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Cheshire East
Health and Wellbeing Board

Agenda

Date:	**Tuesday 26th January 2021**
Time:	**2.00 pm**
Venue:	**Virtual Meeting**

How to Watch the Meeting

For anybody wishing to view the meeting live please click on the link below:

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The agenda is divided into 2 parts. Part 1 is taken in the presence of the public and press. Part 2 items will be considered in the absence of the public and press for the reasons indicated on the agenda and at the top of each report.

It should be noted that Part 1 items of this meeting are recording and the recording uploaded on to the Council's website.

PART 1 – MATTERS TO BE CONSIDERED WITH THE PUBLIC AND PRESS PRESENT

1. **Apologies for Absence**

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

For requests for further information
Contact: Rachel Graves
Tel: 01270 686473
E-Mail: rachel.graves@cheshireeast.gov.uk with any apologies

3. **Minutes of Previous Meeting** (Pages 3 - 6)

To approve the minutes of the meeting held on 24 November 2020.

4. **Public Speaking Time/Open Session**

In accordance with paragraph 2.32 of the Committee Procedural Rules and Appendix 7 to the Rules a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the body in question. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers.

Members of the public wishing to ask a question or make a statement at the meeting should provide at least three clear working days' notice in writing and should include the question with that notice. This will enable an informed answer to be given.

5. **Integrating Care - NHS England's Proposals regarding Integrated Care Systems and the draft MoU for the Cheshire and Merseyside Health and Care Partnership** (Pages 7 - 96)

To consider a report on the proposals for Integrated Care Systems and the draft MoU for the Cheshire and Merseyside Health and Care Partnership.

6. **Test, Trace, Contain, Enable' Update**

To receive a verbal update on Test, Trace, Contain, Enable.

7. **Cheshire East Place Partnership Update** (Pages 97 - 102)

To receive an update on the Cheshire East Place Partnership.

8. **Cheshire East Integrated Care Partnership Strategy and Transformation Plan** (Pages 103 - 130)

To consider the ICP Strategy and Transformation Plan.

CHESHIRE EAST COUNCIL

Minutes of a virtual meeting of the
Cheshire East Health and Wellbeing Board
held on Tuesday, 24th November, 2020

PRESENT

Voting Members

Councillor S Corcoran (Chairman)
Councillor Kathryn Flavell, Cheshire East Council
Councillor Laura Jeuda, Cheshire East Council
Mark Palethorpe, Cheshire East Council
Dr Matt Tyrer, Cheshire East Council
Dr Andrew Wilson (Vice-Chairman)
Clare Watson, NHS Cheshire CCG
Louise Barry, Healthwatch Cheshire
Steven Michael, Cheshire East Health and Care Partnership
John Wilbraham, Cheshire East Integrated Care Partnership

Non-Voting Members
Lorraine O'Donnell, Cheshire East Council

Associate Non-voting Members
Councillor Janet Clowes, Cheshire East Council
Superintendent Peter Crowcroft, Cheshire Constabulary
Chris Hart, Cheshire East Social Action Partnership
Caroline Whitney, CVS Cheshire East

Cheshire East Council Officers/Others
Guy Kilminster, Cheshire East Council
Katie Jones, Cheshire East Council
Rachel Graves, Cheshire East Council
Madeleine Lowry, Cheshire and Wirral Partnership NHS Trust
Alan Yates, Cheshire and Merseyside Health and Care Partnership
Geoffrey Appleton, Cheshire East Safeguarding Adults Board

21 APOLOGIES FOR ABSENCE

Apologies were received from Dr Patrick Kearns and Councillor Jill Rhodes.

22 DECLARATIONS OF INTEREST

Councillor S Corcoran declared a non-pecuniary interest by virtue of his wife being a GP.

23 **MINUTES OF PREVIOUS MEETING**

RESOLVED:

That the minutes of the meeting held on 22 September 2020 be approved as a correct record.

24 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no public speakers.

25 **CHESHIRE AND MERSEYSIDE HEALTH AND CARE PARTNERSHIP**

The Board received a presentation from Alan Yates, Chair of Cheshire and Merseyside Health and Care Partnership, which provided an overview on the Partnership including the make-up of the Partnership, its vision and aims, the importance of Place, and an explanation of the role of the Partnership Board, Partnership Assembly, Partnership Co-ordination Group and the Partnership Executive.

RESOLVED:

That the presentation be received.

26 **'TEST, TRACE, CONTAIN, ENABLE' UPDATE**

Dr Matt Tyrer gave an update on the Test, Track, Contain and Enable system.

He reported that there was currently a downward trajectory in infection rate in Cheshire East and it was presently at around 100 per 100,000. There had also been a decline in the number of admissions to hospital in the region.

Staff were receiving training for the local track and trace services, which was due to go live shortly. This service would focus initially on the areas with the highest positive test results and would be rolled out to cover the whole of Cheshire East. The local track and trace service did not replace the national track and trace system but was complementary to it.

Discussions were taking place with the Government on carrying out mass asymptomatic testing in Cheshire East. This would be via two types of test either a saliva test or a lateral flow test. Any testing would not be on a mass scales as in Liverpool but targeted to specific areas. The Government had announced that visitors to care homes could be tested and the Public Health Team were looking at how this would operate.

The Government was due to announce which tier of restrictions Cheshire East could be in at the end of the lockdown.

RESOLVED:

That the verbal update be noted.

27 **SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2019-2020**

The Board considered the Annual Report of Safeguarding Adults Board 2019/20, in order to keep the Board appraised of the work of the Safeguarding Adults Board. Geoffrey Appleton, Independent Chair of Cheshire East Safeguarding Adults Board, attended the meeting to present the report.

During 2019/20 the Safeguarding Adults Board had focussed on modern slavery, sexual abuse and organisational abuse and the Annual Report detailed the matters considered in these areas. The Report also highlighted the work undertaken by the Services Subgroup, Serious Case Subgroup, Quality & Performance Subgroup and the Learning and Development Subgroup.

The Annual Report set out the five key priorities for Safeguarding Adults Board (SAB) in 2020/21, which had been revised in response to the Covid-19 pandemic and were as follows:

- the SAB will continue to fulfil its legal duties during the Pandemic
- the SAB will continue to promote Making Safeguarding Personal
- the SAB will continue to link with other Boards, particularly the Safer Cheshire East Partnership, to consider and address cross cutting themes
- the SAB will seek assurances and recognise the hard work of organisations are undertaking to deliver safe services
- the SAB will continue to promote positive practice

RESOLVED: That

1 the Annual Report of Safeguarding Adults Board 2019/20 be received and noted; and

2 the five key priorities for 2020/21 be noted.

28 **CHESHIRE EAST INTEGRATED CARE PARTNERSHIP UPDATE**

The Board received an update on the work of the Cheshire East Integrated Care Partnership.

The Partnership had been in discussions with NHS Cheshire CCG had on the proposed devolvement of commissioning to the Integrated Care Partnership (ICP). This would require significant work to understand what would sit within the ICP and be commissioned at this level and would also require the transfer of resources from the CCG to develop the proposals and implement the options within a short timeframe.

The Partnership was still responding to the challenges of the Covid pandemic including the proposals for the vaccine and the increase of numbers in hospitals and challenges faced by care homes.

RESOLVED:

That the update be received.

29 **CHESHIRE EAST PLACE PARTNERSHIP UPDATE**

The Board received an update on the Cheshire East Place Partnership.

It was reported that work was continuing with the development of the integrated care partnership with the governance arrangements having been approved and work commencing on the four key target areas – cardiovascular health, children's health, mental wellbeing and social prescribing and respiratory health.

Steven Michael thanked Mark Palethorpe, Executive Director Place, on behalf of the Partnership, for his work as the Place lead on the Partnership.

RESOLVED:

That the update be noted.

The meeting commenced at 2.00 pm and concluded at 3.10 pm

Councillor S Corcoran (Chairman)

Agenda Item 5

Cheshire East Council

NHS Cheshire Clinical Commissioning Group

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Integrating Care – NHS England's proposals regarding Integrated Care Systems and the draft MoU for the Cheshire and Merseyside Health and Care Partnership
Date of meeting:	26th January 2021
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Mark Palethorpe

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To ensure Members of the Board are sighted on these proposals that will affect the health and care system that Cheshire East is a part of.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	That the Board notes and discusses the local implications of NHS England's proposals regarding Integrated Care Systems (ICS) and the draft Memorandum of Understanding of the Cheshire and Merseyside ICS.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	No
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1 In late November, early December 2020, two documents became available regarding the ongoing establishment of Integrated Care Systems. The first of these was *Integrating Care: Next steps to building strong and effective integrated care systems across England* (published 26th November, see Appendix One). This document was published and formed the basis of a national consultation run by NHS England and which finished on 8 January 2021. The Cheshire East Council response to this document is attached as Appendix Two. The second was the draft Memorandum of Understanding for the Cheshire and Merseyside Integrated Care System (received 8th December, see Appendix Three) which has been circulated to Councils by the Cheshire and Merseyside Health Care Partnership.

1.2 The report summarises the key aspects of the two papers for the Board

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board note the proposals and consider the implications for the Cheshire East health and care system.

3 Reasons for Recommendations

3.1 To ensure that the Board are sighted on these key papers and have had the opportunity to discuss the local implications.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The proposals have the potential to support the delivery of the Joint Health and Wellbeing Strategy priorities, if the health and care system changes can be made quickly and without too great an impact upon day to day business. The risk is that the reorganisation disrupts and/or delays ongoing transformational activity.

5 Background and Options

5.1 In 2016, NHS England, as part of its Five Year Forward View, established across England, Sustainability and Transformation Partnerships (STP). This was in recognition that the strategic planning of health services had been hampered by the reforms of 2012 and the dissolution of the Strategic Health Authorities. The new Partnerships were to include all NHS organisations, GPs and local authorities within specified geographies and Cheshire

East was included within the Cheshire and Merseyside STP. Subsequently the STP has been re-named as the Cheshire and Merseyside Health and Care Partnership (C&MHCP).

5.2 In 2019 the NHS England Long-Term Plan was published, and this has reiterated the future central role of these Partnerships over the next ten years. There is also a requirement that they all achieve Integrated Care System (ICS) status by April 2021. The publication in November 2020 by NHS England of 'Integrating Care: next steps to building strong and effective integrated care systems across England', provides more details regarding how the ICSs will work, their roles and responsibilities (see Appendix One). Legislative change will be required to progress the proposals put forward in the paper.

5.3 ICSs are identified as being central to the delivery of the Long-Term Plan. A key role of the ICS will be to bring together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Their creation recognises the fact that achieving financial and clinical sustainability in health and care needs to be addressed through a combination of system-wide and place-based working.

5.4 ICSs will have a key role in working with Local Authorities at 'place' level. Through ICSs, commissioners will make shared decisions with providers on how to use resources, design services and improve population health (other than for a limited number of decisions that commissioners will need to continue to make independently, for example in relation to procurement and contract award). Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. Two options are proposed regarding how the NHS commissioning functions could sit within the ICS and a decision on the way forward is awaited.

5.5 Integrated Care Systems will undertake two core roles: system transformation and the collective management of system performance. Different systems are at different levels of maturity, however, there are some consistent operating arrangements that NHS England expect all systems to agree with regional directors and to have put in place during 2021 - 22.

5.6 The first of these is system-wide governance arrangements (including a system partnership board with NHS, Local Government and other partners), established to enable a collective model of responsibility and decision-making between system partners. The drafting of the MoU is a part of this element (see 5.9 below).

5.7 The development of a leadership model for the system is a requirement, including a Partnership / ICS leader with sufficient capacity, and a non-executive chair appointed in line with NHS England and NHS Improvement guidance. Alan Yates is the recently appointed Chairman and the Partnership lead officer is Jackie Bene.

5.8 The third element is having in place the system capabilities including population health management, service redesign, workforce transformation and digitisation, that are required to fulfil the two core roles of an ICS. The system should also agree a sustainable model for resourcing these collective functions or activities. NHS England and NHS Improvement will

contribute part-funding for system infrastructure in 2020/21. Cheshire and Merseyside work-streams are established for these areas of activity.

5.9 The draft Memorandum of Understanding is designed to secure the commitment of the partners within the Cheshire and Merseyside health and care system to system working and supporting the next stages of the journey to becoming an Integrated Care System. It is based on a shared understanding of collective objectives/purpose and is to be read in conjunction with Partnership plans and local Place priorities. The Vision and Mission / Overarching aims and Values and Behaviours are set out:

We have worked together to develop a shared vision for health and care services across our region. Our aspiration is that all of our priorities, activities and initiatives support the delivery of this vision:

> *We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer.*

The achievement of our vision will be supported by the delivery of our mission:

> *We will tackle health inequalities and improve the lives of our poorest fastest. We believe we can do this best by working in partnership.*

Overarching aims of our Partnership

We have agreed a set of guiding principles that shape everything we do through our partnership. These principles are underpinned by our aims which themselves are derived from our vision and mission:

1. Improve the health and wellbeing of local people
2. Shift from an illness based to a health & wellbeing model
3. Provide better joined up care, closer to home

To deliver the Partnership's objectives and outcomes it needs to

- Plan and establish approach to financial and performance management
- Enhance integrated commissioning at Place/Borough level and streamline it at system level
- Incorporate NHS Providers through a Provider Collaborative using a peer leadership approach
- Respond to and embed NHS Constitution and other statutory duties

A Portfolio of programmes will be signed off by the Partnership Board following proposals being brought forward by the Partnership Co-ordination Group. These are to be presented to and reviewed by the Partnership Assembly. Programme/Partnership activity is to be outcome focused.

Effective public involvement is expected to supplement existing engagement activities.

The Voluntary and Community Sector is mentioned as being integral to the Partnership's work and a major contributor in supporting the co-designing and delivering on outcomes.

Governance arrangements are set out from page 13 onwards

The Partnership does not replace or override the authority of Partners' Boards or Governing Bodies. It provides a mechanism for collaborative action and common decision-making for issues best tackled on a wider scale. The deadline for responses to the draft was 20th January. It is anticipated that a final version will be circulated for sign off by partners in February/March.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

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Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

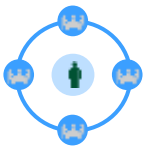
Devolution of functions and resources

1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration



1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

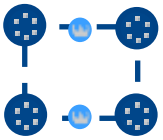
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above (‘vertical integration’); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the “Well Led” assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors’ and governors’ duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an ‘integration index’ for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority’s role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the “end state” for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by “re-purposing” CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS’s primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please submit your response to this address: www.engage.england.nhs.uk/survey/building-a-strong-integrated-care-system

4.29. Alternatively you can also contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.30. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

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Cheshire East Council - Response to NHS England and NHS improvement:

Integrating Care next steps for integrated care systems

Qn	Agree Yes / No	Commentary
1) Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?	Yes	The 2012 restructure of the NHS abolished Strategic Health Authorities. This left a significant gap in the capacity of regions to work on a systemwide basis and impacted upon the ability to effectively plan at anything but an individual organisational level. This gap was recognised in 2016 with the creation of Sustainability and Transformation Partnerships and since the publication of the NHS Five Year Forward View and The Long Term Plan it has been clear that a move towards more formal Integrated Care Systems has been the direction of travel. The recognition of the need to effectively engage and involve local authorities has significantly improved since the STPs were established and the Integrating Care proposals set out very clearly that local authorities should be at the table and fully involved in the work of the ICS. At the same time the emphasis on 'Place-based' local partnerships for the tactical commissioning and delivery of improved health and care provides the opportunity for local authorities to have more influence at the local level. Giving the ICS a statutory footing will enable more effective working at both the Cheshire and Merseyside and local level, allowing for system wide planning and intervention where it makes sense to do something once at scale, but also providing each local authority area with the freedom to focus on its local priorities. We therefore support making ICSs mandatory in all areas but recognise that this legal requirement will need to be backed up with support for system leaders to work collaboratively, with a focus on achieving population health outcomes and to devolve power and resources to place wherever appropriate. **However, we must note that there are concerns amongst elected members across Cheshire and Merseyside, in particular in relation to the geography and democratic deficit of the ICS proposals. These are with regard to the risk of decision making and resources being centralised at a Cheshire and Merseyside level and being removed from the local Places.**

		There is also concern at the lack of reference to Health and Wellbeing Boards and their role within the ICS. We agree with the LGA and Cheshire and Merseyside Directors of Adult Social Care that the proposals (perhaps unwittingly) **are in danger of reducing or replacing established place based leadership**, which is best placed to achieve greater investment in prevention and community-based health and wellbeing services by addressing the wider determinants of health: safe and affordable housing, access to training and good jobs, a safe and healthy environment, support for early years, and infrastructure to support resilient communities. **Place must be recognised and understood by local communities and for local communities 'place' is the Local Authority in which they live.**
2) Do you agree that option 2 (a statutory ICS body) offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?	No	Collaboration and clarity of accountability is absolutely critical to successful system working, as without it those who choose to can use a lack of accountability to delay decision making, frustrate planning and allow organisational self- interest to over-ride system benefits. Whilst option 2 appears to offer that greater incentive for NHS collaboration, and both options recognise the need for local government representation, **neither option proposes local government as an equal partner. If the aim is to accelerate integration of health and care through this statutory reform, then it needs to legislate local authorities as equal partners. As drafted neither option 1 nor option 2 offer parity of esteem between health and local government.** We agree with the LGA that with regard to Option 2, it is hard to see how a corporate statutory NHS body can be a partnership body which relates to all constituents in the health and care system. We are concerned that if Option 2 is adopted systems will lose the wider perspective from local government, on the role of social care, public health, housing, early years and other local government functions in ICS plans and strategies. **We propose that the best option to preserve and promote equal partnerships is to create system level integrated commissioning NHS bodies and also have statutory joint committees to which ICSs are accountable to ensure they deliver integration at place within the system.** The Cheshire and Merseyside Directors of Adult Social Care have proposed an option 3 for consideration, developing this proposal and we ask that this be looked at as an alternative: • ICSs to be a statutory joint committee acting as strategic partnership bodies for the whole system, with a parity of esteem and representation between local government and the NHS • There will be a reciprocal duty of cooperation to address health inequalities on the NHS and local government. • Accountability of the statutory ICS joint committee will be established within existing democratic structures

		• Directors of Adult Social Care will be included as mandatory members of 'place' integrated care partnerships; and representation on the ICS joint committee will be mandated • Partners within the statutory joint committee will take on current clinical commissioning group (CCG) functions, as determined at a local level, recognising the maturity of local systems
3) Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?	Yes	We agree with the LGA in strongly supporting systems having the freedom and flexibility to determine their own membership, beyond the statutory minimum. **We would like to see a stronger emphasis on ensuring the system governance arrangements build on and enhance existing place and neighbourhood governance arrangements. They should not bypass, undermine or duplicate existing governance arrangements at place. In particular, they should ensure local accountability through local systems, including Health and Wellbeing Boards and scrutiny committees.** In addition **we would argue that the statutory role and leadership of DASSs must be recognised as mandatory within ICSs and ICPs**. The Cheshire and Merseyside ICS is a large and complex health and care system, so it will be important for our local needs to determine the nature of the governance arrangements of the ICS and the individual Place (local authority footprint based) Partnerships. This Authority has over the last couple of years been influential in the development of the ICS through the former Chief Executive's attendance at the System Management Board and senior officers' involvement in other key work-streams. This proactive engagement and involvement needs to be maintained to ensure that we influence the direction of travel as the ICS takes shape over the next 15 months.
4) Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?	Yes	There has, since 2012, been confusion in the system with the specialist commissioned services being the responsibility of NHS England, whilst other strategic commissioning responsibilities have been with CCGs. Bringing these together at an ICS level makes sense and gives the system much more local input (particularly for local authorities) into how those specialist services are delivered in Cheshire and Merseyside than is currently possible with them being in NHS England. **We therefore strongly support delegation of NHSEI commissioning to ICSs, where appropriate. Furthermore, we would like to see an equal emphasis on delegating commissioning to place level, ensuring the application of the principle of subsidiarity.**

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Cheshire and Merseyside
Health and Care Partnership

Memorandum of Understanding

D R A FT

November 2020

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Foreword

This draft Memorandum signifies an important step in the maturing of the Cheshire and Merseyside Health and Care Partnership. Much good work has gone on before now and I wish to honour those who made and continue to make practical progress in supporting the integration of health and care in the nine places of the Partnership. I also want to recognise the work of those who have developed and supported the specialist programmes of work and the collaboration at scale which has benefitted the people of Cheshire and Merseyside.

We are clearer now about the Partnership. We know we want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer. We are committed to tackling health inequalities and improving the lives of our poorest fastest. We believe we can do this best by working in partnership.

And we know we will make these things happen best when we support and enable joint and integrated work in the 9 Council areas, sometimes known as Places in Cheshire and Merseyside. If we are to work on a bigger population than Place we need to know why this is the best way to do it, otherwise we operate locally.

As we have made progress over the last year or so, the point has been made clearly that the purpose of the Partnership and the arrangements of the Partnership need to be stated and understood. The Partnership Assembly held in September 2020 confirmed emphatically that this must be done.

What follows is a draft description of the Partnership's purpose and arrangements. It does not seek to be finally definitive. It will change over time by consent. COVID-19 has caused great distress and disruption but it has also increased an understanding of what is possible, lowered barriers between organisations and has increased the pace of change. Amongst other things we expect legislation next year which could change the legal status of the Partnership. Consequently, the following is designed to be a foundation document from which we can develop and not a statement for the next several years. We will develop it together and inclusively.

Alan Yates
Chair
Cheshire and Merseyside Health and Care Partnership

The centrality of place

The NHS and the Councils, within the partnership, have broadly similar definitions of place. We aspire for all of our Councils, CCGs, Healthcare and voluntary sector providers and Healthwatch organisations to be active partners and participants in their respective local place-based partnership arrangements.

The extent and scope of Place arrangements are determined locally, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making between NHS and Local Authorities. Other key members of these partnerships include:

- GP Federations
- Primary Care Networks
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- Other primary care providers such as community pharmacy, dentists, optometrists
- Independent health and care providers including care homes.

The ‘primacy of Place’ and its associated neighbourhoods is sacrosanct to ensure that:

- The lead role of Local Authorities in the integration of care and system design is recognised.
- System design is built on a Place based approach.
- Place at the local authority level is the primary building block for integration between health and care and other sectors of the service system.
- Political engagement, democratic input and legitimacy (stewardship).
- the non health & care aspects of Local Authority’s portfolios are included in the health determinants consideration

Within a criteria based framework Places determine how they achieve outcome improvement, including how they come together to deliver this (i.e. their own model of service delivery) estimated to represent the considerable majority of all care improvement. It is at this level that we expect to continue to see significant local authority, and community engagement.

Our Local Government Partners in Local places

The Cheshire and Merseyside Health and Care Partnership includes nine local government partners. The City Council, four Metropolitan Councils of the Liverpool City Region and four unitary authorities from Cheshire. These authorities lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and local Health and Wellbeing Boards (or equivalent). They work with the NHS as commissioning and service delivery partners, as well as exercising powers to scrutinise NHS policy decision making. When we refer to health and care, the Partnership, it is all of these functions combined with voluntary and community sector provision and the NHS that is our focus.

Cheshire and Merseyside Health and Care Partnership is committed to working with both local authorities and NHS organisations, as equal partners, recognising that each part of the partnership provides a distinct contribution to the collaboration.

Local government's regulatory and statutory arrangements are separate from those of the NHS. As part of this memorandum of understanding all members of the Partnership, including Councils, commit to the mutual accountability principles for the partnership which are described later in this document. However, because of the separate regulatory regime certain aspects of these arrangements will not apply, for example, Councils are not subject a single NHS financial control total and any associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected Councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

Introduction and context

This Memorandum of Understanding (Memorandum) is an understanding between the Cheshire and Merseyside Health and Care Partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, reduce health inequalities and to improve the quality of their health and care services.

Cheshire and Merseyside Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations from across our nine places, with a strengthened partnership with local councils developed since this time. We are not, therefore, a new organisation but a collaboration that consolidates and combines our ambition, approaches and initiatives to meet the diverse needs of our citizens and communities.

Since our establishment we have made progress in building our system's capacity and infrastructure and established our principles and preferred way of working. Such foundations will enable and empower us to achieve our aims going forward. We expect to develop a medium to long term plan for the partnership by the spring of 2021.

Purpose

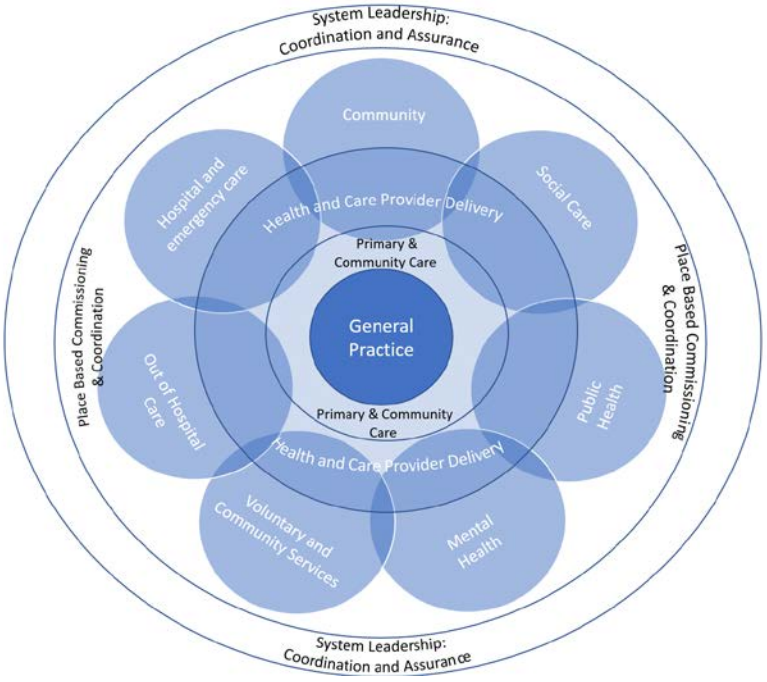
The purpose of this Memorandum is to formalise our partnership arrangements. We do not seek to introduce a hierarchical model; rather provide clarity through a framework, based on the principle of subsidiarity, to ensure collective ownership and coordination of delivery. This approach also provides the basis for a refreshed relationship with national NHS oversight bodies[1], who retain responsibilities for NHS delivery but retain a key interest in seeing the NHS work in partnership.

The Memorandum is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. Rather the Memorandum provides a shared understanding between the Partnership's participants of our collective objectives and purpose. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils.

The Memorandum should be read in conjunction with the Partnership's Plans and local Place priorities. The primacy of Place remains sacrosanct for the Partnership.

[1] We have a current Accountability Agreement in place between the Partnership and NHSE. We expect our current agreement to be reviewed which may result in a refresh.

Our integrated, system approach to collaboration



Our Partnership is grounded in the principle of collaboration which begins in each of our neighbourhoods. For the NHS each neighbourhood is consolidated around our GP practices who in turn work together, with community, voluntary and social care services in Primary Care Networks, offering integrated health and care services typically for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it (definitions of activity will be included in Terms of Reference as appropriate).

Neighbourhoods are part of our nine local Places. Our Places are our system's communities. They are the primary units for partnerships between NHS services, local authorities, charities, voluntary and community groups, all of whom work together to agree how to improve people's health and improve the quality of their health and care services.

The focus of the partnerships within our Places has moved away from simply treating ill health to a greater focus on preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment in addition to inequalities. The role of partners and Health and Wellbeing Boards as well as other place convenors are key to bringing partners together to achieve real and sustained improvements.

However in order to respond to the challenges we have within our region and the aims we have set, collectively, for our system we recognise that there are times when all partners need to work together on a wider footprint than the place, to combine resources, effort or attention to deliver a greater benefit. Such activity will be most critical in the following areas:

- to achieve a critical mass beyond local population level

- to achieve the best outcomes
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling ‘wicked issues’ (i.e. complex, intractable problems).

How we are moving forward in Cheshire and Merseyside

Vision & Mission

We have worked together to develop a shared vision for health and care services across our region. Our aspiration is that all of our priorities, activities and initiatives support the delivery of this vision:

We want everyone in Cheshire and Merseyside to have a great start in life, and get the support they need to stay healthy and live longer.

The achievement of our vision will be supported by the delivery of our mission:

We will tackle health inequalities and improve the lives of our poorest fastest. We believe we can do this best by working in partnership.

Overarching aims of our Partnership

We have agreed a set of guiding principles that shape everything we do through our partnership. These principles are underpinned by our aims which themselves are derived from our vision and mission:

1. **Improve the health and wellbeing of local people**
2. **Shift from an illness based to a health & wellbeing model**
3. **Provide better joined up care, closer to home**

Values and Behaviours

We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our Place and of Cheshire and Merseyside
- We support each other and work collaboratively

- We act with honesty and integrity and trust each other to do the same
- We challenge constructively when we need to
- We assume good intentions
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery

Delivering our objectives and outcomes

In delivering our aims we recognise that the Partnership needs to:

- Plan and establish our approach to financial and performance management
- Enhance integrated commissioning at Place/Borough and streamline it at system level
- Incorporate NHS providers through a Provider Collaborative using a peer leadership approach
- Respond to and embed the NHS Constitution and other statutory duties relevant to the partnership, for example, our shared commitment to quality of care and safeguarding

We anticipate our plans will be developed, reviewed and confirmed annually. The Partnership will set its priorities and area for collaboration and coordination together. From this activity we will identify a number of priority programmes, initiatives and priority investment areas. Such priorities will be guided by our vision and longer-term planning assumptions and commitments.

Our portfolio of programmes will be signed off by the Partnership Board following proposals being brought forward by the Partnership Coordination Group. They will be presented to and reviewed by the Partnership Assembly.

Our programmes and all Partnership activities will be outcome focussed. By working together, we expect to empower and enhance Place or neighbourhood activities and priorities through the opportunity for co-ordinated and combined action. Some recent examples of outcomes secured the Partnership activity include:

- Covid19 Testing & Vaccine collaboration resulting in delivery of regional mass testing and vaccination role out supporting all of our communities
- Pathology and Imaging improvement and efficiency supporting investment
- Digital and technology investments and development particularly supporting delivery through Covid 19 but also longer-term infrastructure needs.

- Corporate Collaboration at Scale, for example, in procurement delivering savings in both the actual cost of purchasing goods but also the investment required to support such activities and their resilience during the recent pandemic

We anticipate that Places, though which a significant number of partners will interact will similarly focus on and track outcomes.

Involving the public

We are committed to meaningful conversations with people and our communities and highly value the feedback that people share with us. This will primarily be through our existing organisations, utilising and supplementing our existing communication channels. Effective public involvement, particularly with those with lived experience and who are seldom heard, ensures that we make the right decisions, together, about our health and care services.

Each of our organisations use a wide range of ways to involve the public. We will seek to supplement these activities, where appropriate, through any discreet work progressed by the Partnership using and linking with established Place channels. Examples of this may include public, resident and patient reference groups, engagement events, participation in our Assembly or through our Board.

Voluntary and Community Sector

Cheshire & Merseyside is home to nearly 14,000 voluntary organisations, community groups and social enterprises working to tackle inequalities, and improve the lives of local people. The sector employs many but also supports and empowers thousands of volunteers and carers.

Our Voluntary, Community, Faith and Social Enterprise (VCFSE) sector is hugely important to the Partnership and is a major contributor to our communities having the resilience, capacity and social value to support us all in co-designing and delivering outcomes but also responding to and challenging inequalities within our communities. This coupled with the trust and expertise the sector brings to our system is why we consider it to be integral to our work.

Definitions and Interpretation

This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

This Memorandum is a dynamic document and is intended to reflect where the partnership is at the date of adoption. As the system, collaboration and any

responsibilities or delegations are developed or assumed this document will be reviewed and updated. When we become a full Integrated Care System the governance arrangements will be subject to review.

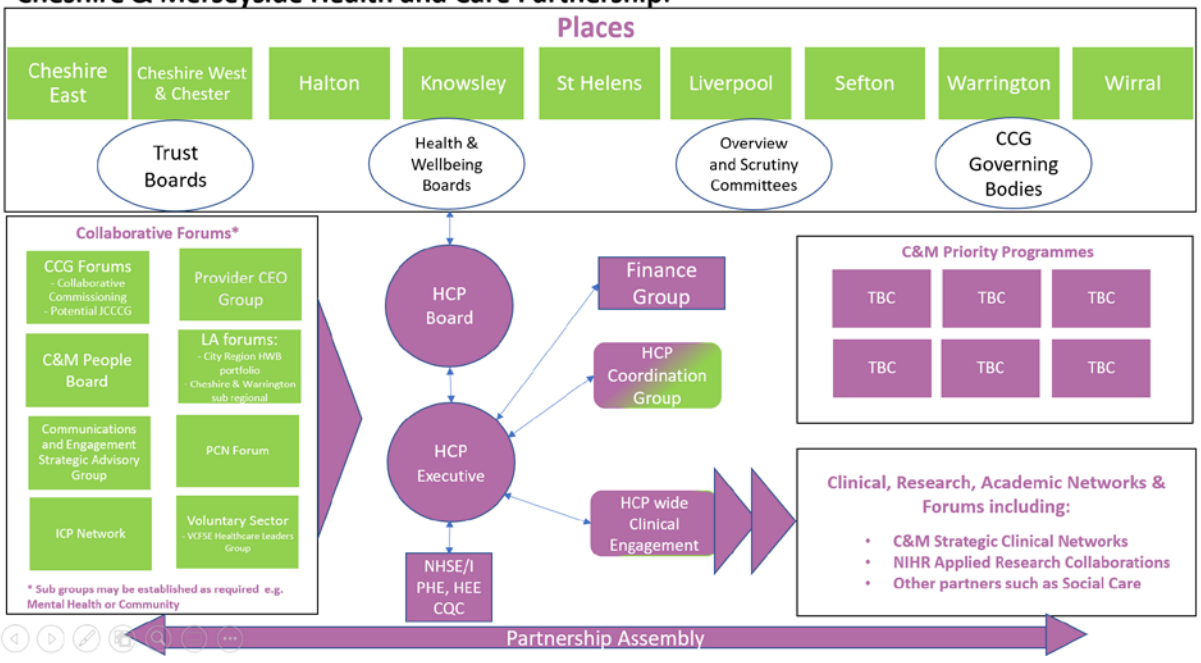
Partnership Governance

The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

The Partnership provides a mechanism for collaborative action and common decision-making for issues which are best tackled on a wider scale.

A schematic of our governance and accountability relationships is provided at Annex 2**,** a summary of the roles and responsibilities of the Partnership Assembly, Partnership Board and Partnership Executive, Partnership Coordination Group and our relationship with collaborative forums is set out below. The terms of reference for each group are subject to review and development and will be added as an annex to this agreement following their agreement by the groups themselves and this governance structure.

Cheshire & Merseyside Health and Care Partnership:



Partnership Assembly

The representative body of the Partnership, bringing together the members of the Partnership akin to a shareholder AGM. The Partnership's representative or democratic council, without it there would be no systematic scrutiny of the Partnership Board & possibly narrower interests represented.

Provides the context in which the Board works and acts as the body of last recourse for the partnership. The Assembly:

- Provide a "democratic" forum for the Partnership
- Represents the wider C&M community
- Holds the Partnership Board to account

- Critiques the decision-making process
- Insist on transparency & blow the whistle as necessary
- Put the public good first
- Act as the conscience of the Partnership
- Acts as a “Community of Interest” in support of the Partnership’s work

The Assembly will meet on average three times a year and is chaired by the Partnership Chair.

The Assembly’s constituencies are detailed in Annex 5 and include all parties to this agreement (Annex A).

Partnership Board

The Partnership Board provides the formal leadership and authority of the Partnership. The Partnership Board is responsible for setting strategic direction. It provides oversight for all Partnership business, and a forum to make decisions together as Partners. It is chaired by the Partnership Chair

The Partnership Board:

- Acts as the governing body of the Partnership
- Sets the strategic framework of the Partnership & monitor performance against it; gives authority for expenditure & policy decisions where appropriate
- Holds the Partnership Executive to account
- Is Accountable to the Partnership Assembly.

The Partnership Board meets monthly.

A representative Board membership is detailed in Annex 6

Partnership Coordination Group

The Partnership Coordination Group was initially established as an ad hoc operational group to coordinate the systems response to Covid-19. However the group has ongoing value as:

- A coordination forum across the partnership
- An informal, regular, communication channel and discussion point to support and influence pre work / thinking in advance of wider Partnership engagement

The co-ordination group meets twice monthly and is chaired by the Partnership Chief Officer

Partnership Executive

The Partnership Executive executes the strategic plan of the Partnership by delivering and helping Partners to deliver the vision and mission of the

Partnership. Accountable to the Partnership Board. It is chaired by the Partnership Chief Officer

The Partnership Executive focuses on:

- Strategic not operational issues.
- Creates & delivers plans to meet the Partnership's vision, mission & value
- Maintains oversight of programmes
- Provides the Partnership Board with information on key decisions
- Collects, collates & communicates data from across the Partnership
- Communicates simple, coherent messages from across the Partnership to stakeholders
- Advises on best practice across the Partnership

Finance Group

The Finance Group has been established to strengthen financial leadership, coordination and prioritisation across the Partnership. The Group makes proposals to the Partnership's decision-making structures on areas related to the Partnership's funding, system allocations and regional prioritisation. Financial leadership is built into each of our work programmes and groups, and the group provides financial advice to all of our programmes.

Where not already in place or available agreed Terms or References for each of the above described groups, or Boards will be developed by each group, discussed and circulated among interested parties before being put forward to the Partnership Board for approval.

It is envisaged that that such terms of reference will be finalised in Q4 of 20-21 and at that point form annexes of future versions of this Memorandum

Programme Governance

Strong governance and programme management arrangements are built into each of our programmes and workstreams. Each programme has a Senior Responsible Owner, typically a Chief Executive, Accountable Officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our Places and each relevant service sector.

Programmes provide regular updates to the Partnership Executive and Partnership Co-ordination Group.

Clinical leadership, contribution and participation is central to all of the work we do and is integrated into the way we work both through our governance, through participation but also through our Strategic Clinical Networks (the number and scope of these networks will respond to the priorities of our system) local forums and research structures.

Clinical leadership is built into each of our work programmes and governance groups, to be supplemented by our developing PCN Forum. Our Strategic Clinical Networks and our regional clinical, research and wider forums provide structures to place clinical advice central to all of our programmes.

The importance of recognising and addressing inequalities in the care we provide, the way we work and within our populations remains central to our purpose, our thinking and our priorities. Accordingly, we identify and prioritise addressing inequalities as a cross cutting theme through all of our work and our programmes.

Other governance

The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (e.g. commissioners, our providers and Councils) that support the way it works. These are described below.

Clinical Commissioning Groups

The nine CCGs in Cheshire and Merseyside are continuing to develop closer working arrangements within each of the nine Places that make up our Partnership.

The CCGs have established joint working arrangements. These arrangements allow for representatives of each CCG to meet to discuss and explore issues of common concern. The CCGs also have the opportunity, through formal delegation and prescribed governance steps, to establish a Joint Committee or Committee in Common, for formal collective decision making. Our CCGs are currently working through their approach to joint working which they will use to embed a shared agenda going forward.

Provider Collaborative

The nineteen provider trusts in Cheshire and Merseyside already work together and collaborate across a variety of initiatives. They meet through an established CEO Group. However in order support our system in achieving our aims we expect the scope and outputs needed of this group to grow over time as our providers collectively plan and integrate care to meet the needs of our population.

Over time we expect the focus of this forum to:

- Deliver on NHS Constitutional requirements: 52 weeks wait, cancer treatment requirements and activity targets:
- Progress detailed planning – marshalling resource around priorities
- Tackle variation through transparent data and peer review
- Realise capacity utilisation - equalize and optimise access
- Target expert support for outlier organizations and specialties – deployed from region to ICS

- Promote innovation at scale – ICS owned

We recognise other networks and forums may exist or be established related to provider delivery, for example, in social care or community services.

Primary Care Network Forum

The Partnership is establishing a forum to bring together our system's Primary Care Networks (PCNs). PCNs bring primary and community services together to work at scale (as set out in the NHS Long Term Plan)

Bringing our Networks together periodically provides a tremendous opportunity to ensure there is a connection with our neighbourhoods, that the Partnership remains connected to and relevant to the front line but also to ensure that a clinical voice is even more prominently connected to our work, strategic planning and decision making.

The scope and frequency of this groups work will be defined in due course.

Integrated Care Partnership Network

The Partnership is establishing a network to bring together our emerging system place-based integrators.

Establishing this forum will support our emerging systems to share best practice, share learning and undertake shared, stepped implementation progress or integration.

The scope and frequency of this groups work will be defined in due course.

Cheshire and Merseyside People Board

The NHS People Plan sets a requirement for systems to develop a local People Board which will be accountable to the NHS North West Regional People Board. The Cheshire and Merseyside People Board (C&MPB) brings together health and care organisations and key stakeholders to provide strategic leadership to ensure the implementation of the People Plan and system wide workforce plans.

It is intended that the local People Board will provide a forum to:

- Monitor the delivery of the Cheshire and Merseyside People Plan targets and milestones
- Agree workforce transformation programmes
- Determine workforce development priorities and allocation and approval of funding accordingly
- Monitor performance of any workforce programmes

The Board meets on a quarterly basis. Membership is drawn from across the health and care sectors. Key NHS members from this group also participate in social care and Liverpool City Region workforce groups to maximise alignment and partnership collaboration.

Communications and Engagement Strategic Advisory Group

The Communications and Engagement Strategic Advisory Group provides leadership and co-ordination for communications and engagement across the Cheshire and Merseyside health and care system.

The group links with the Partnership's Co-ordination Group and aims to facilitate and secure alignment and connection between Partnership activities and those being undertaken in each partner organisation. The group provides leadership to the local communications and engagement community and shares local intelligence on sensitive or contentious issues,

The Group meets monthly. Membership is drawn from across health and care and includes wide, representative, local authority membership.

Local Council Leadership

Relationships between local councils and NHS organisations are well established in each of the nine places. The Partnership places great emphasis on these Place level connections and relationships. How the Partnership interacts with Place, secures intelligence and acts on feedback is and will be critical. The Partnership itself recognises it needs to develop its own relationships, avoid duplication and accordingly focusses primarily on the system level. We will continue to strengthen relationships in our current areas of focus:

- Liverpool City Region Health and Well-being Portfolio Holders
- Cheshire and Warrington sub regional Leaders' Board
- Local authority chief executives engage and collaborate with the Health and Care Partnership;
- Health and Wellbeing Board chairs collaboration
- Provision for Joint Health Overview and Scrutiny Committees as may be beneficial

Local Place Based Partnerships

Local partnership arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers working together in Primary Care Networks, to take responsibility for the cost and quality of care for the whole population.

Each of our Places has developed its own partnership arrangements to deliver the ambitions set out in its own Place Plan. These ways of working reflect local priorities and relationships, but all provide a focus on population health

management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

We anticipate our local, place based, health and care partnerships will develop horizontally integrated networks to support seamless care for patients.

Mutual Accountability Arrangements

A single consistent approach for assurance and accountability[2] between Partners in Cheshire and Merseyside system wide matters will be applied through the governance structures and processes outlined in pages 12 through 17 above. Our mutual accountability framework is set out, in full, at Annex 4

Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health, including tackling inequalities where relevant to committed Partnership activities or delivery.

Our mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places wish to access support from the wider Partnership to ensure the effective management of financial and delivery risk.

As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Cheshire and Merseyside by, overtime, enacting streamlined oversight arrangements

Decision-Making and Resolving Disagreements

Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision- making responsibilities.
- **Decisions delegated to collaborative forums** - some partners may from time to time delegate specific decisions to a collaborative forum, for example, a Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the relevant collaborative forum and not this Memorandum.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in annex 4 below.

[2] Within the NHS and extending to areas of committed Partnership or Place based activity or delivery

Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board will not act where it has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

The Partnership Board will aim to make decisions by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may be referred to the dispute resolution procedure on page 19 below and Annex 4 by any of the affected Partners for resolution.

In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

Where necessary, Place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

The Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

National and regional support

To support Partnership development as an Integrated Care System there will be a process of aligning resources from NHS Arm's Length Bodies, such as some regional NHSE/I focus, to support delivery and establish an integrated single assurance and regulation approach.

National capability and capacity will be available to support C&M from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

Variations

This Memorandum, including the Schedules, may only be varied by the agreement of the Board after consultation with all Partners.

Charges and liabilities

Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a “Contributions Schedule” as may be developed by the Partnership through its Finance Forum.

Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

Information Sharing

The Partners will provide to each other all information that is reasonably required in order to achieve the objectives and take decisions on a Best for C&M basis.

The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

Confidential Information

Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner. It is the responsibility of the disclosing Partner to handle any relevant requests for information as may be disclosable under FOI legislation as such information is held in trust, only, via this agreement on behalf of the information asset owner to support delivery on their behalf via the Partnership.

To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a

waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

The Parties agree to ensure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

Additional Partners

If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

Signatures

This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document. For the document to have effect all Partners must have supported it.

The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm's Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, e.g. NHSE, NHSI, HEE, PHE
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England
GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Annex A
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better
HWB	Health and Wellbeing Board

ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision-making forum. It has delegated commissioning functions
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub-regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	A number of geographical areas which make up Cheshire and Merseyside, in which GP practices work together as Primary Care Networks, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people
NHS	National Health Service
NHSE	NHS England (formally the NHS Commissioning Board)
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS
NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Partners	The members of the Partnership under this Memorandum as set out in Annex A
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Board	The senior governance group for the Partnership set up in accordance with pages 12-17
Partnership Executive	The team of officers, led by the Partnership Chief Officer, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the nine geographical districts that make up Cheshire and Merseyside, being Knowsley, Sefton, Liverpool City Region, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral. and "Place" shall be construed accordingly
Programmes	The C&M programme of work established to achieve each of the objectives agreed by the Partnership

STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
Transformation Fund	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	Shall have the meaning set out in pages 9 and 10

Annex A - Parties to the Memorandum

The members of the Cheshire and Merseyside Health and Care Partnership (the Partnership), and parties to this Memorandum, are:

Local Authorities

- Cheshire East Council
- Cheshire West and Chester Council
- Halton MBC
- Knowsley MBC
- Liverpool City Council
- Sefton MBC
- St Helens MBC
- Warrington Borough Council
- Wirral Council

NHS Commissioners

- NHS Cheshire CCG (Formerly Eastern, Western and South Cheshire and Vale Royal)
- NHS Halton
- NHS Knowsley
- NHS Liverpool
- NHS South Sefton
- NHS Southport and Formby
- NHS St Helens
- NHS Warrington
- NHS Wirral

NHS Service Providers

- Alder Hey Children's NHS FT
- Bridgewater Community Healthcare NHS FT
- Cheshire and Wirral Partnership NHS FT
- The Clatterbridge Cancer Centre NHS FT
- Countess of Chester Hospital NHS FT
- East Cheshire NHS Trust
- Liverpool Heart and Chest NHS FT
- Liverpool University Hospitals NHS FT
- Liverpool Women's NHS FT
- Mersey Care NHS FT
- The Mid Cheshire Hospitals NHS FT
- NW Boroughs Partnership NHS FT
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Southport and Ormskirk Hospital NHS Trust

- The Walton Centre NHS FT
- Warrington and Halton Hospitals NHS FT
- Wirral Community NHS FT
- Wirral University Teaching Hospital NHS FT

Other Partners

- All PCNs in the Cheshire and Merseyside area
- Voluntary Sector North West
- Healthwatch in each of the Partnership's Places

As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and arrangements set out in this Memorandum.

Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

There are other partners who are not members and therefore not signatories to this memorandum. These include:

Heath Regulator and Oversight Bodies

- NHS England and NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission

Other Local Bodies

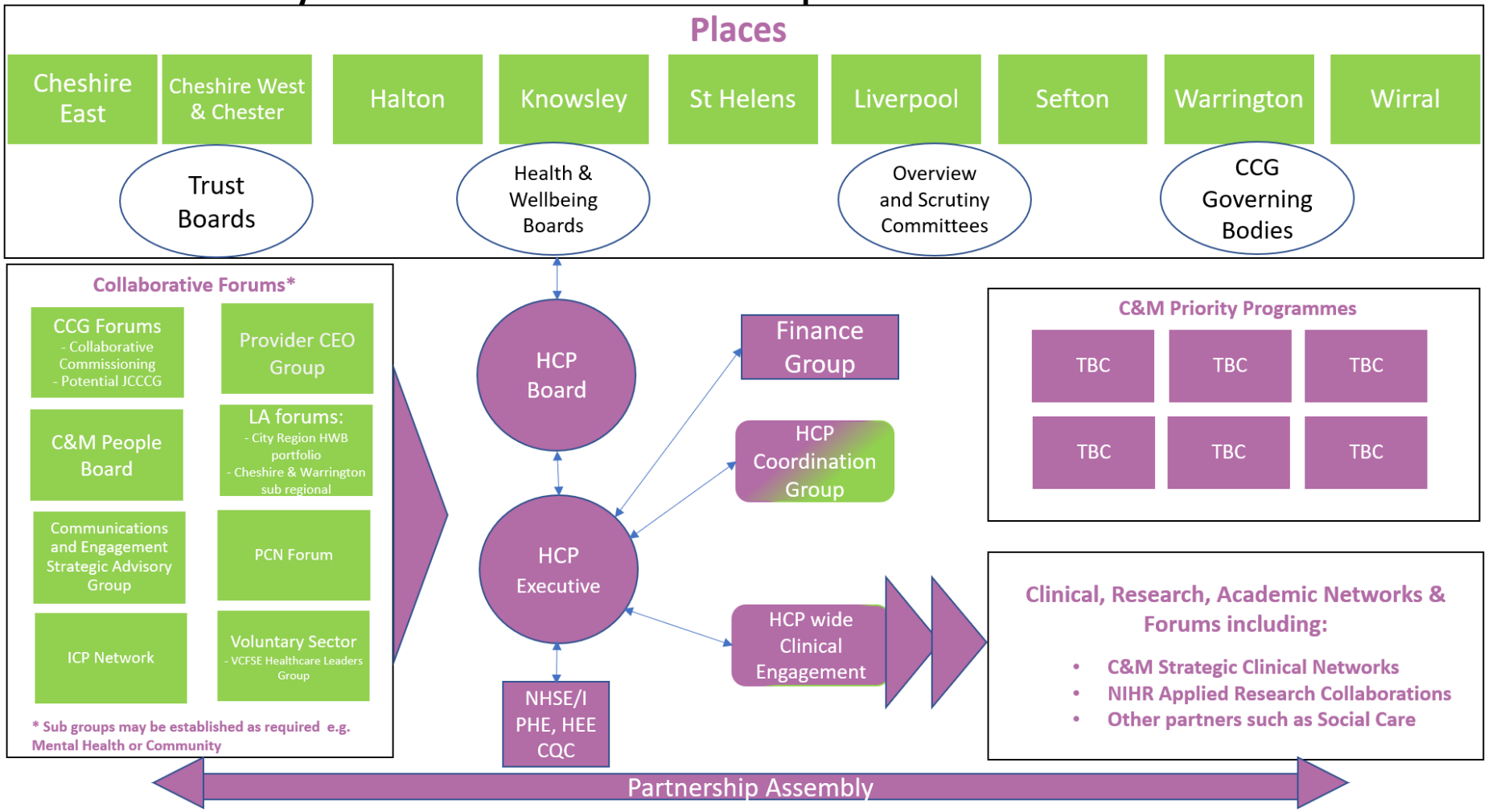
- Fire
- Police
- Probation
- Others, where relevant

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviours	✓	✓	✓	✓	✓	✓
Partnership aims	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financials: • Financial risk management • Allocation of capital and transformation	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

Annex 2 – Schematic of Governance and Accountability Arrangements

Cheshire & Merseyside Health and Care Partnership:



Annex 3 – Signatories to the Memorandum

Annex 4 – Mutual Accountability Arrangements

A single consistent approach for assurance and accountability[3] between Partners in Cheshire and Merseyside system wide matters will be applied through the governance structures and processes outlined in pages 12 through 17 above.

Current statutory requirements

NHS England and NHS Improvement were brought together to act as one organisation in 2019, but each retains its statutory responsibilities. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

We recognise that each non NHS partner has its own statutory and regulatory frameworks and requirements which are of equal importance and consideration. Some of these requirements may have greater relevance to the Partnership or Places than others. We envisage such arrangements will receive primary focus at a Place level e.g OFSTED.

Our model of mutual accountability

Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health including tackling inequalities where relevant to committed Partnership activities or delivery. As Partners we will:

- agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our collaborative groups to support any formally required decision making, engaging people and communities across our system; and

[3] Within the NHS and extending to areas of committed Partnership or Place based activity or delivery

- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

We anticipate as we develop over time, and when legislation or regulation requires, system oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

Progressing any action

We will prioritise work and the deployment of improvement support across the Partnership and agree recommendations for any action or interventions where relevant to committed Partnership activities or delivery. We envisage using our Partnership Co-ordination Group as the forum to agree recommendations on:

- Improvement or recovery plans;
- More detailed peer-review of specific plans;
- Commissioning expert external review;
- Co-ordination of any formal intervention and improvement support; and
- Agreement of any restrictions on access to discretionary funding and financial incentives.

For Places where financial performance is not consistent with plan, the Finance Group may make recommendations to the Partnership Co-ordination Group on a range of interventions.

The role of Places in accountability

This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

The Partnership and its constituent bodies recognise the statutory role and powers of Health Overview and Scrutiny arrangements

Implementation of agreed strategic actions

Our mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places wish to access support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies oversight and escalation

As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Cheshire and Merseyside by, overtime, enacting streamlined oversight arrangements which will support the Partnership to:

- take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;

- Work with NHS England and NHS Improvement who will increasingly hold the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- Work with NHS England and NHS Improvement to agree where they will intervene in individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the Partnership and work with it to seek a resolution prior to making an intervention.

These arrangements will build upon the current Accountability Agreement in place between the Partnership and NHSE. We expect our current agreement to be reviewed which may result in a refresh.

Decision-Making and Resolving Disagreements

Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision- making responsibilities.
- **Decisions delegated to collaborative forums** - some partners may from time to time delegate specific decisions to a collaborative forum, for example, a Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the relevant collaborative forum and not this Memorandum.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out below.

Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board will not act where it has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

The Partnership Board will aim to make decisions by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may be referred to the dispute resolution procedure on page 35 below by any of the affected Partners for resolution.

In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

Where necessary, Place or sector-based arrangements will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

The Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

The key stages of the dispute resolution process are

I. The Partnership, working through the Partnership Executive, will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If the Executive cannot resolve the dispute within 30 days, the dispute should be referred to Partnership Chief Officer who will, likely, involve the Partnership Coordination Group.

II. The Co-ordination Group will consider the issues and, where necessary, make a recommendation based upon a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. The Partnership Executive will advise the affected Partners of its decision inwriting.

III. If the parties do not accept the decision, or Board cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by Partnership's Chief Officer. The facilitator will work with the

Partners to resolve the dispute in accordance with the terms of this Memorandum.

IV. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred back to the Partnership Board for final resolution based upon majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

Annex 5 – Partnership Assembly Constituencies

Organisations that represent constituencies within our Partnership Assembly above and beyond those listed as Parties to this agreement (Annex A):

Age UK Cheshire	Liverpool John Moores University
ANCS	University of Liverpool
Cheshire Fire	Edge Hill University
Cheshire Fire and Rescue Service	Merseyside Fire and Rescue Service
Cheshire Police	Merseyside Police
Healthwatch Cheshire	CPS Mersey-Cheshire
Manchester Metropolitan University	Innovation Agency
Cheshire West Integrated Care Partnership	North West Ambulance Service
Cheshire Halton & Warrington Race & Equality Centre	Torus
The University of Chester	Voluntary Sector North West
Public Health England	Sefton CVS
Greater Manchester Health and Social Care Partnership	Venus Working Creatively with Young Women
Her Majesty's Prison and Probation Service	'Together We're Better' - Staffordshire and Stoke on Trent STP
Citizens Advice Halton	Citizens Advice Warrington
Halton Housing	Fearnhead Cross Medical Centre
Halton & St Helens VCA	People First UK
Healthwatch	Right to Succeed
R-Health	Sovini
Lancashire and South Cumbria STP	VCFSE representatives
Lancashire Care	
Inclusive Community Development	

This list may be extended through a simple process of proposition and agreement via the Partnership Board.

Annex 6 – Partnership Board Membership

4 Local Authority representatives (2x elected members and 2x CEs: covering Merseyside and Cheshire)

2 NHS Commissioning representatives (1x Clinical Chair, 1x Accountable Officer)

Primary Care (1 representative)

Public Health Directors (1 representative)

Voluntary sector (1 representative)

Lay representatives (2)

Members of the Partnership Executive team[4]

[4] To be defined but it is not expected formal members from this constituency will form a majority

Agenda Item 7

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Place Partnership update
Date of meeting:	26th January 2021
Written by:	Claire Heaney Programme Director
Contact details:	Claire.heaney2@nhs.net
Health & Wellbeing Board Lead:	Steven Michael

Executive Summary

Is this report for:	Information X	Discussion ☐	Decision ☐
Why is the report being brought to the board?	To keep the Board updated on progress with the work of the Cheshire East Health and Care Partnership.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	To note the progress and any issues raised and comment as appropriate.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	N/A

1 Report Summary

1.1. Within the Cheshire East Partnership Five Year Plan 2019-2024, our vision *"to enable people to live well for longer; to live independently and to enjoy the place where they live"* is captured alongside our focus, key strategic goals, with reference to wider determinants of health, why we need to change and expected outcomes.

1.2. Since April 2020, despite being immersed in Covid-19 emergency operational response measures, Partnership working across Cheshire East Place has continued and has strengthened to enable progress in a number of key areas these being primarily around:

- Commissioning Intentions
- Financial Recovery Plan
- Health and Care Services Redesign
- Integrated Care Partnership (including Care Communities)
- Wider enabling workstreams including Digital and Workforce

1.3. This report is designed to inform the Board of progress made, key challenges still prevailing and plans moving forward around commissioning, planning and delivery of integrated health and care services.

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board note and comment on the report.

3 Reasons for Recommendations

3.1 To provide an opportunity for the Board to respond to the update on the work of the Cheshire East Health and Care Partnership.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The work of the Cheshire East Health and Care Partnership contributes to all of the Health and Wellbeing Board Strategy priorities.

5. Background and Options

5.1 Within our Five Year Place Plan 2019 - 2024, we have stated four key goals around development and delivery of a sustainable, integrated health and care system across Cheshire East Place, which is financially balanced, supported by a sustainable workforce and significantly reduces health inequalities. An update on the key elements enabling us to achieve this is summarised below.

5.2 In response to NHS England and NHS Improvement's reconfiguration proposals around the formation of Integrated Care Systems and disestablishment of Clinical Commissioning Groups. NHS Cheshire CCG has recently shared its approach, thinking and progress around evolving strategic and tactical commissioning to Cheshire East Integrated Care Partnership (Cheshire East ICP). Key elements emerging from devolving responsibility include:

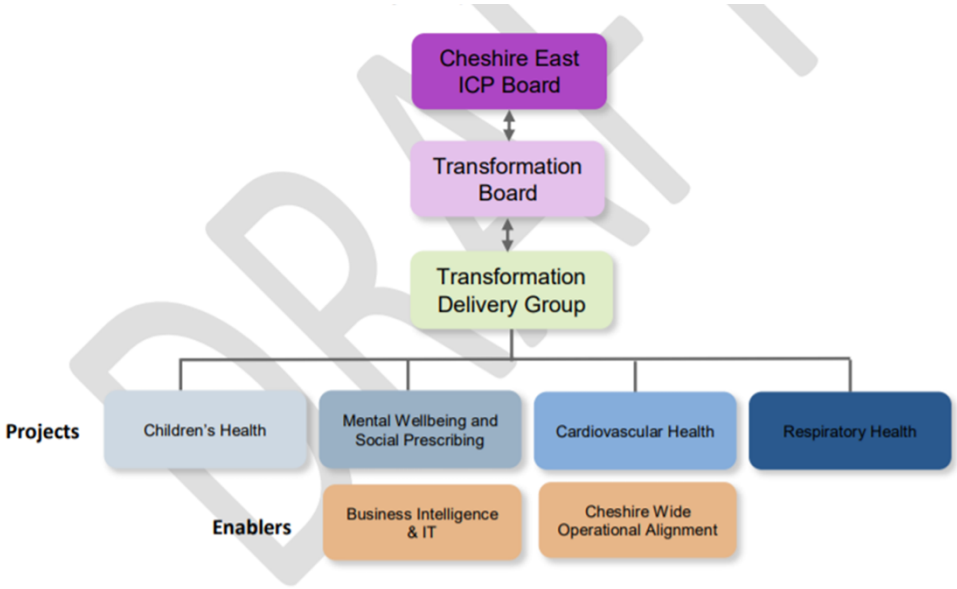
- Changes to contracting mechanisms and impact on budgets, financial frameworks and resources
- Population Health and Performance outcome frameworks and measures
- Clarity on future functions and Governance arrangements
- Business Intelligence requirements
- Communications and Engagement

5.3 To address the underlying financial deficit across the Cheshire wide NHS System, work has continued on the pan-Cheshire Financial Recovery Plan with emphasis specifically on Collaboration at Scale programmes of work designed to generate greater efficiencies and value for money from a broader geographical footprint and organisations working on solutions together, these being Workforce, Procurement, Estates and Facilities, and Medicines Optimisation.

5.4 Work progressed on the Health and Care Services Redesign with Clinical Workshops and Patient Focus Groups held during September/October 2020 to generate draft proposals for the New Model of Care. This work was completed with outcomes shared with respective Partners, presented at NHS Cheshire CCG Governing Body and shared with Cheshire East ICP Board Members. Yorkshire and the Humber Clinical Senate are currently undertaking an independent review of the process followed and outcomes with reporting back of initial findings expected during February 2021.

5.5. At the heart of our Cheshire East Place Transformation programme is the establishment of the Integrated Care Partnership and development of our eight Care Communities to provide the foundation for innovation and focus on meeting the specific needs of our local populations within these communities. The Governance arrangements as outlined in the structure below have now been approved with the respective forum mobilised and work commenced on four key target areas: Cardiovascular Health, Children's Health, Mental Wellbeing and Social Prescribing and Respiratory Health.

Cheshire East ICP Governance Structure



5.6 Two further areas of focus have been highlighted in respect of Business Intelligence & IT, and a Cheshire-wide operational alignment project. Work is also continuing on Workforce & OD, ensuring that the actions emerging from the cultural work supporting the development of the eight Care Communities is successfully completed. In addition, Covid-19 highlighted the importance of Digital in enabling us to work and operate differently. Therefore, focus remains on ensuring that the systems, tools and technology at our disposal are fit for purpose to deliver the services we need both now and in the future for the population of Cheshire East.

5.7 There are a number of implications due to the complexity and challenges associated with the integration of health and care services. However, under the revised Governance arrangements, there is a clear line of sight through Cheshire East Place Partnership Board to the Cheshire East Health and Wellbeing Board (CEHWBBd), with the Independent Chair of the Partnership Board now attending CEHWBBd enabling full visibility of Commissioning Intentions, and progress in respect of achievement of the Place 5 Year Plan.

5.8 Should there be any necessity to radically change the way in which a service is currently provided to the population of Cheshire East, then there may be legal implications to be considered and a robustness of process followed which will required to be evidenced. It is too early to pre-empt any such requirement.

5.9 There are likely to be revenue and capital requirements and discussions to be held with NHS England / Improvement and Cheshire and Merseyside Health and Care Partnership moving forward. Aligned with legal implications, these are yet to be quantified to enable discussions to be held around likelihood of funding availability, timescales and any associated restrictions of deployment.

5.10 Significant emphasis has been on supporting the establishment of the infrastructure in our eight Care Communities before moving onto the development of the Integrated Care Partnership. At a future point in time, there is envisaged to be a “left shift” of activity away from an acute “hospital” setting to a community setting which will involve changes to workforce deployment. As per above, it is too early to pre-empt these and especially as these are inextricably linked to Commissioning Intentions and the wider reconfiguration proposals underway.

6 Access to Information

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Claire Heaney
Designation: Cheshire East Health and Care Place Programme Director
Email: Claire.heaney2@nhs.net

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Agenda Item 8

Cheshire East Council

NHS Cheshire Clinical Commissioning Group

CHESHIRE EAST HEALTH AND WELLBEING BOARD
Reports Cover Sheet

Title of Report:	Cheshire East Integrated Care Partnership Strategy and Transformation Plan
Date of meeting:	26th January 2021
Written by:	Guy Kilminster
Contact details:	Guy.kilminster@cheshireeast.gov.uk
Health & Wellbeing Board Lead:	Dr Patrick Kearns and John Wilbraham

Executive Summary

Is this report for:	Information ☐	Discussion X	Decision ☐
Why is the report being brought to the board?	To ensure Members of the Board are sighted on the Integrated Care Partnership's Strategy and Plans for the future.		
Please detail which, if any, of the Health & Wellbeing Strategy priorities this report relates to?	Creating a place that supports health and wellbeing for everyone living in Cheshire East ☐ Improving the mental health and wellbeing of people living and working in Cheshire East ☐ Enable more people to live well for longer ☐ All of the above X		
Please detail which, if any, of the Health & Wellbeing Principles this report relates to?	Equality and Fairness ☐ Accessibility ☐ Integration ☐ Quality ☐ Sustainability ☐ Safeguarding ☐ All of the above X		
Key Actions for the Health & Wellbeing Board to address. Please state recommendations for action.	That the Board notes and considers the ICP's Strategy and Transformation Plan.		
Has the report been considered at any other committee meeting of the Council/meeting of the CCG board/stakeholders?	No		

Has public, service user, patient feedback/consultation informed the recommendations of this report?	N/A
If recommendations are adopted, how will residents benefit? Detail benefits and reasons why they will benefit.	The delivery of the ICP priorities will improve service provision to the people of Cheshire East. Care pathways will be more effectively joined up, delivery more efficient and effective and outcomes improved.

1 Report Summary

1.1 The Cheshire East Integrated Care Partnership (ICP) has been established as part of the local response to changes set out in the NHS Long-Term Plan, in particular the establishment of Integrated Care Systems in England. The development of the ICP is one of the key work-streams of the Cheshire East Place Health and Care Partnership. The ICP consists of the Council, the two hospital trusts, the mental health trust and the GPs through their Primary Care Networks. A board has been established for the ICP and they have recently published their Strategy and Transformation Plan (see Appendix 1). This aligns to the Place Partnership's Five-Year Plan published in October 2019.

1.2 The report summarises the key aspects of the Plan

2 Recommendations

2.1 That the Cheshire East Health and Wellbeing Board notes and considers the ICP Strategy and Transformation Plan.

3 Reasons for Recommendations

3.1 To ensure that the Board are sighted on the Strategy and Plan and have had the opportunity to discuss.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The priorities within the Strategy and Transformation Plan have been influenced by and take into consideration the priorities of the Joint Health and Wellbeing Strategy. There is a strong alignment and delivery of the ICP priorities will have a positive contribution to moving forward on those in the JH&WS.

5 Background

5.1 The system architecture described in this paper and of which the ICP is a part, is based upon requirements set out in the NHS England Long Term Plan (published in 2019) and builds upon the NHS England Five Year Forward View which established regional Sustainability and Transformation Partnerships back in 2016. Over the last two years at the Cheshire and Merseyside and Place levels, significant work has taken place (and is ongoing) to establish the Integrated Care System (for Cheshire and Merseyside), the Place Partnerships and the Integrated Care Partnerships (both being established in each of the

nine local authority areas), together creating the infrastructure designed to deliver health and care integration and transformation.

5.2 The publication of the Cheshire East Health Place and Care Partnership's Five Year Plan in 2019, set out a local vision for progressing integration and transformation, with a focus upon prevention and early intervention, reducing health inequalities and recognising the significant challenges faced by the system, brought about by increasing demand and a substantial financial gap.

5.3 The Cheshire East ICP vision and plan is aligned to the Cheshire East Place Partnership Plan priorities:

- To develop and deliver a sustainable, integrated health and care system
- To create a financially balanced system
- To create a sustainable workforce
- To significantly reduce the health inequalities

5.4 The Integrated Care Partnership has been established to focus on a number of areas of work that, through an integrated and transformed way of working will deliver better outcomes for residents, and reduce costs to the system. The Transformation Plan sets out in more detail what those priorities will be and the intentions regarding delivery.

5.5 The partners include: the two acute hospital trusts, East Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust; the Cheshire and Wirral Partnership NHS Foundation Trust (mental health); the GPs through the nine Primary Care Networks (working with the eight Care Communities), Cheshire East Council and the Cheshire East Social Action Partnership.

6. **Briefing Information**

6.1 The ICP Transformation Plan sets out the four priority areas of work that will initially be focussed upon:

- Cardiovascular Health
- Respiratory Health
- Mental Wellbeing and Social Prescribing
- and Children's Health (in the form of setting up Children's Hubs)

6.2 These have been agreed through discussion between health and care professionals and with other interested parties. They were selected as there was a perceived need, there is evidence that we are outliers in these areas in our Place and because there is an opportunity to demonstrate the kind of working and thinking that will help the ICP flourish through focussed work in these areas. Additionally, there will be enabling work, in particular in relation to IT and business intelligence to support the four clinical priorities.

6.3 The Plan describes in detail the evidence of need for each of the priorities, proposed interventions, resource requirements, initial thinking in relation to innovation and doing

things differently, and aspirations for taking things further. This includes recognition of the need to address the wider determinants of health.

6.4 The interdependencies between Primary Care, Care Communities and the ICP are explained, and how the success of the ICP will allow for increased activity in the Community, reducing pressures on secondary care and allowing for more care to be delivered closer to home.

7 Access to Information

7.1 The background papers relating to this report can be inspected by contacting the report writer:

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 07795 617363
Email: guy.kilminster@cheshireeast.gov.uk

Cheshire East Integrated Care Partnership
ICP Strategy
And
Transformation Delivery Plan
September 2020 – March 2022

Cheshire East Place Vision

"Our vision is to enable people to live well for longer;
to live independently and
to enjoy the place where they live. "

Contents

Executive Summary

Cheshire East Integrated Care Partnership (ICP) is within the Cheshire East Place. One of the key challenges is how to work differently and how to engage partners and colleagues differently and effectively across our local health and care system.

There are multiple drivers for change: The health inequalities in the population we serve are increasing; There is not enough capacity or finance to deliver the same model of health and social care with an ageing and expanding local population; there is national impetus for change for example with the NHS Long Term Plan; we are required to meet a challenging financial deficit to achieve system financial balance. There are instability and capacity issues in all of our services and particularly in primary and social care.

There are multiple ways of meeting this challenge and various health and care systems around the world can demonstrate where they have been successful in this regard.

We have set out on the journey to have 8 “Care Communities” as our hubs and focus for local care delivery and we are working towards putting structures in place to provide the partnership working, with a common purpose, commensurate autonomy and enablers for them to be effective.

There is a further challenge to ensure that as a system we have a consistency of offer to our population that allows for large scale improvement in health and outcomes to be delivered across the place and allowing innovation and rapid testing of good ideas that will enable our Care Communities to flourish.

The National Association of Primary Care (NAPC) Primary Care Home programme “is about delivering care for patients as locally as we can to them that is sensitive to their needs”. This was how the Care Communities were initially intended to function and our transformation programme will support this aim. The Primary Care Home model moves away from a reactive model of care to a proactive, preventative approach to health using a biopsychosocial model.

By April 2021, The ICP Board will ensure that their role is to improve health and wellbeing, by using all of our assets to support the development of care closer to home, will have developed at a board level to take into account population health and look strategically at care needs and delivery for Cheshire East population. We will have dissolved some silos, developed the partnership and begun the process of reducing unwarranted variation and ensuring consistency of offer across primary, community, mental health and social care to an agreed minimum offer.

Care Communities will be more robust with an identified cost centre, indicative budget and with identified enablers. Their core team will be visible and baseline assessment of community assets and maturity will have been completed in order to understand the sum of their constituent resources and estates. Each will have access to a dashboard showing key metrics “at a glance” to allow rapid interpretation and responsive action.

Each Care Community will have developed a social prescribing offer and this will be available to the whole Cheshire East population. There will be a mental health first offer in development and assessment of wellbeing including formal assessment where necessary as routine in all long term condition reviews. Each Care Community will have completed or be undertaking a quality improvement project in cardiovascular and respiratory health. There will be two established Children’s hubs in Crewe and Macclesfield with advice and guidance for parents on common childhood conditions. Childhood immunisation uptake will be improved.

Public Health colleagues will work with the ICP teams to being to tackle the wider determinants of health. Communities of practice will share learning from all of these projects and test and spread using a quality improvement approach.

By April 2022, Care Communities will be at the heart of care delivery for all of our major providers. Community care team capacity will increase to enhance the offer. We will be making use of technology to enhance monitoring of health and embedding point of care testing. People will be supported to stay safe well and independent in their communities. Hand in hand with the community and voluntary sector we will be working with local authority colleagues to further develop community groups and assets to support wellbeing and keep people as well as possible for as long as possible before needing our health and care services.

Innovation and improvement methodology will be embedded and further local projects encouraged. Community diagnostics and access to rapid specialist advice will become the norm. Care services will respond rapidly to escalation of need and provide an intervention from within the team
The ICP will be taking more responsibility for the local budget and working in partnership with a strategic commissioner to tackle the wider determinants of health and care needs, ensuring that we make inroads into these in order to keep our population well.

Public and service users will be vital partners in this journey and their voice will be heard throughout the ICP structure.

Cheshire East Integrated Care Partnership

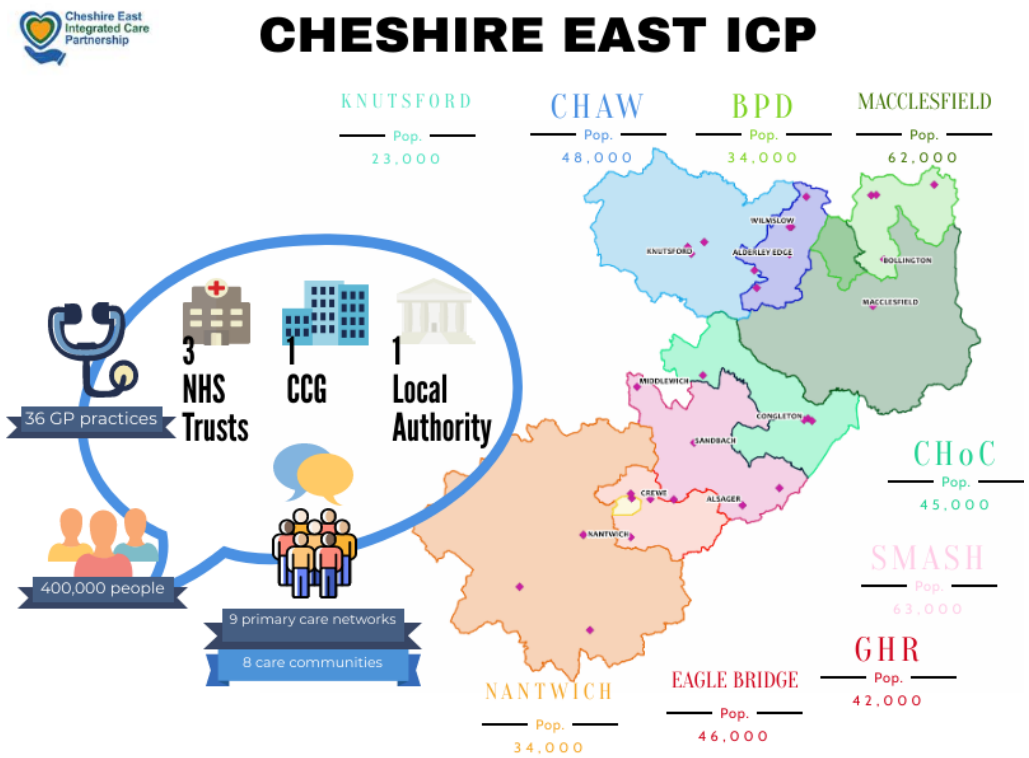


Fig1: Cheshire East ICP

The Cheshire East ICP serves a population of ~400,000 people. Figure 1 describes how it is divided into its constitutional geographies of 8 “Care Communities” and 9 Primary Care Networks (PCNs) within one

Cheshire East Council boundary. In the main the Care Communities and PCNs are coterminous with the exception being Crewe Care Community which contains two PCNs within it.

Since 2017 the Clinical Commissioning Groups (CCGs) had encouraged the local formation of Care Communities. These were collaborations of local provider teams with development support and basic funding provided to encourage them to develop shared aims and take a local view of health and care in their neighbourhood.

During this time they have been supported but have been limited in their overarching co-ordination and scope. This is in part due to not being able to access the funding and resources required to develop further.

Care services have come a long way since the inception of the NHS and evidence based medicine and care has done much to increase life expectancy, healthy years and quality of life. As a result of this we have entered a new era of people living longer with multiple conditions, with multiple medications and family units that are generally more spread across the country. This new challenge requires an additional focus on the individual and for local populations to provide expert generalism and support around people and the communities they live in. For this reason our health and care services need to evolve to maintain this excellence in quality but also provide the support needed in later years to keep people safe, well and independent.

Despite our best efforts inequalities have increased over the last 10 years and these need addressing within our approach. The wider determinants of health and wellbeing will be at the forefront of the ICP plan and in line with the NHS long term plan, the local 5 year plan and our CCG's commissioning intentions.

The advent of the NHS long term plan and the emergence of PCNs have further strengthened commitment to local, functional, robust teams and the resources allocated to these are significant. As an ICP we wish to build on this foundation and wrap the care we provide around this to create functional teams which anchor the ICP in communities directly and we invite specialists and advice in rather than refer out.

Health and care systems are complex, as are individual people and the systems their lives create. We will attempt to create an environment and care system which is flexible enough to meet these needs while still providing assurance on quality and equity of service, access and parity of esteem for all of our population groups.

Cheshire East Place Vision and Strategic Goals

Cheshire East Place Vision - Focus Areas:

- Tackling inequalities, the wider causes of ill-health and the need for social care support through an integrated approach to reducing poverty, isolation, housing problems and debt
- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves
- Having shared planning and decision making with our residents

Cheshire East Place Strategic Goals:

- To develop and deliver a sustainable, integrated health and care system
- To create a financially balanced system
- To create a sustainable workforce
- To significantly reduce the health inequalities

Principles

There are multiple examples of care systems around the world which have found ways of working that have shown benefit. Similar to the model in Jonkoping, Sweden we will use a fictional patient to map our system and look at where the pinch points are in the system for high cost patients, delayed transfers of care and overall public experience.

Realising the benefits of and achieving the Place vision will take some time. However, there are principles that we could all adhere to across the Cheshire East Place in order to demonstrate commitment and support this. Some of these have been set out previously in other documents – but broadly **we should be**:

- Improving the resident and patient experience and the quality of care provided
- Reducing unwarranted variation in care and outcomes ensuring equity of service for our population
- Using system resources effectively, driving value for money and having a single agreed information set to measure and monitor our programme of work
- Using evidence based approaches where possible
- Improving resource utilisation and reducing waste
- Demonstrating a willingness to allow innovation and to follow through with test, prove and implement at scale approach
- Look at high frequency attenders and how they interact with the system
- Improving interactions within teams and between and across providers

To do this we need:

- Access to good and current business intelligence (BI) – not just data but analysis that informs improvement and that we can standardise
- Resources and flexibility
- Strong and effective clinical and practitioner leadership
- A ‘One Team Around A Population’ ethic
- Shared outcomes
- Alignment of purpose from partner organisations to allow our current workforce to work flexibly and with a united purpose
- Increased improvement capability

Lastly there is a need to understand the competing financial drivers and desire for return on investment. Some interventions particularly population health measures may not deliver an in-year return and we need to understand how we facilitate this longer term approach in the current environment of financial restraint.

Scope and Duration of Plan

This document is intended to describe the transformation of the Cheshire East ICP from its inception to the end of the 2022 financial year. The intention is to set the direction of travel and roadmap for the next 18 months for the ICP and the outputs that are expected.

Transformation Themes

The selected transformation themes are key in the development of the ICP and its move towards a sustainable working arrangement. One of the challenges to overcome is that essentially the ICP covers two historically distinct healthcare systems divided by the M6 motorway. The population of the previous East Cheshire CCG footprint with patient flows into and out of Macclesfield Hospital (East Cheshire Trust) and East Cheshire Trust community services and the previous South Cheshire CCG with patient flows into and out of Leighton Hospital (Mid Cheshire Trust) and CCICP community services. Social Care services have also been delivered as a South and East in recognition of this situation

There are issues of sustainability of services to address and also sharing of learning across these historic footprints. One of the first orders of business for the ICP is to bring these two health and social care economies together and develop a shared purpose and team.

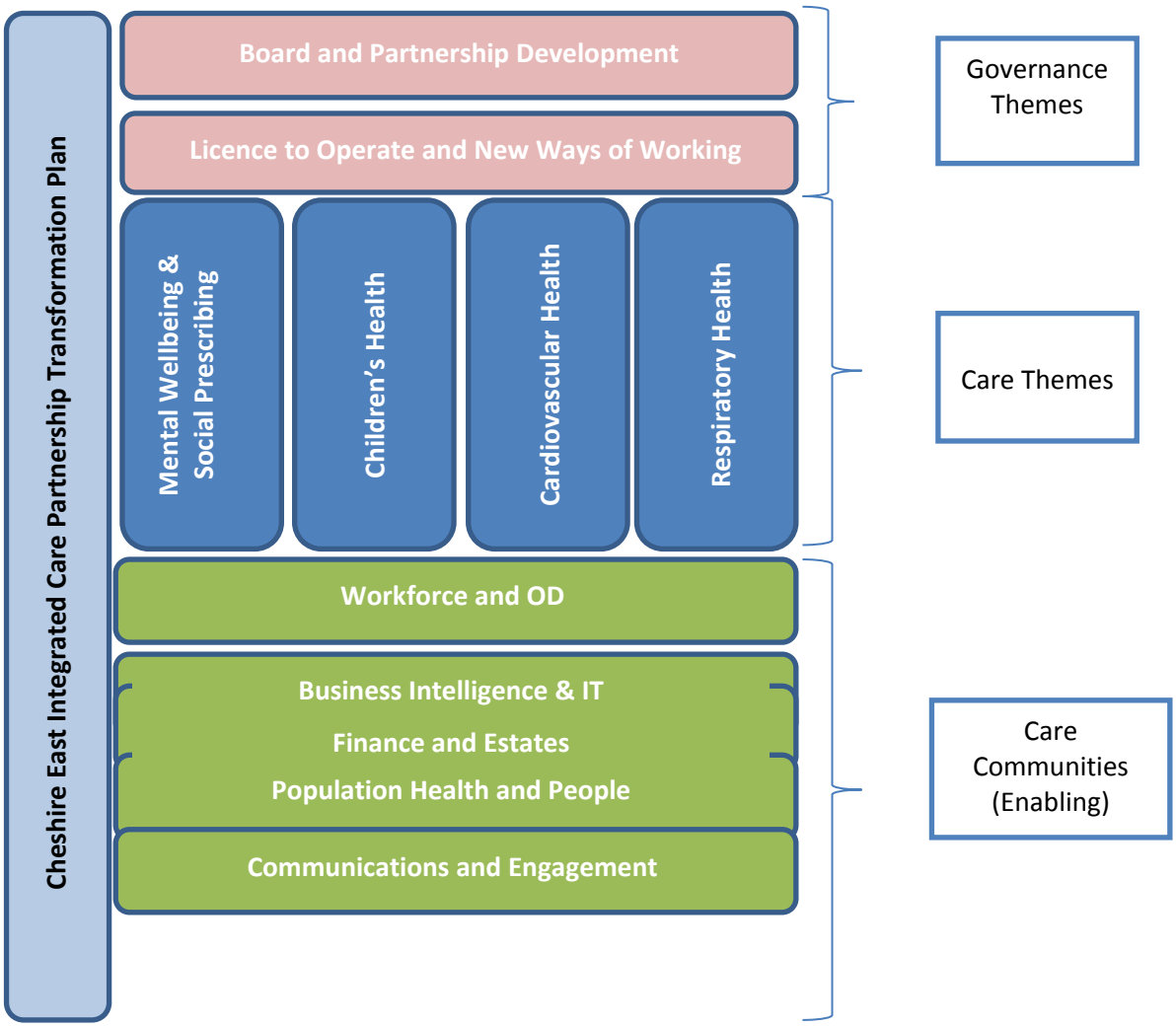
Given the historic differences in services offered, the ICP will spend time until April 2021 understanding and reducing inequity of community services across the new ICP footprint and ensuring that the stage is set to develop these further moving into 2021/22 financial year.

The care themes allow an opportunity to test new ways of working and develop new services.

In December 2019 a development workshop was held at South Cheshire College. Work was done in small groups with representatives from multiple stakeholders to be able to give feedback about how they believed the ICP should develop and what was needed to make this attempt at developing a local integrated care model successful.

The feedback has been collated and supports this transformation document. In summary, the ask was to ensure that Care Communities were supported to develop with recurrent resource and that the population data was readily available to the teams working in those areas. There was also an expressed need to develop infrastructure and governance arrangements to enable devolution of resources and accountability. Lastly there was the issue of trust and how we develop this both in governance sense to share resource risk, clinical risk and accountability, which will only occur through communication and engagement.

For this reason Care Community development is considered separately to the overall ICP development in this plan.



Corporate/Governance Theme

Within this theme is board development and ensuring that the partnership works. Developing trust is essential to working together especially when it comes to sharing risk and reward. To April 21 there will be time and resource dedicated to this and ensuring the governance arrangements facilitate the working we need to see across teams in Care Communities.

Within this theme there will also be a need to look at contracting arrangements, regulation, relationship with the new strategic CCG and how resource is transferred.

A communications plan that is regular and robust also sits within this theme and is currently in development.

Teams need time to coalesce around the Care Community footprints and in the main are aligned. Time will be given to considering how to allow team members to operate at the top of their licence in the interests of the populations they serve.
As part of developing understanding to April 21, a mapping exercise will be undertaken to establish the assets and offers available across both previous CCG footprints and commence the process of ensuring equity of services up in line with this.

A summary of activities is listed in the table below.

Care Themes

Our evidence, which is a combination of public health data, Marmot reviews, Rightcare data, JSNA and local system intelligence shows that key starting areas to develop some of the principles of the ICP with are:

- Cardiovascular Health
- Respiratory Health
- Mental Wellbeing and Social Prescribing
- and Children's Health (in the form of setting up Children's Hubs)

These areas were selected as there was a perceived need, evidence that we are outliers in this area in our Place and an opportunity to demonstrate the kind of working and thinking that will help our ICP flourish.

There are some specific asks within the clinical areas and an explanation of why these were selected is outlined below.

There are many other areas that would have been suitable all with valid claims, for instance care of older adults and frailty (which we will add as a theme in 2022). However, there are already programmes of work underway in these areas and so to make a start on how we want to work we considered the below.
Care communities may have other local priorities to work on and this will continue to be supported with the 80:20 principle, with 80% consistent offer for the population across the Place and 20% local variation and innovation responsive to local need.

All initiatives and improvement plans will be required to demonstrate the impact they are expected to have in the short, medium and long term. Project support for each care community will be available through the ICP and will assist in the setting of outcomes and the monitoring and reporting of progress.

The four areas of activity are not exclusive nor are they a comprehensive plan for the delivery of our ICP in time. They are intended to test and prove some of the ideas discussed in this document.

Children's Health

The potential scope here in children's health and wellbeing is broad. We have for the time being elected to keep safeguarding and child safety out of scope.

Need: Cheshire East Council 'Tartan Rug' – high rates of admissions to hospital across the place for under the age of 4.

Proposed Intervention:

1) Child Health Hubs based on the Imperial Model
2) Potential to expand these to include Women's and Families Health also

Evidence:
https://www.cc4c.imperial.nhs.uk/child-health-gp-hubs
https://www.kingsfund.org.uk/sites/default/files/media/imperial-child-health-general-practice-hubs-kingsfund-oct14.pdf
https://www.england.nhs.uk/integratedcare/case-studies/child-health-hubs-see-patients-closer-to-home-and-reduce-unnecessary-hospital-trips/

In one hub 39% of hospital appointments were avoided altogether, further 42% were seen by a GP, 19% decrease in sub-speciality referrals, 17% reduction in admissions and 22% decrease in A&E attendance.

Resources Identified:
Funding received from the Cheshire and Merseyside Health and Care Partnership for this programme for Year 1. We undertook a successful bidding process and have commenced development of two child health hubs initially.

Plan:
Initially work has commenced with the aim of implementing child health hubs in Crewe Care Community and Macclesfield Care Community first.

There is a lead Paediatrician attached to this piece of work. Initially work will look at 0-4yrs and urgent care including frequent attenders (mainly respiratory issues, gastrointestinal issues and infant feeding).

Medicines management will be looking at data and prescribing behaviour in this cohort to help us understand the need.

Data will also drive where there are gaps in social/community support (eg housing, parenting support, health visitor services).

The hub will aim to be initially staffed by APNPs using current resource with aims to improve upon this over time.

A second strand will look at the use and roll out of the CATCH App – which will help parent signposting.

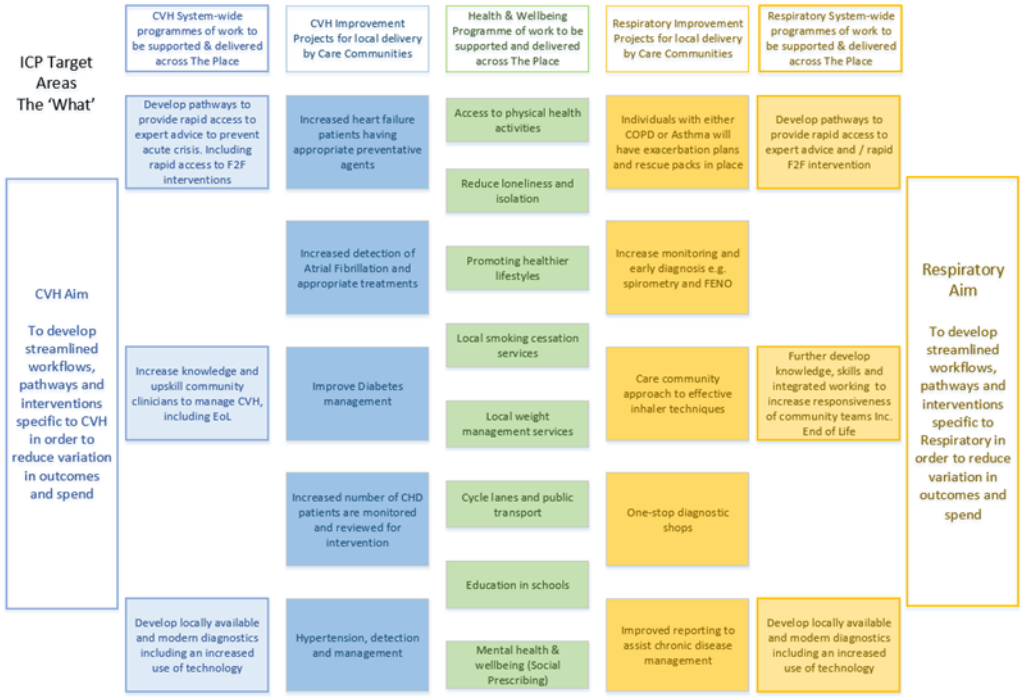
Following this, there will be a move to look at long term illnesses. The work will be based on local data and prescribing information alongside audit of admissions and pathways followed.

The hub approach involves specialists moving into the community to provide rapid access to expert advice and to improve the skills and confidence for clinicians (and families) to manage these conditions without the need for hospital interventions. The development will also identify how to signpost families to non-health support to address the wider determinants impacting on the children and their families. This will

demonstrate this way of working and hopefully provide a platform to be able to do the same for other clinical areas.

Cardiovascular Health

There is some overlap between the Cardiovascular and Respiratory Health Themes in terms of preventative measures. The diagram below illustrates how they overlap in the ICP plan.



Need:
In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality in the under 75s from CVD in comparison with our 10 most similar CCGs. This is a high cost area for the CCG and ICP. Cardiology services are struggling with sustainability issues. There are multiple population interventions that are possible which will allow us to embed a biopsychosocial approach rather than traditional model of care.

In terms of circulatory health alone Rightcare have identified potential opportunities of ~£2.2million for elective conditions and ~£4.1million for non-elective spend compared with the best of our 10 most similar peers. Circulatory conditions are an underlying cause of death in 25.1% of deaths nationally and Cheshire East is broadly similar to this.

The Rightcare data also shows that increased amounts of elective spend seems to correlate to a reduction in non-elective activity. There are also opportunities to streamline workflows, pathways and interventions to be more efficient in how we use our existing resources.

Proposed Interventions:
Several proposed methods of improvement to reduce variation in spend and outcomes have been discussed. Project Charters are being created and items for improvement will be discussed and approved at ICP transformation board. The intention for this area is that a 'menu of options' approach will allow Care Community teams to scrutinise their own data and implement methodology and plans that will address their local needs whilst remaining in line with the ICP plan.

Examples of interventions:

Public Health Intervention and Wider Determinants:-

1) Easy access to physical health activities/exercise
2) Reducing loneliness and isolation
3) Promoting healthier lifestyles
4) Effective and local smoking cessation services
5) Effective and local weight management services
6) Council encouragement to live healthily – provide cycle lanes, good public transport
7) Education in schools
8) "Know your numbers" and "Every Contact Counts" campaign – Hypertension and Atrial Fibrillation screening in all healthcare settings eg Pharmacy, Dentist, Optometrist when appropriate.

Managing Chronic Disease as effectively as possible:

1) Ensuring that all Heart Failure patients have appropriate preventative agents started and titrated to max tolerated dose (equating to 40% reduction in relative risk of long term mortality and hospital admission)
2) Ensuring that all patients with Atrial Fibrillation are encouraged to consider Anticoagulation where appropriate and then appropriately monitored
3) Improve Diabetes management - including local access to current effective treatments such as Libre testing kits and insulin pumps to improve compliance and ease of management
4) Ensuring that CHD (Coronary Heart Disease) patients are appropriately monitored and reviewed for intervention
5) Integrating Mental Health, Social Care and End of Life teams into clinical pathways.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for Heart Failure patients including sick day rules
2) Provide rapid access to expert advice in case of deterioration to prevent acute crisis
3) Explore community rapid access for those in need of rapid face to face intervention

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics and urgent specialist review
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) More locally available diagnostic services with reporting and advice that will allow community clinicians to continue to manage them in their own area
2) QI expertise and methodology to be applied to current workflow with a view to significantly reducing waste in terms of patient footfall, spend and activity both elective and non-elective

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:

All the above interventions have evidence of reduction in morbidity and mortality from various trials and pilots elsewhere. Based on local data it may be that the largest benefit will be from smoking cessation in one area and chronic disease management in another. Care Communities will prioritise interventions with

the greatest impacts. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

This Care Theme gives us an opportunity to show how our Place can work in different ways, streamline clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Respiratory Health

Need:
In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality. This is a high cost area for the CCG and ICP and the Respiratory services are struggling with sustainability. There are multiple population interventions that are also possible here.

Rightcare have identified opportunities for savings of ~£554K in elective conditions and ~£2.4million for non-elective conditions. Activity for Respiratory conditions is increasing across the Place over the last 5years.

Smoking levels have reduced across the Place over the last few years but still remain high in pockets.

Performance across the place for diagnosis confirmed/monitored with Spirometry for COPD is below our peers and also admissions for COPD in particular are on the rise.

Proposed Intervention:
There are several interventions to improve outcomes/spend and reduce unwarranted variation.
Project Charters are being created and items for improvement to be discussed and approved at ICP transformation board.

Public Health Intervention and Wider Determinants:

1) Reducing loneliness and isolation
2) Promoting healthier lifestyles
3) Effective and local smoking cessation services
4) Effective and local weight management services
5) Council encouragement to live healthily – provide cycle lanes, good public transport
6) Education in schools
7) Actions to improve air quality.

Managing Chronic Disease as effectively as possible:

1) Ensuring patients with COPD and Asthma have medications appropriate to their condition and a care plan
2) Ensuring people with COPD/Asthma have effective inhaler technique
3) Monitoring and diagnosis are supported for example with Spirometry and FENO testing and appropriate step up and step down management implemented
4) Increasing provision of and access to pulmonary rehabilitation
5) Access to secondary care advice where there is diagnostic uncertainty

6) Ensuring the IAPT and LTC offer is embedded into Care communities
7) Ensure effective end of life care planning for those with end stage disease.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for those with COPD and Asthma.
2) Rescue packs in place where appropriate
3) Responsive community teams to be able to deal with deterioration – eg Integrated Respiratory Team, Advanced Community Practitioners and Paramedics.

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) Locally available diagnostics including advice on distinguishing between conditions and when to step up to specialist care
2) One-stop diagnostic shops for symptoms where conditions may overlap (for example breathlessness)
3) Improved reporting to assist chronic disease management for all community team members.

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:
The above interventions have evidence of reducing morbidity and mortality from various trials and pilots elsewhere. Using local data it may be that the largest benefit/impact will be from smoking cessation in one area and chronic disease management in another. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

The CURE project in place at MCHfT could also be supported out into the community in terms of smoking cessation and lung cancer care. There is also potential for spread across secondary care providers.

The Clinical Areas give us an opportunity to show how our Place can work in different ways, streamlines clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Mental Wellbeing and Social Prescribing

Need:
There is a national recognised method of improving community resilience and increasing capacity in the voluntary sector. Evidence from Frome has also demonstrated impact on reduced need for GP appointments and ED attendances. A service is needed to cater for all aspects of mental wellbeing but in particular needs to address lower level mental wellbeing and social isolation as these impacts negatively on other aspects of health and social interaction.

The transfer of appropriate work into Primary Care cannot occur without a further transfer of work from Primary Care which is better supported by the community and via self-care.

Interventions:

1) Introduction of social prescribers via PCNs – curation and activation of the local community and voluntary sectors
2) Linking with the mental health forward view and providing first contact mental health practitioners with a particular focus on wellbeing at key (and early) points in all pathways providing an obvious first contact and support
3) Council connected communities project to link with ICP programmes and help provide infrastructure for voluntary sector (in conjunction with CVS)
4) The expansion of IAPT in line with the Mental Health Forward view.

Evidence:
Multiple national examples of where this has been successful in reducing workload across the whole system including A&E admissions and Primary Care activity. Strategic Development Group looked in particular at the Frome Model and how this model could be implemented locally.

Resources Identified:

1) PCNs have been funded for social prescribers at 100% to allow their introduction into primary care.
2) Council Connected Communities project is helping curate the local community
3) Need to develop a directory of services – examples of this are available locally
4) Improve links to 3rd Sector and
5) Mental Health forward view and Mental Health first pilots.

Plan:
To discuss as a Care Community how to best utilise this resource locally.

Work already underway in Care Communities:
Nantwich and Rural Care Community have already made significant strides curating a local directory of services and volunteer recruitment. Other projects are underway in Macclesfield and SMASH also.

The aim is to support this work and help develop the approach across all 8 Care Communities. Residents of Cheshire East should have access to a social prescribing service of some kind by April 2021. These will be mapped across the Place and enhanced in line with the intentions set out above and in keeping with need.

Mental Wellbeing:
Within this theme is also mental wellbeing and we will be looking to implement a mental health first model. We will aim to encourage wellbeing practitioners in Care Communities to enable rapid access and turnaround to support wellbeing in line with the mental health five year forward view.

We will look to embed assessment of mood and/or depression screening in all long term condition pathways and address inequalities and parity of esteem for all mental health conditions.

Local Innovation

There is also a method for allowing rapid testing, innovation and pursuing projects that address local need.

In doing this we need to ensure that we:

1) Use proven risk stratification tools/BI
2) Adopt an experiential learning approach
3) Adopt a QI approach
4) Improve Capability
5) Identify the aim of each project – some may be releasing capacity, others return on investment, others innovation

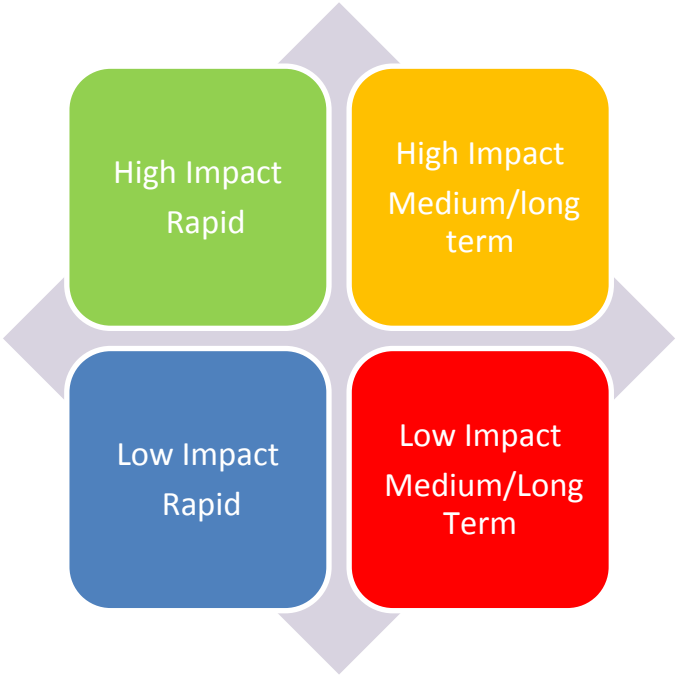
Each project should be commenced with a project initiation document which has been developed and then assessed against an agreed framework to allow development.

Each Care Community should be encouraged to bring their plans for peer critique. If approval for implementation is granted, there will be assistance from the ICP to plan for how this is possible to implement rapidly in other areas if it is relevant.

As a system we should favour plans which address:

1) Increasing GP access
2) Improving long term condition management/planned care
3) Escalating need in the community
4) Early Intervention of those with known needs, using risk stratification
5) Prevention
6) Wider determinants of health.

We will map activities across the Kaizen chart (below) in order to select the most relevant but ultimately this will be down to local determination within the allocated budget constraints.

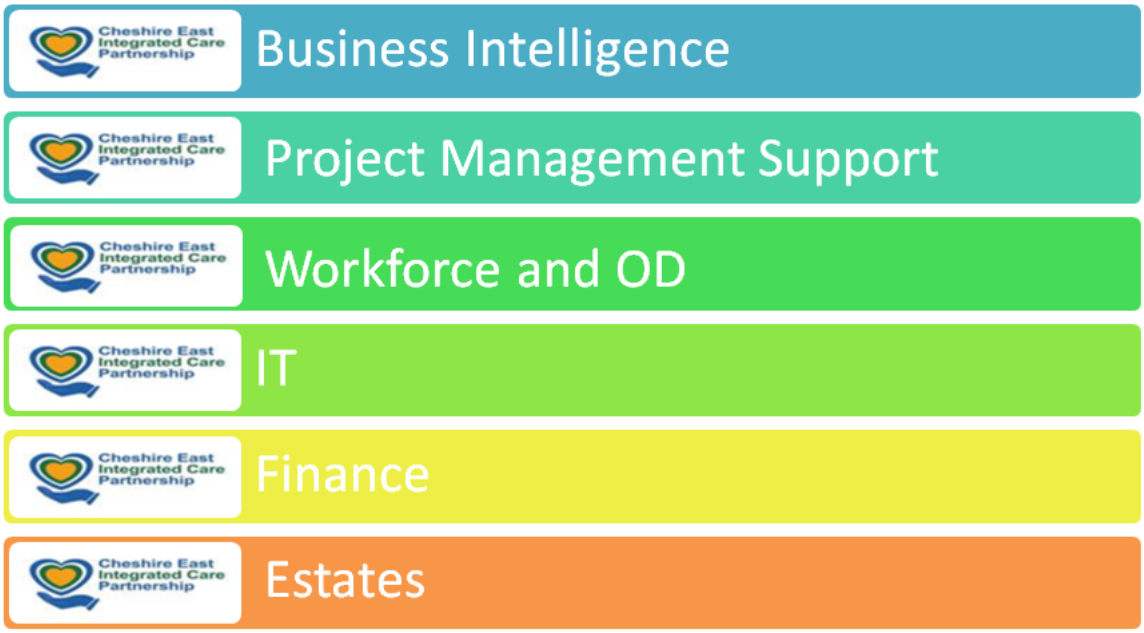


Care Communities Theme

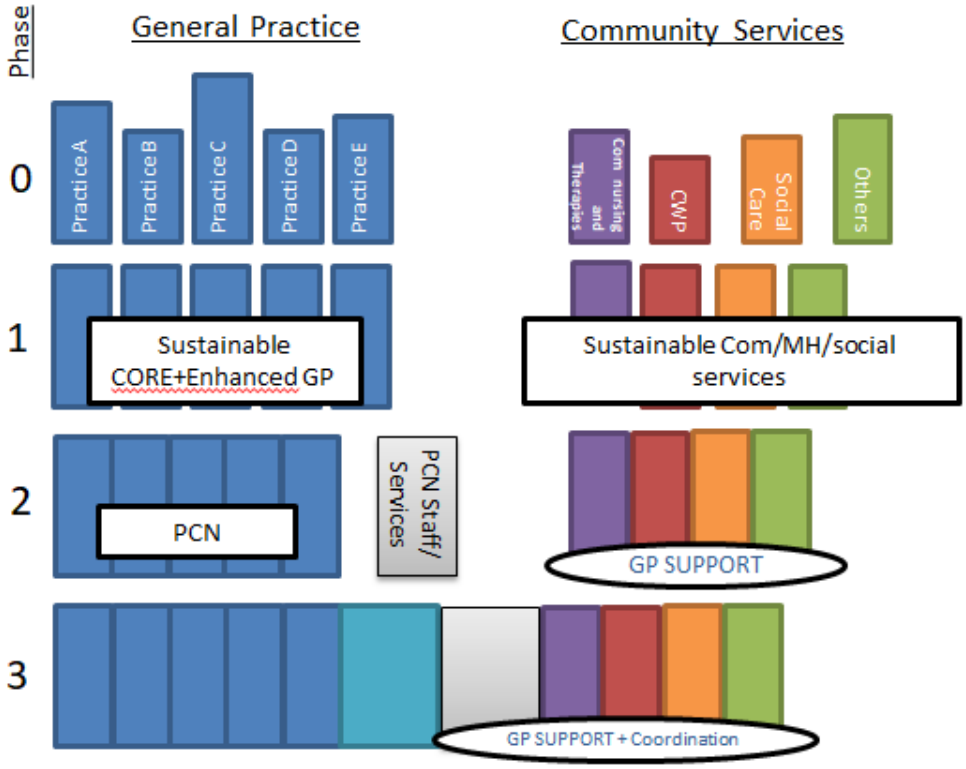
The development of the Care Community itself is of paramount importance in developing the ICP's way of working. All Care Communities are at varying stages of development and maturity.

We have developed an agreed maturity matrix to measure progress along this journey and allow support and enablers to be introduced that will support this process.

By April 2021 every Care Community should be able to identify a named individual responsible for their Care Community for several enabling themes listed below as a minimum:



In terms of functional development, the diagram below illustrates the different stages of development. There needs to be a gradual move from the considerable variation of offer across different areas to a consistent approach. Formation of PCNs will aid this process. In line with this and the work set out above we will level up the other partners' services. The ICP will aim to have all Care Communities working towards phase 3 by April 2022.



Primary Care Stability and Sustainability:
The current building blocks of Care Communities are General Practice and wider Primary Health, Social and Community care. All of these are under unprecedented pressure locally and the capacity of the few individuals that are currently working within each Care Community Team is not large enough to take on the kind of large scale transformational programme that is required. At present there has been temporary resource for clinical leadership but beyond that there is little incentive for practices to engage fully in the ICP mechanism as there is limited capacity.

Capacity:
Within Care Communities there has been provision for leadership but otherwise there is precious little resource (especially resource to be able to effect the changes that are needed, building in improvement and transformation capability). The idea that teams can free capacity to deliver large scale projects from within their current budget and human resource is not feasible and will likely lead to disengagement if not addressed.

Motivation and Engagement:
There needs to be an agreement from executives of Partner organisations to allow teams to flourish and self-determine but also to action change in a way that is meaningful for the populations the teams serve. There needs to be a framework of delegation from partner organisations to support teams and Care Communities to implement change that is required locally.

Teams need to feel they are doing the right thing, based on evidence, have adequate time and resource and have a degree of autonomy in order to be able to flourish in this new model – this is a challenge within the current regulatory frameworks with competing drivers, outcomes, targets and quality measures both local and national.

Estates:
Community estates and sourcing of sites for hubs and teams to work is a priority. We need to give due consideration also about how to bring specialist care into the community without breaking up

communities of practice that exist in secondary care and maintain excellent acute and specialist services for when they are called upon.

Suggestion:
There needs to be an immediate focus for the ICP on the stability and sustainability of Primary Care and in particular General Practice.

It will need to be based on a reciprocal arrangement and acknowledgement that providing services and systems that help General Practice will help the Care Communities and in turn the ICP. This will also create the capacity for them to take on more appropriate work in the revised pathways of care.

Dialogue needs to occur with local populations and third sector organisations to support communities to care for themselves when appropriate both in terms of self-care and communities supporting one another which will free capacity in primary and community care to serve those most in need.

Care Community Teams need access to good business intelligence and potentially be able to rapidly implement and test ideas to foster the idea of team working.

An indicative budget would also go towards making Care Communities more real, with a level of autonomy.

Further ideas for development

CCICP have demonstrated the benefits of working in different ways. They have organised co-located teams around a single point of access with teams that look after a local population rather than a condition group.

There is a shared IT system which is in common with GP practices. Reduced waste by looking at visiting load, reducing the need for duplicate visits and introducing innovative technology like Malinko which is making a real difference in terms of productivity and mapping demand.

The teams are interacting with General Practice to reduce home visiting workload and thinking about reducing waste in professional prescribing areas for example in Stoma Care has both improved care quality and reduced spend.

There have been projects across East Cheshire Trust which have also supported Care Community and team working successfully for example Frailty teams, Buurtzorg working, joint working between practice nurses and community nurses and developments in home visiting for those in crisis

However we need to go further and:

1) Expand the community offer
2) Bring specialist experience into the community providing rapid if not instant advice
3) Break down barriers between teams and reduce silo working, the Jonkoping approach
4) Understand the pressure points across the system and work collaboratively to resolve them
5) Reduce unwarranted variation across providers and ensure equity of services to all our population
6) Provide rapid access to diagnostics, guidance and advice
7) Invest in a population health approach
8) Invest in education and health promotion

9) Population education about how best to use services and when and how to access appropriate care
10) Utilise MDTs, the 3rd sector and assets in the community where possible
11) Look at high frequency attenders and high risk groups with an eye on equity of access, equality and parity of esteem for vulnerable groups
12) Reduce waste from multiple contacts for the same problem
13) Develop and invest in Primary Care and General Practice
14) Integrate Mental Health, Community and Social Care colleagues more effectively
15) Identify areas that improve experience for all care professionals in the system
16) We need to look at high cost pathways across the system and see where we can improve efficiency or transform work patterns.

Work needs to be done on engagement with General Practice. GPs are a large part of the senior clinical presence in primary care. As a system we would benefit from them supporting other community based clinicians and dealing with complex care and cases.

To allow this we need to explore ways of removing work from them that could be performed by other team members. GPs will need in return to reduce their unwarranted variation and agree to be part of the system working in line with agreed local pathways and guidance to provide seamless patient journeys and transitions between teams.

We need to avoid unintentional consequences of actions and understand the impact of plans – for example bringing resource into the community and unintentionally destabilising secondary care provision.

Impact for Secondary Care Clinicians

Working in this ICP will require Consultant colleagues and other specialists in secondary care to support community teams in a different way. We will need to blur the boundaries between Primary and Secondary Care to provide seamless transfers of care and advice for our local population.

We will need to use their expertise to see the most complex individuals who really need their expert care and we will rely on them to provide subject leadership and insight into which evidence based interventions would benefit our population most.

We need them to provide advice and guidance to community teams and work with them to help upskill the entire workforce through experience and over time reduce the reliance on attending hospital for interventions that could be provided in the community. This will mean that “routine care” is provided in the Community with the hospital being reserved for only those most at need.

This will mean working in a different way. The ICP recognises that secondary care have Communities of Practice and the benefit that working in clusters with other specialists brings. Integrating specialist care in the community would need to be done without deconstructing functions that work well and we need to be mindful of this as a system. We need to protect them and use their time wisely.

Impact for Community Teams

Community Teams can expect to expand in numbers, scope and skill. There are members of the Community who traditionally in our local area have not been part of mainstream care. There will be increased integration with Dentists, Optometrists, Pharmacies, Paramedics as well as Social Care and Mental Health colleagues.

There will need to be an increased skill mix with teams having more members (for example respiratory/heart failure nurses) and working with more support and advice from colleagues.

Access to rapid expert advice and point of care testing will mean an increased ability to manage conditions locally without the need to transfer to other care environments.

We will aim to improve satisfaction and team morale by making it easy for staff to do the right thing for the local population and see the benefit of their new way of working.

Impact for the Population & Individual

There will be increased stability of local health and care services. There will be an understanding of "the local offer" and more care away from hospital settings and in the local community.

We will have responsive local health and care teams that are working to help people stay safe, well and independent in their communities and providing care close to them when their health or wellbeing deteriorates. There will be an overall increased level of confidence in living with long term conditions and support provided from early years until the end of life.

Individuals will experience care delivery which is much more streamlined, easier to access and focussed on the individual's health and wellbeing. The Jonkoping approach to improving care coordination and the experiences of particularly elderly individuals will be central to developments in the Community.

Impact for General Practice

GPs provide the senior clinical resource in the community. The ICP will work with local practices and PCNs to form the foundation for the Care Communities and ensure that in line with secondary care clinicians we respect and protect that vital infrastructure.

We hope to encourage them to contribute to the development and leadership of the Care Communities. Over time as the workforce expands and the new care models develop they will be able to provide support and guidance to community teams and support multi-disciplinary working in mutual benefit for our local population.

Resources and Allocation

It is recognised that the investment required to deliver significant transformation through a new models of care programme will be substantial. This aligns with current and historical understandings of local need

to fully develop proposals for service change that meets the future health and care requirements of our population. It is acknowledged that some funds will be released from changing the way services are currently provided but others need to be prioritised from new investment through robust business cases and commissioning support.

The ICP does have a limited amount of non-recurrent funding available for this year to support the initiation of our transformation plan. This will encourage the high trust system that we aspire to. Each Care Community will receive some small amount of funding directly as an indicative budget with an intent for the ICP to find a way to continue to invest in this if teams generate/demonstrate a value return (not merely in cash terms). The remainder of the non-recurrent funding for this year will be allocated to support ICP wide projects as set out in this plan and to deliver the business cases for the service redesign proposals.

The aim is to be ambitious and innovative. We will continue to apply to be part of national and HCP schemes which will enable us to achieve delivery of our theme areas and that will attract investment and benefit for our local population.

Summary

The purpose of the ICP is to improve population health and individual person centred outcomes, to reduce variation in those outcomes across the Place and to maximise our productivity. That is, do as much as we can with the money we have, and at the same time develop a programme of investment which is clear and agreed across our whole system.

There is not enough capacity in Primary Care or Care Communities to do whole system change alongside current service delivery. We need to increase capacity and sustainability in Primary Care and Care Communities which will improve the clinical capacity and ability to do other things.

The four Care Themes present an opportunity to demonstrate:

- Reduction in waste and clinical variation
    - via the Cardiovascular and Respiratory themes
- Reducing the need for specialist hospital services by introducing new ways of working (leading to improved primary care capacity)
    - via the Social Prescribing and Mental Wellbeing theme
- Providing access to specialist advice and bringing the specialist into the community for support and education
    - via the Children's Health Hubs

The learning from these target areas will allow us to develop our approach as an ICP and move towards defining our operating model going forward.

Future Plans and Evolution

As the ICP evolves in maturity we will expand the remit of Care Communities and the resources that are made available to them. The system will develop a shared accountability for the care of the population, no matter which parent organisation they originate from.

In terms of the care themes, we will add an “Older People’s Health” theme in 2021/22 to ensure that the care of older adults remains in focus for our ICP. This will allow us to build on the work completed at that time and fold in the work going on across multiple sectors on frailty and ageing well.

As we improve our coding, business intelligence and system working, the intelligence picture we gather will lead our plans into 2023 and beyond and we will keep the populations needs at the heart of this. Population health and tackling the wider determinants of problems will ensure that we make our system sustainable into the future and we continue to measure the impact of our plans.

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