Subject:	How we work at a more local level in our Integrated Care System
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Submitted to:	Interim ICS Partnership Board, 5 August 2021

Summary:

As Integrated Care Systems have developed, it has been clear that much of the work to join-up delivery and planning of care can't happen at Norfolk and Waveney level, and needs to take place more locally. To collectively develop our thinking about how we work together, we established a cross-system Steering Group in the autumn of 2020, which brings together Primary Care Networks, district and county councils, health and care service providers and the Clinical Commissioning Group.

This paper sets-out the Steering Group's recommendations about the geographic areas or footprints that we should use in future to work together in partnership at a more local level in our Integrated Care System. The recommendations were developed following engagement with a wide range of stakeholders from across the system.

It is important to note the Steering Group will continue to further refine and develop our approach in the coming weeks and months, particularly in light of any further national guidance we receive about place-based working, as well as any changes to the Health and Care Bill. There will also be further discussions between stakeholders locally about how our arrangements will work in practice. In addition, the Steering Group will conduct more detailed work to clarify the functions that will take place at each level of our system and to determine the governance arrangements for our place-based working.

Even after our Integrated Care System is established in April 2022, it is clear that our place-based arrangements will continue to develop and evolve over time as relationships mature, best practice is identified, lessons are learned and guidance changes.

Recommendation:

The interim ICS Partnership Board is asked to agree:

- **Primary Care Networks will form the 'neighbourhood' level of our Integrated Care System**, in order to support our work to integrate operational health and care teams, as well as to work in partnership to reduce health inequalities and address the wider determinants of health at a very local level.
- Existing national policy and draft national guidance about sub-ICS working says that in two-tier areas 'places' should usually be built-up from district council boundaries. In any case, given the responsibility of district councils for many of the issues affecting the wider determinants of health, including housing, leisure services and the local environment, **our partnerships at 'place' level should be based on district council boundaries**. This would help to integrate the local

public sector more effectively, give us the ability to develop much more ambitious, integrated local strategic plans and support our work to address the wider determinants of health and to reduce health inequalities.

- In recognition of the reservations raised about having eight 'places' following district council boundaries, **we will create four or five 'places' by grouping district councils together**. This would provide the right balance between our 'places' being small enough to have a detailed understanding of their local area, while also being large enough to be able to effectively manage future delegation of funding and accountability and keep running costs to a reasonable level.
- **We will ask colleagues from district councils, Primary Care Networks and other stakeholders to discuss in more detail how this will work in practice in each local area,** how they would like to work together and what support they would need, and to develop consensus-based recommendations by the end of September. We know that colleagues will want to balance achieving a high degree of coterminosity with our existing working relationships and the health and care needs of different communities.
- **Primary Care Networks should not have to work across two 'places'**, so that they can use their resources to best effect.
- **We will call our place-based working arrangements 'Local Improvement Partnerships'** to reinforce that our future working arrangements will be different from the current Local Delivery Groups, that the partnerships will have different functions and will have a broad remit around improving people's health and wellbeing.
- **We will work flexibly with colleagues in Suffolk** to ensure that the Local Improvement Partnership which covers Waveney fully links with key parts of our neighbouring system, notably Suffolk County Council's Adult Social Care, Children's Services and Public Health teams, East Suffolk District Council's teams covering Waveney, and voluntary, community and social enterprise sector partners.
- **The shadow Integrated Care Partnership, once established, will approve the final decision about our sub-ICS working arrangements.**

Main body of report

A. Background

1. Over the past few years health and care services have worked together with increasing collaboration in Norfolk and Waveney, as they have done across the country. As Integrated Care Systems (ICS) have developed, it has been clear that much of the work to join-up delivery and planning of care can't happen at Norfolk and Waveney level, and needs to take place more locally. This is because it requires more local and detailed knowledge about our different communities, as well as strong relationships between those providing care on the ground, including both statutory and non-statutory organisations.

2. There has recently been a significant amount of discussion and thought about place-based working. The King's Fund has explored the potential role and contribution of place-based working in their publication 'Developing place-based partnerships' (April 2021).

Defining 'place'

In their report, The King's Fund use the term 'place' to refer to the geographical level below an ICS at which most of the work to join up budgets, planning and service delivery for routine health and care services (particularly community-based services) will happen.

They go on to say that the factors that determine the size and boundaries of a place will vary. They note that where unitary authorities exist, those boundaries are generally being used to define the place footprint. The King's Fund also point out that, where there are two-tier local authorities, it is more complex to define the right scale and boundaries for place. In some such cases, place footprints have been established around clusters of district councils, the area served by a hospital or established groupings that are already being used for joint working across the NHS and local government.

3. The King's Fund conclude the rationale for collaborating over these smaller geographies is two-fold, and their observations align well with our local experience to date.

4. First, collaboration at this level creates opportunities to bring together budgets, planning and service delivery for non-specialist health and care services (particularly community-based services) to deliver better coordinated and personalised care, avoid duplication and improve the efficiency of services. Bringing together budgets and services in this way is also intended to support a wider shift towards prevention, population health and tackling inequalities as it is at this local level where the many organisations responsible for shaping the determinants of health – whether NHS, local authority, voluntary, community and social enterprise sector (VCSE) organisations or others – can come together to understand and respond to local needs.

5. The second part of the rationale for working together at this level is the opportunity to build a different relationship with communities themselves, framed around local people being active partners in creating healthier places and communities. The report argues this shift needs to be a fundamental part of place-based working if it is to deliver the improvements in population health and reductions in health inequalities that partnerships seek to achieve.

B. Changing context: the development of Integrated Care Systems and the Government's Health and Care Bill

6. The importance of working effectively together at a more local level has been set-out in series of NHS and Government documents, including the NHS Long Term Plan, NHS England and Improvement's 'Integrating Care', the Government's subsequent white paper and the ICS Design Framework, all culminating in the Health and Care Bill that has been introduced into Parliament. Together they set out a clear course for the future structure of the NHS.

7. One notable feature of both the recent NHS publications and the Government's approach is the considerable emphasis put on the importance of local partnership working below the system-wide level. The NHS includes a commitment to a "principle of subsidiarity" and envisages considerable delegation in the reformed system. The

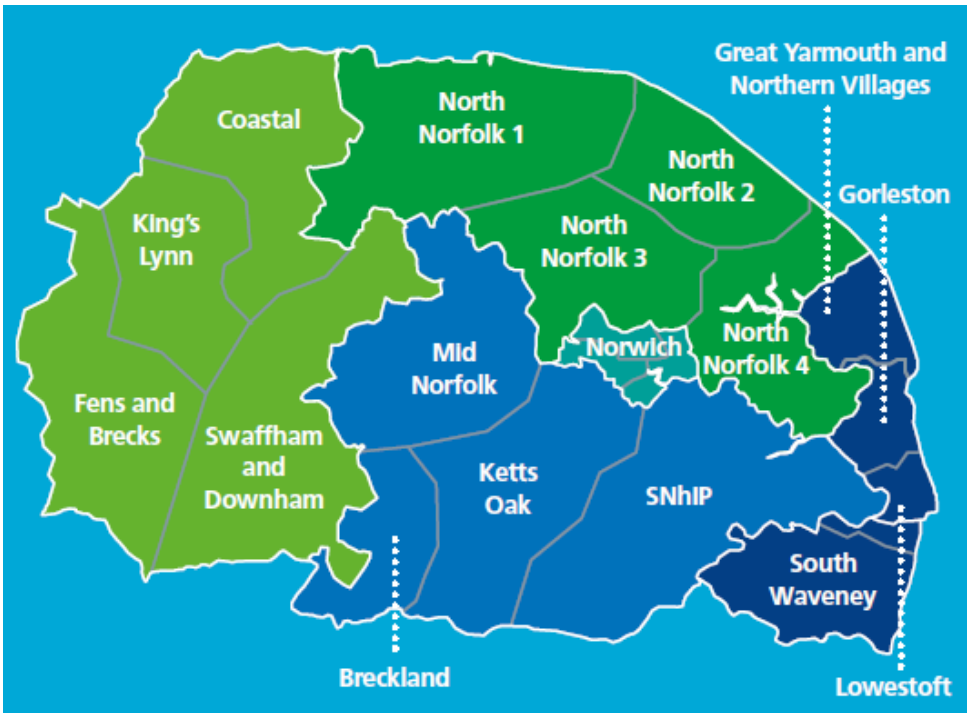
white paper refers to the "primacy of place" and sets an expectation that ICSs will work to "support places…to integrate services and improve outcomes".

8. It should be noted that we expect further NHS England guidance to be published about sub-ICS working, but our expectation is that it will say in two-tier areas like ours 'places' should usually be built-up from district council boundaries. This would be in line with existing national policy documents, such as the white paper and ICS design framework, which give a steer towards using local authority boundaries.

C. How we currently work together in Norfolk and Waveney: neighbourhood, place and system working

9. It is important to note that we are not starting from scratch and do already work in partnership at a range of levels. Locally, in line with the rest of England, there are three broad levels at which partnership working currently takes place in our Integrated Care System:
   - Neighbourhood: our 17 Primary Care Networks
   - Place: our five localities based on the boundaries of the five former CCGs
   - System: Norfolk and Waveney

10. This map shows our 17 primary care networks, five localities and our whole system:



11. It is important to emphasise that the three elements of our existing ICS are not a hierarchy. We are building our ICS on the principles of distributed leadership - leadership at every level - and that of subsidiarity. The experience of working together during the COVID-19 pandemic has been very helpful in this respect; people have worked together in teams to do their best for individuals, families and communities, regardless of which organisation each individual works for. That spirit of team working and common purpose is what we seek to embrace as an ICS.

12. We have learnt a great deal about place working through the existing locality structures, which are increasingly bringing partners together to agree joint priorities, establish share work programmes and pool resources. Appendix B is a set of case studies from our current local working arrangements:

D. Developing our approach to sub-ICS working in future

13. To collectively develop our thinking, we established a cross-system Steering Group in the autumn of 2020 to guide our work on place; this brings together PCNs, district and county councils, health and care service providers and the CCG.

14. In March 2021, the Health and Care Partnership's Oversight Group (now the interim ICS Partnership Board) and the Norfolk Health and Wellbeing Board both agreed that we should conduct an engagement exercise to inform and support our thinking about sub-ICS working and a decision on our place 'footprints'. The engagement exercise was overseen by the Steering Group and ran between 17 May and 13 June 2021.

E. Findings of our engagement

15. Overall, the engagement showed there is strong support for the principle of local working and a place-based approach. There is a recognition that this is complex and that there is no straightforward answer. But equally there is excitement about the opportunities and potential improvements that can be made to local people's health, wellbeing and care through place-based working.

16. It was clear from the engagement exercise and the Steering Group's discussions that our local partnership arrangements will need to support **both** the operational integration of health and care services and our work to address the wider determinants of health, and that both functions should be considered of **equal importance**.

17. It was also highlighted that place-based working and subsidiarity aren't just about decision-making processes and governance, but about a real culture change too. We will need to continue to ensure that we have a development programme that supports the journey our system and workforce are going on.

18. The full engagement report detailing the methodology and the findings is attached as Appendix D.

F. Determining the number and geographic footprints for our partnerships at 'place' level

19. Following the engagement exercise and taking into account published and draft national guidance, the Government's Bill and learning from our local experience, the Steering Group considered a wide range of options in order to come to a set of recommendations about the best-fit geographic footprints for our future local working arrangements.

A small number of larger 'places'

20. As part of the engagement exercise, we tested a few options with stakeholders where we had two or three larger 'places'.

21. The feedback showed there was no support for having two large places covering the East and West of our ICS. Many concerns were raised, including:
    - Each place would be too large to enable meaningful discussion of local issues or to empower local communities.
    - There would be significant differences within these two places.
    - These areas would not be meaningful to local people.
    - The areas would not take account of existing patient flows, how services are configured, or our existing local knowledge and relationships.

22. In light of the significant concerns raised, the Steering Group discounted this option.

23. We also tested two variations of three 'places', one option was three places based on Functional Economic Areas and the other was three places based on catchment areas for the three acute hospital trusts.

24. There was some support for both three place options, as well as some significant reservations. Stakeholders said they felt having a smaller number of places would make future delegation from ICS level easier and that both options would resonate to some degree with local people. Aligning to the acute trusts would also recognise the key role hospitals play as anchor institutions and make sense in terms of secondary care pathways.

25. Many of the concerns raised were similar to those set-out above for the two place option. There were also particular concerns that aligning our local working arrangements to the acute trusts would not be in line with our ambitions around prevention or tackling the wider determinants of health, and that this would not make sense as acute pathways will be designed at system level.

26. The Steering Group noted that the potential configuration of the East place is exactly the same in almost all of the options and the options in West Norfolk are all fairly similar too. So for our acute trusts in the East and West of our system, there will be comparatively little difference whether we choose to align our 'places' to acute catchment areas or most of the other options.

27. The complexity really lies in central Norfolk, where there is one acute hospital trust serving quite different communities in North Norfolk, South Norfolk and in and around Norwich. Consequently, the Steering Group felt both these options would not be the best-fit for central Norfolk.

28. On balance, the Steering Group felt that much of what stakeholders liked about the three place options could be achieved by some of the other options too, without some of the disadvantages raised by stakeholders, and so discounted both these options.

A large number of smaller 'places' – seven or eight places based on district council boundaries

29. There was a lot of support from some partners for having seven or eight places based on district council boundaries. It was felt this could help to bring together the whole of the local public sector and would enable statutory organisations and the VCSE sector to better work together to address the wider determinants of health. This was

considered by some to be likely to enable integrated strategic planning involving all partners.

30. However, significant reservations were also raised. Concerns included that having so many relatively small places could hinder future delegation of NHS funding and complicate accountability in the way it is envisaged in the ICS Design Framework, that it would incur significantly greater running costs and bureaucracy, and that it would result in reduced coterminosity between PCN and district council boundaries when compared to other options.

31. On balance, the Steering Group concluded that because of the significant concerns raised and because much of what partners liked about this option could potentially be achieved in other ways, that this option should also be discounted.

Five 'places'

32. As part of the engagement exercise, we tested two options with stakeholders where we had five 'places'; one option aligned to the current health localities and one based on how community services operate.

33. There was a lot of support from some partners for these, particularly for basing our future working arrangements on the footprints of the current health localities. Stakeholders tended to see the two five 'place' options as having fairly similar benefits and risks.

34. It was felt these options would best support the operational integration of health and care services, enable us to build on our collaboration and the relationships we've developed, as well as minimize disruption.

35. However, significant reservations were also raised about these options. In particular, a number of partners who currently work in or are aligned to district council boundaries expressed strong concern that this configuration would not enable more integrated local strategic planning and would not lead to a sharper focus on addressing the wider determinants of health – both of which are priorities for the future ICS.

G. Conclusion: four or five 'places'

36. Taking everything into account, the Steering Group has concluded that having four or five 'places' would be an appropriate configuration for our system. This is because having four or five 'places' would provide a reasonable balance between them being small enough to have a detailed understanding of their local area, while also being large enough to be able to effectively manage future delegation of funding and accountability and keep running costs to a reasonable level. However, the group also felt that we should explore other potential configurations in order to mitigate some of the concerns raised.

H. Conclusion: building our 'places' using district council boundaries and neighbourhoods using our Primary Care Networks

37. There has been a significant debate about whether our placed-based arrangements should be based on district council boundaries or our Primary Care Networks. There are clear, strong and valid points in favour of both options. On balance, the Steering

Group has concluded that our partnerships at 'place' level should be based on district council boundaries.

38. The Steering Group has agreed that building our places from district council boundaries has several advantages. This approach would:

- help to integrate the local public sector (beyond just health and care) more effectively and achieve better alignment with a wide range of services, including Children's Services, housing, leisure services, the Constabulary and economic growth partnerships.
- give us the ability to develop much more ambitious, integrated local strategic plans, engaging the full range of partners.
- signal our intent as a system about the importance of addressing the wider determinants of health, preventing ill-health and tackling the causes of health inequalities.
- enable us to better align funding from multiple sources, such as the Better Care Fund.
- help us to potentially develop a more integrated local public health 'offer'.
- be better aligned with existing national policy such as the white paper and draft NHS England guidance about sub-ICS working, which we expect to say in two-tier areas that 'places' should usually be built-up from district council boundaries.

39. The Steering Group also noted that we are looking to create structures for the future that will deliver on our shared system's ambitions. The current Local Delivery Groups have been really positive and helped us make important and tangible improvements to people's health, wellbeing and care. These new arrangements should build on our achievements and enable us to have a greater focus on prevention and wider wellbeing, which is not only better for individuals, but is also vital for reducing pressure on health and care services.

40. There are a range of potential configurations of district councils that meet the principles being proposed in this paper. The Steering Group's conclusion is that we should now encourage further discussions between district councils, Primary Care Networks and other stakeholders locally about these options and how this would work in practice and what support they would need.

41. The Steering Group has also concluded that Primary Care Networks should form the 'neighbourhood' level of our Integrated Care System, in order to support our work to integrate operational health and care teams at the most local level. At this level there is a real opportunity to continue to, amongst other things, improve people's care by developing multidisciplinary community teams.

I. Recommendations

42. The Steering Group is recommending that:

- **Primary Care Networks should form the 'neighbourhood' level of our Integrated Care System**, in order to support our work to integrate operational health and care teams, as well as to work in partnership to reduce health inequalities and address the wider determinants of health at a very local level.
- Existing national policy and draft national guidance about sub-ICS working says that in two-tier areas 'places' should usually be built-up from district council boundaries.

In any case, given the responsibility of district councils for many of the issues affecting the wider determinants of health, including housing, leisure services and the local environment, **our partnerships at 'place' level should be based on district council boundaries**. This would help to integrate the local public sector more effectively, give us the ability to develop much more ambitious, integrated local strategic plans and support our work to address the wider determinants of health and to reduce health inequalities.

- In recognition of the reservations raised about having eight 'places' following district council boundaries, **we should create four or five 'places' by grouping district councils together**. This would provide the right balance between our 'places' being small enough to have a detailed understanding of their local area, while also being large enough to be able to effectively manage future delegation of funding and accountability and keep running costs to a reasonable level.
- **We should ask colleagues from district councils, Primary Care Networks and other stakeholders to discuss in more detail how this will work in practice in each local area,** how they would like to work together and what support they would need, and to develop consensus-based recommendations by the end of September. We know that colleagues will want to balance achieving a high degree of coterminosity with existing working relationships and the health and care needs of different communities.
- **Primary Care Networks should not have to work across two 'places'**, so that they can use their resources to best effect.
- **We should call our place-based working arrangements 'Local Improvement Partnerships'** to reinforce that our future working arrangements will be different from the current Local Delivery Groups, that the partnerships will have different functions and will have a broad remit around improving people's health and wellbeing.
- **We should work flexibly with colleagues in Suffolk** to ensure that the Local Improvement Partnership which covers Waveney fully links with key parts of our neighbouring system, notably Suffolk County Council's Adult Social Care, Children's Services and Public Health teams, East Suffolk District Council's teams covering Waveney, and voluntary, community and social enterprise sector partners.
- **The shadow Integrated Care Partnership, once established, should approve the final decision about our sub-ICS working arrangements.**

J. Risks and mitigations

43. It has always been clear that when thinking about 'place' there would be no perfect solution, that there will always be some boundaries and that we needed to find the best possible fit for us. We also knew that we would need to endeavour to find a solution that works for all partners, both those involved the planning and delivery of health and social care services, as well as those who play a hugely important role in addressing the wider determinants of health. The Steering Group's view is that this approach achieves the best-fit for our system.

44. The Steering Group has identified the following potential or perceived risks and issues with the approach, and has developed suggested mitigations:

Risk / Issue	Response / Mitigation
Changing from our current arrangements will cause disruption, especially to PCNs and current relationships.	PCNs will not be asked to reconfigure; funding flows to PCNs will continue as now, as will governance within PCNs. There is likely to be a high degree of continuity in these arrangements, so many relationships would stay the same. Where changes are proposed, there would be a transition period and we would provide support to all the new Local Partnerships to build relationships and form effective teams.
The 'places' may vary in geographic size and population.	As outlined above, the Steering Group believes that aiming for maximum coterminosity would best enable us to deliver the functions at 'place' and 'neighbourhood' level, and feels like a more appropriate way to determine our local working arrangements than just aiming for an even division of our geography or the population. We would ensure that resources are allocated to our 'places' based on the size of the population and needs of the people living in each 'place'.
There may be differences in the demographics, needs and health and care outcomes within 'places'.	This is always going to be the case to some degree and there is no perfect solution. Where there are significant differences between places and different pathways or interventions are needed, it's important to remember that our PCNs could put in place bespoke offers or programmes to meet the needs of people living in their area. Just as it doesn't make sense to make all decisions at system level, it also doesn't make sense to make all decisions at 'place' level either; our neighbourhoods will be an equally important part of our ICS.
The areas may not all be meaningful to local people.	We recognise that this approach could create areas that people do not normally identify with. There is a clear logic to operating at this scale and by grouping districts together though, and there are already many examples of partners working together across PCN and district council boundaries. The key will be to tailor our communications and to ensure that messages are delivered by trusted partners in each area. For example, if a 'place' agrees that general practices in the area will deliver a particular intervention, then patients would almost certainly be contacted by their GP practice or perhaps by another local practice from the PCN. Or in tackling the wider determinants of health, a 'place' might decide that local authorities will put in place a particular intervention, in which case people could be contacted by their district council.
The 'places' may not all take account of existing patient flows, how services are configured, or our existing local knowledge and relationships.	We are aiming to achieve a high degree of continuity, so in many areas partners would not see a significant impact in terms of patient flows or local relationships. That said, some change would be required of some partners. As recognised by partners though, there is no perfect solution – there are and will always be some boundaries that we will have to navigate.
It would be easier to delegate NHS funding to our 'places' if we	We are aiming to achieve a high degree of coterminosity between the 'places' and our PCNs. There would need to be a piece of work done to consider the implications in what would

used PCNs as the building blocks.	be a small number of areas where there would not be coterminosity. It is also worth noting that this would not affect any funding streams that go straight to PCNs.
We would have better access to health data at 'place' level if we used PCNs as the building blocks.	One the reasons the Steering Group is recommending an approach where there is a high degree of coterminosity between the district councils and our PCNs is that it means we will have good access to data about both the wider determinants of health and health conditions and outcomes at 'place' level. In the small number of areas where there is not coterminosity, we would need to work through this issue on a case by case basis and we would ensure that there is support from Business Intelligence and Public Health colleagues available.

K. Next steps

45. The Steering Group will continue to further refine and develop our approach in the coming weeks and months, particularly in light of any further national guidance we receive about place-based working, as well as any changes to the Health and Care Bill. Importantly, this will include further engagement with and between district councils, PCNs and other stakeholders locally about how this will work in practice and what support they would need. In addition, the Steering Group will conduct more detailed work to clarify the functions that will take place at each level of our system and to determine the governance arrangements for our place-based working.

46. Once established, the shadow Integrated Care Partnership would then be asked to make a final decision about our sub-ICS working arrangements. Even after our Integrated Care System is established in April 2022, it is clear that our place-based working arrangements will continue to develop and evolve over time as relationships mature, best practice is identified, lessons are learned and guidance changes.

47. The Secretary of State for Health and Social Care's announcement about ICS boundaries provides welcome clarity as we intensify our planning to become a statutory ICS from April 2022. In relation to Waveney, there is a long history of strong collaboration between the local NHS, Suffolk County Council and East Suffolk District Council, which has been further strengthened during the pandemic. As the Norfolk and Waveney ICS, we will build on these close relationships so that, together, we can plan health and care services and improve the health and wellbeing of the people of Waveney.

48. Finally, it should also be noted that we will be using the findings from the engagement exercise to inform other pieces of work, including our ICS transition planning. It was highlighted in our engagement that place-based working and subsidiarity aren't just about decision-making processes and governance, but about a real culture change too. So our system workforce team will ensure that the development programmes for our workforce continue to support colleagues on the journey we are going on and that we have a culture change programme that complements the arrangements we are putting in place for working together at a more local level in our ICS.

Appendix A: Principles

The Steering Group drafted the following broad principles to guide the development of our approach to place-based working:

- **Subsidiarity** – we need to take decisions as close to communities as possible, where this will have the greatest impact
- **Vertical and horizontal accountability** – our arrangements needs to encompass both the relationship between the different levels of our ICS, as well as the relationship and commitments partners make to one another
- **Flexibility** – our arrangements needs to be adaptable, so that it can be tailored to meet local circumstances and take account of different stages of development
- **Clarity** – accountability for decisions and budgets must be clear
- **Future proofed** – our arrangements needs to be adaptable, so that they can be developed over time (for example if we want to delegate more or different decisions and/or funding in future)
- **Inclusive** – our arrangements should promote and enable participation of all relevant system partners

Appendix B: Examples of local partnership working

Here are some case studies of previous and current projects from our existing local working arrangements:

Great Yarmouth and Waveney: Increasing COVID-19 vaccine uptake

Partners in Great Yarmouth have worked together to increase uptake of the COVID-19 vaccines. The approach involved Great Yarmouth Borough Council's 'Community Champions' engaging with some of the area's most vulnerable residents about getting vaccinated.

The Community Champions knocked on over 1,800 doors during two phases. The first phase supported the arrival of the vaccination bus and the second encouraged people to attend walk-in vaccination clinics and to book appointments via the National Booking System. There was a direct correlation in vaccine uptake rates found with an increase in people from the most deprived wards getting vaccinated following the door knocking.

The approach involved PCN Social Prescribers and Clinical Directors working very closely with Borough Council colleagues. The approach was developed using insight from the CCG's Health Equalities Partnership research, which highlighted the important role that 'trusted communicators' play in sharing messages and encouraging behavior change. PCNs supported the work by helping to create a script for those out door knocking and a local GP held a Zoom Q&A session with the Community Champions so that they were informed when out knocking on people's doors.

West Norfolk: Housing Support to people at risk of a fall

The Queen Elizabeth Hospital and the Borough Council of King's Lynn and West Norfolk have worked together to improve support for a group of patients who are at greater risk of having a fall. The Integrated Housing Adaptations Team at the Borough Council now contacts patients waiting for hip and knee treatments to offer them housing support so that they are less likely to fall in their home.

As part of the pilot, 42 patients received housing related support after they were contacted by the council. The referral process has now been established and plans are in development to extend the approach to other departments within the hospital. Data had not previously been shared in this way between the hospital and the council, so a really important outcome from the pilot was that we agreed the Information Governance and data processing arrangements required in order for us to now extend the approach.

Norwich: GP practice wellbeing triage

Partners working in Norwich have developed a pilot scheme designed to improve support for some of the most complex patients and families living in some of the most deprived areas* in Norwich PCN. The initial four-week pilot will look to support people's mental health and wellbeing, as this has been highlighted as a particular issue by GP practices. It has been agreed that practice staff will be able to refer appropriate patients directly onto a wellbeing practitioner list that will then be managed on a daily basis.

The pilot will educate and empower practice and PCN staff to make more informed decisions and get patients on the most suitable pathway as efficiently as possible. It is expected it will have a positive impact on the workload of and demands on GPs and other practice staff. This approach will also raise awareness of the Integrated Care Coordinator and Social Prescriber offer. All the learning from the pilot will be shared with practices during Protected Learning Time and used to develop new guidance on caring for and supporting these individuals and families.

*Reflecting some of the Reducing Inequalities Target Areas (RITA) identified by Norwich City Council.

South Norfolk: Mental health transformation pilot

Breckland PCN was a pilot site for the system wide mental health practitioner transformation project, part of the Additional Roles Reimbursement Scheme. The aim was for partners to work together to identify cultural, process and operational challenges at that very local level when transforming how community mental health services work, as well as identifying how these challenges can be overcome.

Breckland PCN, Norfolk and Suffolk Foundation Trust and the CCG's South Norfolk PCN Development Team were all involved in this really important transformation, which fundamentally is aiming to improve access to mental health services. The lessons learnt revealed the importance of appreciating the different characteristics of all the providers when seeking to embed shared staff across differing cultures. The findings are helping us to embed this transformation across Norfolk and Waveney.

North Norfolk: NN1 PCN and NCH&C Community Pilot

Similarly, clinicians from NN1 PCN and Norfolk Community Health and Care are working together to explore how we can best integrate PCNs and community health services. This is an ongoing project and iterative change process, with several work strands underway each looking at quite specific interventions, such as the identification of gaps in leg ulcer doppler provision. The team have a work plan, with identified teams and names to lead on each area, but what is really fundamental is the relationships that have now been formed that are enabling us to make progress and at the heart of this to improve people's care.

Appendix C: Place-based working in our neighbouring Integrated Care Systems

- Suffolk and North East Essex ICS has three 'places' broadly aligned to their acute hospitals. Their alliances cover 'North East Essex', 'West Suffolk' and 'Ipswich and East Suffolk'.

- Cambridgeshire and Peterborough ICS is proposing to create two 'places' aligned to their acute trusts.

- Lincolnshire ICS is proposing to have one 'place', coterminous with Lincolnshire County Council.