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Health and Adult Social Care and Communities Overview and Scrutiny Committee

Agenda

Date:	**Thursday, 14th January, 2021**
Time:	**10.00 am**
Venue:	**Virtual Meeting**

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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 foot of each report.

It should be noted that Part 1 items of Cheshire East Council decision making meetings are audio recorded and the recordings are uploaded to the Council's website

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

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 5 - 8)

For requests for further information
Contact: Joel.Hammond-Gant
Tel: 01270 686468
E-Mail: joel.hammond-gant@cheshireeast.gov.uk with any apologies

To approve the minutes of the meeting held on 3 December 2020.

3. **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.

4. **Declaration of Party Whip**

To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the Agenda

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

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake and background research, it would be helpful if members of the public notified the Scrutiny Officer listed at the foot of the Agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **NHS Integrated Care Systems** (Pages 9 - 90)

To scrutinise, discuss and feedback on the NHS England and Improvement proposed merger of CCGs and introduction of Integrated Care Systems, as well as the Cheshire and Merseyside Health and Care Partnership's proposed Memorandum of Understanding.

7. **Emerging Futures** (Pages 91 - 100)

To consider an update from Emerging Futures on the work it undertakes with, and service it provides for, residents in Cheshire East.

8. **Pre-Budget 2021/22 Consultation** (Pages 101 - 112)

To consider the Pre-Budget 2021/22 Consultation proposals within the remit of this committee.

9. **Covid-19 Update** (Pages 113 - 122)

To consider the standing update report on the Covid-19 pandemic and the work undertaken by the council to respond and recover to it.

10. **Forward Plan** (Pages 123 - 134)

To consider the council's Forward Plan of key decisions.

11. **Work Programme** (Pages 135 - 144)

To review the current work programme.

Membership: Councillors J Barber, S Brookfield, J Clowes, A Critchley, D Edwardes, B Evans, S Gardiner, A Moran (Vice-Chairman), D Murphy, J Parry, P Redstone, R Vernon, L Wardlaw (Chairman), J Weatherill and N Wylie

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care and Communities Overview and Scrutiny Committee** held on Thursday, 3rd December, 2020 at Virtual Meeting

PRESENT

Councillor L Wardlaw (Chairman)
Councillor A Moran (Vice-Chairman)

Councillors J Barber, S Brookfield, J Clowes, A Critchley, D Edwardes, B Evans, L Smetham, D Murphy, P Redstone, J Weatherill and N Wylie

PORTFOLIO HOLDERS IN ATTENDANCE

Councillor L Jeuda, Portfolio Holder for Adult Social Care and Health; Deputy Leader of the Labour Group
Councillor J Rhodes, Portfolio Holder for Public Health and Corporate Services

OFFICERS IN ATTENDANCE

Win Lawlor, Strategic Policy and Partnerships Manager (Irish Community Care)**
Madeleine Lowry, Associate Director of Operations (Cheshire and Wirral Partnership NHS Foundation Trust)*
Sandra Murphy, Head of Safeguarding**
Mark Palethorpe, Executive Director of People
Dawn Taylor, Manager Cheshire and Warrington Traveller Team (Cheshire West and Chester Council)**
Nichola Thompson, Director of Commissioning
Dr Matt Tyrer, Director of Public Health

* Attended for Minute No. 59 only
** Attended for Minute No. 60 only

54 **APOLOGIES FOR ABSENCE**

An apology for absence was received from Councillor S Gardiner, who was substituted for by Councillor L Smetham.

55 **MINUTES OF PREVIOUS MEETING**

RESOLVED –

That the minutes of the previous meeting held on 5 November 2020, be approved as a correct record and signed by the Chairman.

56 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

57 **DECLARATION OF PARTY WHIP**

There were no declarations of a party whip.

58 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present who wished to speak.

59 **COVID-19 UPDATE**

The committee received an update on the Covid-19 pandemic, and the work undertaken by the council to manage the borough's response to the public health situation. The update provided information on the national vaccination development progress and of the forthcoming mass vaccination programme.

Members asked questions and put comments in relation to;

- how the NHS and partners were working to ensure that there was a high uptake of the Covid-19 vaccination;
- surprise that staff and residents at care homes had not yet accessed flu vaccinations, and what the reasons were for the low uptake;
- concern about the unpaid carers in Cheshire East – a cohort of people who may not be immediately eligible for the Covid-19 vaccine – but have a very important caring role for residents; and
- how long it takes for people to achieve a state of immunity after taking the Covid-19 vaccination.

RESOLVED –

That the update be received and noted.

60 **GYPSY, ROMA AND TRAVELLER COMMUNITY WELFARE - WE'RE STILL HERE**

Pursuant to the previous updates and informal briefing sessions it had held on Gypsy, Roma and Traveller community welfare, the committee received and considered the recently-published 'We're Still Here' report – a research study into the needs and preferences of Gypsy/Traveller communities in the Cheshire, Halton and Warrington region.

Members put questions and comments in relation to;

- how the Covid-19 pandemic had impacted on the mental wellbeing of communities that had not been able to travel and visit relatives;

- the rights of the Police in relation to authorised and unauthorised encampments;
- the Inequalities Commission that had been established by Cheshire East Council's Health and Wellbeing Board;
- why there were reportedly higher rates of suicide amongst the Gypsy/Traveller communities, and what could be done to address this; and
- how authorities could ensure that positive messaging is provided to these communities regarding the Covid-19 mass vaccination programme, which would help to ensure a high uptake.

RESOLVED –

1 That the relevant studies and further reading in relation to mental health and wellbeing struggles, and higher prevalence of suicide, amongst Gypsy/Traveller communities be circulated to the committee electronically.

2 That hard copies of the We're Still Here report be sent to members of the committee and be made available to other members of the council.

61 **FORWARD PLAN**

Pursuant to the previous updates and informal briefing sessions it had held on Gypsy, Roma and Traveller community welfare, the committee received and considered the recently-published 'We're Still Here' report – a research study into the needs and preferences of Gypsy/Traveller communities in the Cheshire, Halton and Warrington region.

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1 That the relevant studies and further reading in relation to mental health and wellbeing struggles, and higher prevalence of suicide,

amongst Gypsy/Traveller communities be circulated to the committee electronically.

2 That hard copies of the We're Still Here report be sent to members of the committee and be made available to other members of the council.

62 **WORK PROGRAMME**

The committee reviewed and discussed its work programme.

RESOLVED –

That the Scrutiny Officer liaise with officers and partners to obtain more information on when the following updates could appropriately be presented to the committee:

- Specialist Orthodontic and Oral Surgery Services in Cheshire East (in response to a recent communication to health scrutiny committees that outlined the proposed next steps for this piece of work)
- Review of Autism Screening at Cheshire's Custody Suites
- Re-design of Adults and Older People's Mental Health Services in Cheshire East.

The meeting commenced at 10.00 am and concluded at 11.56 am

Councillor L Wardlaw (Chairman)

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.

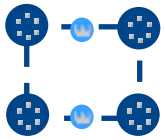
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- 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 and Merseyside
Health and Care Partnership

Date: 8th December 2020

Dear Colleagues,

Partnership Memorandum of Understanding (MoU)

You will recall I wrote to you in October after our successful Partnership Assembly, following which I committed to develop a simple draft memorandum of understanding which sets out the proposals for revised governance arrangements taking into account the points captured as outputs of our discussions.

We have completed this work and discussed a draft at our November Partnership Board. Following some initial feedback, I share this document with you, now, for your consideration and discussion within each of your organisations.

My hope is that you will now review and feedback any observations or comments on this draft by no later than Wednesday 20 January 2021. While tight such a timetable should allow for consideration to be given and a recommendation made by our January Board meeting resulting in proposals which I hope each Partner organisation will be able to adopt in February 2021.

The value of the MoU and the benefit it brings to our work includes setting out the principles and objectives of the Partnership, bringing clarity to the way we organise ourselves and interact with each other. Critically we recognise the statutory responsibilities of each of the established organisations in our system. We have agreed that the Partnership will only act where it adds value and we continue to place significant emphasis on Place based working.

Our system is interwoven, mutually dependent and complex. However, through alignment and a tight focus on priorities in *Place* we believe we can, as a whole, ensure everyone in Cheshire and Merseyside has a great start in life, and gets the support they need to stay healthy and live longer.

I do not anticipate that the MoU will be installed in one “big bang”. We will need an introductory period when, for example, the supporting structures are put in place to enable representatives on the Board to properly represent their constituency.

Ben Vinter (ben.vinter@nhs.net, 07767246103) is available as a resource to support your discussions and Jackie Bene and I will be available to discuss with senior leaders.

Finally, let me direct your attention to Partnership microsite:

https://www.cheshireandmerseysidepartnership.co.uk/partnership-assembly

Regards

Alan Yates
Chair, Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership
Regatta Place, Brunswick Business Park,
Summers Lane, Liverpool, L3 4BL

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D R A FT

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

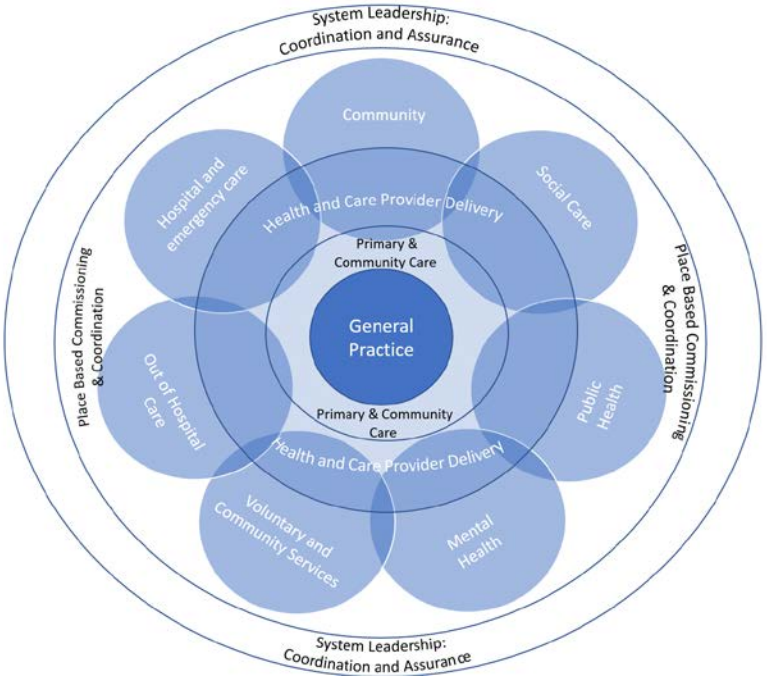
The purpose of this Memorandum is to formalise our partnership arrangements. We do not seek to introduce a hierarchical model; rather provide clarity through a framework, based on the principle of subsidiarity, to ensure collective ownership and coordination of delivery. This approach also provides the 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.

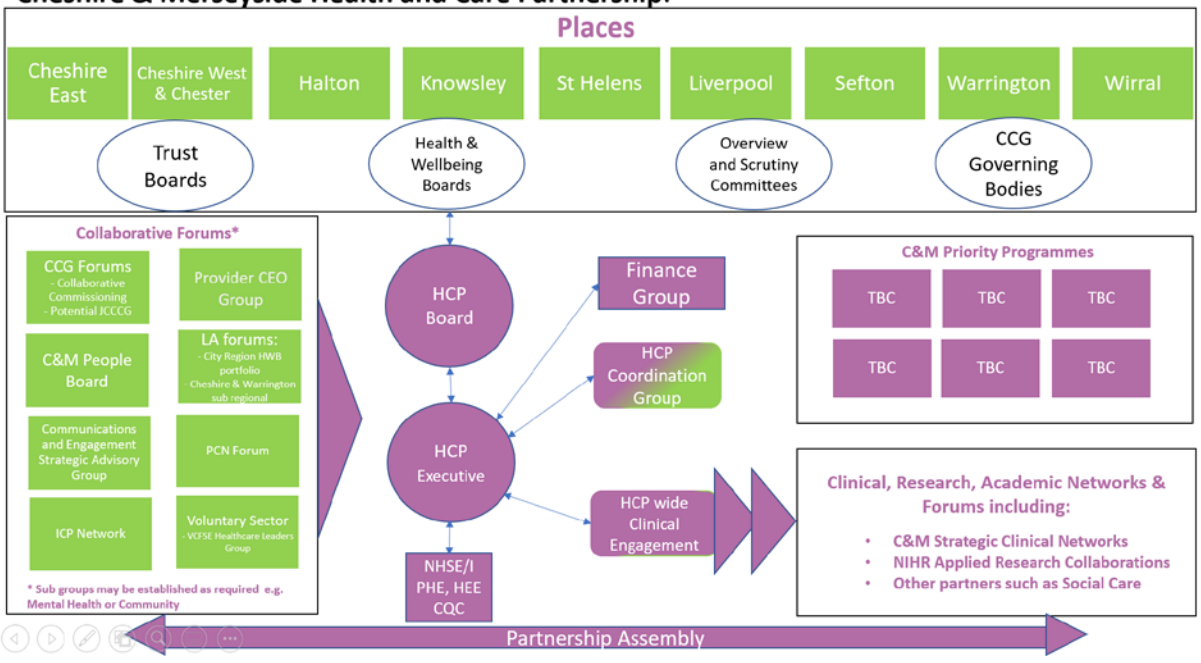
Partnership Governance

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

Annex A – Parties to the Memorandum

Annex 1 – Applicability of Memorandum Elements

Annex 2 – Schematic of Governance and Accountability Arrangements

Annex 3 – Signatories to the Memorandum

Annex 4 – Mutual Accountability Framework

Annex 5 – Partnership Assembly Constituencies

Annex 6 – Partnership Board Membership

Annex 7 – Terms of Reference - will be added in due course

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

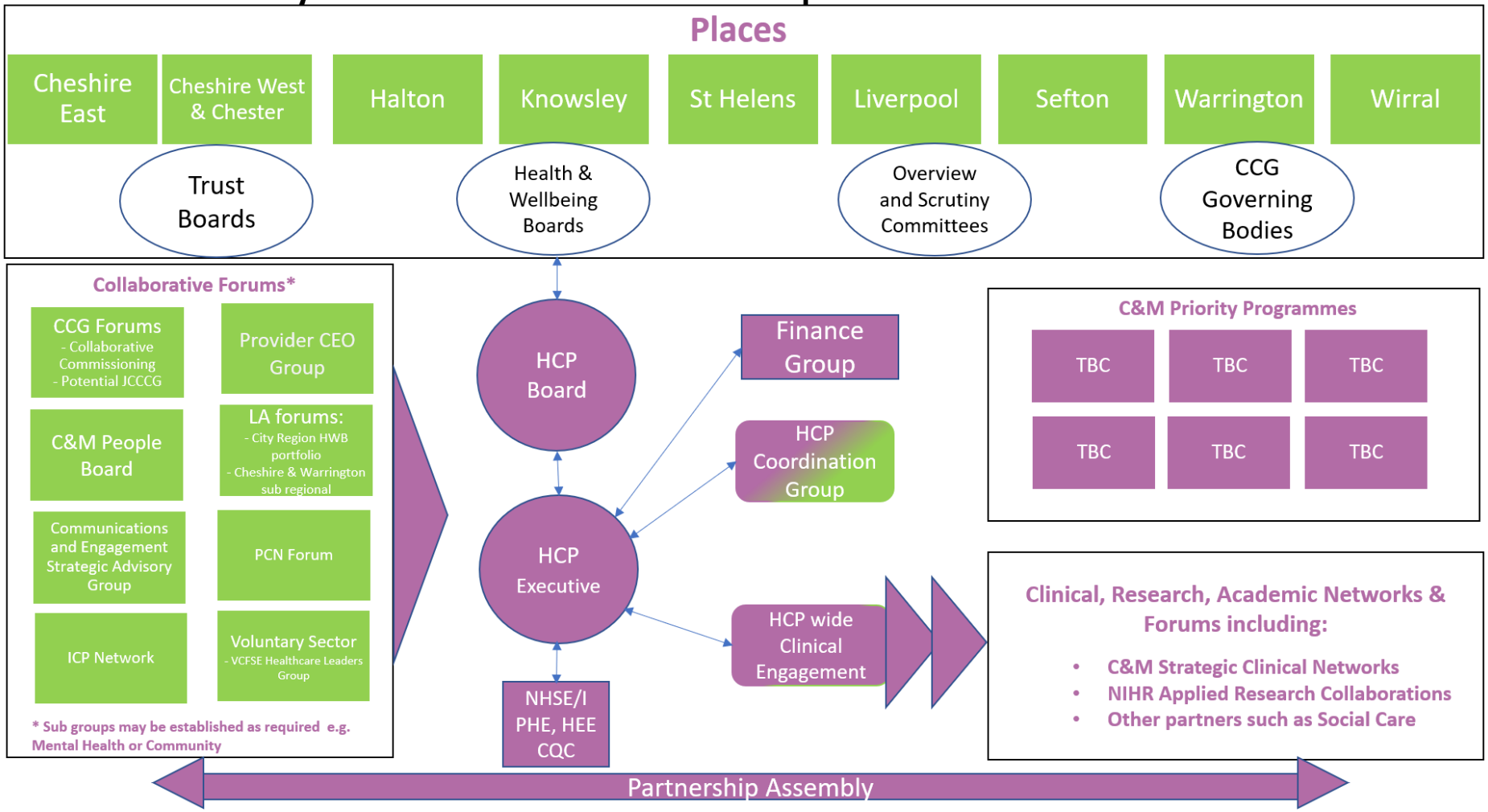
- Fire
- Police
- Probation
- Others, where relevant

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

Working for a brighter future together

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 14th January 2021

Report Title: Emerging Futures: Housing Related Support

Portfolio Holder: Councillor Mannion, Environment and Regeneration
Councillor Jill Rhodes, Public Health and Corporate Services

Senior Officer: Frank Jordan, Executive Director of Place and Deputy Chief Executive
Mark Palethorpe, Executive Director of People - Director of Childrens Services & Director Adult Social Services

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1. Report Summary

1.1. Emerging Futures CIC is a not for profit organisation that exists to create opportunities for people to change. Emerging Futures help individuals to recognise and build on their strengths, abilities and inherent potential whilst supporting them to be the best that they can be.

1.2. Emerging Futures provide low-income and emergency shelter to individuals in need of safe and temporary living environments, and deliver services across Cheshire East, Lancashire, Manchester, Hertfordshire, Norfolk, Gloucestershire, Sussex, Surrey and Leeds.

1.3. Models are informed by evidence based behavioural change interventions delivered within safe, flexible accessible accommodation that is community based. Emerging Futures believe that in order to sustain positive behavioural change people need someone to love, something to do and somewhere to live.

1.4. Emerging Futures actively challenge socio-economic disadvantage: Providing practical interventions that reduce social isolation through our commitment to

supporting those with lived experience. Emerging Futures adopt an Asset Based Community Development (ABCD) model that works with communities to solve entrenched social issues.

2. Recommendations

2.1. To review and explore the Housing Related Support, and the Community Substance Misuse Recovery Substance Misuse services delivered by Emerging Futures (EF) in Cheshire East.

3. Reasons for Recommendations

3.1. A number of queries have been raised with regards to the Housing Related Support service.

4. Other Options Considered

4.1. No other options considered.

5. Background

5.1. In Cheshire East, Emerging Futures are commissioned to deliver two different contracts:

- The behaviour change, volunteering and community development element of the Cheshire East substance misuse and are sub-contracted via Change, Grow, Live, who are commissioned directly by Cheshire East Council.
- A complex needs service as part of the Housing Related Support contract on behalf of Cheshire East Council.

5.2. As part of the Housing Related Support contract, Emerging Futures provide accommodation and support for service users assessed as having complex needs, specifically individuals who are deemed high risk or highly vulnerable, and who would require, and agree to receive, a substantial package of support. Emerging Futures deliver several elements of the contract including No First Night Out (NFNO) emergency accommodation, mental health beds, emergency beds for people found to be statutorily homeless and in priority need and a support service for over 25s. Most tenants are socially marginalised, stigmatised, lack social support, often street homeless and have a history of failed accommodation placements. They are often chaotic drug and alcohol users with physical and mental health difficulties, significant offending histories and/or acute behavioural difficulties.

5.3. Emerging Futures use a blend of therapeutic harm reduction interventions, elements of a ‘Housing First’ model and a ‘Transitional Recovery Housing’

model. Emerging Futures manage 131 beds of accommodation across Macclesfield, Crewe, Congleton and Middlewich, employs 51 staff and operates at approximately 98% occupancy. All referrals are received via Cheshire East Housing Options and Homelessness Team and are Cheshire East residents. All tenants are fully risk assessed and stays vary from 1 day to over 1 year depending on move on options.

5.4. Emerging Futures work closely with local services, amongst others:

- Cheshire East Adult Social Care
- Mental health crisis teams
- Change, Grow, Live (CGL)
- Public Health
- Police, probation and other blue light services (excellent relationships and protocols have been developed with the police, ambulance service, Cheshire and West Fire Service and local hospitals)
- Housing Providers- private, voluntary and statutory
- DWP / Jobcentre Plus
- Hospital Discharge Teams
- Cheshire East Children and Young People Services
- Prison Service
- Cheshire East Domestic and Sexual Abuse Partnership & Cheshire Without Abuse
- Community and Faith groups

5.5. Community engagement is at the core of our delivery for the Housing related Support Service. All staff, coaches and volunteers receive formal training in Asset Based Community Development; this assures Emerging Futures that their teams know how to engage with the communities they are based within. Emerging Futures work at:

- Neighbourhood level, by being open and transparent with our neighbours; contacting all neighbours to ensure they have a contact point if any issues arise; Emerging Futures are committed to be an actively participating part of our communities.
- Community level, for example, repairing fences as part of our restorative justice model, litter picking in Crewe, working with local landlords (in particular SG Lettings) through our connected residential network, regular neighbour meetings to develop a sense of community and manage feedback/issues. *
- With other clients as peers, delivering a soup kitchen to street homeless people in Crewe*

- With stakeholders through monthly meetings with police, ambulance and fire services and local authority homelessness teams to manage risk and develop relationships.
- Local charities, for example, food is sourced from local foodbanks and in return, Emerging Futures residents volunteer at the foodbank in Macclesfield.
- Business level through developing our relationship with local elected members and local business leaders in order to develop a network of businesses.

5.6. For example, Emerging Futures and its tenants are involved in:

- Reducing inequalities: Emerging Futures coaching pathways recruit directly from disadvantaged communities - 58 Recovery and Family Coaches trained during 2019.
- Employment: To date17 individuals have moved into full time jobs
- A greener and cleaner environment: supporting the LA Connected Communities initiative, Emerging Futures residents participate in litter picking in local parks and litter hotspots.*
- Better connected communities: bringing isolated communities out of the cold. 300 presentations attended ‘Bite to Eat’ drop in.*
- Healthier residents: Tenants complete pre and post-match clean ups at Crewe FC. Emerging Futures will mirror this at Macclesfield FC.*
- Economic opportunities: Basic drug awareness and coaching training to local businesses in exchange for essential items for residents.*

* COVID has restricted the majority of community activity and volunteering opportunities.

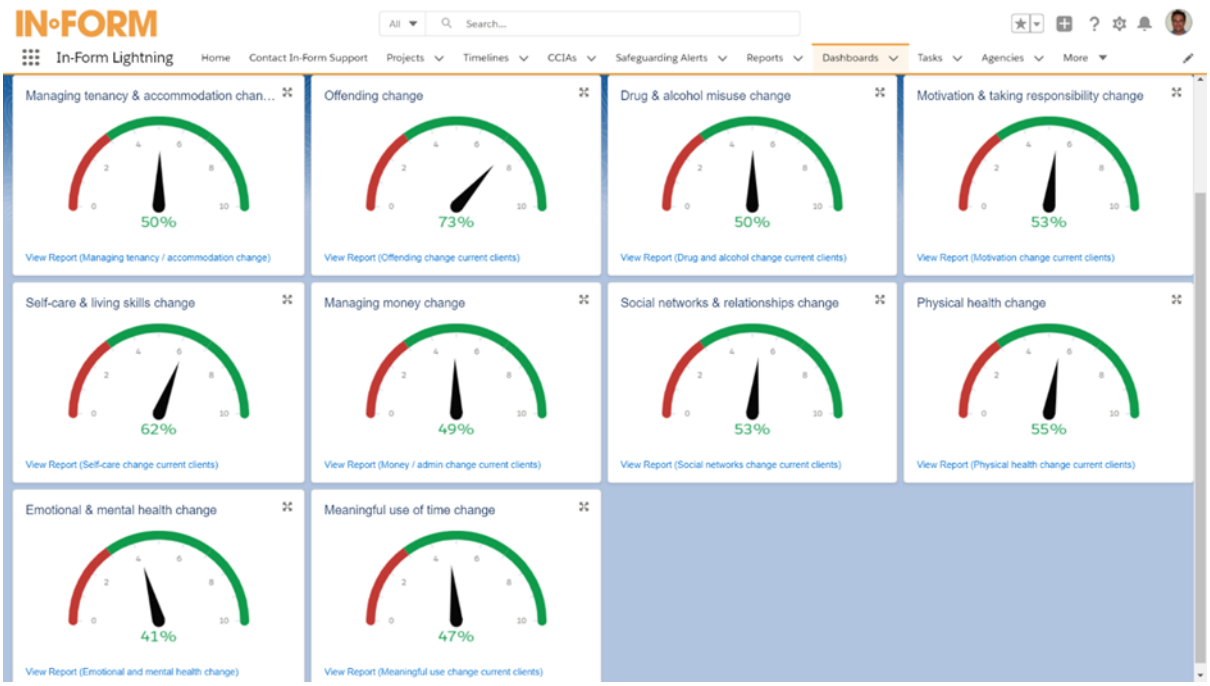
5.7. Contractually as part of the Housing related Support Service Emerging Futures are required to deliver 6 broad outcomes ensuring service users:

1	Feel safe and secure in their accommodation
2	Are less likely to sleep rough
3	Have flexible support plans, moving with them through their support journey
4	Gain skills to maintain a tenancy, including life and domestic skills
5	Connect with the right formal and informal support networks with a view to sustainment and reducing dependency on housing related support

6	Focus on gaining economic independence through access to education, training and employment

5.8. Emerging Futures routinely gather both quantitative and qualitative feedback from current clients in order to demonstrate the positive impact of our service provision. Clients report that accessing emergency accommodation has enabled them to make more positive lifestyle choices allowing sustainable move on to their own accommodation.

5.9. Emerging Futures use a data collection system that provides both outcomes and acts as the foundation for a detailed plan with measurable goals for the time that they live with us. During the time available for the project we would expect to see improvements in all ten areas of the Outcomes Star, maximising planned move-on from the project.



5.10. Over and above the tenancy and housing related support that is offered by Emerging Futures, each client spends time with a keyworker on a weekly/daily basis (dependant on need) to discuss and measure their individual progress, set and monitor goals, and evaluate their activity in line with their plan.

5.11. Emerging Futures believe that having somewhere safe to live is a basic human right. As such, the assessment and risk management procedures have been designed to be inclusive and empowering to ensure that Emerging Futures are able to accept all referrals. The guiding principle is to

keep services users who reside with Emerging Futures and the communities in which they live safe.

5.12. Emerging Futures deploy a robust risk assessment, incident reporting and management systems that is live both by PC and mobile phone which allows incidents to be dealt with swiftly and appropriately. Where appropriate Emerging Futures supply mobile staff numbers for residents to report any incidents and work closely on a daily basis with local police to prevent, identify and, where necessary, prosecute criminal activity.

5.13. Emerging Futures monitor and analyse incidents and behavioural trends and act on any 'hotspots' that might develop around particular properties. Emerging Futures will move or, in extreme circumstances, evict tenants who breach tenancy license agreements and enforce personal behavioural action plans.

5.14. Processes undertaken by Emerging Futures are augmented by rigorous safeguarding procedures that seek to identify vulnerable adults (and those with contact with children) from the first point of contact & promote integrated multi-agency working.

5.15. As an organisation Emerging Futures employ robust systems for recognising, reporting, investigating and responding to incidents. These include:

- Staff trained to identify serious incidents, near misses, incidents and are required to report any incident immediately to an on-call Team Leader and/or manager;
- Staff are encouraged to engage with neighbours and local residents to prevent and respond to any concerns regarding anti-social behaviour or community disruption;
- Clear procedures for taking immediate action following an incident including the collection/retention of evidence and the accurate recording of case notes;
- Recording all incidents using our approved risk management template
- Early, meaningful and sensitive engagement with affected service users and/or their families/carers via a named member of staff (point of contact);
- Timely information to the Commissioner of all untoward incidents, including reports arising from investigations, lessons learnt and service recommendations;
- Using trained staff and/or investigation teams (including Root Cause Analysis), that are sufficiently removed from the incident;

- Joint approach to investigations involving partner agencies including Police, Primary Care, Housing Crisis Teams, NPS etc. supporting collaboration, communication, avoiding duplication and developing a 'one response' approach;
- High-quality investigation reports and action plans to enable timely learning and closure of investigations and facilitate learning;
- CCTV is installed in most of our properties and is monitored via mobile phone and from our assessment hubs.

6. Implications of the Recommendations

6.1. Legal Implications

6.1.1. Contracts are in place between the Council and Emerging Futures and Change Grow Live (CGL) following commissioning activities in line with the Council's Contract Procedure Rules.

6.2. Finance Implications

6.2.1. Emerging Futures are contracted service provider delivering both the Housing Related Support contract and are subcontracted by Change Grow Live (CGL) to deliver the community-based recovery element of the Cheshire East Substance Misuse service. There are no additional finance implications as a result of this report.

6.3. Policy Implications

6.3.1. The Housing Related Support service is underpinned by the Homelessness Strategy 2018 – 2021 which was produced by Cheshire East Council and provides a framework and an action plan so that any agency or individual can clearly understand what the Council and its partners are doing to support people in housing need.

6.3.2. The service specification for the Substance Misuse Services, including the Emerging Futures element of the service are in line with local policy including the Cheshire East Partnership Plan. The service is also underpinned by national drug and policy, NICE guidance and evidence-based practice.

6.4. Equality Implications

6.4.1. Equality Impact Assessments are undertaken for all commissioning and procurement activities.

6.5. Human Resources Implications

6.5.1. The Housing Related Support service is supported by a Contract Manager based within the Housing Team.

6.5.2. The Substance Misuser service is supported by a Contract Manager and Commissioning Manager based within the People Commissioning Team.

6.6. **Risk Management Implications**

6.6.1. Both the Housing Related Support contract and the Substance Misuse service contracts are contract managed, including risk management processes with risks recorded and managed via risk registers.

6.7. **Rural Communities Implications**

6.7.1. The Housing Related Support contract is delivered in Crewe, Macclesfield, Congleton and Middlewich wards.

6.7.2. The Substance Misuse Service is delivered across the whole borough at a community level. The service is accessible via a number of options including two hubs based in Crewe and Macclesfield, virtual appointments, community level support groups, a community based vehicle which attends various locations including individuals own homes, online information, GP provision, Pharmacy provision, and telephone support.

6.8. **Implications for Children & Young People/Cared for Children**

6.8.1. The Cheshire East Substance Misuse Service supports both adults and young people, and also takes a 'whole family approach'. This means that support provided to adults will also have a positive impact on the health and wellbeing of the whole family, including children and young people.

6.9. **Public Health Implications**

6.9.1. Housing support is a basic and fundamental need for all individuals. Evidence shows that the provision of housing support has a positive impact on the health and wellbeing of individuals. The Marmot Review, Fair Society, Healthy Lives, states that action on health inequalities requires action across all social determinants of health including home and community.

6.9.2. The Substance Misuse service provides evidence based public health interventions to support individuals with substance misuse needs. A core element of recovery capacity including housing support, which is why the two services (Housing Related Support & Substance Misuse) are closely aligned.

6.10. **Climate Change Implications**

6.10.1. Social Value indicators including those for climate change are reviewed as part of the Housing Related Support and Substance Misuse contracts.

7. Ward Members Affected

7.1. All wards are supported by the services however, Crewe, Macclesfield, Congleton and Middlewich wards are particularly affected in terms of the Housing Related Support service.

8. Consultation & Engagement

8.1. A core component of the service model delivered by Emerging Futures is based on community engagement as described within this report.

9. Access to Information

9.1. No additional supporting documents are included.

10. Contact Information

10.1. Any questions relating to this report should be directed to the following officer:

Name: Hayden Duncan

Job Title: Managing Director (Emerging Futures)

Email: hayden.duncan@emergingfutures.org.uk

Name: Karen Carsberg

Job Title: Head of Housing

Email: karen.carsberg@cheshireeast.gov.uk

Name: Shelley Brough

Job Title: Head of Integrated Commissioning

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Working for a brighter future together

Version Number: 0.1

Key Decision ¥/N

Date First Published:

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 14 January 2021

Report Title: Medium Term Financial Strategy 2020 to 2025 - Consultation

Portfolio Holder: Cllr Amanda Stott - Portfolio Holder for Finance, Communications and ICT

Senior Officer: Alex Thompson – Director of Finance & Customer Services

Mark Palethorpe, Executive Director of People

1. Report Summary

1.1 The Council is required to set a balanced budget each year. On 1st December 2020, Cabinet approved a balanced set of proposals for consultation, with a comprehensive programme to promote the proposals and seek responses from stakeholders.

1.2 Part of the annual process for setting the budget sees Scrutiny Committees review the proposals and provide feedback prior to Cabinet making its recommendations to Council.

1.3 Cabinet will review the feedback received from all sources, including the Local Government Settlement issued on 17th December 2021 and will aim to make recommendations to Council at it's meeting on 2nd February 2021. These recommendations will include proposals for a balanced budget based on robust estimates and supported by adequate reserves.

2. Recommendations

That Committee:

2.1 Review the consultation information approved by Cabinet on 1st December 2020 (appended to this report), focusing on the proposals relevant to this Committee.

2.2 Provide feedback on the proposals to Cabinet as necessary in advance of their meeting of 2nd February 2021.

3. Reasons for Recommendations

3.1 Overview and Scrutiny Committees provide an important element of the Council's governance arrangements. The Medium-Term Financial Strategy presents a set of key decisions for Members each year and it is important that Members are provided with opportunities to review the proposals being consulted upon and the Scrutiny Committees fulfil a significant element of this requirement.

3.2 To ensure that budget proposals are robust, it is appropriate to subject them to appropriate scrutiny throughout the consultation period. Appendix A provides the list of proposals subject to consultation and identifies those most relevant to each Committee.

3.3 Additionally some proposals will be subject to further consultation activity directly with services users. All feedback received during the consultation period will be provided as part of the reporting to Cabinet and Council in February 2021.

4. Other Options Considered

4.1 The consultation process was discussed with Members in their various roles within political groups and as Members of committees. Options to support responses to the consultation were considered and a full suite of service scrutiny meetings was agreed as the most appropriate way to engage Members this year.

5. Background

5.1 The background and context to the process and development of the Medium-Term Financial Strategy are contained within the Cabinet Reports dates 10th November and 1st December.

5.2 Since publication of the Cabinet reports the Chancellor of the Exchequer has published the Spending Review 2020 and the Provisional Local Government Financial Settlement. The

announcements relevant to local authorities focused on additional funding schemes related to COVID-19, and an overall increase in Local Government Spending Power for 2021/22 of 4.5%. The increase in Spending Power reflects a net effect of new and continuing grants compared to grant reductions but is mostly based on an ability to increase Council Tax by including an additional 3% precept for Adult Social Care.

5.3 Cabinet will utilise the information provided during the consultation period in making their recommendations to Council in February 2021. However, to provide additional context to Scrutiny Committees, it is important to note the most significant impacts of the Spending Review for Cheshire East Council compared to the published consultation documents. Committee members should therefore note the following points from the Spending Review:

- Option to increase Council Tax by an additional 3% for Adult Social Care (1% = £2.3m for Cheshire East Council)
- Potential pay freeze across the public sector, apart from some key workers and those affected by minimum wage requirements (pay inflation of 2.5% assumed within the Cheshire East Council budget consultation)
- New Social Care Grant (equal to c.£0.4m for Cheshire East Council)
- Reduction in New Homes Bonus, by not continuing legacy payments for previous housebuilding (reduces grant to Cheshire East Council by c.£3.6m)
- Removal of access to the Public Works Loans Board for borrowing associated with yield. Cheshire East Council was forecasting c.£0.5m of income from activities associated with the approved Investment Strategy.

6. Implications of the Recommendations

6.1. Legal Implications

6.1.1 There are no legal implications associated with the recommendations of this report.

6.2. Finance Implications

6.2.1 There are no financial implications associated with the recommendations of this report, however the consultation process may

lead to amendments to the Medium-Term Financial Strategy which is a Key Decision for the Council.

6.3. Policy Implications

6.3.1 The MTFS will be considered alongside the new Corporate Plan, which sets out a new vision, aims and priorities for Cheshire East Council.

6.4. Equality Implications

6.4.1 Equality Impact Assessments have been drafted based on the consultation proposals and will be updated alongside final recommendations on the budget.

6.5. Human Resources Implications

6.5.1 There are a number of proposals which will impact on staff. These have been shared with staff and recognised Trade Unions as part of the consultation process.

6.6. Risk Management Implications

6.6.1 There are a number of risks associated in particular with the ongoing uncertainties around Covid response and recovery which are reflected in the MTFS.

6.7. Rural Communities Implications

6.7.1 Any implications will be considered in the final responses.

6.8. Implications for Children & Young People/Cared for Children

6.8.1 The implications are set out in the draft budget and will be considered by the relevant Overview and Scrutiny Committee.

6.9. Public Health Implications

6.9.1 There are a number of implications, particularly related to the ongoing Covid pandemic.

6.10. Climate Change Implications

6.10.1 The implications are set out in the draft budget and will be considered by the relevant Overview and Scrutiny Committee.

7. Ward Members Affected

7.1. All

8. Consultation & Engagement

8.1 This report is a part of the Council's consultation process to support the development and future implementation of the Medium-Term Financial Strategy.

9. Access to Information

9.1 There are several important supporting documents members may wish to review to support engagement with the Medium-Term Financial Strategy 2020 to 2025:

9.1.1 Cheshire East Council Medium-Term Financial Strategy

9.1.2 Cabinet Reports to launch the MTFS Consultation:

9.1.3 10th November 2020 – Item 51

9.1.4 1st December 2020 – Item 63

9.1.5 Cheshire East Council Budget Consultation (Webpage)

9.1.6 Spending Review 2020

9.1.7 Provisional Local Government Settlement 2021/22

10. Contact Information

10.1 Any questions relating to this report should be directed to the following officer:

Name: Alex Thompson

Job Title: Director of Finance & Customer Services

Email: alex.thompson@cheshireeast.gov.uk

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*Important Note: Proposals marked **RED** / **AMBER** have been identified as those only being considered for consultation and any subsequent implementation if the Local Government Funding Settlement does not sufficiently increase the funding to Cheshire East Council. **RED** items would be removed first where possible.

		Note		Change from Previous Years Budget			
Detailed List of Proposed Budget Changes	**OSC**			**2021/22 £m**	**2022/23 £m**	**2023/24 £m**	**2024/25 £m**
Ensure that there is transparency in all aspects of Council decision making							
Local Election Costs	Corporate			0.150			
				0.150	**0.000**	**0.000**	**0.000**
Listen, learn and respond to our residents, promoting opportunities for a two-way conversation							
Census 2021	Corporate			-0.020			
				-0.020	**0.000**	**0.000**	**0.000**
Support and sustain a financial future for the Council, through service development, improvement and transformation							
Pay inflationary increase	Corporate			4.591	3.825	3.907	3.998
Housing Benefit – Supported Accommodation	Corporate			1.300			
Core Financial System	Corporate			0.764	-0.459		
Mitigation of reduction in the Dedicated Schools Grant (Corporate Services)	Corporate			0.117	0.042	0.033	0.027
B4B unachievable savings - HR & TSC Budget Shortfall - ADD TO CORE FINANCIAL SYSTEM				0.000			
Mitigation of the year-on-year reduction in the Dedicated Schools Grant (ICT) - ADD TO DSG	Corporate			0.033	0.065	0.089	0.109
Direct Payments	Health	A	*	-1.000			
Continuing Healthcare Reviews	Health	A	*	-1.000	-1.000		
Prevention and Early Help Service – Reduction of frontline workers in Prevention	Children	R	*	-0.265	-0.697		
Reduce the numbers of Business Support Staff in line with the repurposing of Children & Family Centres	Children	R	*	-0.200			
Reduce Base budget assigned to Community Grants	Health	A	*	-0.150			
Efficiency savings and Restructures within Corporate Services	Corporate	A	*	-0.300	-0.250		
Review Terms and Conditions	Corporate	A	*	-0.300	-0.100	-0.100	
Shared services review	Corporate	A	*			-0.200	
Improved Debt Recovery and correcting budgeted court costs income targets to reflect actual levels	Corporate	A	*	-0.290	0.225	0.050	0.050
Capital Programme Review	Corporate			-1.000	1.000		
Member allowances and reduced mileage	Corporate			-0.030			
Reduced travel and supplies and services for Early Help services	Children			-0.026			
Reduce pensions budget to match latest forecasts	Corporate			-0.140			
Review of corporate subscriptions	Corporate			-0.035	-0.015		
Flexible Resourcing for Service Delivery for Regulatory Services	Environment			-0.050			
Urban Grass Cutting	Environment	A	*	-0.100			
Improving customer experience – Highways correspondence	Environment	A	*	-0.100			
Transfer of Congleton Visitor Information Centre	Environment			0.001	-0.020	-0.010	-0.020

Detailed List of Proposed Budget Changes	OSC			2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
Regulatory Services and Environmental Health ICT procurement	Environment				-0.009		
CCTV migration to wireless networks	Environment				-0.085		
Constellation Partnership	Environment			-0.040			
				1.780	**2.523**	**3.769**	**4.164**
Maximise commercial opportunities for the Council							
Orbitas income and management fee	Environment			0.032	0.021		
Public Rights of Way Resources (Revenue implications of Capital)	Environment			0.010			
Everybody Sport and Recreation Annual Management Fee	Health	A	*	-0.043	-0.042	-0.041	-0.040
Commercial Workstream	Corporate	A	*	-0.100			
Commercialisation of the Highway Service Contract	Environment	A	*	-0.080			
Brighter Futures Together Programme Customer Experience	Corporate	A	*	-0.120	-0.133	-0.081	
Contract savings in the Peoples Directorate	Health			-0.500			
Client Income in the Peoples Directorate	Health			-0.100			
Establish an Education Psychologist traded service to enable a proactive early support and intervention offer	Children				-0.025	-0.075	
Establish a traded service for non statutory elements of Attendance Service	Health				-0.035	-0.035	
Review of governance of ASDVs and seeking increased opportunities for savings/ commercial opportunities	Environment			-0.315	-0.225	-0.100	
Increase income from hire of Children's Centres	Children			-0.010			
Ansa income generation and efficiencies - Food Waste Recycling	Environment			-0.259			
Strategic Leisure Review	Health			0.000	-0.250		
				-1.485	**-0.689**	**-0.332**	**-0.040**
Support and develop our workforce to be confident, motivated, innovative, resilient and empowered							
Infrastructure Investment Programme (Revenue implications of Capital)	Corporate			0.310	0.410	0.520	
Unified Communications (Revenue implications of Capital)	Corporate			0.251	0.283	0.296	
People Directorate - ICT Procurements 2020-24 (Revenue implications of Capital)	Health			0.060	0.063	0.066	0.019
Place Directorate - ICT Procurements 2020-24 (Revenue implications of Capital)	Corporate			0.011	0.011	0.011	0.011
Corporate Directorate - ICT Procurements 2020-24 (Revenue implications of Capital)	Corporate			0.002	0.002	0.002	0.002
Productivity and Efficiency in Adult Social Care	Health	A	*		-1.000		
Estates Transformation - Office Accommodation	Corporate			-0.044	-0.100	-0.460	
Prevention and Early Help Service – Locality working and changes to the management structure of the Family Service	Children	R	*		-0.140		
Neighbourhood Estate Review	Environment			-0.090	-0.260		
Increased Useage of Digital Technology	Corporate			-0.125			
To review of use of School Improvement Grant to provide capacity to support maintained schools	Children			-0.060			
Reduce central training budget	Corporate			-0.080			
				0.235	**-0.731**	**0.435**	**0.032**
Open				**0.660**	**1.103**	**3.872**	**4.156**

Detailed List of Proposed Budget Changes	OSC			2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
Reduce health inequalities across the Borough							
Pathfinder Cheshire East - Cheshire Community Action	Health	A	*	-0.100			
Mental Health Floating Support	Health	A	*	-0.120			
				-0.220	**0.000**	**0.000**	**0.000**
Reduce the reliance on long term care by improving services closer to home and more extra care facilities, including those with dementia							
Investment in Adult Social Care	Health			4.000	4.000	4.000	4.000
Growth for Care Fees in Adult Social Care	Health			2.441			
Extra Care Housing – Catering / Restaurant Provision	Health			0.300			
Investment in Advocacy Service	Health			0.112			
Direction of travel for the Communities Team to focus more on the Intervention and Prevention Agenda to make cost savings, growth and future cost avoidance	Health	A	*	-0.750	-0.750		
Fund the Cygnet programme for cared for children from pupil premium	Children	A	*	-0.015			
Day Opportunities, Redesign, Strategy and Savings	Health	A	*	-0.030	-0.070	-0.150	
Mental Health Services Review	Health	A	*	-1.000			
Review agreements linked to intermediate care beds	Health	A	*	-0.268			
Reduced capacity in Family Information Service	Children			-0.050			
Electronic Call Monitoring Reclamation	Health			-0.245	-0.030		
Cheshire Care Record	Health			-0.138			
Review the use of the Cheshire East Lifelong Learning Service grant to reduce the requirement of Council funding	Children			-0.110			
To reduce costs of School Liaison and Governance service with less use of external support	Children			-0.010			
				4.237	**3.150**	**3.850**	**4.000**
Safeguarding our children from abuse, neglect and exploitation							
Increase capacity in SEND service to meet continuing demands on the service	Children			0.100			
Move to Integrated Early Help Locality Service model	Children	R	*	-0.167			
Learning Disabilities Future Service Development and Review	Health	A	*	-1.000	-1.000	-1.000	
Reduced travel and supplies and services for Early Help services	Children			-0.032			
Reduction in cost of external placements for cared for children	Children	A	*	-0.435	-1.571	-2.007	
				-1.534	**-2.571**	**-3.007**	**0.000**
Increase the life opportunities for young adults and adults with additional needs							
Development and Partnerships Service	Health	A	*			-0.300	
				0.000	**0.000**	**-0.300**	**0.000**
Be the best Corporate Parents and improve outcomes for vulnerable children and young people							
Investment in Cared for Children and Care Leavers	Children			1.300	1.300	1.300	
				1.300	**1.300**	**1.300**	**0.000**

Detailed List of Proposed Budget Changes	OSC			2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
A collaborative way of working with partners and families to support children to achieve their full potential							
Reduction in contribution to Cheshire Youth Justice Service	Children			-0.045			
				-0.045	**0.000**	**0.000**	**0.000**
Fairer				**3.738**	**1.879**	**1.843**	**4.000**
A great place for people to live, work and visit							
Development of a Transit Site (Revenue implications of Capital)	Environment			0.027			
Tatton Park	Environment			0.000	-0.006	-0.028	-0.046
Asset / Service Transfer	Environment			-0.150	-0.030	-0.020	
				-0.123	**-0.036**	**-0.048**	**-0.046**
Welcoming, safe and clean neighbourhoods							
Fixed Penalty Income target	Environment			0.118			
Housing Services	Environment			-0.045			
				0.073	**0.000**	**0.000**	**0.000**
To reduce the impact on our environment							
Waste Contract Inflation and Tonnage Growth	Environment			0.810	0.644	0.657	0.613
Environment Strategy and Carbon Neutrality	Environment	A	*		0.020	-0.081	
Tree Risk Management	Environment				0.500		
Carbon Reduction - Replacement of existing illuminated signs and bollards with LED units	Environment	A	*		0.030	-0.004	-0.031
				0.810	**1.194**	**0.572**	**0.582**
A transport network that is safe and promotes active travel							
Parking Strategy (Revenue implications of Capital) - Subject to separate consultation	Environment	A	*	-0.327	-0.955		
Local Supported Buses - Subject to separate consultation	Environment	A	*	-0.117			
Community Transport	Environment			-0.025			
				-0.469	**-0.955**	**0.000**	**0.000**
Greener				**0.292**	**0.203**	**0.524**	**0.536**
Total Proposed Budget Change				**4.689**	**3.185**	**6.239**	**8.692**

Detailed List of Proposed Budget Changes	OSC		2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m
Increased Council Tax Base - % increase planned at 1.99%	Corporate		-4.567	-4.694	-4.835	-4.979
Increase Council Tax Base - New Homes	Corporate		-1.838	-2.365	-2.412	-2.461
Central Pension adjustment based on Actuary results	Corporate		-4.567	-1.900	1.500	
Use of Earmarked Reserve - Collection Fund deficit	Corporate		-2.000			2.000
Use of (-) / Contribution to (+) Earmarked Reserves - General	Corporate		2.237	-0.881	-0.820	
Deficit on Collection Fund due to COVID-19	Corporate		2.147			-2.000
Minimum Revenue Provision	Corporate		2.000	3.977	1.024	1.000
Capital Receipts Income removed from base budget	Corporate		1.000			
Reduced commercial growth in Business Rates Retention Scheme	Corporate		0.700			
Bad Debt Provision	Corporate		0.200			
Contribution to General Reserves	Corporate			1.000		-1.000
Change to New Homes Bonus funding estimate	Corporate			1.679	1.427	1.213
Central Budget Items			**-4.689**	**-3.185**	**-4.116**	**-6.227**
Funding Deficit			**0.000**	**0.000**	**2.123**	**2.465**
Funding Deficit - Cumulative Position			**0.000**	**0.000**	**2.123**	**4.589**

*Important Note: Proposals marked **RED** / **AMBER** have been identified as those only being considered for consultation and any subsequent implementation if the Local Government Funding Settlement does not sufficiently increase the funding to Cheshire East Council. **RED** items would be removed first where possible.

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Working for a brighter future together

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 14th January 2021

Report Title: Adult Social Care COVID-19 Update

Portfolio Holder: Cllr. Laura Jeuda - Adult Social Care and Health

Senior Officer: Mark Palethorpe - Executive Director of People

1. Report Summary

1.1. At the time of writing the rate of new infection across Cheshire East has remained stable for the past few weeks with Cheshire and Merseyside and the North West showing an overall fall in the rate of new cases. Lockdown restrictions remain in place nationally.

1.2. This update summarises the current situation in relation to COVID-19 in care homes, care at home, and complex care in Cheshire East. It also summarises measures which have already been put in place and actions which will be taken to minimise risk of COVID-19 transmission in Adult Social Care settings.

2. Recommendations

2.1. The committee is asked to:

2.1.1. Note the actions undertaken.

2.1.2. Review and scrutinise plans to continue to support care provision in Cheshire East due to the Covid-19 pandemic.

3. Reasons for Recommendations

3.1. To ensure that the Council has robust contract management, and quality assurance process in place to minimise risk of COVID-19 transmission in Adult Social Care settings.

4. Other Options Considered

4.1. The Council has a statutory duty to manage the Care Market, to ensure that our residents are safeguarded, and also has contractual responsibilities directly with a number of carer providers across Cheshire East. Therefore it is not an option to do nothing.

5. Update on Settings

5.1. Accommodation with Care

5.1.1. Current situation

- At the time of writing: 9 care homes are currently experiencing a COVID-19 outbreak, an outbreak is defined as 2 or more linked cases amongst staff and residents.
- Of these, 4 homes have completed the 14-day isolation period

5.2. Care at Home

5.2.1. Current situation

- At the time of writing suspected and confirmed COVID-19 cases amongst staff and service users have remained relatively low. Currently there are 23 confirmed cases among service users and 38 amongst staff.
- Care at Home providers are generally operating effectively. One or two providers have experienced issues over staffing levels particularly due to unplanned school closures, however, the Contract Management team has worked closely with these providers to resolve these issues as they arise.

5.3. Complex Care

5.3.1. Current situation

- At the time of writing, within complex care settings we are aware of 1 confirmed case amongst service users and 3 confirmed cases amongst staff. We also have 12 staff members self-isolating due to contact with a Covid positive relative.

6. Background

6.1. Accommodation with Care

6.1.1. Measures currently in place

- The Whole Home Testing Programme in which staff are tested weekly, and residents are tested every 4 weeks, continues and is generally working well. The programme has helped to identify asymptomatic staff members at an early stage so that they are able to self-isolate and prevent

the spread of the virus to residents and other staff members. Due to the current demand on the Laboratory service a small proportion of homes have reported a delay in test result being returned. Local monitoring remains in place via the Infection Control Team on this matter.

- Officers are continuing to work closely with Care Homes to support the roll out of the national rapid testing programme, better known as Lateral Flow Testing (LFT).LFT kits in Care Homes are subject to national deployment and to date there have been a large proportion of homes across Cheshire East who have received their test kits. In preparation for and upon receipt of delivery, officers will continue to engage with Care Homes to understand the local position relating to test kits and the appropriate technology being issued.

- A webinar has been delivered for Care Homes focusing on the implementation and logistical planning that homes will have to undertake to ensure that LFT is completed in a safe way. Care Homes have shared that the request to undertake testing will present financial implications, staffing challenges and additional cost pressure to homes due to the time and planning required to safely facilitate testing prior to any visit taking place. Officers will continue to monitor the implementation of the test kits and work as pragmatically as possible with Care Homes going forward.

- Cheshire East is expected to receive the second tranche of funding from Round 2 of the Infection Control fund in the New Year. This will support care providers to limit staff movement, support safe visiting among other workforce resilience and infection control measures.

- All care homes have an Infection Prevention Control Outbreak Plan supported by an Outbreak Management Toolkit issued by the Council. These can be quickly stepped up in the event of an outbreak and appropriate support put in place from the Infection Prevention and Control service and the Council's Quality Assurance team.

- Officers are also working with care providers to ensure that their staff and care home residents can access flu vaccinations to ensure that there is resilience in the care workforce.

- Monthly care home webinars have been set up in partnership with Cheshire CCG for care home providers with themed agendas such as winter planning, infection control, digital services etc. The next webinar is taking place in January 2021 and has a focus on hospital discharge.

- Weekly mutual aid calls continue for Accommodation with Care providers. These calls provide an opportunity for care home managers to share good practice and offer mutual support.

- 74 Care Homes have been allocated a free iPad via NHSE. The benefits iPad continue to enable residents to stay in touch with their loved ones and facilitate GP consultations. Local visiting guidance has been produced to support care homes to facilitate safe visiting of relatives. A number of Care Homes across the Borough are continuing to put in place bespoke arrangements to facilitate visits for family member, such as external visiting pods, internal allocated visiting rooms with the appropriate PPE and risk management plans.Public Health and the Quality Assurance team are working closely with Care Homes to ensure they are doing all they can to support safe visiting arrangements in care homes for family members and relatives.

- The Care Home COVID-19 flu vaccination delivery plan has been completed, verified and submitted to Cheshire CCG.

- Infection Prevention and Control (IPC) visits continue to be made by IPC nurses to care homes that have experienced more serious outbreaks. These calls provide vital support and advice to homes and are well received.

- The newly appointed Cheshire East Council Infection Control Nurse will be working with Care Homes in the coming months to undertake an analysis of Infection Prevention Control Practices across Care Homes. The focus will be to audit and analyse current Infection Prevention Control systems and process place and offer technical advice and support

- Market position/sustainability reviews continue to be undertaken on a monthly basis by way of a multi-disciplinary preparedness call on a fortnightly basis.

- The Quality Assurance Team continue to undertake weekly contact calls to all care homes across the Borough. The purpose of this contact call is to seek assurance of the effective ongoing safe service delivery and address any emerging risk.

- Analysis of COVID-19 outbreak data has been undertaken to identify trends or patterns in the types of homes in which outbreaks occur. This information will be used to target additional support to prevent future outbreaks.

- A two-tiered approach has been introduced for Quality Assurance; care homes will be sent a list of trigger questions, and a desktop review will be used to determine which homes are at higher risk of quality issues and therefore require a face-to-face Quality Assurance visit, and which homes can continue to be monitored virtually.

- Care homes continue to be asked how they are communicating with friends and family of their residents, and whether any support is needed to improve this, to help ensure that friends and family adhere to visiting guidance. Recommendations from this are being taken forward in partnership with the Councils Public Health Team.

- The Quality Assurance team will be working closely with Skills for Care to support the roll out of the newly launched Deputy Managers network across Cheshire East which is a virtual network specifically for deputy Care Home managers. The focus of the network is to build supportive connections and share best practice and aims to enhance support and development along with delivering themed sessions on Wellbeing & Resilience, Self Confidence, Personal Effectiveness and Delegation with Confidence.

6.1.2. **Actions to be taken**

- The Council continues to work with CCG colleagues to identify designated settings which are capable of supporting Covid 19 hospital patients who are medically for discharge but require support to enable them to fully recover. This is proving difficult as these settings must be able to isolate patients from any other residents to prevent any risk of onward transmission of the virus and meet the required Care Quality Commission, Infection Prevention Control Regulations.

- Ongoing work has been taking place locally with CCG colleagues in relation to seasonal flu vaccination for both Care Homes residents and staff along with the wider provider market. Officers will work with home and care provider managers to identify a Flu Champion in their organisations who will highlight the immunisation programme and encourage colleagues to get their flu jab. The Flu Champion will work alongside their local GP practice to arrange vaccination through district nurse or community pharmacy support.

- Commissioners are working closely with colleagues in Health to ensure that the vaccine is rolled out to care home staff and residents who are a priority cohort. Leighton Hospital received stocks of the vaccine shortly

after Christmas and it is expected that stocks will arrive at Macclesfield Hospital shortly after the New Year. Care home providers have been asked to supply details of their staff to mid Cheshire Hospital Trust so that an appointment can be booked for them to have their vaccination at Leighton Hospital.

- Administering the Pfizer vaccine to care home residents is more problematic due to the storage conditions required. However, it is understood that some Primary Care Networks have contacted care home providers and offered to vaccinate their residents and staff in the New Year.

- Commissioners are working with Health colleagues across Cheshire to develop an hospital discharge pathway for patients who are being discharged to a care home. The pathway, which reflects latest national guidance, is designed to provide guidance and assurance for care home providers. It will be promoted to Regional Managers and policy makers in the care market via a clinically led webinar in January.

- A multi-agency Communications Task and Finish group has been established to co-ordinate and enhance joint communications between Cheshire East and Cheshire West and Chester Councils, Cheshire CCG and other Health colleagues. This will support and supplement local ongoing communication methods such as monthly webinars, Mutual Aid calls and Provider briefings.

6.2. **Care at Home**

6.2.1. **Actions taken to support Providers**

- The CLIPPER system continues to help providers source PPE and there continues to be positive feedback on the system. CEC continue to support providers with PPE where providers are approaching critical need.

- Professor Rod Thomson from our Public Health Team attended a mutual aid call as a guest speaker and answered providers' questions about COVID-19. The main questions asked related to PPE and testing. Providers gave very positive feedback on this session.

- Infection Prevention and Control training has been rolled out to all domiciliary care providers. Training was delivered over MS Teams by a nurse from Cheshire CCG, and attendees demonstrated donning and doffing (taking on and off) of PPE to check they were doing it correctly. Thirty-six Cheshire East providers were trained in total, and those who attended gave positive feedback.

- £672k has been distributed to community care providers with a registered office in Cheshire East from the second round of the Government's Infection Control Fund for specified Infection Control and workforce resilience measures.

6.3. Complex Care

6.3.1. Actions taken to support providers

- Cheshire East Council is part of a pilot scheme to roll out COVID-19 testing for Supported Living settings and Extra Care Housing schemes, similar to the Whole Care Home Testing Programme.
- The 'outbreaks preparedness toolkit' for care homes has been rolled out to Complex Care settings. It will contain information and advice on what steps these settings can take to reduce the risk of outbreaks of COVID-19 and seasonal infectious illnesses and minimise the impact if outbreaks do occur.
- Providers are being supported with PPE, as described above for Accommodation with Care and Care at Home.
- Complex and Extra Care Housing care providers with registered offices in Cheshire East have now received a share of the Government's Infection Control Fund.

7. Implications of the Recommendations

7.1. Legal Implications

- Local Authorities have a duty under the Care Act 2014 to ensure we meet our statutory obligations.
- The Council effectively manages contracts to ensure that value for money is provided, and that the person continues to receive quality of care in accordance with the Provider's contractual obligations.
- The Council has a statutory Safeguarding role which it must fulfil diligently and in accordance with statutory requirements.

7.2. Finance Implications

- The sector has reported they are facing challenges due primarily low occupancy and increased costs relating to PPE. Close monitoring of business viability remains in place.

7.3. **Policy Implications**

- This proposal is in keeping with the requirements of the Care Act 2014 and does not have any specific policy implications

7.4. **Equality Implications**

- The focus has been on ensuring that service users and carers continue to be able to access information, advice, and be able to continue visiting family members placed within Care Homes and Complex Care settings. Care providers have made extensive use of new technologies to ensure communication between family members and relatives.

7.5. **Human Resources Implications**

- There are no known direct Human Resource implications for the Council arising from this report at this time. Depending on the staffing requirements of the designated settings there may be a need to redeploy Care4CE staff to support these schemes.

7.6. **Risk Management Implications**

- The continuing Covid-19 pandemic and with the risk of a second wave or spike in COVID19 combined with winter pressures could place significant pressures on the Social Care market. Detailed planning is taking place with CCG colleagues and with social care providers to plan for the coming months and mitigate risks.

7.7. **Rural Communities Implications**

- There are no direct Rural Communities implications arising from this report.

7.8. **Implications for Children & Young People/Cared for Children**

- There are no implication arising from this report to note in relation to Children & Young People.

7.9. **Public Health Implications**

- COVID19 has had profound impacts on many people who use services and their carers. It will be important to understand and support Adult Social Care service users and carers with any long-term impacts in terms of both Mental and Physical Health and Wellbeing.

7.10. **Climate Change Implications**

The Council is currently reviewing policy developments for Social Value in response to Covid-19 recovery planning. This includes local Social, Economic and Environmental impacts

8. Ward Members Affected

8.1. All wards are affected

9. Consultation & Engagement

- Ongoing engagement continues a regular basis with providers across the Borough. The main methods of communication are via the provider mutual aid calls, themed Webinars and weekly contact calls via the Quality Assurance team. In addition to this engagement direct support is provided from the local Infection Prevention Control service and CCG teams.

10. Access to Information

N/A

11. Contact Information

11.1. Any questions relating to this report should be directed to the following officer:

Name: Nichola Thompson

Job Title: Director of Commissioning

Email: Nichola.thompson@cheshireeast.gov.uk

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FORWARD PLAN FOR THE PERIOD ENDING 31ST MARCH 2021

This Plan sets out the key decisions which the Executive expects to take over the period indicated above. The Plan is rolled forward every month. A key decision is defined in the Council's Constitution as:

> "an executive decision which is likely –
>
> (a) to result in the local authority incurring expenditure which is, or the making of savings which are, significant having regard to the local authority's budget for the service or function to which the decision relates; or
>
> (b) to be significant in terms of its effects on communities living or working in an area comprising one or more wards or electoral divisions in the area of the local authority.
>
> *For the purpose of the above, savings or expenditure are "significant" if they are equal to or greater than £1M."*

Reports relevant to key decisions, and any listed background documents, may be viewed at any of the Council's Offices/Information Centres 5 days before the decision is to be made. Copies of, or extracts from, these documents may be obtained on the payment of a reasonable fee from the following address:

Democratic Services Team
Cheshire East Council
c/o Westfields, Middlewich Road, Sandbach Cheshire CW11 1HZ
Telephone: 01270 686472

However, it is not possible to make available for viewing or to supply copies of reports or documents the publication of which is restricted due to confidentiality of the information contained.

A record of each key decision is published within 6 days of it having been made. This is open for public inspection on the Council's Website, at Council Information Centres and at Council Offices.

This Forward Plan also provides notice that the Cabinet, or a Portfolio Holder, may decide to take a decision in private, that is, with the public and press excluded from the meeting. In accordance with the Local Authorities (Executive Arrangements) (Meetings and Access to Information) (England) Regulations 2012, 28 clear days' notice must be given of any decision to be taken in private by the Cabinet or a Portfolio Holder, with provision for the public to make representations as to why the decision should be taken in public. In such cases, Members of the Council and the public may make representations in writing to the Democratic Services Team Manager using the contact details below. A further notice of intention to hold the meeting in private must then be published 5 clear days before the

meeting, setting out any representations received about why the meeting should be held in public, together with a response from the Leader and the Cabinet.

The list of decisions in this Forward Plan indicates whether a decision is to be taken in private, with the reason category for the decision being taken in private being drawn from the list overleaf:

1. Information relating to an individual
2. Information which is likely to reveal the identity of an individual
3. Information relating to the financial or business affairs of any particular person (including to authority holding that information)
4. Information relating to any consultations or negotiations, or contemplated consultations or negotiations, in connection with any labour relations matter arising between the authority or a Minister of the Crown and employees of, or office holders under the authority
5. Information in respect of which a claim to legal and professional privilege could be maintained in legal proceedings
6. Information which reveals that the authority proposes (a) to give under any enactment a notice under or by virtue of which requirements are imposed on a person; or (b) to make an order or direction under any enactment
7. Information relating to any action taken or to be taken in connection with the prevention, investigation of prosecution of crime

If you would like to make representations about any decision to be conducted in private at a meeting, please email:

Paul Mountford, Executive Democratic Services Officer
paul.mountford@cheshireeast.gov.uk

Such representations must be received at least 10 clear working days before the date of the Cabinet or Portfolio Holder meeting concerned.

Where it has not been possible to meet the 28 clear day rule for publication of notice of a key decision or intention to meet in private, the relevant notices will be published as soon as possible in accordance with the requirements of the Constitution.

The law and the Council's Constitution provide for urgent key decisions to be made. Any decision made in this way will be published in the same way.

Forward Plan

Key Decision and Private Non-Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-6 Development of a Gypsy and Traveller Transit Site	To approve the progression of the project, subject to planning approval, to enable the scheme to be developed in line with the capital budget outlined within the report; and to authorise the Executive Director of Place, in consultation with the Portfolio Holder for Environment and Regeneration and the Portfolio Holder for Communities, to enter into a construction contract with the preferred bidder and make related decisions to deliver the Cledford Hall project.	Cabinet	1 Dec 2020		Karen Carsberg, Strategic Housing and Intelligence Manager	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-7 Covid-19 - Update on Response and Recovery	To receive an update report on the Council's response to Covid-19 and the Recovery Plan. To note the financial effects of Covid-19 on the Council, as regards additional expenditure and loss of income, and to consider the potential options for managing residual financial implications within the Council's Medium-Term Financial Strategy. An update report will be presented to each successive Cabinet meeting up to and including 4th May 2021.	Cabinet	1 Dec 2020		Jane Burns, Executive Director of Corporate Services	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-14 Adult Social Care: Our Covid-19 Winter Plan 2020/21	To provide Cabinet with an overview of the Council's response to the Government's publication of the adult social care winter plan. Officers are to be authorised where necessary to implement the adult social care recommendations/actions.	Cabinet	1 Dec 2020		Nichola Thompson, Director of Commissioning	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-15 Better Care Fund S75 Agreement	To enter into a new S75 Partnership Agreement with the local health partner (NHS Cheshire Clinical Commissioning Group) to cover the period from 1st April 2020 until 31st March 2021 with the option to extend the agreement for a further period of one year, subject to there being a national requirement to operate the Better Care Fund as a Section 75 pooled budget agreement until 2021/22.	Cabinet	1 Dec 2020		Nichola Thompson, Director of Commissioning	N/A
CE 19/20-49 Council Tax Base 2021-22	For Cabinet to consider the Council Tax Base for Cheshire East and identify any changes to the calculation of the tax base for 2021-22 with a view to recommending the amount calculated to Council.	Council	16 Dec 2020		Paul Manning	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 19/20-42 Congleton Leisure Centre Redevelopment Project	To seek authority to enter into the construction contract with Rock Merchanting (T/A Pulse Fitness) for the redevelopment of Congleton Leisure Centre.	Portfolio Holder for Communities	December 2020		Paul Bayley	Fully exempt - para 3
CE 20/21-11 Procurement of Facilities Management Service and the Council's Energy Supply	To approve the re-procurement of facilities management services, to include maintenance, statutory compliance and energy supply management and to authorise officers to take all necessary actions to implement the proposal.	Cabinet	12 Jan 2021		Denise Griffiths	N/A
CE 20/21-18 Vision for Children and Young People in Cheshire East	For Cabinet to endorse and adopt the Vision for Children and Young People in Cheshire East.	Cabinet	12 Jan 2021		Lauren Conway	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-8 Carbon Action Plan Key Decisions	To authorise Officers to take all necessary actions relating to land allocation and procurements for initial projects contributing to sustainable energy generation and green sequestration.	Cabinet	2 Feb 2021		Ralph Kemp, Corporate Manager for Commissioning	N/A
CE 20/21-16 Third Quarter Review (Finance) 2020/21	To note and comment on the three quarter year finance and performance position, and to approve any supplementary estimates and virements.	Cabinet	2 Feb 2021			N/A
CE 20/21-19 Procurement of Occupational Health Contract	Decision to procure a contract for the provision of Occupational Health Services for the Council, Schools and ASDVs. Following the necessary procurement process, that the Executive Director of Corporate Services be authorised to award the contract to the successful bidder.	Cabinet	2 Feb 2021		Craig Hughes	N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-20 Orbitas Bereavement Services Contract Extension	Contract extension to Orbitas Bereavement Services to allow completion of contact review work paused due to Orbitas role as a key frontline provider as part of the Council.	Cabinet	2 Feb 2021		Ralph Kemp, Corporate Manager for Commissioning	Fully exempt - paras 3 and 5
CE 20/21-21 Policy on the Pre-purchase of Graves at Cheshire East Cemeteries	To approve a new policy with regard to advance purchase of graves in Council-managed cemeteries.	Cabinet	2 Feb 2021		Ralph Kemp, Corporate Manager for Commissioning	N/A
CE 19/20-50 Medium Term Financial Strategy 2021-25	To approve the Medium Term Financial Strategy 2021-25 incorporating the Council's priorities, budget, policy proposals and capital programme. The report will include the capital, treasury management, investment and reserves strategies.	Council	17 Feb 2021	Corporate Overview and Scrutiny Committee – 1 February 2021 Cabinet – 2 February 2021		N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-3 Flowerpot Junction Improvement Scheme	To approve procurement of works to improve Flowerpot Junction, utilising the NPIF allocation from DfT and local funding contributions from s106 contributions and council match funding. Authorise the preparation and making of a CPO relating to land required for the junction improvements where this cannot be acquired through negotiation, and delegate authority to the Director of Infrastructure and Highways, in consultation with the Portfolio Holder for Strategic Transport to finalise the scheme details and enter into an agreement with the Council's appointed Highways Term Services to deliver the scheme.	Cabinet	9 Mar 2021			N/A

Key Decision	Decisions to be Taken	Decision Maker	Expected Date of Decision	Proposed Consultation	How to make representation to the decision made	Private/ Confidential and paragraph number
CE 20/21-22 Housing Repairs and Adaptations for Vulnerable People Financial Assistance Policy	To approve the Housing Repairs and Adaptations for Vulnerable People Financial Assistance Policy 2021-2026, and to authorise Officers to take all necessary actions to implement the proposal.	Cabinet	9 Mar 2021		Karen Whitehead	N/A
CE 18/19-60 The Minerals and Waste Development Plan	To seek approval to consult on the first draft of the Minerals and Waste Development Plan.	Cabinet	4 May 2021		David Malcolm	N/A

Cheshire East Council

Working for a brighter future together

Version Number: 1

Key Decision N

Date First Published: N/A

Health and Adult Social Care and Communities Overview and Scrutiny Committee

Date of Meeting: 14 January 2021

Report Title: Work Programme

Senior Officer: Mark Palethorpe, Executive Director of People

1. Report Summary

1.1. To review items in the work programme listed in the schedule attached, together with any other items suggested by committee members.

2. Recommendation

2.1. To approve the work programme, subject to the agreement to add new items or delete items that no longer require any scrutiny activity.

3. Reason for Recommendation

3.1. It is good practice to regularly review the work programme and update it as required.

4. Background

4.1. The committee has responsibility for updating and approving its own work programme. Scrutiny liaison meetings – held between the Chairman and Vice-Chairman of the committee, alongside the portfolio holders and key senior officers – ensure that there is continued awareness and discussion of upcoming policies, strategies and decisions within the committee's remit area.

5. Determining Which Items Should be Added to the Work Programme

5.1. When selecting potential topics, members should have regard to the Council's three year plan and to the criteria listed below, which should be considered to determine whether scrutiny activity is appropriate.

5.2. The following questions should be considered by the committee when determining whether to add new work programme items, or delete existing items:

- Does the issue fall within a corporate priority?
- Is the issue of key interest to the public?
- Does the matter relate to a poor or declining performing service for which there is no obvious explanation?
- Is there a pattern of budgetary overspends or underspends?
- Is it a matter raised by external audit management letters and or audit reports?
- Is there a high level of dissatisfaction with the service?

5.3. The committee should not add any items to its work programme (and should delete any existing items) that fall under any one of the following:

- The topic is already being addressed elsewhere by another body (i.e. this committee would be duplicating work)
- The matter is sub-judice
- Scrutiny would not add value to the matter
- The committee is unlikely to be able to conclude an investigation within a specified or required timescale

6. Implications of the Recommendations

6.1. There are no implications to legal or financial matters, equality, human resources, risk management, or for rural communities, children and young people or public health.

7. Ward Members Affected

7.1. All.

8. Access to Information

8.1. The background papers can be inspected by contacting the report author.

9. Contact Information

9.1. Any questions relating to this report should be directed to the following officer:

Name: Joel Hammond-Gant
Job Title: Scrutiny Officer
Email: joel.hammond-gant@cheshireeast.gov.uk

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Work Programme **Health and Adult Social Care and Communities Overview and Scrutiny Committee** Updated 05.01.21

14.01.21 10.00am Virtual meeting	**04.02.21** 10.00am Virtual meeting	**04.03.21** 10.00am Virtual meeting	**15.04.21** 10.00am Virtual meeting	**06.05.21** 10.00am Virtual meeting

Item	**Purpose**	**Lead Officer**	**Portfolios**	**Suggested by**	**Scrutiny role**	**Corporate priorities**	**Date**
Covid-19 Update	To receive an update on care homes, domiciliary care, complex care and test, trace and isolate, in the context of the Covid-19 pandemic response and recovery.	Executive Director of People	Adult Social Care and Health	Chairman	Overview	People live well and for longer	Standing item until further notice.
NHS Integrated Care Systems	To scrutinise and provide formal feedback on the NHS England and Improvement proposed merger of CCGs and introduction of Integrated Care Systems.	Alan Yates, Jackie Bene, Clare Watson	Adult Social Care and Health Public Health and Corporate Services	Executive Director of People	Pre-decision scrutiny	People live well and for longer	14.01.21

Pre-Budget 2021/22 Consultation	To consider the Pre-Budget 2021/22 Consultation proposals that fall within the remit of the committee.	Director of Finance and Customer Services Executive Director of People	Adult Social Care and Health Communities Public Health and Corporate Services	Committee	Budget scrutiny	Our local communities are strong and supportive People live well and for longer	14.01.21 – moved back from Dec 20
Emerging Futures	To consider an update on how effective/successful the Emerging Futures contract has been in supporting people's health issues and re-housing them, as well as what wider impacts Emerging Futures properties have had on local communities due to rises in anti-social behaviour.	Managing Director, Emerging Futures	Communities Adult Social Care and Health	Committee (Cllr S Brookfield)	Performance monitoring	Our local communities are strong and supportive People live well and for longer	14.01.21
Sustainability of Health Services in Cheshire East	Following the meeting in March 2020, the committee decided to request quarterly updates from NHS Trusts on the sustainability / fragility of services. Should issues arise in between these, updates will be brought to committee as and when required.	East Cheshire NHS Trust / Mid Cheshire NHS Trust / CWP / Cheshire CCGs	Adult Social Care and Health	Committee	Quarterly monitoring of service sustainability	Our local communities are strong and supportive People live well and for longer	04.02.21 (moved back from Jan 21)

Adult's Mental Health and Wellbeing Support Offer	Following a recommendation/ request by the Children and Families Overview and Scrutiny Committee (23.11.20), the committee to consider an update on the support offer for adults experiencing mental health and wellbeing issues.	Executive Director of People	Adult Social Care and Health	Children and Families Overview and Scrutiny Committee	Scrutiny	Our local communities are strong and supportive People live well and for longer	04.02.21
Everybody Sport and Recreation – Annual Report 2019-20	To receive the annual report of Everybody Sport and Recreation.	Chief Executive, ESAR	Communities	Committee	Performance monitoring	People live well and for longer	04.02.21
Provision of Specialist Orthodontic and Oral Surgery Services in Cheshire East	To consider a further update on the plans to develop a new model of care for specialist orthodontic and oral surgery services.	NHS England / NHS Improvement	Adult Social Care and Health	Committee	Monitoring development of new model of care	People live well and for longer	TBD – Feb 2021
Cheshire and Wirral Partnership NHS Foundation Trust – Quality Accounts 2020/21	To consider the 2020/21 Quality Account and provide feedback to be included in the final version of the accounts.	CWP	Adult Social Care and Health	CWP	Performance monitoring	People live well and for longer	06.05.21
East Cheshire NHS Trust – Quality Accounts 2020/21	To consider the 2020/21 Quality Account and provide feedback to be included in the final version of the accounts.	East Cheshire NHS Trust	Adult Social Care and Health	East Cheshire NHS Trust	Performance monitoring	People live well and for longer	06.05.21

Mid Cheshire NHS Trust – Quality Accounts 2020/21	To consider the 2020/21 Quality Account and provide feedback to be included in the final version of the accounts.	Mid Cheshire NHS Trust	Adult Social Care and Health	Mid Cheshire NHS Trust	Performance monitoring	People live well and for longer	06.05.21
Review of Autism Screening at Cheshire's Custody Suites	To consider a report from the Cheshire and Wirral Partnership (CWP) on autism screening at Cheshire's custody suites, following a campaign to identify suspects with, or suspected of having, a condition on the Autistic Spectrum.	CWP	Adult Social Care and Health	Committee (following CWP Quality Account 2016/17)	Performance monitoring	People live well and for longer	To be included on the agenda when the necessary information is available to provide an update.
Update on the Re-design of Adults and Older People's Mental Health Services in Cheshire East	Following the previous update in February 2020, to consider the progress made to date by health partners to establish the new, redesigned service provision for adults and older people's mental health services in Cheshire East, as well as performance against key targets and objectives.	NHS Eastern Cheshire CCG / CWP / CEC	Adult Social Care and Health	Committee	Performance monitoring	People live well and for longer	TBD

Director of Public Health Annual Report 2019/20	To receive the annual report of the Director of Public Health	Acting Director of Public Health	Adult Social Care and Health Public Health and Corporate Services	Committee	Performance monitoring	People live well and for longer	TBD
Syrian Vulnerable Person Resettlement Programme	To consider an update on the Syrian Vulnerable Person Resettlement Programme	Executive Director People		Chairman	Reviewing progress of programme	People live well and for longer	TBD

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