Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2223/093

Subject: ICS Locality Mapping

*I can confirm that the ICB **does hold the information requested**; please see responses below:*

QUESTION	RESPONSE
We are looking to nationally benchmark metrics across all Places within an ICS. We noticed that the Places within your ICS are not mapped to your Local Authorities or old CCGs (to our knowledge). We want to know what geography (ward, LSOA, LTLA etc..) was used to create your place boundaries. Ideally, we would receive a mapping file that shows how to go from your Place boundaries to established mappings provided by the ONS. **Clarification received 20/10/22: By places I am referring to the NHSE official terminology for place-based partnerships (see here: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf)** **I believe you refer to them as 'localities'? https://bnssg.icb.nhs.uk/locality-partnerships/**	Please see enclosed document.

We need to know on what basis these boundaries were drawn (LTLA, LSOA, wards, etc..) and, if possible, a mapping file for this?	

The information provided in this response is accurate as of 8 November 2022 and has been approved for release by David Jarrett, Director of Integrated and Primary Care for NHS Bristol, North Somerset and South Gloucestershire ICB.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Integrated Care Partnership (ICP) Footprints

Healthier Together Executive Group – 11th March 2021

1. Introduction and Context

On 25th January 2021 Executive Group agreed the process to engage partners on three place level footprint options for Integrated Care Partnerships (ICPs), before coming to Healthier Together Partnership Board on 1st April 2021 to approve a preferred option.

The Executive Group raised further questions concerning how we assure equity across ICPs and system infrastructure including but not limited to questions about governance, provider representation, management of risk and delegation of powers.

A decision on place level footprints is now required as it is integral to determining our approach to the implementation of Community Mental Health (CMH). Place based integrated CMH services will continue our integrated working in response to the pandemic, and will be well positioned to meet the forecasted surge in demands for mental health services.

2. Purpose

The purpose of this paper is to seek agreement for six ICP footprints ahead of 1st April Healthier Together Partnership Board, following the January HT Executive Group discussion and further consultation with agreed stakeholder groups, as summarised later in this paper.

3. Evidence to support decision making to define 'place'

NHS Confederation (2020) describes the term 'place' flexibly in recognition of the variability observed in local arrangements. No single 'one size fits all' approach to defining place exists: each place reflects a unique geography and relationship to local people and communities. The NHS has defined 'place' as meaning geographies comprising populations of 250,000 to 500,000 (NHS Confederation 2020). In many areas, there are existing geographies at the scale of upper and lower-tier local authorities that already have a significant degree of coherence, including effective governance structures. According to the Local Government Association in 'Shifting the centre of gravity: making place-based, person-centred care a reality', **the boundaries of the local place should be determined**

"following local discussion and considering the role of all the partners who contribute to health and care in a place" (Local Government Association *et al*., 2018).

Local definitions of 'place' should also build incrementally on previous efforts to integrate care and local services, such as the Better Care Fund and integrated care pioneers. The place level should facilitate integrated working at an appropriate scale and scope for tackling population health challenges – from health inequalities to the wider determinants of health – and for maximising opportunities across all public services through integration, service changes and aligned resources.

(Source: From-Place-Based-to-Place-led_FNL.pdf (nhsconfed.org))

Professor Chris Ham explains **there is no one blue print for agreeing 'place'**. Rather finding local solutions that work for local areas recognising geography, demography, need and demand across population should be considered (Source: Moving towards place-based systems of care | The King's Fund).

4. ICP Footprint Engagement

a. Approach and chronology

A presentation and summary paper was shared with identified stakeholders capturing evidenced collated in the ICP discovery phase, the Healthier Together context and three footprint options being considered for our formal ICP developments, which are:

- Option 1 Integrated Care Partnerships align with existing six localities
- Option 2: Integrated Care Partnerships aligned to LA areas
- Option 3: Single Integrated Care Partnership across BNSSG

The GP Collaborative Board received the presentation on 27th January 2021 and a summary of the discussion was drafted and summarised for consultation with the 18 PCN Directors. The conclusions were ratified at the GP Collaborative Board on 24th February.

The white paper 'Integration and innovation: working together to improve health and social care for all' was published on 11th February 2021.

The Building Healthier Communities Board was engaged on 15th February 2021.

South Gloucestershire LA aligned the White Paper, ICS MOU process and ICP footprint discussion in an update with members and executives at an informal cabinet on 22nd February 2021.

Bristol LA also aligned an update on the white paper and ICP footprint discussion with a cabinet member briefing on 1st March 2021.

North Somerset LA shared written feedback from councillors and executives on 5th March 2021

b. Feedback on the options

The GP Collaborative Board, Building Healthier Communities' Board and three Local Authorities **unanimously supported retaining the six locality footprints**.

The comments/feedback from the engagement undertaken has been thematically collated and presented below.

I. Equity

Assurances were sought concerning equity of funding and resource to populations served, specifically referencing South Gloucestershire and its larger population than the other localities.

The plan for six ICPs must not end up resulting in residents experiencing a postcode lottery in terms of healthcare access, provision and outcomes across BNSSG.

We need a way of ensuring outcomes are consistent across BNSSG, with investment following population need at the macro BNSSG level, whilst also ensuring each place has a clear role in understanding and guiding the ICP across their patch.

II. Variability between communities

Localities are serving very different communities and are at different stages of maturity. Comments from GPs in the process noted these differences being witnessed first-hand whilst attending meetings in different localities as part of the Peloton programme.

The clinical delivery group which coordinated vaccine plans at a BNSSG footprint worked well. However, multiple layers of deployment across localities and PCNs were recognised as required to address variability between communities.

Woodspring and Weston are very different, requiring very different responses to service specifications.

Localities will allow for JSNA (Joint Strategic Needs Assessment) to be assessed locality by locality, recognising different demography and need across communities/populations.

Subsidiarity will be required with services provided at different levels i.e. Bristol LA, three localities and their subsidiaries.

III. Building on existing structures

Trust and relationships have been established within existing localities, meaning GP representatives on the locality boards are trusted as reliably seeking feedback/engagement with general practice when required.

Furthermore, during the Covid-19 pandemic, the voluntary sector was an integral partner to the locality response within their footprints, highlighting successful integrated working between localities and voluntary sector.

IV. Leadership

South Bristol Locality has appointed a local authority representative as its co-chair, which is an existing positive step taken supporting integration.

GPs role to lead emergent ICPs were discussed, recognising each practice is its own small organisation and the requirement to now begin to lead at scale more consistently.

V. Governance

It is essential to support the voluntary sector to dock with ICPs at a local level and the six locality footprints are deemed a sensible size to allow this to happen successfully.

Health and Wellbeing Boards (HWBB) were held up as a strong example of integrated working, which ICPs should dock into. Councillors wanted to see the HWBB role in future ICS and ICP.

There is a requirement to agree what should be core and standard across the integrated system and what is specific to communities, via the ICS MOU process.

There may be a requirement to consider the role of larger organisations and whether there is a need to adapt to the six localities as a consequence of ‘place based services’ responsive to local communities.

It is clear that ICPs must be a partnership of equals.

VI. Other observations/comments

Whilst footprints are important, significant complexity requires the ICPs to also be flexible to support populations which do not always conform to any identified ‘place’ e.g. homeless, the LGBTQ+ community etc.

It’s important to remember the characteristics and substance of any partnership are more important than any boundary decision or naming of a partnership.

A Councillor questioned the regular cycle of NHS reforms and discussion as to why ICS and ICPs would be different this time.

It is important that the success criteria for ICPs are focused on measurable improved outcomes for our local population and the reduction of health inequalities, rather than process or structural measures.

5. Integrated Care System (ICS) Memorandum of Understandings (MOU)

We have established clear governance structures, including a Partnership Board and Executive Group, and we were officially recognised as a maturing Integrated Care System (ICS) by NHS England in December 2020. We have agreed to develop a Memorandum of Understanding (MOU) on how we will work together to achieve our shared aims in the next phase of our development as an ICS. Through the process of developing the MOU we will need to agree how we will implement the new legislation on ICSs, which was announced in the government White Paper published in February 2021 and is expected to be implemented from April 2022.

The development of integrated working at place level will be an important theme in developing our MOU. We will need to reach agreements on what functions should be performed at the place level to enable achievement of our aims and objectives. We will in turn need to agree what the ICS will delegate to ICPs, and what assurances the ICS will require of ICPs, and define the governance structures and processes that will enable this to happen over time.

The Executive Group has agreed a facilitated engagement process to develop these agreements, including:

- Facilitated workshops with each ICS Partner organisation (Feb - April).
- Facilitated development of areas for agreement within the MOU (April - June)
- Review of draft documents (June - July)
- Governance and sign off (July - Sept)

6. Summary

Agreeing Integrated Care Partnerships (ICPs) footprints is the first step to allow locality provider partners to progress their discussions on how they can formally work together at a ‘place’ level.

In addition, a decision on footprints will support our ICS process to agree what will delegated to ICPs, what assurances the ICS will require of ICPs, and what functions should be performed at the place level to enable achievement of our aims and objectives.

The engagement feedback shared in this paper recognises the progress made across the existing six localities in establishing the relationships, trust and frameworks. These current ways of working across existing partnerships would be significantly set back if the footprints were reset now.

7. Recommendations

The Executive Group is asked agree the future ICP partners' feedback to continue with the six footprints in the developments of ICPs.

References

- NHS Confederation (2020) From place-based to place-led A whole-area approach to integrating care systems
- Local Government Association, ADASS, NHS Clinical Commissioners, NHS Confederation, NHS Providers, & ADPH. (2018). Shifting the centre of gravity: making place-based, person-centred health and care a reality. London: Local Government Association.