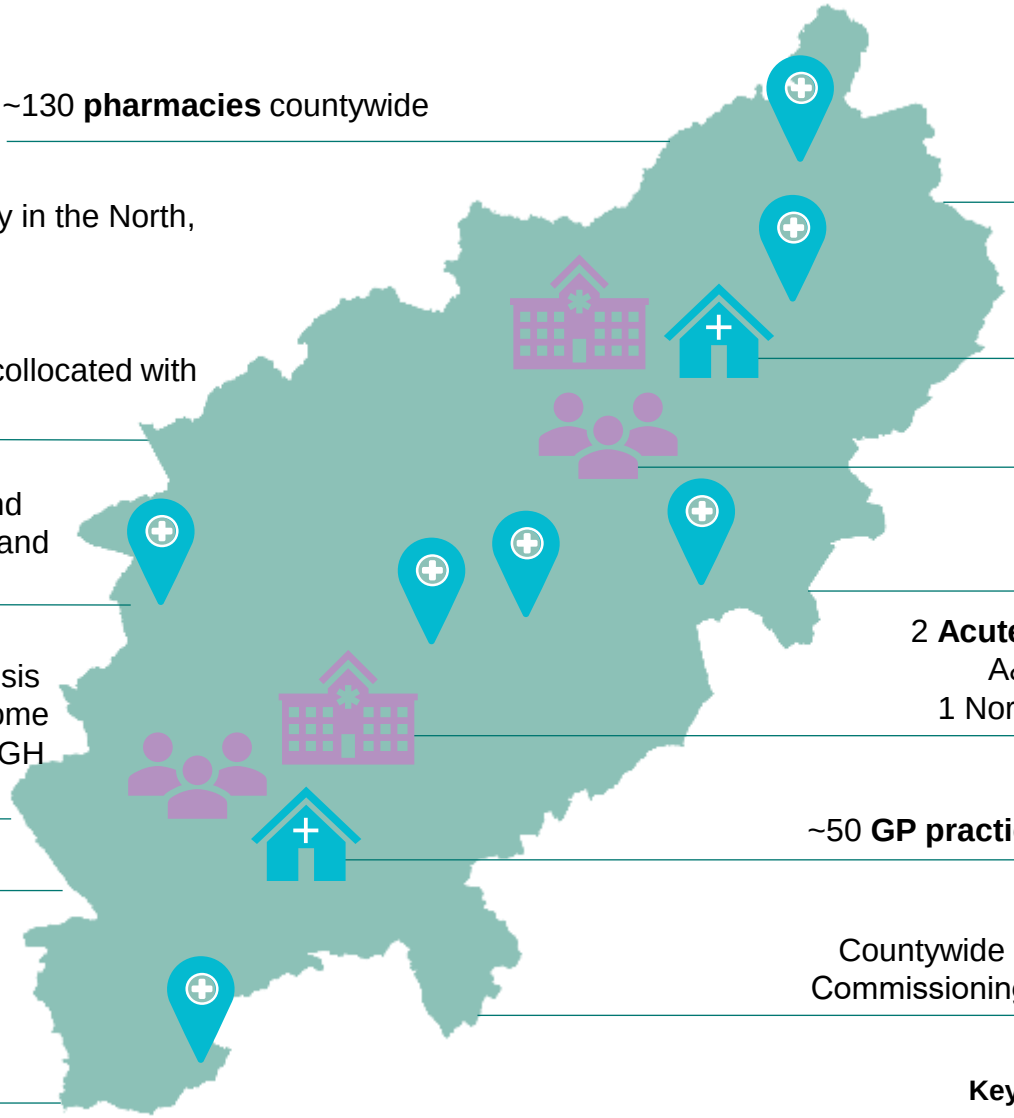
ASC Community Hubs
Wellingborough, Raunds, Kettering and Corby in the North,
Towcester, Daventry and two in Northampton
in the West
4 community adult social care teams in West
Community adult social care teams in North collocated with hubs – LD team and Inclusion team

7 **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.

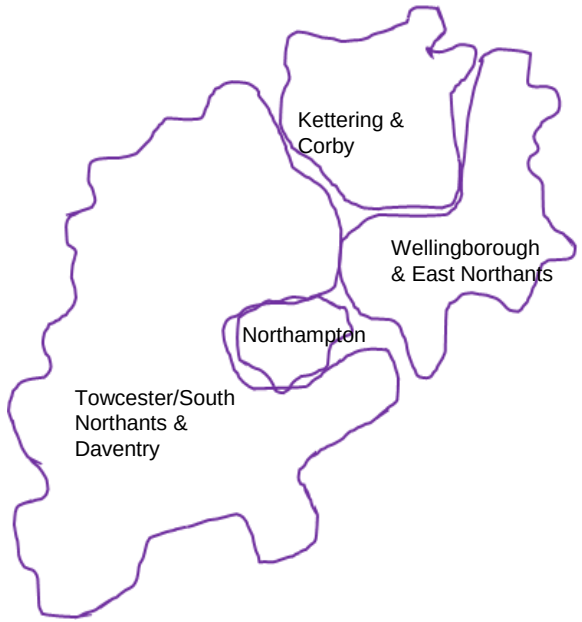
Long-list of community and neighbourhood options

Northamptonshire Health and Care Partnership

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

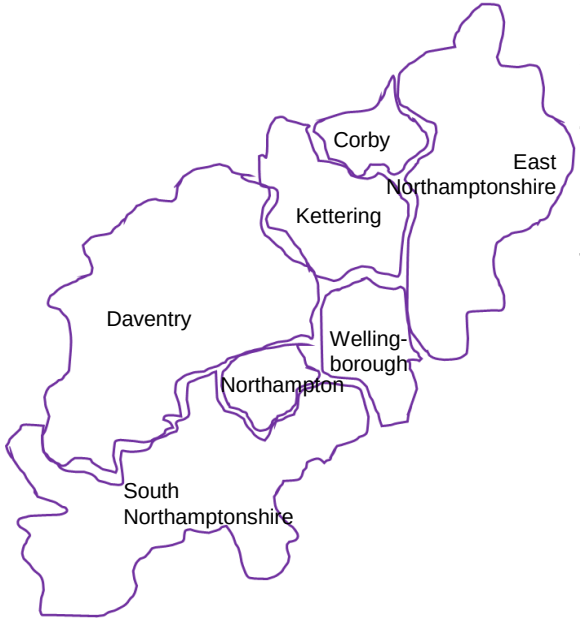


Shortlisted Option 1 – Four Localities

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

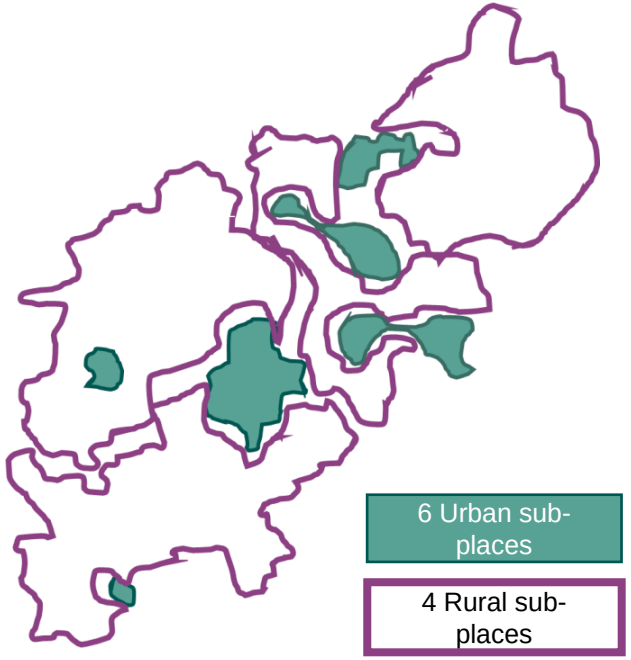


Shortlisted Option 2 – Seven Former Districts

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

	Option:	Option 1: Localities		Option 2: Former District Boundaries	
		North Output	West Output	North Output	West Output
Appraisal Against Agreed Principles	**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 recommended that 'communities' are a formal level of planning below 'place', with communities being constituted of 'neighbourhoods' at the lowest local level. It should be noted that these are naming definitions for the purposes of service planning. Each community and neighbourhood layer will include various groups of citizens with disparate needs – new service planning boundaries will support better identification and meeting of those needs. 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. 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). 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

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. 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 Clusters of wards, likely ~30-50k population clusters, reflecting particular needs	**Local service delivery, local engagement and voice**	• **Providers** (including collaboratives) across the system work together to deliver services at a local level, targeting specific needs through locally integrated teams and using shared neighbourhood assets. • **People** receive more integrated and targeted services, supporting them to remain well for longer. • **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 West: 2 Localities in Northampton and Towcester/ South Northants & Daventry North: 4 Localities in Kettering, Corby, Wellingborough, East Northants (former districts)	**Community/ neighbourhood commissioning, service design and delivery**	• **Health and care providers** (including collaboratives) 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. • **Commissioners** make resourcing decisions based on Outcomes Framework / JSNA, tailored to communities and neighbourhoods through 'Local Area Profiles'. • **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 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. • **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

Northamptonshire Health and Care Partnership

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

Health centre

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

Specialist hospital

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.

The Mental Health collaborative will deliver a variety of different services across this pathway

Case study example: frail and elderly

Northamptonshire Health and Care Partnership

Maggie is an 82-year old woman who lives alone in rural South Northamptonshire. She has family who regularly keep in touch but live abroad and are concerned for her health and general wellbeing. Maggie has osteoarthritis and has suffered from minor falls at home and in the community, but these have not resulted in significant injuries so far. In the past Maggie has experienced loneliness and social isolation, but she now attends a regular lunch club in her neighbourhood and has made new friends in her area.

Home

Maggie is happy and comfortable living at home and wants to continue to do so. She has a carer come in to visit twice a week to assist her with tasks around the house and review her health and care needs on a regular basis.

Maggie's carer referred her to West Northamptonshire's Assistive Technology service, who have fitted her with a falls detector. This is monitored by a 24 hour responder centre who are able to assist Maggie if she needs it.

Neighbourhood

Maggie relies on public transport, mainly buses, to allow her to access what she needs in her local neighbourhood, including the shops, village halls and health centres. Accessible transport therefore allows her to continue living independently.

Maggie uses public transport to attend local lunch clubs which improve her mental health by alleviating her social isolation and loneliness and she has made many new friends nearby. She also goes to Falls Preventions classes run by Age UK once a week in her village hall. These classes improve her balance, increase her confidence, and allow her to better manage her long-term condition.

Community

To manage her osteoarthritis, Maggie has regular check-ups at her GP. Her GP has recently let her know about the new 'Age Well' teams run by NHFT that are operating across several GP surgeries in her community. These teams are supported by specialist Frailty GPs, Advanced Nurse Practitioners and Pharmacists to ensure Maggie is getting all the care she needs.

Maggie's community Age Well team have just arranged for Maggie to have a 45-minute review appointment to ensure a detailed assessment of her needs and, if required, create a new care plan for her.

Place

Maggie knows that, in the future, her condition may require her to have a hospital stay and could even mean that she needs a full hip replacement.

Maggie and her family know that the hospital in Northampton has the services to support these medical needs. Additionally there is a hospital discharge team who work with housing and social care teams to create integrated health, social care and voluntary care sector packages to ensure that Maggie will be able to keep living well and independently.

The ICAN collaborative will deliver a variety of different services across this pathway

7. Communities and Neighbourhoods Governance Proposal

Proposal for how places, communities and neighbourhoods governance will work

Overview of ICS governance

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 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)
   - May encompass 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 (1)

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 West:
    - Development of two localities in Northampton and Towcester, South Northants & Daventry.
    - Progress with plans to design neighbourhoods through clusters of wards at a ~30-50k population size
2. Governance proposal West: Endorse governance recommendations to
    - Widen HWBB remit and membership
    - Establishment of Community 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 – 2nd December (complete) West – 9th December
Wider System governance	Review and endorse recommendations	LMC – 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 relevant NHCP organisations	For sign-off and approval	By March 2022

Next steps: Phase 2 immediate practical next steps

Northamptonshire Health and Care Partnership

This slide describes immediate next steps to implement the recommendations in this paper. The following slide describes the ongoing transformation which will be required to implement and embed a genuinely transformed place approach.

Level	Next Step	Timeline
Overall System Governance	Identification of Place alignment with overall ICS Partnership and Collaborative governance.	*December 2021*
Communication and Engagement	Wider public and organisational engagement and communications required to inform, engage and co-produce more detailed plans for communities and neighbourhoods.	*March to July 2022*
Place	Identify the individuals required to broaden the remit or membership of the Health and Wellbeing Boards.	*-January 2022*
	Amend HWB Boards ToRs.	*Early 2022*
	Bring together HWB Boards with new membership and remit, including clinical and wider determinants of health representation within the new engagement and governance structures.	*Prior to April 2022*
	Identifying how data and insight will be developed to target needs and outcomes at various levels of place.	*Prior to April 2022*
	Confirmation of impact on existing system governance structures and role of these members in new governance e.g. Locality Boards, HWBB Forums and PCNs.	*Prior to April 2022*
Community	Agree outline membership for Community Wellbeing Forums, and identify individuals to fill roles.	*-January 2022*
	Produce ToR for community locality boards, defining their precise remit, responsibilities, and feedback into the HWB Boards.	*Early 2022*
	Meeting of the community locality boards in shadow form.	*Prior to April 2022*
Neighbourhood	Undertake exercise to draw the boundaries and agree clusters of wards, according to commonality of need, that will constitute neighbourhoods.	*Early 2022*
	Identify the engagement forums to ensure feedback into the system from neighbourhood level.	*Prior to April 2022*

Next steps: Phase 2 wider Place transformation required

There will be wider ongoing transformation work to be undertaken to ensure that all levels of Place will thrive within the future Integrated Care System. The below roadmap outlines the high-level activities as part of this wider transformational work – to be defined in more detail in the next phase.

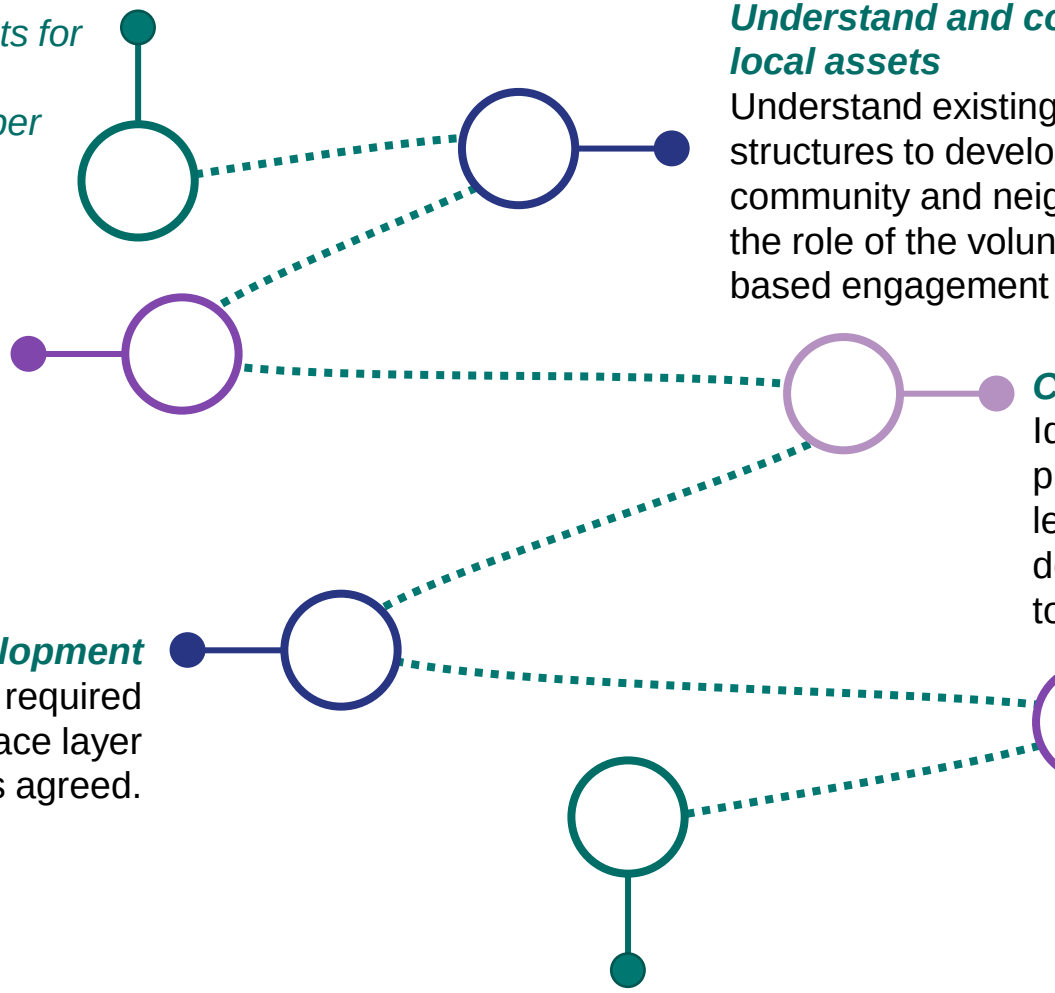
Agreement of principles, geographical boundaries and governance arrangements for Place, community and neighbourhood. Implementation of governance plans as per previous slide.

System Governance, Commissioning and Finance plans for Place

Developing more detailed plans for place within overall system governance, the overall ICS commissioning strategy and ICS financial strategy to support place-based service delivery at the right levels of the system.

Organisational Development

Identifying the functions and capabilities required at each level, to ensure that the each place layer delivers on the outcomes agreed.



Understand and co-produce approach with local assets

Understand existing community assets and structures to develop a place-based model at community and neighbourhood level. Includes the role of the voluntary sector within place-based engagement and delivery.

Collaborative and Provider model

Identifying how collaboratives and providers will work together at a place level; ensuring that the resources, and defined working practices are in place to deliver on the agreed outcomes.

Local Engagement Approach

Develop the approach to engage and act on feedback from residents and patients through a place-based model.

By April 2023: *Place, community and neighbourhood fully functioning as levels within a thriving ICS.*

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

Northamptonshire Health and Care Partnership

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

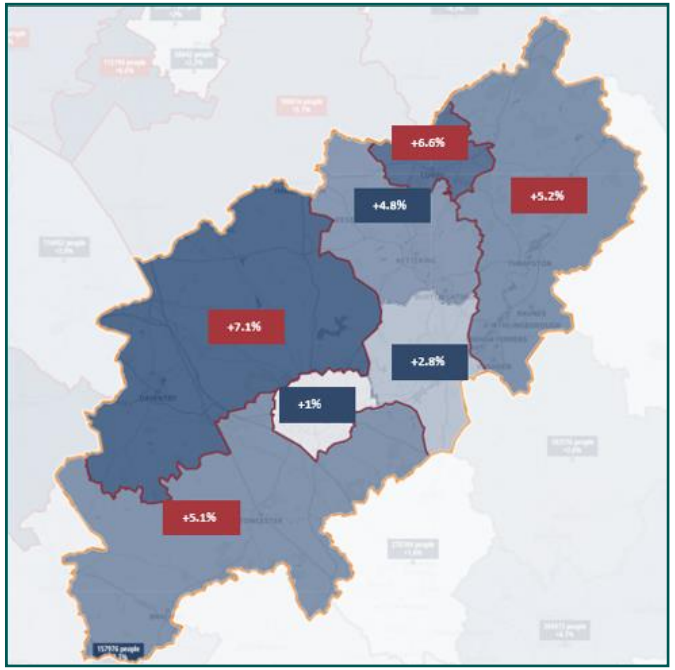
Stakeholder	Organisation/ Role
Samantha Fitzgerald	Assistant Director of Adult Social Services, North Northants
Dr Raf Poggi	PCN Clinical Director
Shaun Sannerude	Community Development Officer, North Northants
Hazel Webb	Kettering HWB Forum and North Northants Council
David Maher	Deputy Chief Executive, 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

Northamptonshire Health and Care Partnership

Appendix B – Part 1

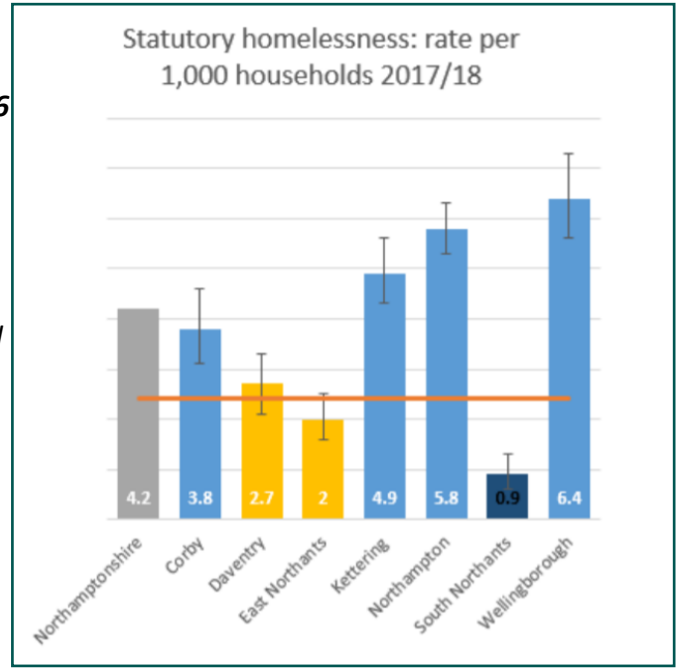
Evidence base: demographic mapping

Population Outcomes

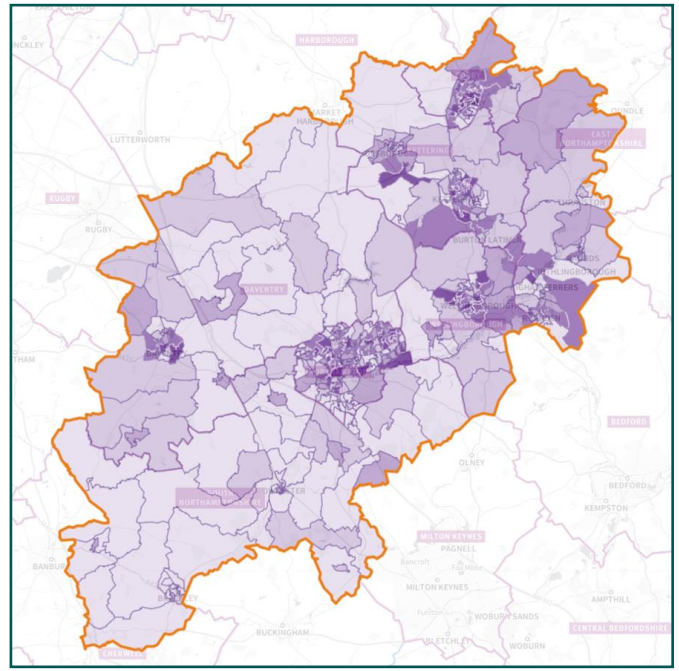


Source: SHAPE Place Atlas

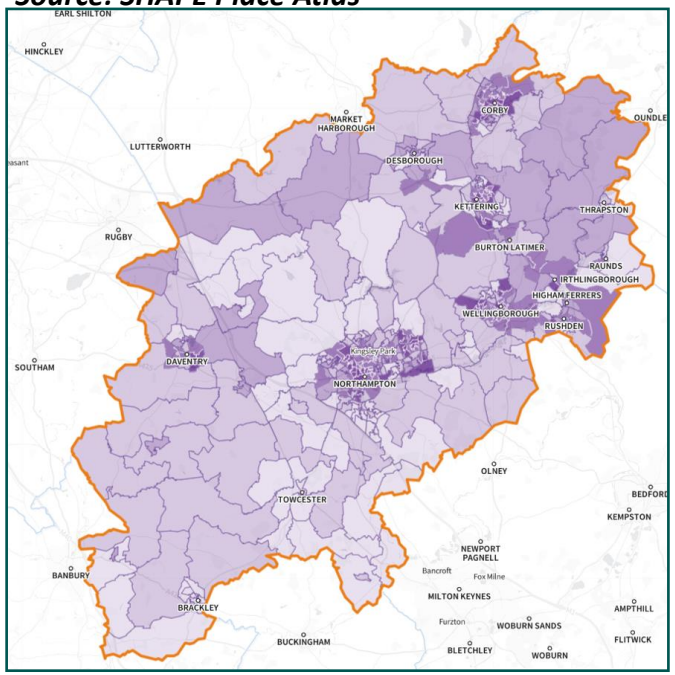
Predicted Population Growth by 2026 Against 2021 Baseline- Dark Blue= Higher Growth
Demonstrates higher expected growth in Daventry and Corby, followed by South and East Northants



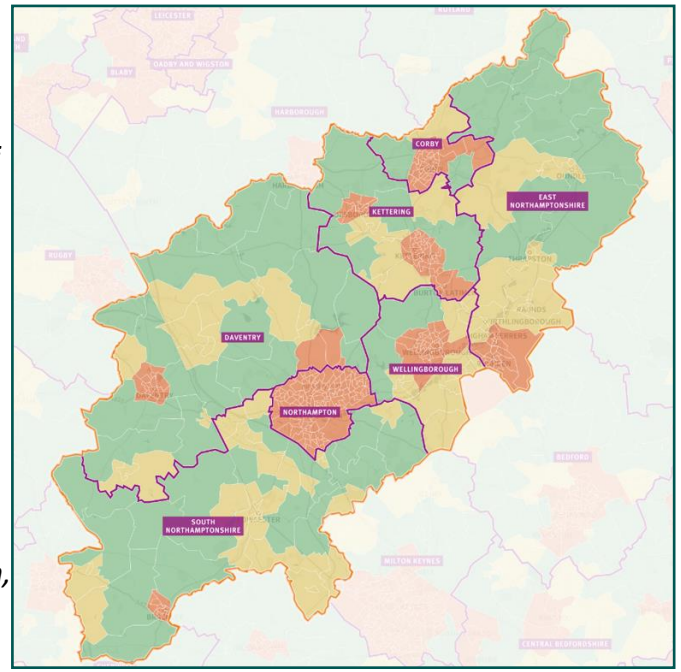
Statutory Homelessness Broken Down by District- Orange Line= England Average
Statutory homelessness is more prevalent in Wellingborough, Northampton, Kettering and Corby
Source: PHN JSNA Insight Pack, 2019



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

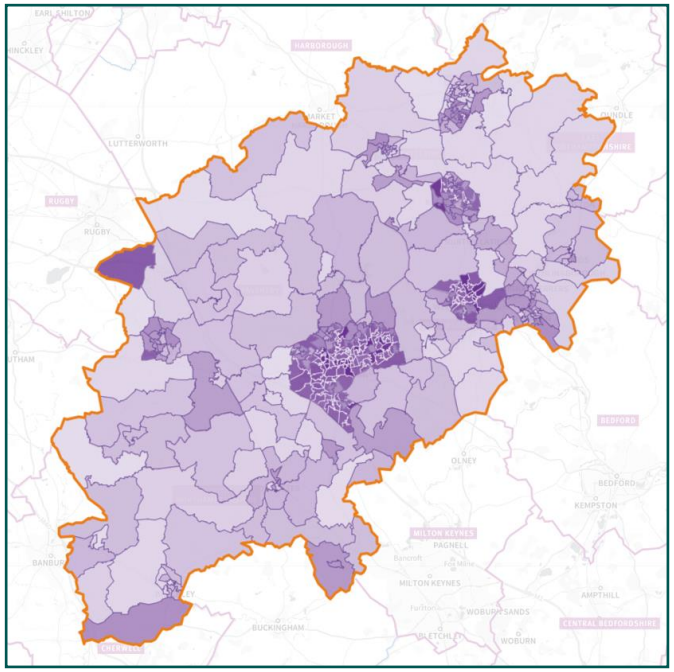


Index of multiple deprivation (internal) Deeper purple= greater deprivation
Higher deprivation is associated with more urban areas, and is higher in the North areas of East Northants, Wellingborough, Corby and Kettering

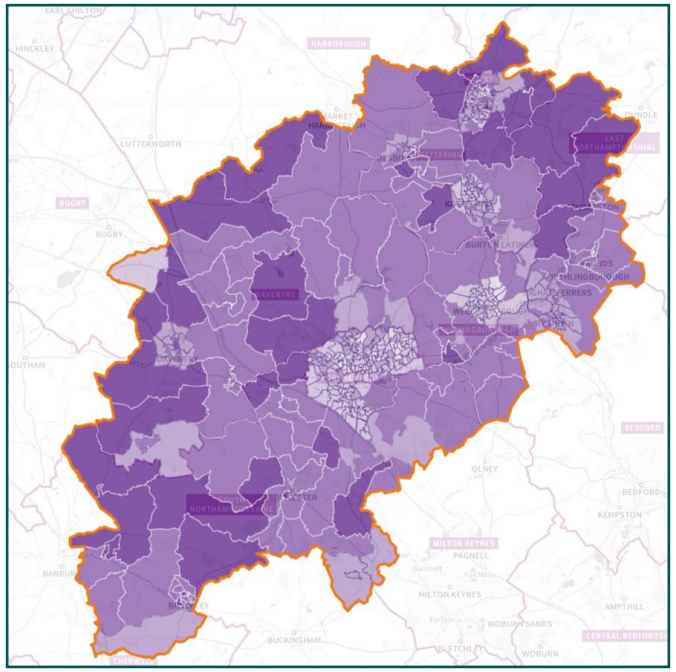


Level of rurality- Green= Rural and dispersed/ Orange= Urban city and town
Northampton, Wellingborough, Corby and Kettering are more urban, with the more rural areas in South Northants and Daventry
Source: SHAPE Place Atlas

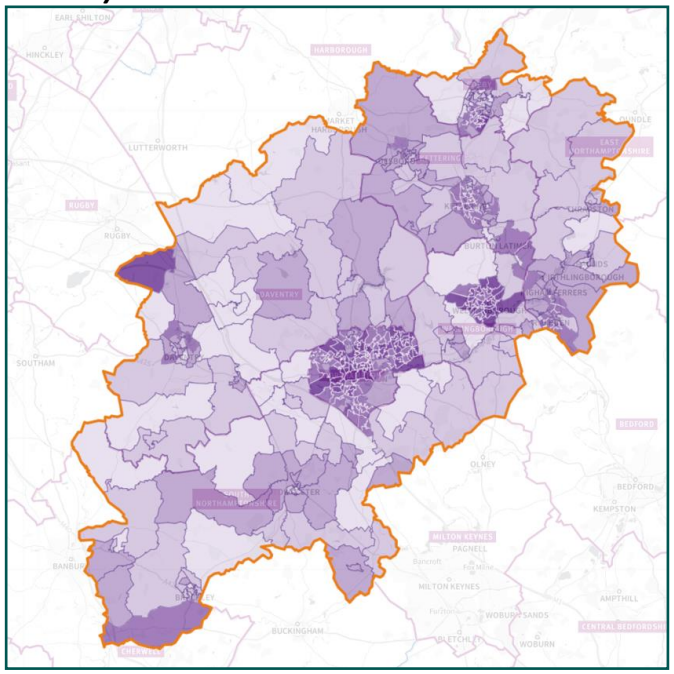
Internal Ethnicity Distribution



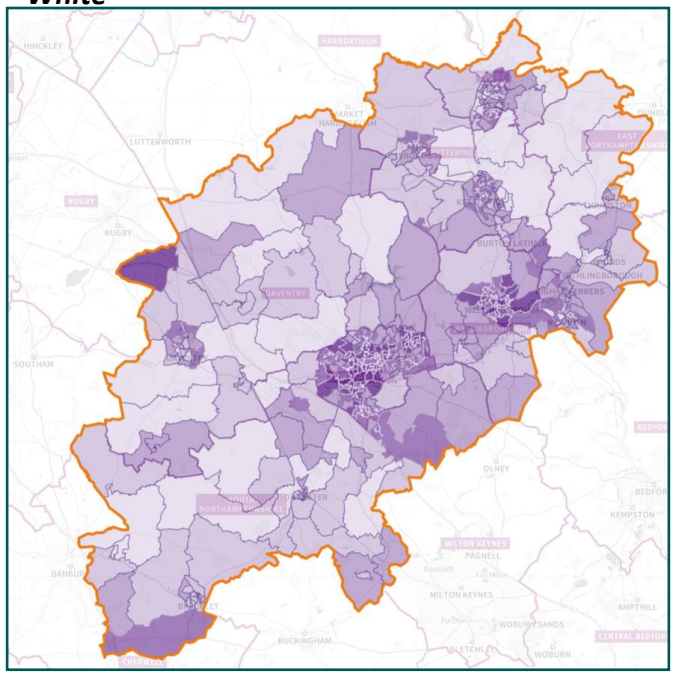
Asian/ Asian British



White



Black, African, Caribbean and Black British



Mixed Multiple Ethnic Groups

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

- 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

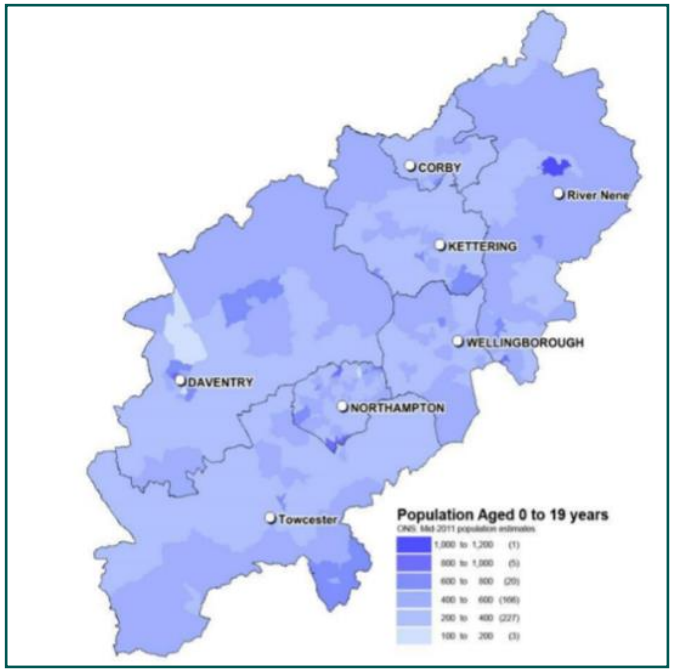
Black, African, Caribbean and Black British

- 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

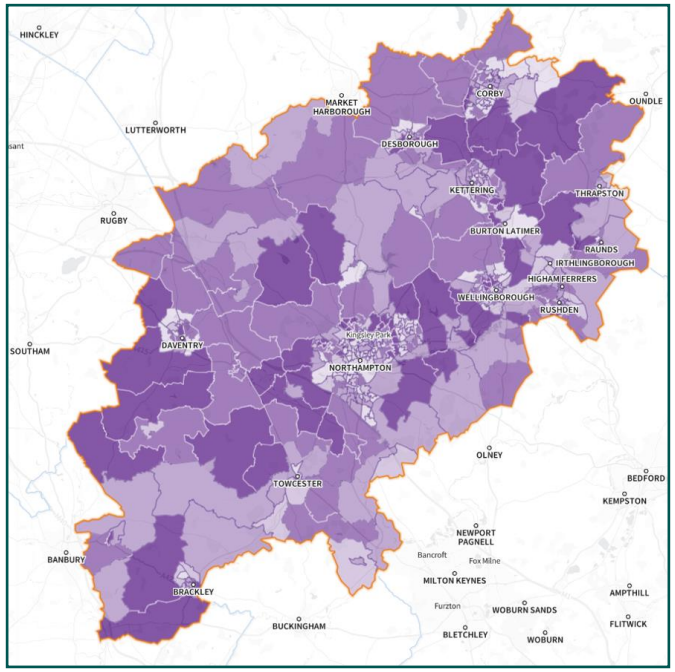
Mixed Multiple Ethnic Groups

- 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

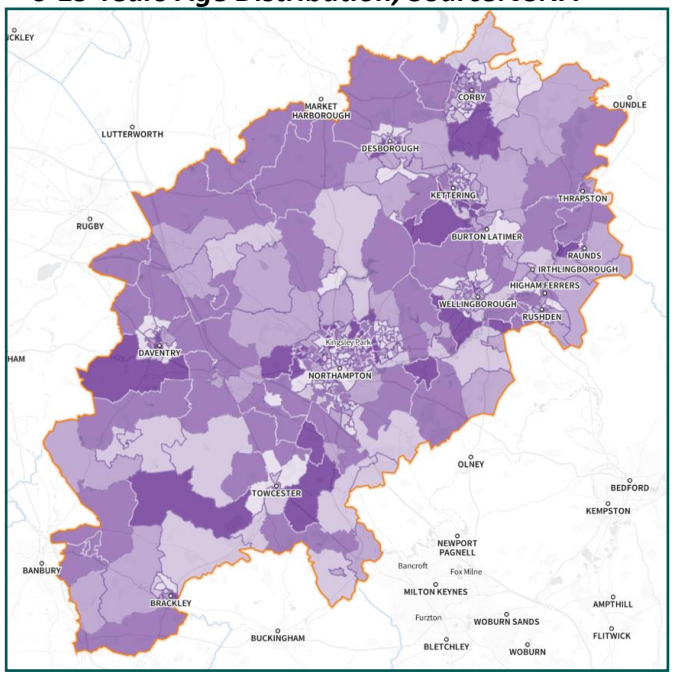
Age Distribution



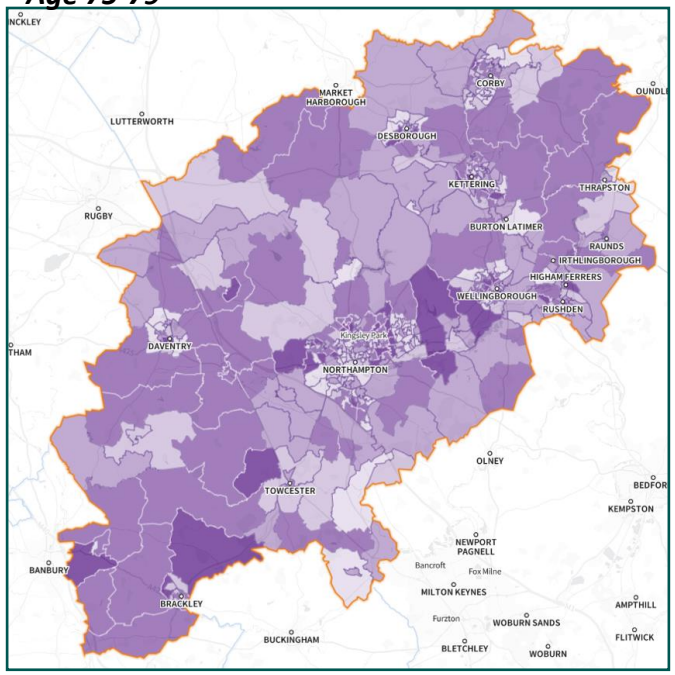
0-19 Years Age Distribution, Source: JSNA



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:

- 5% to 14%: 65 areas
- 4% to 5%: 84 areas
- 3% to 4%: 89 areas
- 2% to 3%: 85 areas
- 0% to 2%: 90 areas

80-84:

- 4% to 15%: 48 areas
- 3% to 4%: 84 areas
- 2% to 3%: 87 areas
- 1% to 2%: 92 areas
- 0% to 1%: 102 areas

85-89:

- 2% to 10%: 47 areas
- 2% to 2%: 84 areas
- 1% to 2%: 99 areas
- 1% to 1%: 85 areas
- 0% to 1%: 98 areas

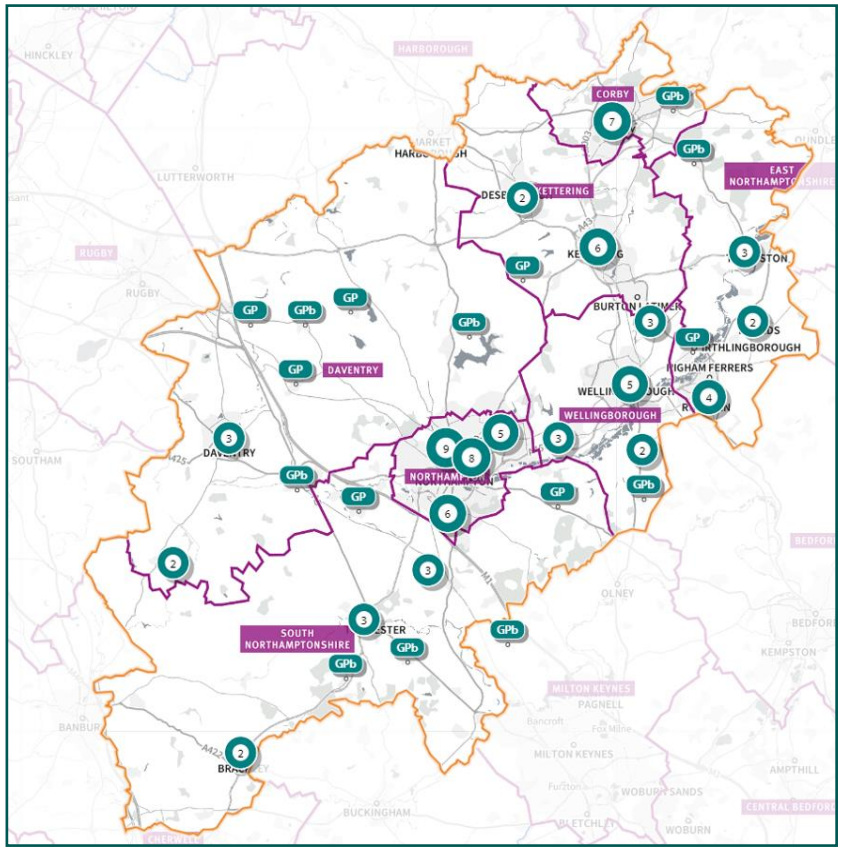
Source: SHAPE Place Atlas

Appendix B – Part 2

Evidence base: services, assets

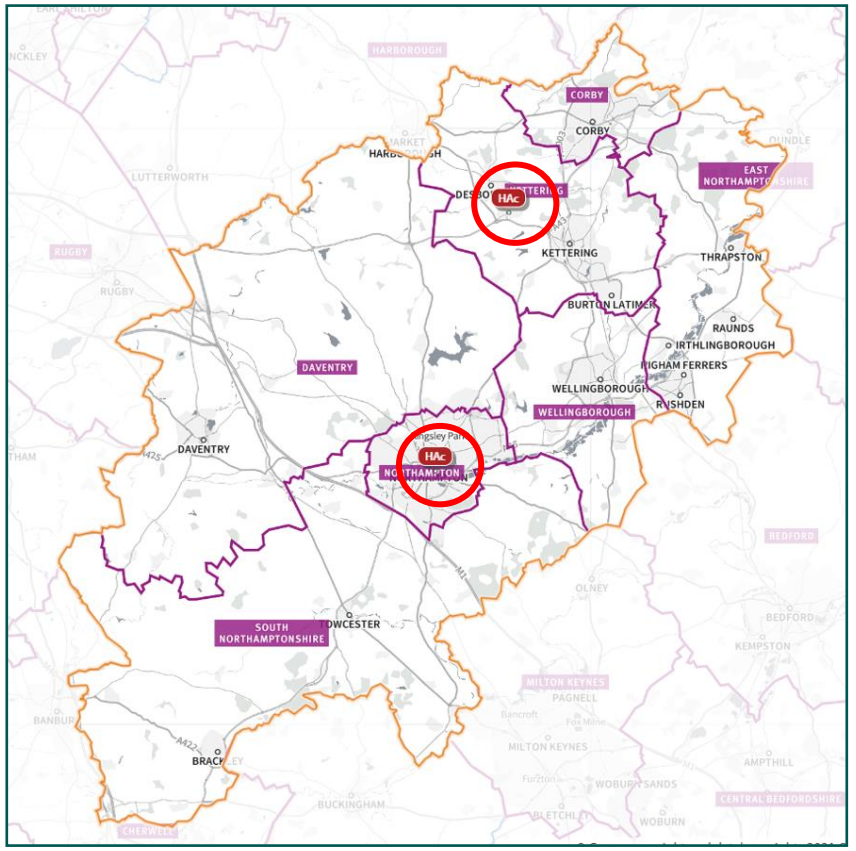
NHS assets across primary care and acute, and care home distribution

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.



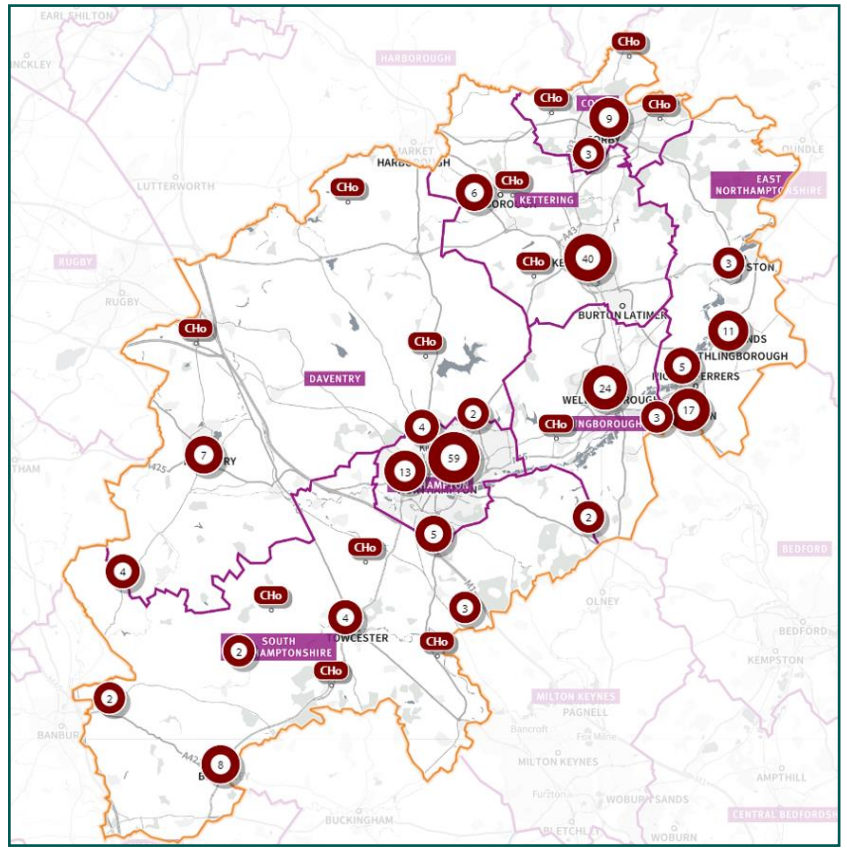
GP Practices and Branch Practices

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)

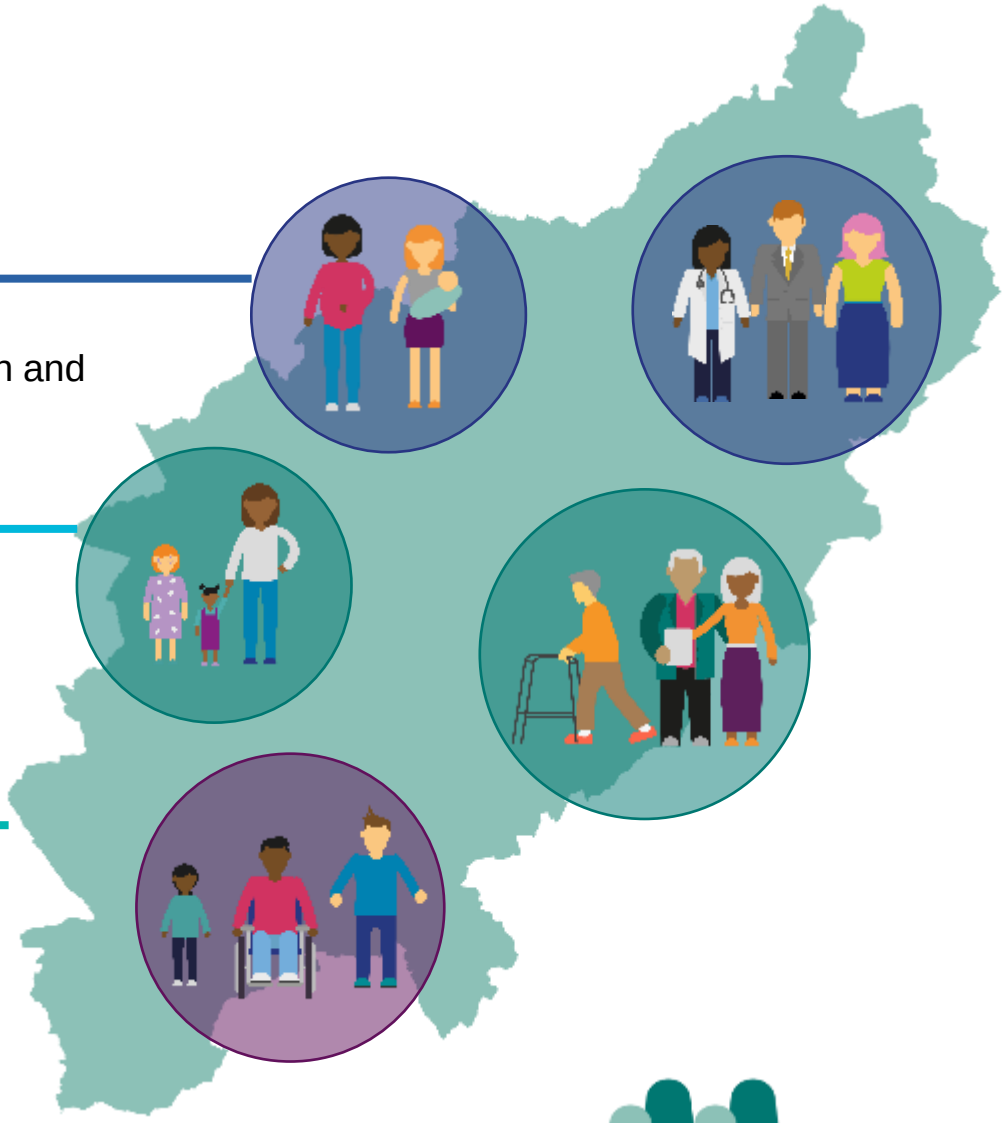
Adult Social Care Teams- 2 in the North and 2 in the West

Community / Neighbourhood Model

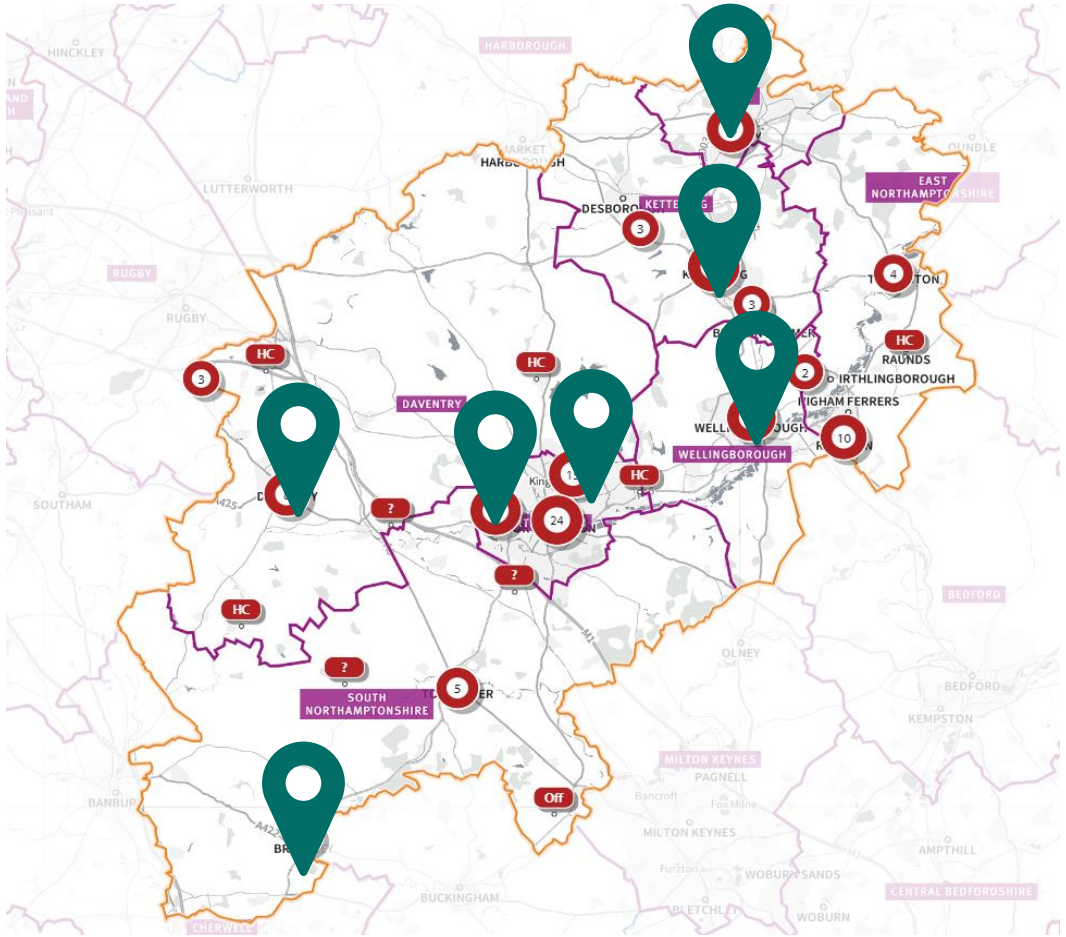
Community hubs, beds and health services, fire, police and ambulance and housing and DFGs; NHFT services e.g. Crisis Cafes, Age Well Teams (via PCNs), and 7 key delivery sites

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 Workshop Discussion

Northamptonshire Health and Care Partnership

Principles

- Tailoring services allows for specific targeting of commonality of needs and particular outcomes, however we need to consider the practicalities of localising and managing services on a small scale.
- Each person's construction of their own 'community' is different and it's important to construct 'Place' in a way that allows for these.
- Geographical locations are an important consideration: access to services is as important as where you draw delivery boundaries.
- Living in a particular location should not preclude you from accessing a service; but geographies should be targeted by need.
- 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 other population sets it matters less.
- 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.
- In governance terms, you have to consider the capacity that low-levels of the system have, whilst maximising input from the 'local voice'.

Options

- 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.
- If we were to use the former district structures, it would have to be clear that we are not using the former local authority arrangements and governance routes. The geographies of these places make sense but the old governance structures are no longer relevant.
- There was general agreement that PCNs should be excluded, as they have large, overlapping geographies which are not recognisable to local people.
- There was general agreement that the 57 wards option should be considered; as wards are recognisable and allow 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.
- The urbanity/rurality structure would allow commissioners and service delivery to target commonality of needs; and force them to think differently about what different populations need. However, splitting between urban and rural populations could create inequity and may be more suitable for the West were there is more of a disparity of need between Northampton and the vast rural area.
- There was general agreement to exclude grouping by IMD as there was belief that this could further ingrain inequalities and was duplicative of the urban / rural option.

West November Workshop Discussion

Northamptonshire Health and Care Partnership

Principles

- We need to consider localisation of services in terms of strategy, commissioning and delivery; and there needs to be a feedback loop in terms of data and engagement telling us what communities and neighbourhoods need.
- Cross-boundary contracts need to be taken into consideration to ensure that whatever structures put in place do consider providers.
- Recognisable neighbourhoods don't matter to everyone; particularly in the West where there should be more importance placed on access for rural areas.
- Expertise is needed to set strategy and to understand delivery in one place – you can't do one without the other.
- Improvement of services and feedback through the system can only happen where there is good local engagement.
- We need to ensure we aren't burdening the lowest levels of the system in terms of governance, decision-making and engagement.
- Prevention needs to be considered; in terms of defining Place through balancing long-term prevention initiatives against short-term critical issues that need to be addressed now.

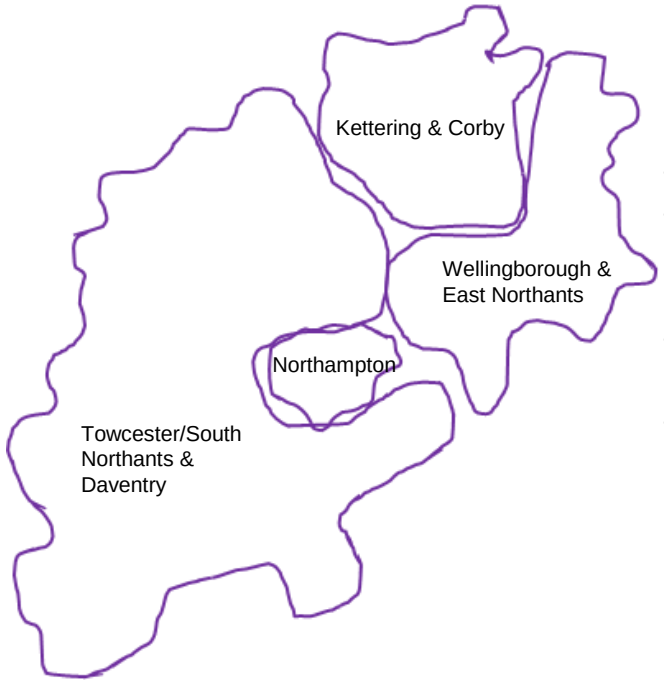
Options

- Localities are a good structure for planning and commissioning as they are large in size and largely split urban/rural populations- but you have to keep in mind the fact that there will be pockets of severe rural deprivation.
- Within West Northants, the former districts split the rural population, meaning more attention would be focussed on Northampton, and do not make sense as structures after the local government reorganisation.
- There was general agreement that PCNs should be excluded, as they have large, overlapping geographies which are not recognisable to local people.
- Electoral wards individually are too small a unit to be helpful, but clustering wards works in terms of targeting commonalities of need; and there are already strong opportunities for representation and local engagement.
- The grouping of urban and rural areas in the West creates unrecognisable geographical boundaries; the localities achieves the same goal on a larger scale in a more logical way.
- Grouping by IMD was agreed to be excluded as participants felt that this would not be a recognisable structure, nor does it make sense in terms of commissioning and service delivery.

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

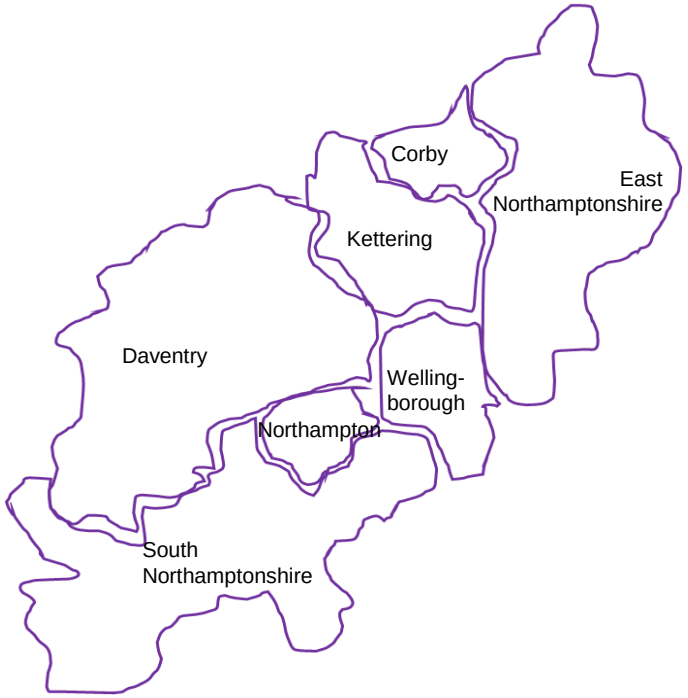
Governance

- 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 • 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) • 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 • Structure is not recognisable to local communities and Locality governance will not be part of the future ICB in line with current plans • 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 • 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

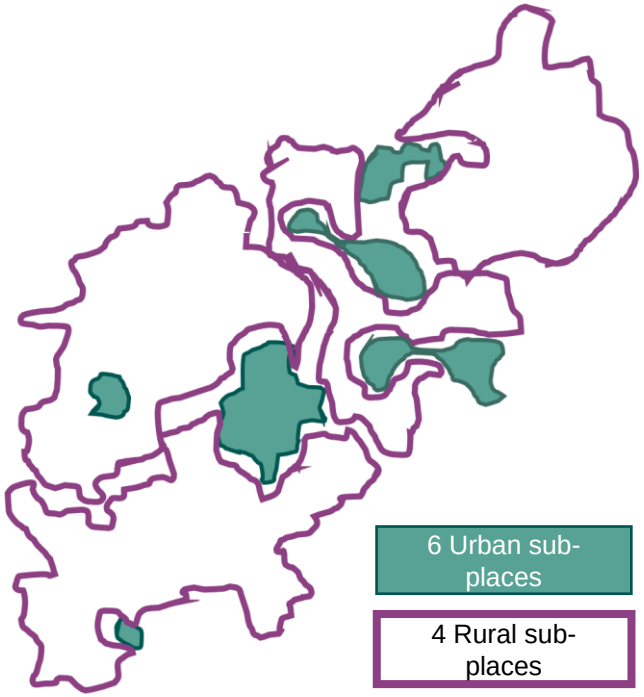
Governance

- 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 • Boundaries broadly align to the urban/rural divide so could be used to address commonality of need • 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 • 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 • Encourages providers and commissioners to think differently for urban and rural areas • 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 • 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 • 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 • Identifiable to council and social services across both North and West Northants • Local informal governance groups are already in place and in some areas working as the link between local people, council and VCS • Allows wider representation as there are clear champions for each area i.e. members	• Too small segmentation for effective service delivery and governance • Electoral boundary review planned which may change ward structures • 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 • Allocate resources • Establish joint working arrangements with partners, embed collaboration • Establish governance arrangements to support collective accountability for whole system delivery and performance • Arrange for the provision of health services in line with allocated resources • Lead system implementation of people priorities • Lead system wide action on data and digital • Use joined up data and digital capabilities • Ensure NHS plays full part in achieving wider goals of social and economic development and environmental sustainability • Drive joint work on estates, procurement, supply chain and commercial strategies • Lead for Emergency Preparedness, Resilience and Response • 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 • 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 • Preparation of Joint Strategic Needs Assessment (JSNAs) • Encourage the integration of health and social care services • 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 • Oversee the publication of the Directors of Public Health Annual Report • To endorse and oversee the successful implementation of Better Care Fund (BCF), Improved Better Care Fund (IBCF) and Disabled Facilities Grant (DFG) arrangements locally • Review NHS Northamptonshire Clinical Commissioning Group and Unitary Council commissioning plans • 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 • Publication of a Pharmaceutical Needs Assessment	Elected LA members Local Authority Chief Executive Director of Adults Services Director of Children's Services Director of Public Health Representative of Healthwatch Representative of CCG Northamptonshire Police Northamptonshire Healthcare Foundation Trust Northampton General Hospital and Kettering General Hospital Group Northamptonshire Local Medical Committee NHS England Voluntary and Community Sector University of Northampton Office of Police Fire Crime Commissioner Northamptonshire Health and Care Partnership Northamptonshire Fire and Rescue Service East Midlands Ambulance Service
Proposed changes to meet future requirements	***Recommended changes to functions:*** • *Review ICB commissioning plans (replaces CCG commissioning plan due to new ICB organisation)* • *Input to, and review ICS Strategy, providing HWBBs with an interface to the new ICP*	***Recommended changes to membership:*** • *A representative from the Integrated Care Board (ICB) (replaces CCG)* • *A representative from the Integrated Care Partnership Board* • *A representative system clinical lead* • *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 *(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:* • *Joint planning of community / neighbourhood services, including new transformed pathways, aligned to 'Local Area Plans'* • *Integrated oversight of local services across collaboratives / other providers* • *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* *Councillors from HWBB forums, including 'neighbourhood' councillor representatives* *Community and MH provider* *Collaborative providers* *Social care representatives (children's and adults)* *Voluntary sector representative* *Chair should be a member of HWBB* *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*	