in good health
The Norfolk and Waveney Health and Care Partnership

Engagement document: How we work together at a more local level in our Integrated Care System (May 2021)

A. Introduction

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 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. COVID-19 has underlined the case for collaboration and integration, and accelerated some aspects of integration. Much of this innovation has been led at a more local level than system or Norfolk and Waveney level.

3. The Government's recent white paper, 'Integration and Innovation: working together to improve health and social care for all' (February 2021), recognises the importance of working effectively at a local level and supports the principle of subsidiarity. We anticipate that legislation will follow the white paper that will make Integrated Care Systems statutory bodies, replacing CCGs, coming into operation in April 2022.

4. The purpose of this engagement exercise is 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.

5. We're holding this engagement exercise now because we know that people from across the system have differing views on what we should do and how we should work in future. This is a complex decision, with no clear 'right answer' and therefore it is important that all partners have an equal and fair opportunity to contribute and have their say on what we should do. This exercise will therefore build on what people have previously said and help us to come to a conclusion about how we will work together.

6. It should be noted that a separate review of the boundaries of Integrated Care Systems (ICS) is currently taking place. We expect this review to conclude in the summer too, enabling us to make an informed decision about our local arrangements. Our engagement exercise considers options for if we continue with our existing boundaries of Norfolk and Waveney, as well as options for if ICS boundaries are aligned to upper tier local authority boundaries.

B. The importance of working together locally

7. 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 new 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.

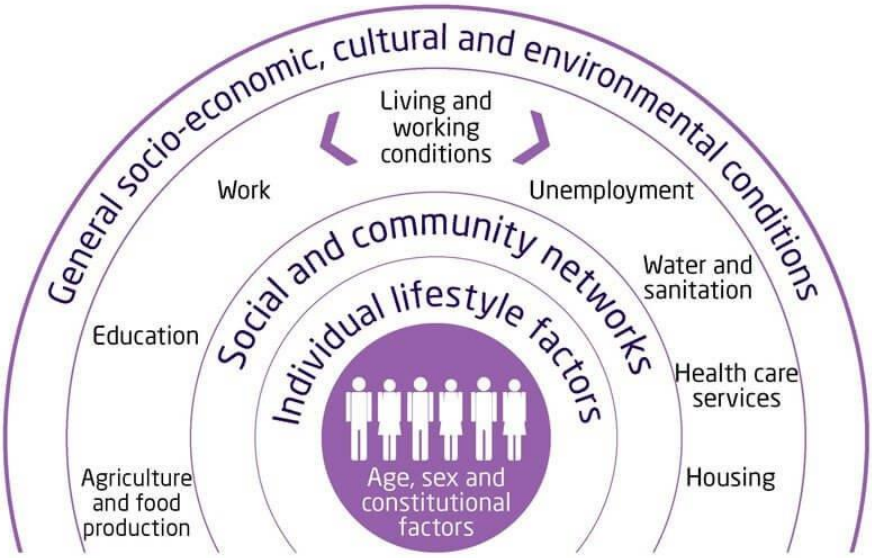
8. The King's Fund conclude the rationale for collaborating over these smaller geographies is two-fold. This aligns well with our local experience to date.

9. 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 co-ordinated 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.

10. Several studies have attempted to estimate the impact of the broader determinants of health. The results of all the studies have a common theme: the majority of what shapes our health has little to do with health and care services.

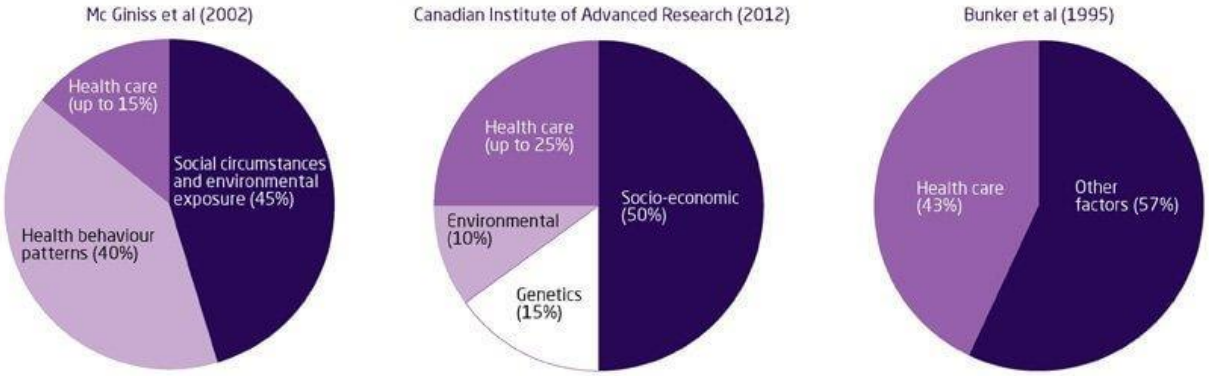
11. The King's Fund and the Local Government Association both use the following diagrams to show the wider determinants of health and their estimated impact.

The wider determinants of health



Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

The estimated impact of the wider determinants of health



Sources: McGinnis, J.M., Williams-Russo, P. and Knickman, J.R. (2002) The case for more active policy attention to health promotion. Health Affairs 21 (2) pp.78-93.

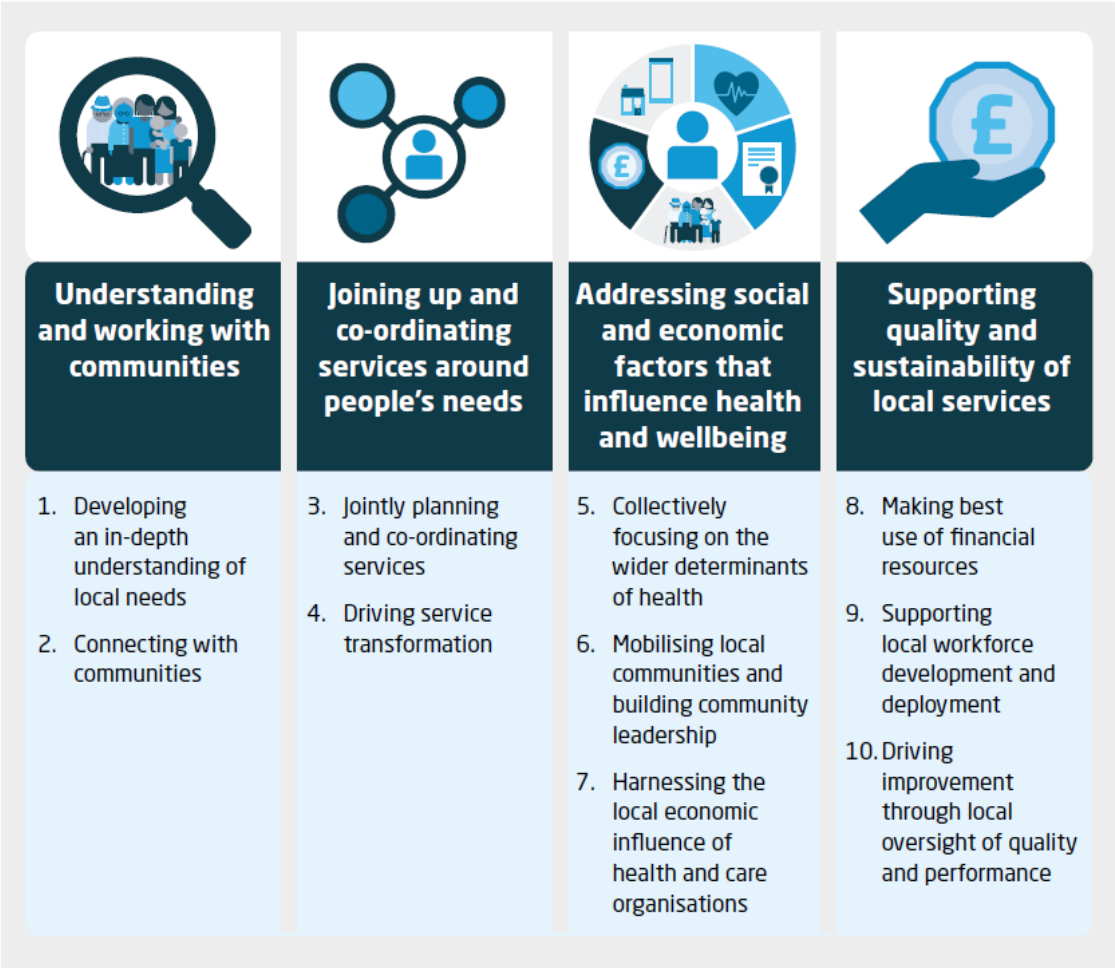
Canadian Institute of Advanced Research, Health Canada, Population and Public Health Branch. AB/NWT 2002, quoted in Kuznetsova, D. (2012) Healthy places: Councils leading on public health. London: New Local Government Network.

Bunker, J.P., Frazier, H.S. and Mosteller, F. (1995) The role of medical care in determining health: Creating an inventory of benefits. In, Society and Health ed Amick III et al. New York: Oxford University Press. Pp 305-341.

12. 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.

13. The King's Fund has also identified the following key functions of place-based partnerships:



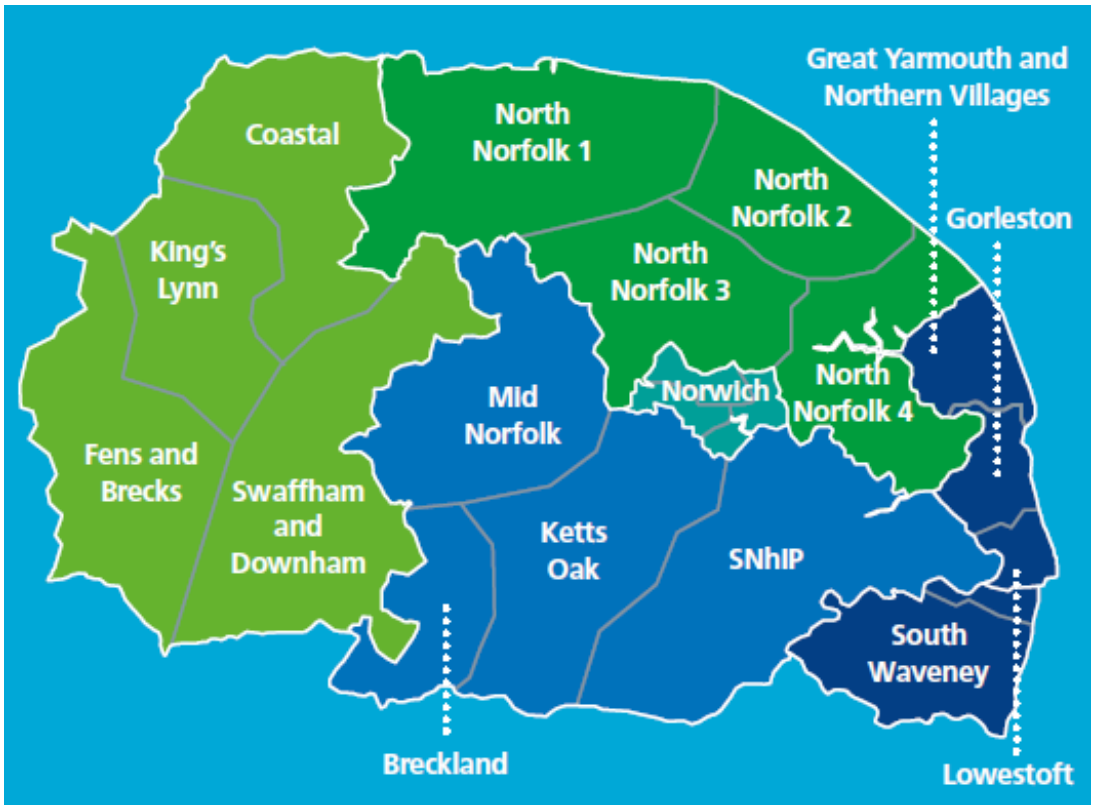
Source: The King's Fund, 'Developing place-based partnerships' (April 2021).

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

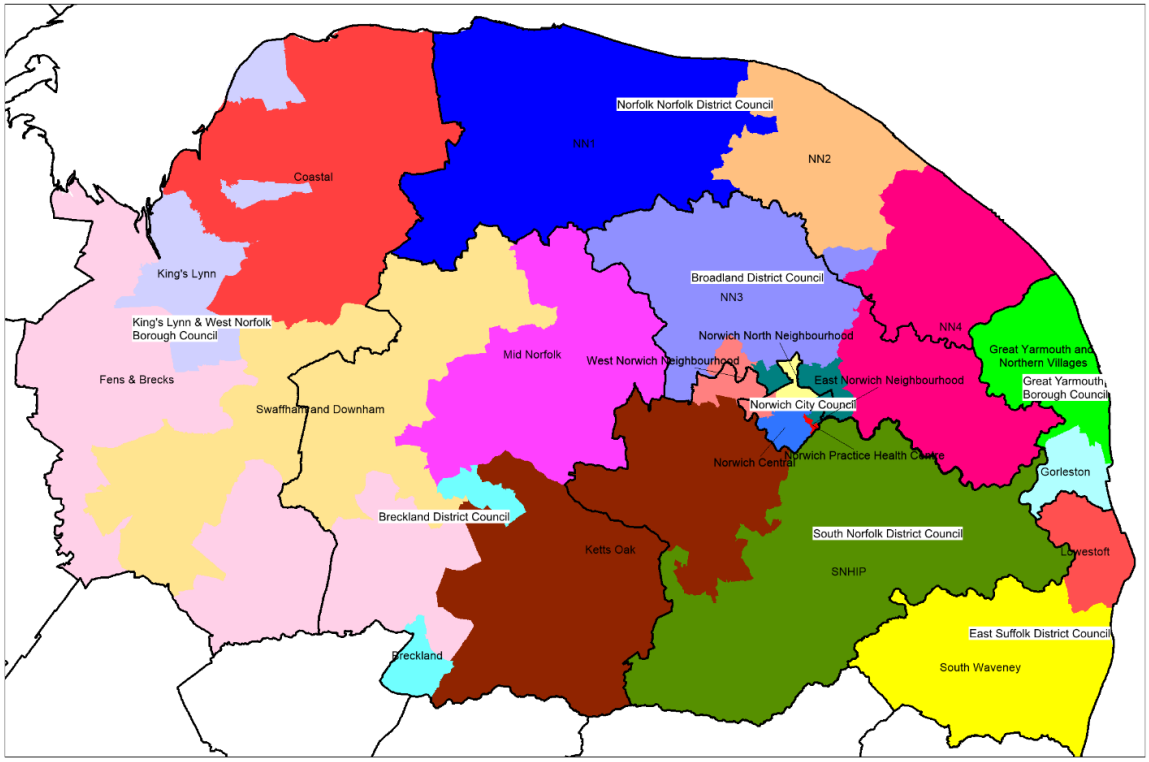
14. Locally, in line with the rest of England, there are three broad levels at which partnership working currently takes place in our Integrated Care System – neighbourhood, place and system:

Level	Features
Neighbourhood: our 17 Primary Care Networks	• Defined by GP practices and their registered lists • Strengthen primary care • Promote prevention and self-care • Be responsive to the characteristics and needs of their local populations, e.g. addressing the needs of a more deprived population than the rest of the footprint • Care for their populations through multidisciplinary community teams, including the VCSE sector
Place: our five areas based on the boundaries of the five former CCGs	• Integrate primary care, acute care, community/mental health and social care services together, as well as the VCSE sector • Greater district council involvement at this level, particularly housing, leisure and community developments • Potential for provider-led partnerships
System: Norfolk and Waveney	• System strategy and planning for the future • Develop accountability arrangements across the system, including the VCSE assembly. • Set and implement strategic change and transformation at scale (e.g. workforce planning, digital, information governance) • Manage performance and finances

15. This map shows our 17 primary care networks, five ‘places’ and our system:



16. This map shows the alignment between our PCNs (shown in different colours) and the district council areas (whose boundaries are shown by a thicker black line):



17. 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.

18. 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.

19. We have learnt that working together as equal partners at a very local level enables us to come up with innovative solutions to shared challenges – for example, identifying people or families in our communities who are particularly vulnerable, and finding new ways of meeting their needs. We have learnt that together we are able to share data and insights to build up an in-depth understanding of our local communities. We have learnt that we can successfully mobilise the local community, build community resilience and make best use of local assets. And we have learnt the importance of developing and investing in strong local relationships and forging a shared vision and sense of purpose.

D. Changing context: the development of Integrated Care Systems and the Government's white paper

20. The recent NHS England and Improvement publication 'Integrating Care' and the subsequent white paper set out a clear course for the future structure of the NHS. One of the core aims both documents set out is to promote integration both within the NHS and between local partners, particularly with local government. The white paper proposes establishing Integrated Care Systems (ICS) as statutory bodies to integrate the delivery of local health and care services, coming into operation in April 2022. It also envisages ICSs taking on both the functions currently held by CCGs and some of those held by NHS England and Improvement.

21. One notable feature of both the NHS publication and the white paper is the considerable emphasis put on the importance of local partnership working below the system-wide level. The NHS paper 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".

22. The reforms build on the NHS's Long Term Plan proposals and a bill will be laid in Parliament when parliamentary time allows to carry the proposals into law. Subject to parliamentary business, the intention is that the legislative proposals for health and care reform outlined in the paper will begin to be implemented in 2022.

E. Work done to date

23. 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.

24. The Steering Group has considered the likely key priorities and functions at place level, the potential 'footprints' for place level working and how accountability between the statutory ICS and place might operate, including how relevant decisions and budgets might be delegated to place level by a statutory ICS.

25. Interviews have also been conducted with a wide range of local partners to help inform our thinking. This engagement exercise builds on what people told us during those interviews, during discussions at partnership forums and the work of the Steering Group.

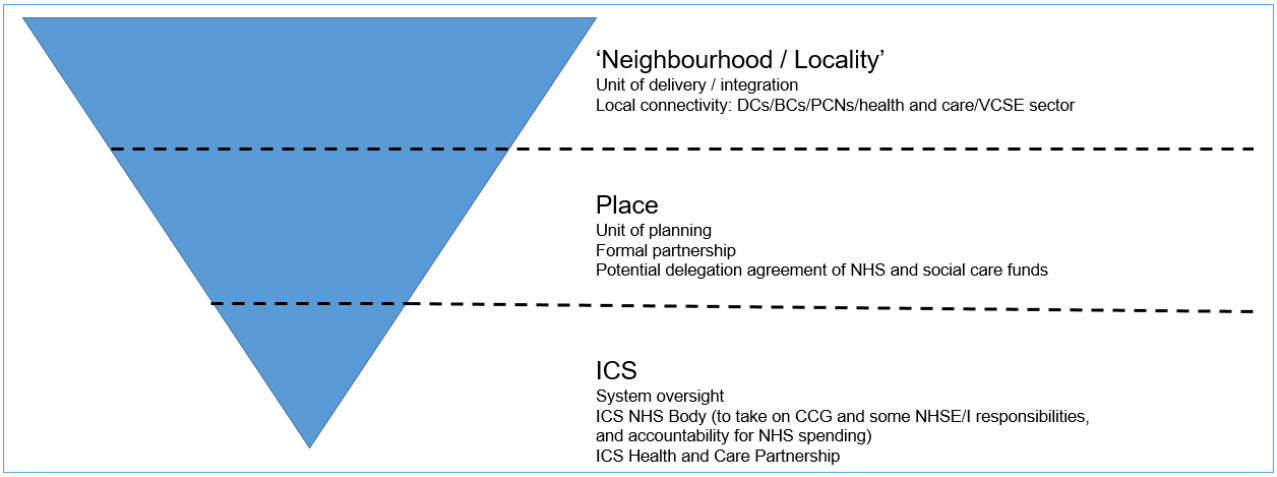
26. The Steering Group has drafted the following broad principles to guide the development of our approach to place-based working:

    - **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

F. A potential three-tier model

27. Through our discussions so far, a potential three-tier model has begun to develop that seeks to accommodate the twin demands of ensuring real connectivity locally (especially with PCNs, district councils and the VCSE sector) and the local leadership/infrastructure that may be required if there is in future to be significant delegation of tasks, functions and funding.



28. We think that neighbourhoods, which will bring together at a very local level district councils, PCNs and local statutory and non-statutory partners, will have a pivotal role in integrating services in response to local need. They will also agree and pursue key shared objectives, such as the prevention of ill health, narrowing inequalities and economic development. Neighbourhoods are characterised by being highly connected, with partners having shared intelligence about the needs and preferences of local communities.

29. Place-level structures may need to cover a wider geography. As such, they have a key role in supporting the development of neighbourhoods, and in taking the lead on issues that affect wider populations. We see the relationship between the ICS and place forming the primary focus of a formal accountability agreement, setting out place objectives and specifying which decisions or budgets are delegated (within agreed parameters).

30. As a result, it may be that our place arrangements will need to be underpinned by more formal partnership and accountability arrangements than at neighbourhood level.

G. Functions and tasks

31. Building on what we've learnt from our existing local partnership arrangements, we have begun to develop views on key functions and tasks that could happen at

neighbourhood, place and system levels. Identifying these functions is key, as they should be the principal driver in determining the 'best fit' local footprints – form following function.

32. In considering functions and tasks, however, it is important to recognise two issues. Firstly, the size of places and neighbourhoods will affect which functions each is best placed to deliver. And, secondly, there will never be – and should not be – a firm or neat delineation between the 'levels': there will be some functions where all parts of the system (neighbourhood, place and system) have a role to play as part of a common objective or programme (for example public health interventions and narrowing inequalities).

33. Broadly speaking we might expect that at system level we would set our overall strategies and identify best practice or a range of interventions to solve the challenges we face, which would then be implemented at place or neighbourhood level depending on the particular issue and tailored to our different communities.

34. For example, we might develop a system level prevention strategy that sets out what we want to achieve and some of the best practice interventions we could make. Some interventions would be delivered at system level, while others would be implemented at place or neighbourhood depending on the needs of each community.

35. It would not be sensible or desirable though to limit those working more locally to just implementing strategies and plans agreed at system level. We don't want to waste time or duplicate effort with colleagues from different parts of the system independently trying to identify the best way to solve a particular issue, but neither would we want to stifle innovation or disempower frontline staff.

36. There will need to be a two-way flow and interaction between those working at system level and those working more locally to enable us to achieve the best outcomes for the local people, to tackle inequalities, to limit unwarranted variation in care, to make good use of our resources and to empower staff to be creative in how they care for and support people.

Neighbourhood level

37. Key functions and tasks at neighbourhood level could include:

- **In-depth understanding of local communities** – by sharing data about and insights into local needs, preferences and assets.
- **Joining up and coordinating local services around people's needs** – health, care and wider public services, including housing, primary and social care, community and mental health services, and the voluntary, community and social enterprise sector. This would include regular multi-disciplinary team (MDT) meetings held to discuss the care needs and plans of specific individuals as part of the operational integration of teams.
- **Inequalities** – development of targeted programmes locally tailored to meet the needs of priority groups.
- **Prevention and self-care** – design and implementation of key programmes such as social prescribing, promotion of healthy lifestyles, and primary prevention, for

example as with the COVID-19 vaccination programme, which has seen PCNs, volunteers, local authorities and others working together.

- **Community engagement** – mobilising the local community and building community resilience.
- **Supporting wider health, social and economic development** – by aligning plans.

Place level

38. Key functions and tasks at place level could include:

- **Supporting the development of neighbourhoods** – including access to capacity and skills.
- **Accountability for delegated NHS and social care functions and resources** – for identified ICS functions that are better delivered at sub-ICS level but still at scale.
- **Implementing system-wide strategies** that are better delivered at sub-ICS level but still at scale, for example our approach to discharge from hospital.
- **Strategic planning** – for example shaping major developments such as capital investment or infrastructure programmes.
- **Integration of key services** – joining-up the local response to health and care needs in the community.
- **Forming a 'bridge' between neighbourhoods and the ICS** – helping to inform the development of ICS strategy, frameworks and resource allocation.
- **With neighbourhoods, supporting wider health, social and economic development** – by aligning plans and as major local employers (anchor institutions).

System level

39. Key functions and tasks at system level could include:

- **Strategic planning** – including agreeing the priorities and plans to deliver the ICS contribution to health and wellbeing strategies, as well as to deliver the national NHS England 'must do's'.
- **Build a shared understanding of overall population needs and inequalities** and agree population health management priorities for Norfolk and Waveney.
- **Lead the development of a shared culture, behaviours and values across the ICS**, based on team-working, mutual respect, diversity and inclusion.
- **Ensure/enable system transformation across sectors** (mental/physical health; NHS/social care; primary/community/acute).
- **Ensure the public, patients and service users are effectively engaged at all levels of our ICS**.

- **Ensure there are effective partnerships with the VCSE sector at all levels in our ICS through our VCSE Assembly**.
- **Support the development of our neighbourhood and place level arrangements** – including access to capacity and skills.
- **Agree and deliver the ICS financial strategy** – including increased budget pooling and co-commissioning; agree capital and estates strategy for system.
- **Agree and secure delivery of system workforce and digital strategies**.
- **Provide assurance for the system** to NHS regulators on NHS finance and performance, and to the health and wellbeing boards on the ICS contribution to health and wellbeing strategies.

H. Geographic footprints

Factors we need to take into account

40. We have developed a list of factors to help us determine the 'best fit' geographic areas or 'footprints' for us to work at 'place' and 'neighbourhood' levels. When you are assessing the options we've developed below for different 'footprints' we could use to organise ourselves, please consider these factors and how well each option takes account of the different factors.

41. The factors we have developed to take into account are to:
    - ensure that the footprints support the delivery of the partnership's priorities
    - ensure that our 'places' will be able to manage delegated decision-making and funding
    - ensure there is real local connectivity, including with the voluntary, community and social enterprise sector
    - ensure our arrangements will support the integration of services, joining-up of people's care and pooling of budgets and resources
    - build on existing relationships and local knowledge
    - consider how meaningful the areas are to local people
    - take account of the alignment with local authority boundaries
    - take account of the alignment with our PCNs
    - take account of existing patient flows

Options for our place level

42. Based on the work we have completed so far, we have developed six options for different geographic footprints that we could use to organise ourselves.

43. When developing these options, we identified two ways in which we could configure our places – either by grouping PCNs together or by grouping district councils together.

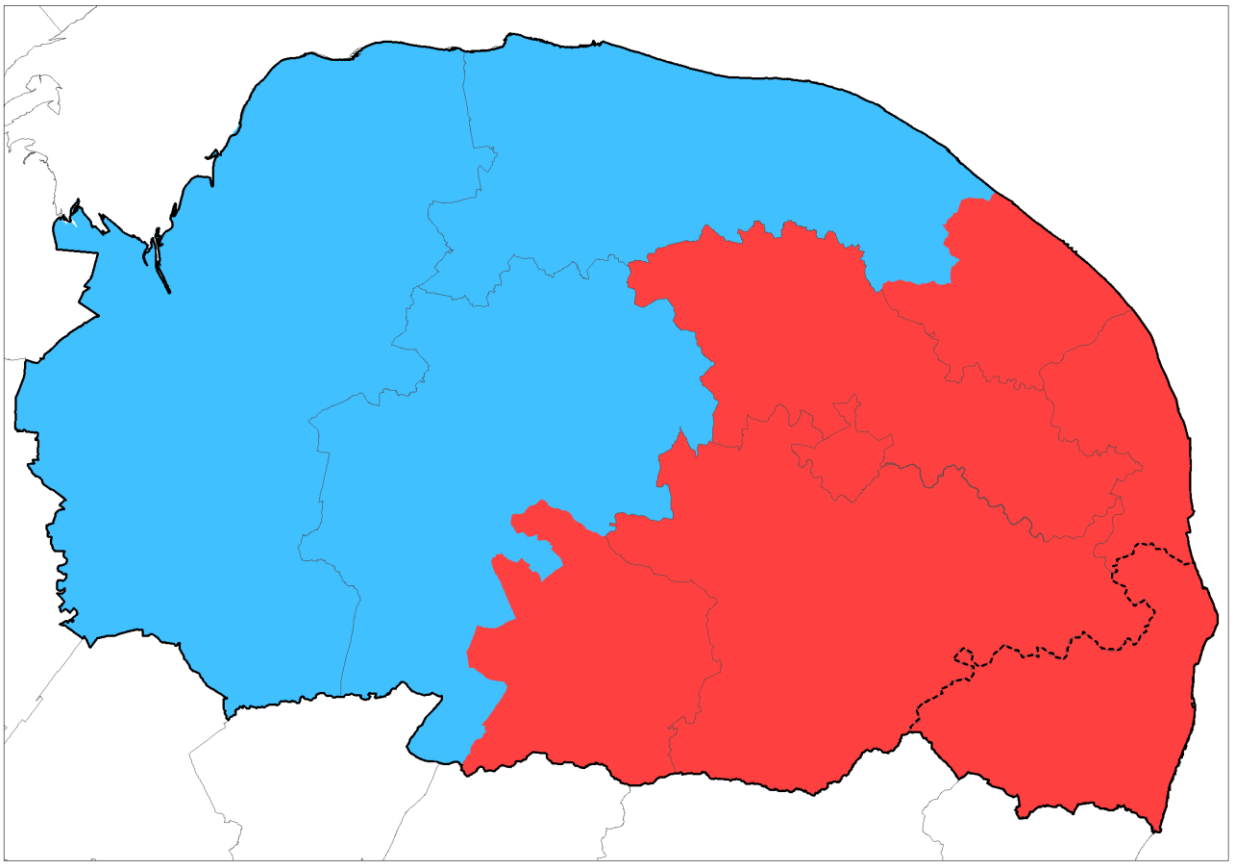
For the purpose of illustration, the options presented tend to use groupings of PCNs and overall they provide a high degree of alignment with district council boundaries. Appendix C shows which PCNs would be located in each place for each option. We would welcome your thoughts on the most appropriate way to configure our places.

44. The six options we have developed are:

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

45. In this option we would have two places covering the East and the West of our ICS, dividing our geographic area approximately in half. The boundary of each place would be determined by grouping PCNs together. The PCNs would be grouped in order to closely align with the district council boundaries. This table shows the population for each place, using the practice lists of the PCNs:

Place	Population with Waveney	Population without Waveney
East place	721,504	588,888
West place	352,402	352,402

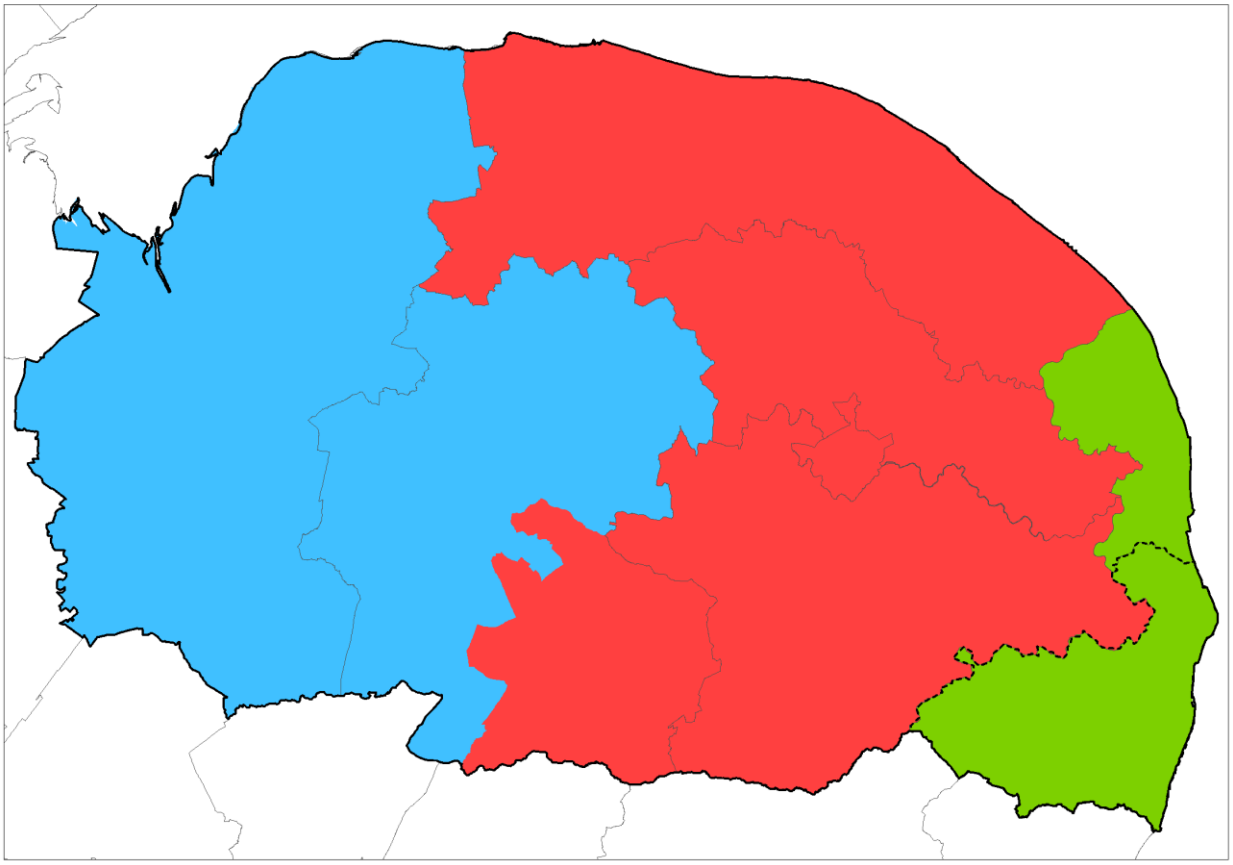


Option two: Three places based on Functional Economic Areas

46. In this option we would have three places based on Functional Economic Areas (FEAs), which are broadly speaking the areas in which people live, work and access services. FEAs are areas that share a number of similar economic factors with boundaries that ideally reflect the drivers of the local economy.

47. The boundary of each place would be determined by grouping PCNs together. The PCNs would be grouped in order to closely align with the FEAs (and by extension the boundaries of the district councils, as when grouped together the boundaries of the district councils broadly match each FEA). This table shows the population for each place, using the practice lists of the PCNs:

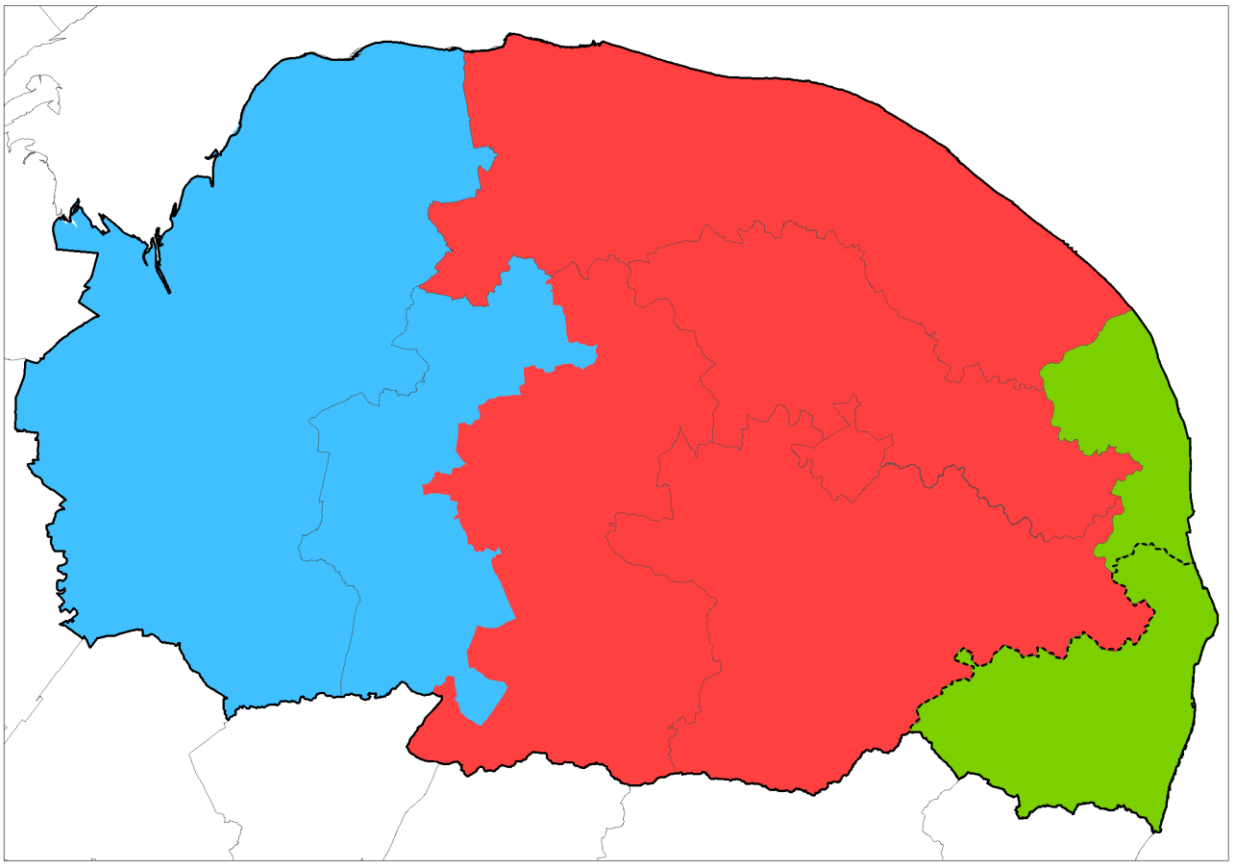
Place	**Population with Waveney**	**Population without Waveney**
East place	241,574	108,958
Central place	562,791	562,791
West place	269,541	269,541



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

48. In this option we would have three places made-up of the PCNs that are aligned to our three acute hospitals, as shown on the map below. This table shows the population for each place, using the practice lists of the PCNs:

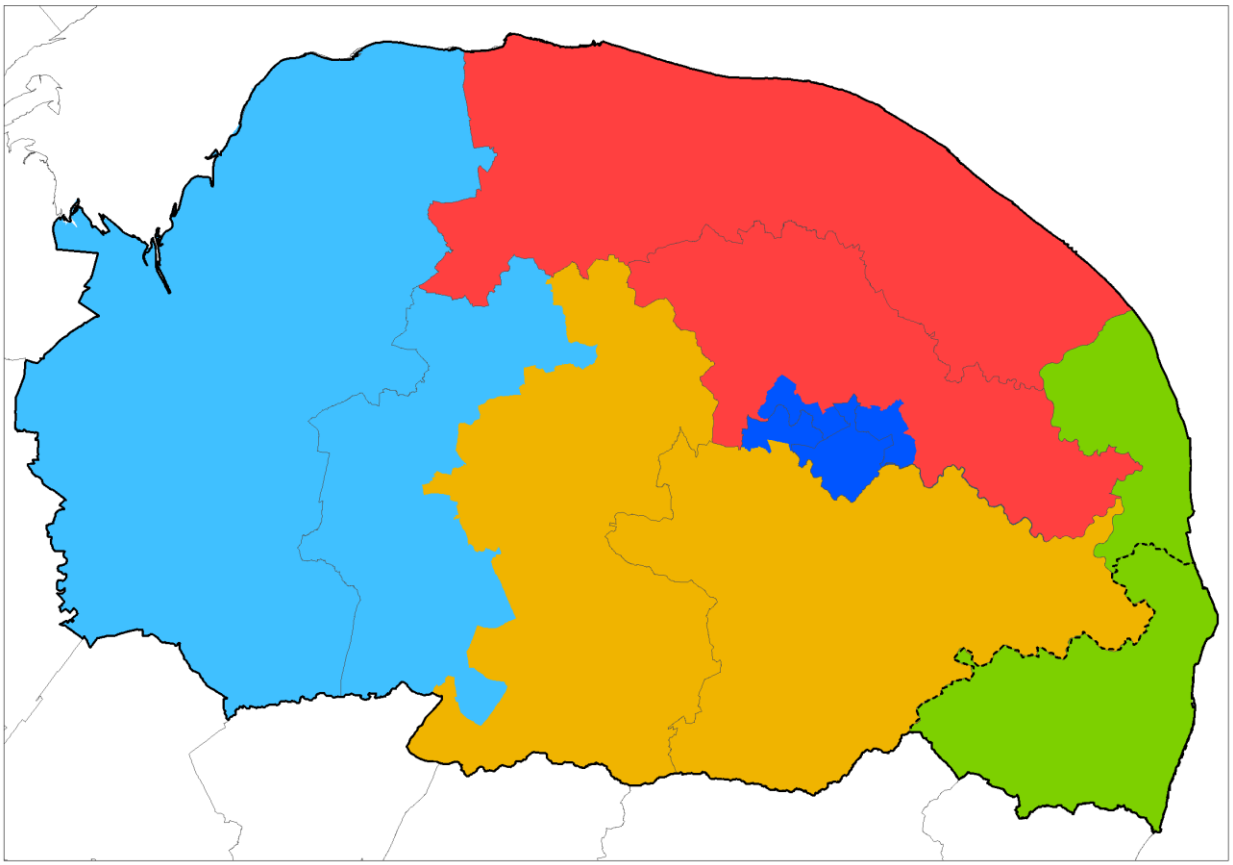
Place	**Population with Waveney**	**Population without Waveney**
East place	241,574	108,958
Central place	653,233	653,233
West place	179,099	179,099



Option four: Five places based on the current health localities

49. In this option we would have five places based on the current health localities / former five CCG areas, as shown on the map below. This table shows the population for each place, using the practice lists of the PCNs:

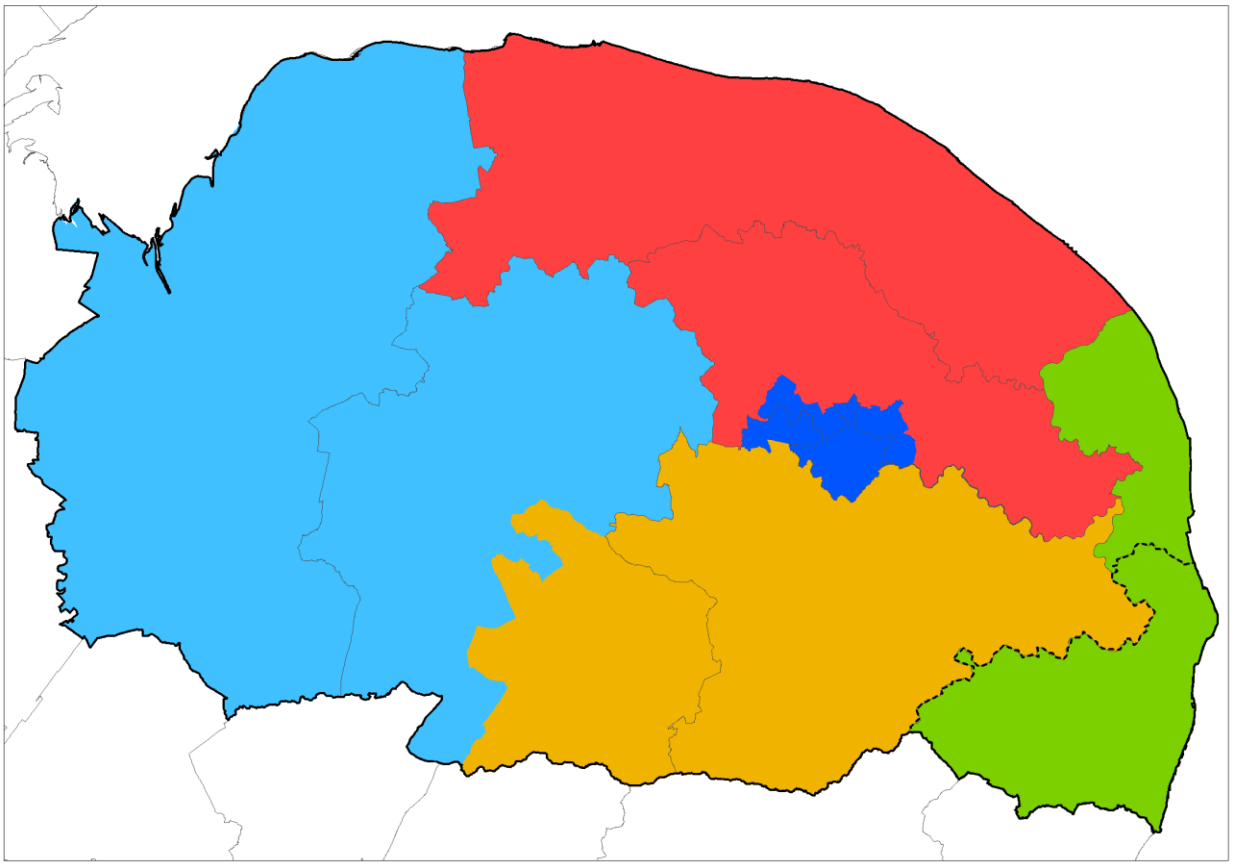
Place	**Population with Waveney**	**Population without Waveney**
North Norfolk	176,627	176,627
Norwich	239,182	239,182
South Norfolk	237,424	237,424
West Norfolk	179,099	179,099
Great Yarmouth and Waveney	241,574	108,958



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

50. In this option we would have five places based on the way community services, including community health, social care and district councils, are operationally organised and delivered. The boundary of each place would be determined by grouping PCNs together to match how these services work. This table shows the population for each place, using the practice lists of the PCNs:

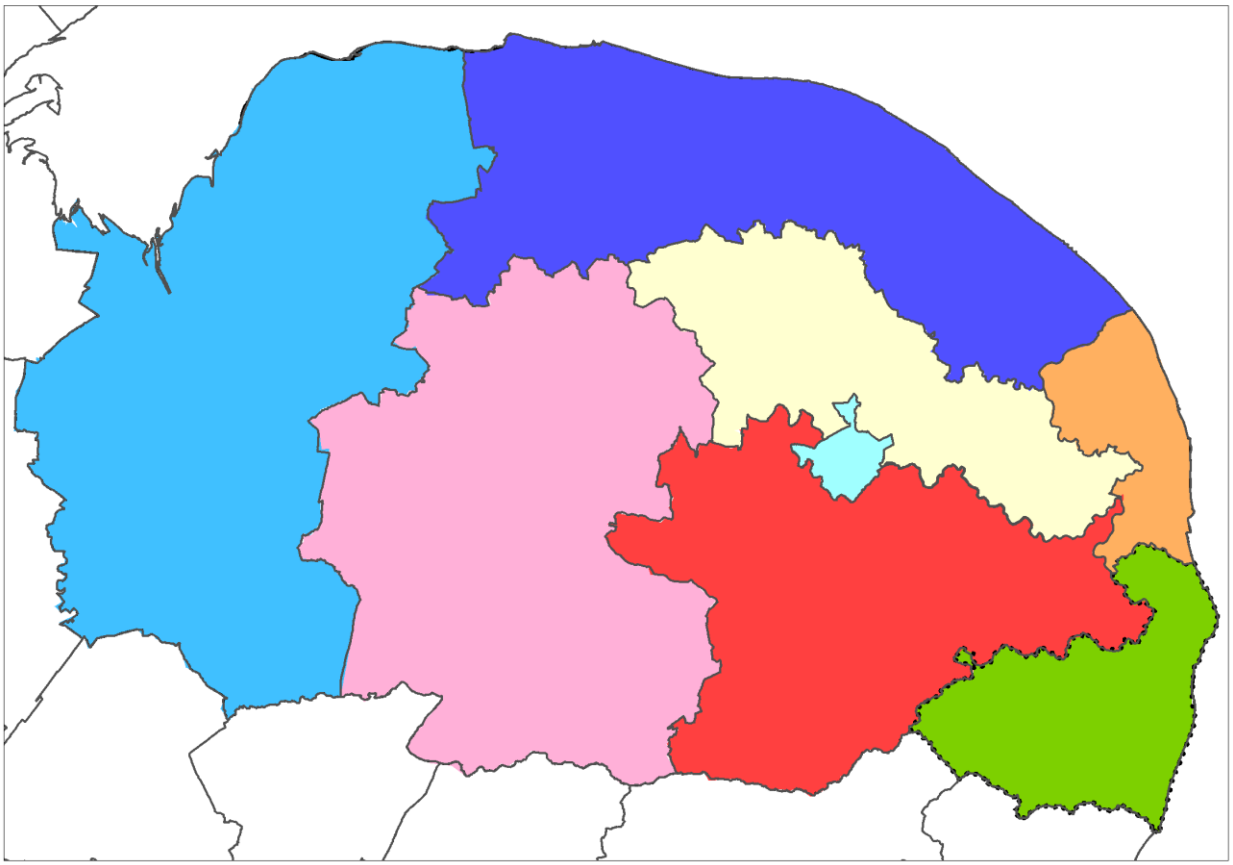
Place	**Population with Waveney**	**Population without Waveney**
North Norfolk	176,627	176,627
Norwich	239,182	239,182
South Norfolk	146,982	146,982
West Norfolk	269,541	269,541
Great Yarmouth and Waveney	241,574	108,958



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

51. In this option we would have places based on the district council boundaries. This table shows the population for each place, using the mid-2019 population estimates for each district council:

Place	**District council area population**
North Norfolk	104,837
Broadland	130,783
Norwich	140,573
South Norfolk	140,880
Breckland	139,968
King's Lynn and West Norfolk	151,383
Great Yarmouth	99,336
East Suffolk (N.B. not just Waveney)	249,461



52. We also considered whether Norfolk and Waveney, or just Norfolk could be our ‘place’ level. In other parts of the country place level is at upper tier local authority level. However, we have discounted this on the basis that for us it would mean our system and place levels would have the same boundaries. We would of course revisit this though if it was agreed that the boundary of our ICS would cover more than one county council area, for example if our ICS boundary was Norfolk and Suffolk.

Neighbourhood working

53. While there are some advantages to having place arrangements that cover quite large populations (for example in options one to five above), a potential downside is that they are not truly connected to local communities, which we know is a vital feature of effective local working.

54. One way of mitigating this risk is to ensure that, if we have large ‘places’, we also establish strong neighbourhood arrangements at a much more local level. These neighbourhoods could be built around existing district councils (are even areas within them) and primary care networks, as well as local health and care providers and the voluntary sector. Although this configuration could be flexible, it would be important to ensure that neighbourhoods were clearly connected to – and represented at – place level.

Our questions

55. There are three main areas that we would like your views on:

- 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). What do you think of these?
- 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). Do these feel like the right factors to take into account? Are there any missing? Which is the most important to you?
- We have developed six options for different geographic footprints that we could use to organise ourselves (as set out in section H). 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?

I. How to respond

56. We will be attending meetings of key groups and forums to discuss this piece of work, and will take notes at these meetings and include them in our analysis. We expect that organisations and individuals will want to submit their views in writing though and this can be done by:
    - Completing our online survey: www.smartsurvey.co.uk/s/Working-at-a-local-level-in-our-ICS/
    - Emailing us at: nwccg.communications@nhs.net.

57. Please can you make it clear in your response whether you are responding on behalf of an organisation or group (and if so which one), or if you are responding as an individual.

58. The deadline for responses is 13 June 2021.

J. Next steps – proposed decision making

59. The outcome of the engagement exercise will be taken to the Place Steering Group for further discussion. It is anticipated that the Place Steering Group will then make a recommendation as to an appropriate Place footprint. This recommendation will then be put to the interim ICS Partnership Board in August 2021 for discussion and ideally agreement.

60. It may be that some other boards, groups or people will also need to make decisions as well following the engagement exercise. This will depend on a number of factors, including:
    - The outcomes of our engagement exercise
    - The nature of the decisions to be made and who has the legal power to make them

- The contents of the expected health and care bill or any associated guidance, and the implications this may have on our understanding and planning for how Integrated Care Systems are constructed and will operate
- The decision made by the Secretary of State for Health and Social Care regarding the boundaries of Integrated Care Systems in England.

K. Questions

61. If you have any questions about this engagement exercise, please email anneborrows@nhs.net.

Appendix A: Summary of 'Integrating care: Next steps to building strong and effective integrated care systems across England'

In November 2020, NHS England and Improvement (NHSE/I) invited views on strengthened proposals to put ICSs on a statutory footing. Nationally, thousands of responses were received, which included every part of the health and care system as well as the public. The responses are summarised in 'Integrating care: Next steps to building strong and effective integrated care systems across England'.

The responses to the November 2020 paper have directly informed NHSE/Is recommendations to Government and Parliament, which are detailed in this paper: 'Legislating for Integrated Care Systems: five recommendations to Government and Parliament'. The paper sets the five recommendations NHSE/I are making, alongside principles to guide how the Government progresses this work, these are:

1. The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change

2. ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place based arrangements

3. ICSs should be underpinned by an NHS ICS statutory body and a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency

4. There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well

5. Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

Appendix B: Summary of 'Working together to improve health and social care for all'

Based on NHSE/I's legislative proposals, the Department of Health and Social Care has set out new proposals to streamline and update the legal framework for health and care in its white paper: 'Integration and Innovation: working together to improve health and social care for all'.

Key elements of the paper include:

Working together to integrate care

- ICS's are to be established on a statutory setting throughout the country. They will be accountable for the health outcomes of their population.
- There will be both an ICS NHS Board AND a Health and Care Partnership making up each ICS.

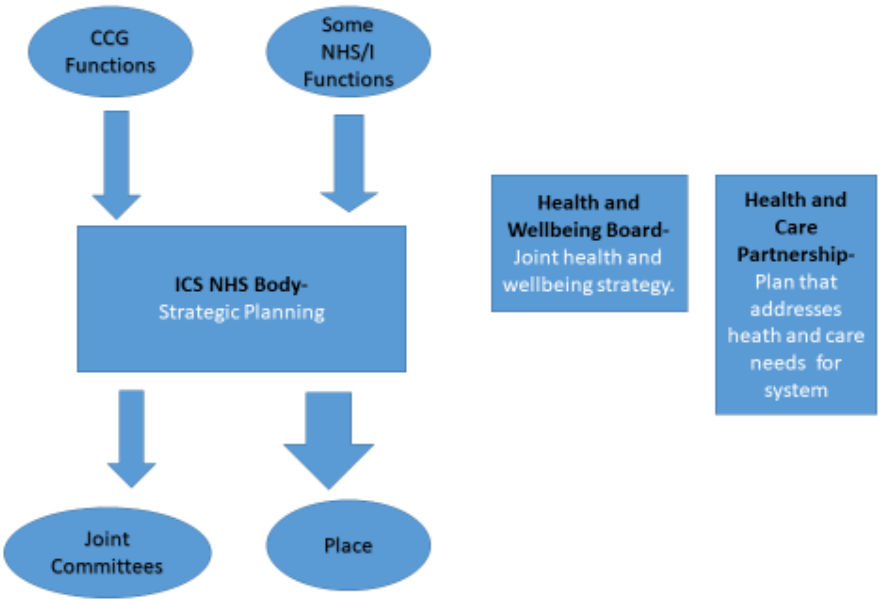
- Health and Wellbeing boards will stay in place with the same function as now.
- A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. The duty will apply to NHS organisations (both ICSs and providers) and local authorities.

ICS NHS Bodies

- Responsible for Strategic Planning, takes on all responsibilities of CCG and some of those of NHS E/I.
- The ICS NHS board will, as a minimum, include a chair, the chief executive and representatives from NHS trusts, general practice and local authorities, with others determined locally.
- The ICS NHS body will be responsible for developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography; and securing the provision of health services to meet the needs of the system population.
- There will be a new duty to compel providers to have regard to the system financial objectives.

ICS Health and Care Partnerships

- Only specified that an ICS should set up a health and care partnership. The details regarding their functions and membership are to be left to the discretion of the local area.
- Responsible for developing a plan that addresses the wider health, public health and social care needs of the system.
- HCP Board will include NHS, Local authority and other partners for example perhaps VCSE, care providers.
- Further guidance to support the establishment of these partnerships will be developed with NHSE/I and the Local Government Association.



Delegations

- ICSs will be left with responsibility to make arrangements as to what is devolved to place level.
- Joint committees between ICS and providers will now be permitted. However what can be delegated will be prescribed.

- Providers will also be able to form joint committees.

Further collaboration

- Legislation will be changed to remove the barriers to collaboration between CCGs and NHSEI, across CCGs, and between CCGs and local authorities (LA) to enable alignment of decisions and pooling of budgets.
- This will mean that we can now "double delegate," allow groups of ICS's to jointly commission and create pooled funds across all functions not just commissioning functions.

Appendix C: The PCNs that would be located in each of our options for place level

Section H sets-out six options for different geographic footprints that we could use to organise ourselves. The following tables show which PCNs would be located in each place for each option.

Please note that if the boundary of our ICS becomes Norfolk, rather than Norfolk and Waveney, it would mean that South Waveney and Lowestoft PCNs would no longer be part of our system.

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

Place	PCNs
East place	South Waveney, Lowestoft, Gorleston, Great Yarmouth & Northern Villages, NN3, NN4, East Norwich, West Norwich, North Norwich, Central Neighbourhood, Ketts Oak, SNhIP PCNs
West place	NN1, NN2, Breckland, Mid Norfolk, Coastal, Fens & Brecks, King's Lynn, Swaffham & Downham PCNs

Option two: Three places based on Functional Economic Areas

Place	PCNs
East place	South Waveney, Lowestoft, Gorleston, Great Yarmouth & Northern Villages PCNs
Central place	NN1, NN2, NN3, NN4, East Norwich, West Norwich, North Norwich, Central Neighbourhood, Ketts Oak, SNhIP PCNs
West place	Breckland, Mid Norfolk, Coastal, Fens & Brecks, King's Lynn, Swaffham & Downham PCNs

Option three: Three places aligned to the three acute hospitals

Place	PCNs
East place	Great Yarmouth & Waveney Locality (South Waveney, Lowestoft, Gorleston and Great Yarmouth & Northern Villages PCNs) around the JPUH
Central place	North Norfolk, Norwich and South Norfolk Localities (NN1, NN2, NN3, NN4, East Norwich, West Norwich, North Norwich, Central Neighbourhood, Ketts Oak,

	SNhIP, Breckland and Mid-Norfolk PCNs) around the NNUH
West place	West Norfolk Locality (Coastal, Fens & Brecks, King's Lynn and Swaffham & Downham PCNs) around the QEH

Option four: Five places based on the current health localities

Place	PCNs
North Norfolk	NN1, NN2, NN3 and NN4 PCNs
Norwich	East Norwich, West Norwich, North Norwich and Central Neighbourhood PCNs
South Norfolk	Ketts Oak, SNhIP, Breckland and Mid Norfolk PCNs
West Norfolk	Coastal, Fens & Brecks, King's Lynn and Swaffham & Downham PCNs
Great Yarmouth and Waveney	South Waveney, Lowestoft, Gorleston and Great Yarmouth & Northern Villages PCNs

Option five: Five places based on provision of community services

Place	PCNs
North Norfolk	NN1, NN2, NN3 and NN4 PCNs
Norwich	East Norwich, West Norwich, North Norwich and Central Neighbourhood PCNs
South Norfolk	Ketts Oak, SNhIP PCNs
West Norfolk	Breckland, Mid Norfolk, Coastal, Fens & Brecks, King's Lynn and Swaffham & Downham PCNs
Great Yarmouth and Waveney	South Waveney, Lowestoft, Gorleston and Great Yarmouth & Northern Villages PCNs

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

Primary Care Network (PCN)	Primary care locality	Acute trust catchment	District council
South Waveney	Great Yarmouth & Waveney	James Paget University Hospital	East Suffolk
Lowestoft	Great Yarmouth & Waveney	James Paget University Hospital	East Suffolk
Gorleston	Great Yarmouth & Waveney	James Paget University Hospital	Great Yarmouth
Great Yarmouth & Northern Villages	Great Yarmouth & Waveney	James Paget University Hospital	Great Yarmouth
North Norfolk 1	North Norfolk	Norfolk & Norwich University Hospital/ Queen Elizabeth Hospital	North Norfolk

North Norfolk 2	North Norfolk	Norfolk & Norwich University Hospital	North Norfolk
North Norfolk 3	North Norfolk	Norfolk & Norwich University Hospital	Broadland/ North Norfolk
North Norfolk 4	North Norfolk	Norfolk & Norwich University Hospital/ James Paget University Hospital	North Norfolk/ Broadland
East Norwich Neighbourhood	Norwich	Norfolk & Norwich University Hospital	Broadland/ Norwich City Council
West Norwich Neighbourhood	Norwich	Norfolk & Norwich University Hospital	Broadland/ Norwich City Council/ South Norfolk
Norwich North Neighbourhood	Norwich	Norfolk & Norwich University Hospital	Norwich City Council
Central Neighbourhood	Norwich	Norfolk & Norwich University Hospital	Norwich City Council
Breckland	South Norfolk	Norfolk & Norwich University Hospital	Breckland
Ketts Oak	South Norfolk	Norfolk & Norwich University Hospital	Breckland/ South Norfolk
Mid Norfolk	South Norfolk	Norfolk & Norwich University Hospital	Breckland
SNhIP	South Norfolk	Norfolk & Norwich University Hospital	South Norfolk
Coastal	West Norfolk	Queen Elizabeth Hospital	King's Lynn & West Norfolk
Fens & Brecks	West Norfolk	Queen Elizabeth Hospital	King's Lynn & West Norfolk
King's Lynn	West Norfolk	Queen Elizabeth Hospital	King's Lynn & West Norfolk
Swaffham & Downham	West Norfolk	Queen Elizabeth Hospital	King's Lynn & West Norfolk/ Breckland