WEST NORTHANTS
Health and Wellbeing Board
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West Northants - Place

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

Role of the Integrated Care Partnership

ICPs' central role is in the planning and improvement of health and care. They should support place-based partnerships and coalitions with community partners which are well-situated to act on the wider determinants of health in local areas. ICP should bring the statutory and non-statutory interests of places together.

- ICPs will be required to develop an integrated care strategy to address the broad health and social care needs of the population within the ICP's area, including determinants of health such as employment, environment, and housing issues. ICBs and LAs will be required by law to have regard to the ICP's strategy when making decisions, commissioning and delivering

- The ICP is expected to highlight where coordination is needed on health and care issues and challenge partners to deliver the action required. These include, but are not limited to:
- helping people live more independent, healthier lives for longer
- taking a holistic view of people's interactions with services across the system and the different pathways within it
- addressing inequalities in health and wellbeing outcomes, experiences and access to health services
- improving the wider social determinants that drive these inequalities, including employment, housing, education environment, and reducing offending
- improving the life chances and health outcomes of babies, children and young people
- improving people's overall wellbeing and preventing ill-health

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

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

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

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Neighbourhood Partnerships

West Northants Neighbourhoods

- 9 Neighbourhoods across West Northants
- Based on populations of between 30,000 – 50,000
- Small enough to provide personal care, but big enough to make sure residents can use the range of services they need
- Each Neighbourhood recognised as unique and individual with variety of assets (people, organisations and buildings and physical places)

Benefits of Neighbourhood Partnerships:

- Enables local leaders to determine local Neighbourhood priorities across the whole system
- Allows for a population health approach based on the needs of local residents
- Moves decision making closer to local people and local needs
- Gives opportunities to bring in social and economic determinants of health

Neighbourhood Partnerships

West Northamptonshire Council

1. Each Neighbourhood will have a data and insight profile that describes the strengths and assets of the area alongside its issues and challenges. This profile will be structured across the 10 LYBL domains. The profile will be the evidence base that informs the activity of each neighbourhood partnership.

2. In each Neighbourhood will be a partnership of local elected members, residents, statutory organisations and the community and voluntary sector. These partnership will have required involvement and representation to enable local improvement across the 10 LYBL domains. This improvement will be the focus of our Neighbourhood plans.

Five potential responses to identified Neighbourhood need…

3. **Peoples Charter**

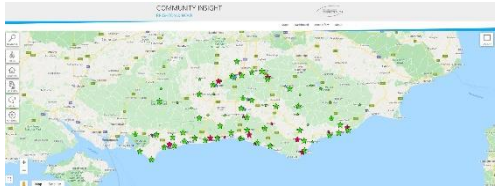
4. **Devolved monies** to fund specific local responses to identified Neighbourhood need

5. Local direct response through **improved collaboration & Integration** between local organisations working within that Neighbourhood

6. **Place wide response** where need is beyond that which can be tackled within a Neighbourhood

7. **System wide response** where need is beyond that which can be tackled within Place

An example of Neighbourhood profiles can be seen through the following link



Local Insight (communityinsight.org)

How Neighbourhood Partnerships would work:

- **Local Neighbourhood partnerships** which bring together elected members residents, voluntary and community and statutory organisations to help coordinate and respond to identified local needs to deliver the integrated care strategy.
- Underpinned by a **co-produced People charter** which outlines commitments between citizens and partners to work together.
- **Resource light in terms of administration** to support functioning of partnership within each Neighbourhood.
- Some **responsibility in directing funding to priorities** based on identified Neighbourhood need – but not all services would be commissioned or budgets devolved at a Neighbourhood level.
- **Local Partnership leadership** from elected members residents ("school governor type model"), statutory / voluntary providers and/or PCN Clinical Directors.

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Neighbourhood Partnership - Examples

West Northamptonshire Council

3 **Peoples Charter**

- West Northants Big Conversation
- West Northants Place and People Pledge

4 **Devolved monies** to fund specific local responses to identified Neighbourhood need

- Public health grant
- Integrated Care Board via Integrated care partnership
- Local authority

5 Local direct response through **improved collaboration & Integration** between local organisations working within that Neighbourhood

6 **Place wide response** where need is beyond that which can be tackled within a Neighbourhood

- Specialist Falls Service

7 **System wide response** where need is beyond that which can be tackled within Place

- Acute Mental Health Beds

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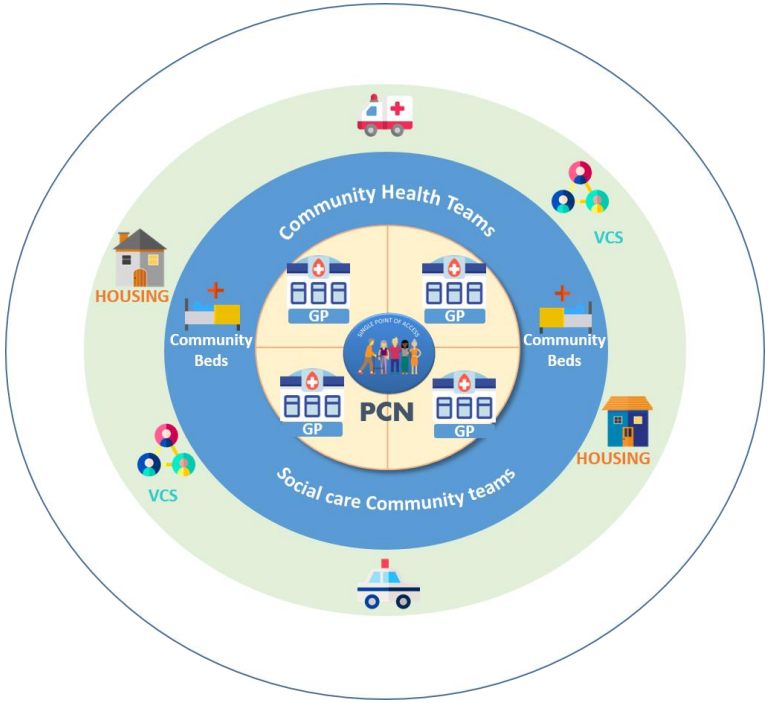
Thoughts and suggestions?



Neighbourhood Integrated Teams

Consistent team across all Neighbourhoods within a single Place based leadership structure

1. Primary Care Network (including MDT welfare teams as part of iCAN collaborative)
2. Adult Social Care – Community teams
3. Community Nursing
4. Community Therapy (WNC and NHFT)
5. Community and Voluntary Sector
6. Ageing well/Supporting Independence
   Social prescribing (iCAN collaborative)
7. Children and Young People's services (CYP collaborative)

8. Housing Teams
9. Welfare Benefit & Debt
10. Learning Disability and Autism Team (collaborative)
11. Mental Health (collaborative)
12. Neighbourhood policing
13. Community safety.
14. spaces and sport and leisure

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INTEGRATED CARE PARTNERSHIP

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CYP Collaborative

iCAN Collaborative

Mental Health Learning Disability & Autism Collaborative

Elective Care Collaborative

South Northants and Daventry Health and Wellbeing Forum

- Neighbourhood Partnership
- Neighbourhood Partnership
- Neighbourhood Partnership
- Neighbourhood Partnership

Northampton Health and Wellbeing Forum

- Neighbourhood Partnership
- Neighbourhood Partnership
- Neighbourhood Partnership
- Neighbourhood Partnership
- Neighbourhood Partnership

Data & Insight Community of practice

Co-production and Engagement Community of practice

Neighbourhood Partnerships Development Group

Neighbourhood Team Development Group

Place Commissioning Group

Neighbourhood Assets and Estates Group

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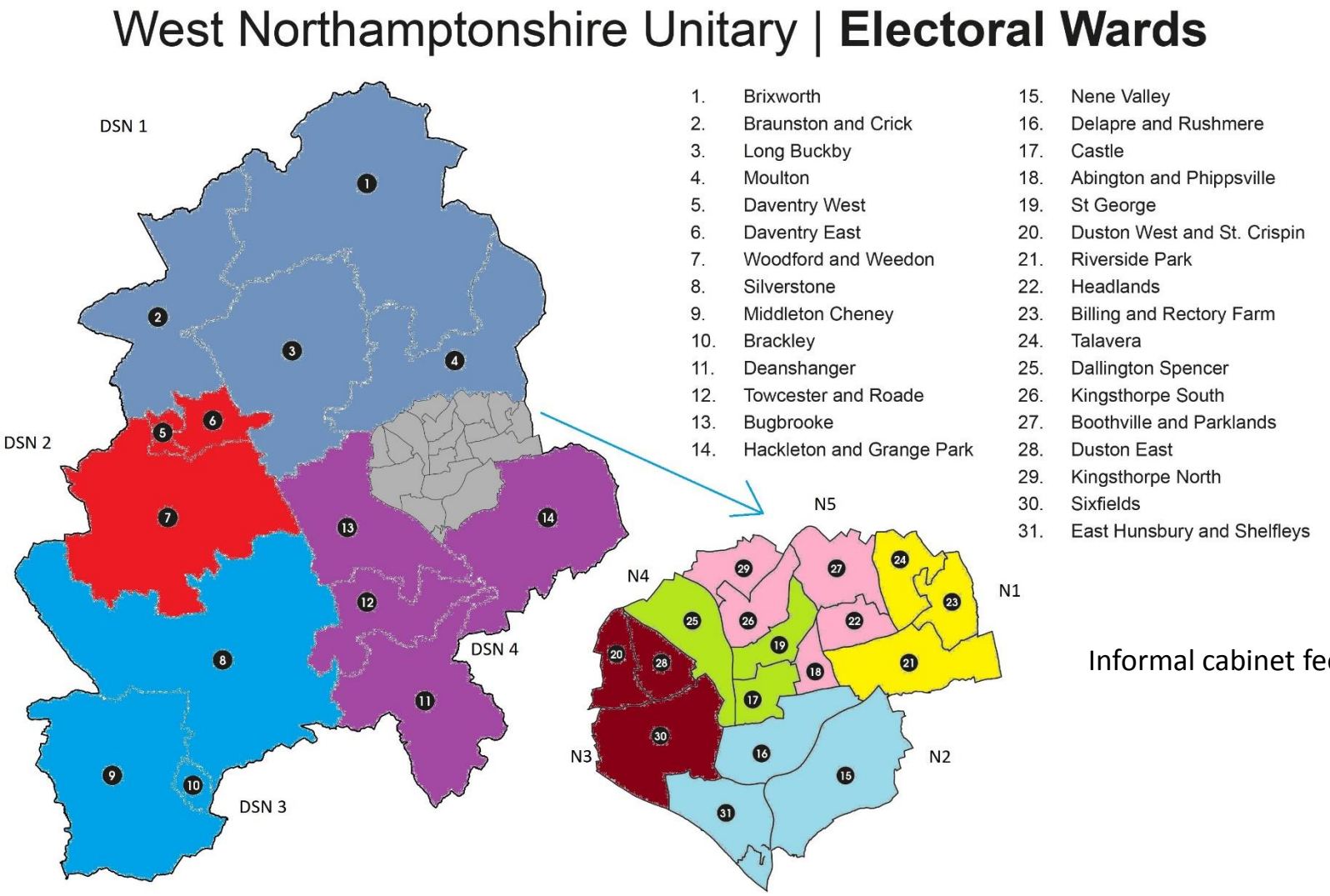
Proposed Neighbourhoods



Informal cabinet feedback: Move 18 to N4

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

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.

Village Hall

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

GP Surgery

Health centre

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.

Specialist hospital

Reablement and Hospital Discharge Teams

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