Engagement report: How we should work together at a more local level in our Integrated Care System
(June 2021)

Background

We ran an engagement exercise to gather the views of stakeholders about how we work together at a more local level in our Integrated Care System, particularly the geographic areas or footprints in which we will work together to integrate services, make best use of our combined resources and narrow inequalities. This report provides an analysis of what people told us during the engagement period.

Executive summary

Here is a summary of what people have told us how we should work together at a more local level in our Integrated Care System:

- Overall, there is strong support for the principle of local working and a place-based approach. Stakeholders recognise that this is complex and that there is no straightforward answer; but are equally excited by the opportunities and potential improvements that could be made to local people's health, wellbeing and care through place-based working.

- Stakeholders said they felt the functions and tasks outlined in the engagement document were broadly right. However, once we have determined the geographic footprints for our local working, and in light of any further national guidance, it will be important to review and refine these.

- It is recognised that there will never be a neat and exact delineation between what happens at each level, and that all levels of our ICS are important and are not a hierarchy. Effective local working arrangements will complement our system level working.

- Stakeholders also broadly agreed we had identified the right factors to take into account and to guide our decision about the best fit geographic footprints for our sub-ICS working. It was widely recognised that form should follow function and that it is imperative that we ensure the footprints we decide on support the delivery of the partnership's priorities.

- We asked stakeholders for their views on six options for different geographic footprints that we could use to organise ourselves. Stakeholders provided detailed and nuanced views, but overall there were two options that were felt would have more advantages. These were five places based on the current health localities and seven or eight places based on the district council boundaries. There was also some support for having three places based on Functional Economic Areas or acute hospital catchment areas, as well as five places based on the provision of community services.

- 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.

Methodology and respondents

The engagement period ran from 17 May to 13 June 2021. We used a range of approaches to involve stakeholders and to get people's views:

- We held a briefing event at the start of the engagement period for system leaders to ensure that they understood the purpose, context and objectives of the engagement.

- We attended 22 meetings, groups and forums during the engagement period and the full list is included as Appendix A. We took notes at each meeting and included the comments made in our analysis.

- We ran an online survey and offered people the opportunity to email us their views. We received written responses from 18 organisations and groups, as well as five individuals. The organisations and groups that responded in writing included county and district councils, NHS commissioners and providers (primary, secondary and community care) and VCSE organisations. The full list is included as Appendix B.

Functions and tasks

We asked: Building on what we've learnt from our existing local partnership arrangements, we have developed some suggested key functions and tasks that could happen at 'place' and 'neighbourhood' levels (as described in section G of the engagement document).

Here is a summary of what people told us:

- Stakeholders said they felt the functions and tasks outlined in the engagement document were broadly right. However, once we have determined the geographic footprints for our places and neighbourhoods, and in light of any further national guidance, it will be important to review and refine these.

- Stakeholders recognised that there will never be a neat and exact delineation between what happens at each level, and that all three levels of our ICS are important and they are not a hierarchy. Effective local working arrangements will complement our system level working, which will continue to remain important.

- A few stakeholders also stressed that place-based working and subsidiarity aren't just about decision-making processes and governance, but about a real culture change too. They suggested we will need to continue to ensure that we have a development programme that supports the journey our system and workforce are going on.

Some stakeholders did suggest additional functions and tasks; these were:

Neighbourhood

- There should be an opportunity to delegate to the neighbourhood level too. We could build on the opportunities that present themselves through funding that is being directed to PCNs. The PCN Investment and Impact Funding could be built on as a means to delegate system funding to local areas to address specific issues. This would enable existing partnerships to continue to develop their wider integrated care plans, based on local need, but could be done in a way that meets the parameters / framework set by the system.
- Integrated care hubs
- Care at home, where appropriate
- Integrated primary and community services

Place

- The continued development of effective local partnerships – bringing all partners together (multi-agency approach) and very much building on the work we have already progressed across a range of partners.
- Addressing health inequalities and embedding population health management – using data better to improve health and care.
- Simplifying and standardising care pathways to expedite patient discharges to ensure the patient receives the right care, in the right place, at the right time. Place delivery offers the opportunity of agile working across local partners, focused on patient need.
- Developing new models of out-of-hospital care – such as with the PCNs and community service providers.
- Budget management.

Factors to help us determine the 'best fit' geographic areas

We asked: We have developed a list of factors to take into account and to help us determine the 'best fit' geographic areas or 'footprints' for us to work at 'place' and 'neighbourhood' levels (as set out in section H of the engagement document). Do these feel like the right factors to take into account? Are there any missing? Which is the most important to you?

Here is a summary of what people told us:

- Stakeholders broadly agreed we had identified the right factors to take into account and to guide our decision about the best fit geographic footprints for our

sub-ICS working. However, stakeholders did emphasise different factors as being more important to them.

- It was recognised that form should follow function and that it is imperative that we ensure the footprints we decide on support the delivery of the Integrated Care System's priorities. Stakeholders highlighted a range of different priorities that our place-based arrangements could help to deliver, including the operational integrational of health and care services, having a greater focus on prevention, addressing the wider determinants of health and tackling inequalities.

- Many health commissioners and providers said they feel it is important to take into account alignment with PCN boundaries and existing patient flows, as well as footprints that build on existing relationships and local knowledge.

- Local authorities said they feel it is important to take into account alignment with district council boundaries and achieving the greatest degree of coterminosity with how wider public services are organised. They said they felt this would help to deliver long term and sustainable transformation that improves people's health, wellbeing and social mobility.

- A range of stakeholders said that it is more important that the footprints have similar health and care needs, rather than grouping areas due to organisational structures alone.

- It was widely recognised that our places should be meaningful areas to local people. And it was suggested that our places should look to empower local communities and follow the principle of subsidiarity.

- It was recognised that it is inevitable that organisations will need to continue to operate across multiple areas and that not all boundaries will match. It is important that there is good planning, clear communication and support for people to work across multiple areas in order to mitigate this.

- It was suggested it is important to base our decisions on the level of complexity across the system as a whole, and not on the complexity for individual providers.

- At the same time, it was commented that we need to bear in mind the capacity of providers, as we would not want to see a situation where the sustainability of an individual provider's business model is adversely affected by creating new working arrangements. Not only would this affect the individual provider, but it would undoubtedly impact on other partners too and on the services available to care for and support people.

- It was suggested that we need to consider people's behaviour, the way in which they access services and where they want to access them as a guiding principle for our decision-making. This includes considering the impact on both urban and rural areas, and ensuring that everyone will need to be able to access services, regardless of which place they happen to live in.

- Stakeholders noted we also need to be mindful that people don't just access services in the local authority area or within the ICS boundary; acute patient

pathways for example extend to Cambridge, Bury St Edmunds and beyond. And there are also significant communities of interest who are spread out across our system who needs must be considered when planning and delivering services and support.

Footprint options

We asked: We have developed six options for different geographic footprints that we could use to organise ourselves (as set out in section H of the engagement document). What do you think would be the advantages and disadvantages of each option for how the system plans and delivers people's care? Do you have an alternative suggestion?

Building blocks for our sub-ICS working

There was quite a lot of discussion during the engagement about how we could and should construct our geographic footprints. Stakeholders had mixed views about this, in particular whether the building blocks for our sub-ICS working arrangements should be groupings of PCNs or the district councils.

PCNs

Here is a summary of what stakeholders considered would be the advantages of using the PCNs as the building blocks:

- **We should build on the good progress we've made and strong relationships in place:** The PCNs and the current Local Delivery Groups which are based on the PCNs have made significant progress, both before and particularly during the pandemic. The COVID-19 vaccination programme is an excellent example of what we can achieve as place-based partnerships. Other examples of effective, integrated solutions that have emerged from our current structures include Homeward, NEAT, Community Fully Integrated Community Services, Integrated Home Visiting Services and Care Homes at Scale. We should look to build on that progress and the established relationships. Conversely, splitting the PCNs or asking them to work in different places would risk losing this progress.

- **District councils and community providers have engaged in the current arrangements which are based on PCNs:** Health colleagues said based on their experience from the current arrangements that they felt district councils work well together. They also said they appreciate the willingness of district councils to engage and said from their perspective there have not been significant issues with district councils working across more than one locality. For example, in the current South Norfolk locality the PCNs and other partners have worked successfully with both South Norfolk and Breckland District Councils.

- **PCNs have access to health data which is vital for tackling health inequalities:** There is significant amount of health data available at PCN level and this is vital for the effectiveness of our population health management work and approach to addressing health inequalities. There would be difficulty accessing health data at place level if we don't use PCNs as our building blocks.

- **Using PCNs as the building blocks would enable delegation of NHS funding to place level:** We would want to ensure that any delegation of health funding is fair and equitable, based not just on population size but the needs of each place too. The most effective way to achieve this is to use PCNs as our building blocks because the NHS already divides up funding in this way. If we were to use an alternative building block, then we would have to spend a significant amount of time and resource trying to divide up NHS funding according to a new set of boundaries. This could limit the amount of delegation from the NHS, or at the very least the speed at which funding could be delegated.

- **PCNs have experience of and mechanisms for receiving delegated NHS funding:** PCNs are used to receiving and managing funds (both capitation based and for quality improvement projects) and have the financial infrastructure to manage budgets. They already have a maturity matrix to measure themselves against and track progress. All of this would support places built on PCNs to more quickly take on delegation of funding and accountability.

- **Local people have a relationship with their GP practice:** While many people do of course identify with their local council, experience also tells us that people have a strong relationship with their local GP practice and that GP practices are an important part of every community.

- **Our place-based partnerships will need to address both the operational integration of health and care services, as well as the wider determinants of health:** District councils are a vital part of our system and if our placed-based working was solely focused on addressing the wider determinants of health then there would be a stronger argument for using the district council boundaries. However, our place based arrangements will need to both progress the operational integration of health and care services, as well as act as a key mechanism for our system to address the wider determinants of health. Health colleagues felt that using PCN building blocks would be the better fit for delivering on both of these.

District councils

Here is a summary of what stakeholders considered would be the advantages of using the local government boundaries as the building blocks:

- **Form must follow function:** There is wide variance in population health and care needs across the ICS, including within footprints that have historically been recognised as one area. To address these challenges, place footprints should be based on natural, physical or social geographies that focus on the issues pertinent to their local area, avoiding grouping areas due to organisational structures alone. Tackling the most ‘wicked’ health and care challenges and truly addressing the wider determinants of health will require partnership working at a place level between statutory and non-statutory partners, which already happens with partners coming together around district footprints. People residing in an area are part of the same community and share risks and hazards from their socio-economic, built and natural environments which consequently then impact on their health and care needs.

- **This decision is not just about the health and care system:** We have an opportunity to integrate our whole public sector to more effectively deliver services which produce better outcomes and focus on the wider determinants of health for our residents. A number of wider partners in our ICS are already working, or interfacing with each other around district council footprints, including Children's Services, the Constabulary and economic growth partnerships. Using district council boundaries would enable these partners to play a larger role in our place-based working.

- **Communities need recognisable, natural boundaries:** For most people, day-to-day care and support needs alongside wider interactions with their community, will be expressed and met locally in the place where they live. These are the places where we have our bins collected, receive housing advice, are supported by a carer in our home or join a walking group in our local park. The best definition of place that residents will understand is their district area; strengthened more-so this year by the support for our communities during the pandemic being heavily driven via district footprints, where district councils have supported each other and partners and worked across boundaries when needed. Alongside this, as a large rural area, a larger scale footprint would not be as effective and would not necessarily deliver economies of scale – there can be diseconomies to scale.

- **We need to prioritise a focus on resident population rather than registered population:** Populations registered to a particular service (e.g. GP or a school) are not necessarily resident in the same area where that service is located. A registered population is not where people live, making integration with community services more challenging.

- **District councillors are elected to advocate better experiences and outcomes for residents and communities:** Living within the communities and alongside the people they represent, councillors know and understand the places where people live and the challenges and obstacles they face. As a subset of an ICS, people would know they can go to their local district council as a democratic and recognisable body who have been chosen to represent them.

- **We will need to articulate and measure progress:** Rich data around the wider determinants of health (e.g. employment, housing, the built environment, open spaces, air and water quality, pest control, licencing and food hygiene) is already collected at a district council level. Having defined District Council places will make the greatest contribution to data and intelligence enabler, where data is accessible, reported regularly, replicable, comparable and contextualised to the geographical places people live in. This would better support a strengthened joint strategic vision at place and the principle of subsidiarity.

Option one: Two places covering the East and West of our ICS

People identified the following potential **advantages**:

- It would be easier to delegate funding and accountability to just two places, as they should have the requisite skills and capacity to effectively manage that delegation.

People identified the following potential **disadvantages**:

- Each place would be too large to enable meaningful discussion and planning, informed by a detailed understanding of local people, communities and services.
- There would be significant differences in the demographics, needs and health and care outcomes within these two places, which would be hard to address working on these footprints, in part because of the lack of detailed local knowledge.
- There is a risk that small areas of deprivation or with particular needs would get lost when working and planning across such large places, negatively impacting on our work to address health inequalities.
- There is poor alignment with health and local authority boundaries.
- These footprints could make it harder for those partners who are vital to addressing the wider determinants of health to engage, for example VCSE organisations who don't operate at such a large scale.
- While the option would provide an even geographic division of our area, the two would be places would be very unbalanced in terms of population size.
- These areas are also not meaningful to local people and don't take account of existing patient flows or the way that services are configured.
- This option would not build on our existing local knowledge or relationships.

Overall, there was little support for this option.

Option two: Three places based on Functional Economic Areas

People identified the following potential **advantages**:

- Functional Economic Areas do have some resonance with local people in that they represent areas in which people live, work and access services; they are areas to which people relate to.
- It would be easier to delegate funding and accountability to three places, as they should have the requisite skills and capacity to effectively manage that delegation.
- If based on district council building blocks, this option would bring some alignment of commissioning functions of health and social care to housing,

benefits, criminal justice, planning and economic growth systems, and on the basis on which economic discussions occur.

People identified the following potential **disadvantages**:

- Each place would be too large to enable meaningful discussion, informed by a detailed understanding of local people, communities and services.

- While there is a logic for West Norfolk and the East of our system, there are significant differences between the demographics, needs and health and care outcomes of those living in central Norfolk. These would be hard to address working on these footprints, in part because of the lack of detailed local knowledge.

- From a health perspective, the only real common factor that binds these areas together is that most patients go to the Norfolk and Norwich University Hospital, although some also travel to other hospitals including the West Suffolk Hospital. Overall, these areas don't take account of existing patient flows or the way that services are configured.

- There is a risk that small areas of deprivation or with particular needs would get lost when working and planning across such large places, negatively impacting on our work to address health inequalities.

- These footprints could make it harder for those partners who are vital to addressing the wider determinants of health to engage, for example VCSE organisations who don't operate at such a large scale.

- Smaller footprints and working at a more local level may make it easier to empower local communities and would be more in line with the principle of subsidiarity.

- This option would not build on our existing local knowledge or relationships.

- We would need to be clear what neighbourhood arrangements would be in place. If PCNs were the neighbourhood level, there is a risk that because of the existing strong relationships and ways of working, that work would continue to happen in the North Norfolk, South Norfolk and Norwich health localities, effectively adding in a layer between place and neighbourhood levels. This would make our arrangements more complex, rather than clearer.

Broadland District Council and South Norfolk District Council favoured either this option, if it was based on groupings of district councils, or of having seven or eight places based on district council boundaries. They explained that it would depend on the functions offered to place and the scale needed to deliver those functions. Under this option, they felt that district council boundaries could act as defined neighbourhoods, working closely with PCNs.

This option was favoured by the James Paget University Hospital. They felt it would enable us to build on the progress made by partners in the East of our ICS and it recognises the role of the hospital as an anchor institution.

Mid-Norfolk PCN said they are concerned by this option as their patients flow clinically and socially to Norwich and the NNUH rather than the West and the Queen Elizabeth Hospital. They explained that aligning patient flows to the Queen Elizabeth Hospital would produce clinical problems as nearly all clinical lab results are linked to the NNUH hospital. Currently the three main hospital do not have a shared results platform for primary care to be able to see all historic results. They also noted that using public transport from mid-Norfolk it is much easier to get to Norwich than it is to King's Lynn.

Option three: Three places aligned to the catchment areas of the three acute hospitals

People identified the following potential **advantages**:

- These areas would have some resonance with local people in that people recognise, know and use their local hospital.
- There would be alignment with patient pathways for secondary care.
- Acute hospitals play an important role as anchor institutions in their communities and this option could enable the trusts to further develop that role.
- It could make it easier for our three acute trusts to engage in place-based working, as all three acute providers would be able to have one conversation with PCNs and community providers.
- It would be easier to delegate funding and accountability to three places, as they should have the requisite skills and capacity to effectively manage that delegation.

People identified the following potential **disadvantages**:

- Each place would be too large to enable meaningful discussion, informed by a detailed understanding of local people, communities and services.
- While there is a logic for West Norfolk and the East of our system, there are significant differences between the demographics, needs and health and care outcomes of those living in central Norfolk. These would be hard to address working on these footprints, in part because of the lack of detailed local knowledge.
- The only real common factor that binds these areas together is that most patients go to the Norfolk and Norwich University Hospital, although some also travel to other hospitals including the West Suffolk Hospital.
- There is a risk that small areas of deprivation or with particular needs would get lost when working and planning across such large places, negatively impacting on our work to address health inequalities.
- It is vital that we have consistent acute pathways and policies and so this work will be progressed at system level, not place level. It therefore isn't a logical choice to use the acutes catchment areas to organise our place-based working.

- Aligning our planning and work around the acute trusts feels like it goes against the national NHS Long Term Plan and our own local ambitions to move care closer to home, to increase our focus on prevention and to tackle health inequalities.

- Acute hospitals are a key part of our ICS, but at a place level opportunities for joint working fall predominantly within community partners, which place footprints must support.

- These footprints could make it harder for those partners who are vital to addressing the wider determinants of health to engage, for example VCSE organisations who don't operate at such a large scale.

- Smaller footprints and working at a more local level may make it easier to empower local communities and would be more in line with the principle of subsidiarity.

- This option would not build on our existing local knowledge or relationships.

- We would need to be clear what neighbourhood arrangements would be in place. If PCNs were the neighbourhood level, there is a risk that because of the existing strong relationships and ways of working, that work would continue to happen in the North Norfolk, South Norfolk and Norwich health localities, effectively adding in a layer between place and neighbourhood levels. This would make our arrangements more complex, rather than clearer.

This option was favoured by Healthwatch Norfolk and Healthwatch Suffolk, who felt that it would work well if we used the district council boundaries as the building blocks. They said they feel people tend to identify more with their local district general hospital, but that it is imperative that there are close links established with district councils.

The James Paget University Hospital NHS Foundation Trust said this would be their second preference. Similarly, they felt it would enable us to build on the progress made by partners in the East of our ICS and it recognises the role of the hospital as an anchor institution. The Queen Elizabeth Hospital King's Lynn said they would favour either this option or the five places based on the current health localities.

Option four: Five places based on the current health localities

People identified the following potential **advantages**:

- Five places provides a good balance, enabling each place to have a detailed understanding of local people, communities and services, while still ensuring that the places are of sufficient size that they should have the requisite skills and capacity to effectively manage any delegation.

- These five areas have evolved like this for a reason, in part because they recognise the significant differences between the demographics, needs and health and care outcomes of those living across the system, but particularly in the differences in central Norfolk. While the PCNs and Local Delivery Groups are relatively new, health services have operated using these boundaries for much longer.

- We have made good progress together since we established the Local Delivery Groups. Close working relationships are key to the success of the ICS and can take a long time to build. We should look to build on this collaboration and the relationships that have been developed.

- Any change of geographical footprints will inevitably cause disruption and given the significant challenges we are faced with following the pandemic there is significant value in continuity. Because of this, there needs to be a really strong case for change and clear value to be gained.

- While this is undoubtedly true of all sectors, health providers in particular fed back that the pandemic has been incredibly challenging and tiring. They also reflected that are other changes being planned or made to the health service, including the abolition of clinical commissioning groups, the introduction of statutory integrated care systems and the development of provider collaboratives. Bearing this all in mind, they said they felt that minimising the amount of change would help them and enable them to focus on caring and treating patients, and working with partners to progress our wider agenda around prevention, addressing the wider determinants of health and tackling inequalities.

- Great examples of effective, integrated solutions have emerged from our current structures, such as Homeward, NEAT, Community Fully Integrated Community Services, Integrated Home Visiting Services and Care Homes at Scale. Because we have a track record of delivery in the current system, it would mean delegation of resources and accountability could happen quicker.

People identified the following potential **disadvantages**:

- Because the PCN and district council boundaries are not completely coterminous, this option would mean that some district councils would have to interface with more than one place.

- These footprints could make it harder for those partners who are vital to addressing the wider determinants of health to engage, for example district councils, Children's Services, the constabulary and some VCSE organisations, as they are currently work around district council boundaries.

There was also some debate about the extent to which this option would feel and be seen as different to what we have now or have had in the recent past. On the one hand, some said they thought it would be perceived as a step backwards or an indication that the merging of the CCGs wasn't the right decision. It was suggested that it would mean our place-based working would be overly focused on health services and not the work of the wider partnership.

On the other hand, some reflected that this wouldn't be about re-creating the former CCGs and that our place-based arrangements will be different in two key ways. Firstly, they will be multi-agency and not just made-up of NHS commissioners like the CCGs. And secondly, they will have different functions and tasks, notably including a much greater emphasis on prevention and addressing the wider determinants of health. They also reinforced that system-level working is incredibly important for making those decisions and

performing those functions that are best done for the whole of Norfolk and Waveney, so it was the right decision to merge the CCGs, it was in line with the national direction and it put us ahead of many other areas.

This option was favoured by the CCG and the PCNs, and both community health providers also said they would favour this option or the other five place option based on the provision of community services. The Queen Elizabeth Hospital King's Lynn also said they would favour either this option or the three places based on the catchment areas of the three acute trusts. Norfolk Community Advice Network felt this was the best option, while Age UK Norwich said that either this option or option five would offer the best solution.

Option five: Five places based on the provision of community services

If the PCNs are used as the building blocks for this option, then it is very similar to the previous option based on the current health localities. Because the only difference is in the mid-Norfolk area, for large parts of Norfolk and Waveney the advantages and disadvantages set-out for the previous option remain the same for this option.

Some distinct advantages and disadvantages were identified though:

People identified the following potential **advantages**:

- There would be alignment with patient pathways for out of hospital care.

People identified the following potential **disadvantages**:

- This option would mean that some PCNs would have to interface with more than one place.

Both community health providers also said they would favour this option or the other five place option based on the provision of community services. Age UK Norwich said that either this option or option four would offer the best solution.

As with option two, Mid-Norfolk PCN said they are concerned by this option as their patients flow clinically and socially to Norwich and the NNUH rather than the West and the Queen Elizabeth Hospital.

Option six: Seven or eight places based on the district council boundaries

People identified the following potential **advantages**:

- Having seven or eight places would enable each area to have the most granular understanding of local people, communities and services, as each place would have a smaller area to focus on. There is also more readily available data available about the wider determinants of health at district level.

- The district council areas recognise the significant differences between the demographics, needs and health and care outcomes of those living in different parts of Norfolk and Waveney.

- This option would also support our ambition to address the wider determinants of health and to further the prevention agenda. This is because it would make it easier for a wider range of relevant partners to engage, for example district councils, Children's Services, the constabulary and some VCSE organisations, as they are currently work around district council boundaries.

- This option also provides opportunities for democratic engagement and there are existing mechanisms in place for wider engagement too.

- Smaller footprints and working at a more local level may make it easier to empower local communities and would be more in line with the principle of subsidiarity.

People identified the following potential **disadvantages**:

- Some stakeholders felt that having this many places would make it more difficult to delegate NHS funding. This is because more places means greater management overheads, which is hard to justify at a time when we have a significant financial challenge, and it also builds in greater risk in terms of each place having the requisite skills and particularly capacity to effectively manage delegated funding and accountability.

- Because the PCN and district council boundaries are not completely coterminous, this option would mean that some PCNs would have to interface with more than one area.

- This option would align local health and care decisions with elected representatives who could be held to account by communities. However, this also adds complexity; having separate representatives at different tiers of local government with potentially different perspectives and priorities could make planning more complex with multiple local government cabinets and committees to involve.

This option was favoured by Norfolk County Council and our district councils. Broadland District Council and South Norfolk District Council suggested that under this option, the PCNs could act as neighbourhoods.

Alternative five place option based on groupings of district councils

Norfolk County Council said that they feel whilst meeting population need, tackling 'wicked' issues and bringing the right partners together would predominantly favour having seven or eight places based on district councils, having five places by grouping some district council areas could also provide these benefits.

They said they would welcome working with the whole of the ICS to look across these geographies at needs, demography and total resourcing and using that geography as the base unit for strategic analysis and collaboration. They added they would always strongly consider designing operational service models aligned to these footprints as a core option of any design, acknowledging that some structures would continue to require other footprints when serving specific cohorts or client groups.

They said that whilst PCNs and district councils largely have boundaries that align, there are a few instances (particularly around the greater Norwich area and in South Norfolk) where they do not. The County Council suggest an approach that in these instances district councils are the starting building block, but where a PCN crosses the boundaries, they are not split and having to act in both places, but instead the boundary incorporates them in to one area. This could increase opportunities for joint working with primary care, whilst forming places that still remain largely conterminous with district councils.

Feedback regarding Waveney

- It was widely recognised, particularly by those working predominantly in the East of our system, that regardless of the decision about our overall ICS boundary, there will need to be continued close joint working across Great Yarmouth and Waveney. If the decision is made to make ICSs coterminous with upper tier local authorities, there would need to be a carefully planned and managed transition to the new working arrangements.

Suffolk County Council:

- If our ICS is based on a Norfolk and Waveney footprint, then Suffolk County Council's preference is for there to be a Great Yarmouth and Waveney place. This is because:
  - It would build on the current good work done with the Local Delivery Group.
  - It fits well with local PCNs and the catchment areas of the James Paget Hospital and ECCH.
  - It fits reasonably well with the district and borough councils, covering all of Great Yarmouth and the northern half of East Suffolk District Council, which is the closest fit that is possible.
  - It is an area that people broadly recognise as a natural boundary and feel that it fits with their communities.

- However, they add, their view is that this place would need to be recognised as fundamentally different from others in that it would cross two county councils. They feel there would need to be a level below place so that the Waveney part could look towards Suffolk and the Great Yarmouth part towards Norfolk. This would need to be done to allow for differentiation in how these two 'sub-places' would work. Suffolk County Council are keen to that the place arrangements in the ICS work in such a way to ensure equity of outcomes and the services on offer across the whole of Suffolk, whatever ICS Waveney is in.

- Their view is that this 'sub-place' could need to have more functions delegated to it than in other places and have more freedom to work differently, so it could reflect local need and be fully part of Suffolk. Should this not be possible, the County Council's preference would be for eight places based on district council boundaries.

East Coast Community Healthcare CIC:

- Their view is that the demography, health and care needs and social challenges in Great Yarmouth and Lowestoft are very similar, and different to the surrounding places in all the options considered. This lends itself to very similar planning and delivery consideration. Whether they are considered as a single

'place' or not, any change must not make it harder to plan and deliver appropriate services.

- They add that the health framework around Great Yarmouth and Waveney is a coherent system based around the James Paget Hospital and a single community provider, well integrated with the four PCNs within the area. There is also a coherent plan to deepen this integration based on aligned objectives and trust built over time. They feel that any new structure that disrupts this framework must be able to provide a similar level of local integration quickly, or it risks seeing a deterioration in performance and outcomes in the short to medium term.

Other comments

Other comments made during the engagement included:

- Transparency and clarity around how we make a decision about our place-based working arrangements is really important. Evidence around the decision-making process should be published and made widely available, so as to ensure that there is broad visibility and understanding.

- There is a complexity with the concurrent development of ICS-wide provider collaboratives. Greater consistency and common ways of working across the ICS will have significant advantages, but a balance must be retained to allow effective collaboration across partners at Place level.

- As we further develop our place-based working, it will be important to make clear the relationship between neighbourhood, place and system levels and how accountability will work as we move forwards.

- It is important that we engage the public, as well as those working in health and care, as we further develop our Integrated Care System. This must include young people so that we understand their health and wellbeing needs too.

- The VCSE sector should be represented on the Place Steering Group.

- UNISON queried whether a greater number of smaller places could lead to differences in approach in commissioning services and raised whether that could lead to increased fragmentation or privatisation of the workforce.

- Regardless of the boundaries chosen for the different place areas a well trained workforce in sufficient numbers is vital to deliver the services the population of Norfolk and Waveney rely on.

- We need to be mindful that people don't just access services in the local authority area or within the ICS boundary; it is important that whatever our future working arrangements are that we continue to engage with our neighbouring systems and their local working arrangements.

Appendix A: Meetings, forums and groups attended

Here is a list of the meetings, forums and groups attended during the engagement period:

- Norfolk Public Sector Leaders Board
- Norfolk Health and Wellbeing Board District Council Sub-Committee
- Suffolk County Council Health and Social Care Integration Group
- Suffolk County Council Cabinet
- VCSE Assembly workshop
- NHS Norfolk and Waveney CCG Governing Body
- Norfolk Community Health and Care Foundation Trust Board
- East Coast Community Healthcare CIC Board
- Norfolk and Suffolk Foundation Trust Board
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Board
- James Paget University Hospital NHS Foundation Trust Board
- Norfolk and Norwich University Hospitals NHS Foundation Trust Executive Management Team
- West Norfolk PCN Clinical Directors
- South Norfolk Locality Weekly Operational meeting
- Norwich Clinical Strategy meeting
- Norfolk and Waveney Local Medical Committee
- Clinical and Care Transformation Group
- North Norfolk Local Delivery Group
- South Norfolk Local Delivery Group
- West Norfolk Local Delivery Group
- Great Yarmouth and Waveney Locality Group (Local Delivery Group)
- Norwich Partnership meeting (Local Delivery Group)

Appendix B: Organisations and groups that submitted written responses

Here is a list of the written responses we received from organisations and groups:

- Norfolk County Council
- Suffolk County Council
- District Council Sub-Committee of the Norfolk Health and Wellbeing Board
- South Norfolk District Council
- Broadland District Council
- NHS Norfolk and Waveney CCG
- James Paget University Hospital NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- East Coast Community Healthcare CIC
- OneNorwich Practices
- Mid-Norfolk PCN
- Elmham Surgery and Toftwood Medical Centre
- Healthwatch Norfolk and Suffolk
- Norfolk Care Association
- Community Action Norfolk
- NCAN
- Age UK Norwich
- UNISON