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Sefton Council

MEETING: CABINET

DATE: Thursday 1st April, 2021

TIME: 10.00 am

VENUE: Remote

DECISION MAKER: **CABINET**

Councillor Maher (Chair)
Councillor Atkinson
Councillor Cummins
Councillor Fairclough
Councillor Hardy
Councillor John Joseph Kelly
Councillor Lappin
Councillor Moncur
Councillor Veidman

COMMITTEE OFFICER: Ruth Harrison
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The Cabinet is responsible for making what are known as Key Decisions, which will be notified on the Forward Plan. Items marked with an * on the agenda involve Key Decisions
A key decision, as defined in the Council's Constitution, is: -

- any Executive decision that is not in the Annual Revenue Budget and Capital Programme approved by the Council and which requires a gross budget expenditure, saving or virement of more than £100,000 or more than 2% of a Departmental budget, whichever is the greater
- any Executive decision where the outcome will have a significant impact on a significant number of people living or working in two or more Wards

If you have any special needs that may require arrangements to facilitate your attendance at this meeting, please contact the Committee Officer named above, who will endeavour to assist.

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A G E N D A

Items marked with an * involve key decisions

	Item No.	Subject/Author(s)	Wards Affected	
	1	**Apologies for Absence**		
	2	**Declarations of Interest** Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda. Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room by switching their camera and microphone off during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation. Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.		
	3	**Minutes of the Previous Meeting** Minutes of the meeting held on 4 March 2021.		(Pages 5 - 12)
*	4	**Strategic Integrated Care Partnership and Governance** Report of the Chief Executive.	All Wards	(Pages 13 - 36)
*	5	**Cheshire and Merseyside Health Care Partnership Draft Memorandum of Understanding** Report of the Executive Director Adult Social Care and Health.	All Wards	(Pages 37 - 86)

*	6	**Southport Town Deal – Heads of Terms**	Ainsdale; Birkdale; Cambridge; Dukes; Kew; Meols; Norwood	(Pages 87 - 92)

Report of the Executive Director (Place).

THE "CALL IN" PERIOD FOR THIS SET OF MINUTES ENDS AT 12 NOON ON TUESDAY 16 MARCH, 2021.

CABINET

REMOTE MEETING HELD ON THURSDAY 4TH MARCH, 2021

PRESENT: Councillor Fairclough (in the Chair)
Councillors Atkinson, Cummins, Hardy, John Joseph Kelly, Lappin, Moncur and Veidman.

ALSO PRESENT: Councillor Sir Ron Watson viewed this meeting remotely.

105. APOLOGIES FOR ABSENCE

An apology for absence was received from Councillor Maher.

The Deputy Leader of the Council, Councillor Fairclough reported that Councillor Maher was recovering after recent surgery and requested that the Cabinet's best wishes for a speedy recovery be sent to Councillor Maher.

106. DECLARATIONS OF INTEREST

No declarations of any disclosable pecuniary interests or personal interests were received.

107. MINUTES OF THE PREVIOUS MEETING

Decision Made:

That the Minutes of the Meeting held on 11 February 2021 be approved as a correct record.

108. DOMICILIARY CARE CONTRACTS

The Cabinet considered the report of the Executive Director of Adult Social Care and Health that sought approval to extend the existing Lead Provider Domiciliary Care Contracts and detailed an update on work taking place in relation to Domiciliary Care.

Decision Made: That:

(1) the current Lead Provider contracts for Areas 1, 2, 3 and 6 be extended for a further twelve months (from 1st August 2021 onwards) as is provided for in the Contract, as detailed in paragraph 1.3 to the report, be approved;

(2) the Executive Director of Adult Social Care and Health in consultation with the Cabinet Member for Adult Social Care be granted delegated authority to make any decisions on the making of any final twelve-month extensions (after the proposed extension period), be approved; and

(3) the work taking place within the Domiciliary Care sector, be noted.

Reasons for the Recommendations:

To ensure that Lead Provider contract arrangements remain thus ensuring that current services and commissioning processes are maintained.

Alternative Options Considered and Rejected:

1. **Not extending current Lead Provider contracts and re-procuring services** – this option was considered and rejected as there is a need to ensure market stability at a time where the sector is dealing with the COVID-19 pandemic and there is uncertainty around both the duration of the pandemic and the longer-term ramifications of it. In addition, should the tender for Areas 4 and 5 of Sefton commence, then any further procurement exercises may impact on the stability of the sector. It is also recognised that the current situation has identified opportunities to review new ways of working that have been implemented to respond to the pandemic, which could then be permanently implemented into new models of service, both for Domiciliary Care but also wider models of service linked to further supporting strategic aims around creating and maintaining Service User independence.

2. **Extending contracts for the permitted two-year period** – this option was considered and rejected as it was viewed that this extension period option was too long and that should new ways of working (as outlined in point 1 above) be identified, then they could be implemented as soon as practicable.

109. SAVIO SALESIAN COLLEGE - APPROVAL OF LEGAL DOCUMENTATION FOR ACADEMY CONVERSION

The Cabinet considered the report of the Interim Head of Education that detailed the decision by the Secretary of State for Education to convert Savio Salesian College, to a sponsored academy in accordance with statutory requirements and sought authorisation for officers to sign the documentation required to by the academy conversion process.

The Cabinet Member for Children's Services and Safeguarding, Councillor J. J. Kelly thanked the Leader of the Council, Councillor Maher for all his hard work in securing the future of Savio Salesian College and in maintaining a Secondary School focus in South Sefton.

Councillor J. J. Kelly also thanked Officers of Sefton Council, the Catholic Archdioceses, all School Staff and the Academy Trust for all their hard work and on behalf of the Cabinet wished them well for the future.

Decision Made: That:

(1) the statutory requirements regarding academy conversion, be noted;

(2) the financial implications to the Council of the academy conversion, be noted; and

(3) authorise appropriate officers, the Executive Director of Corporate Resources and Customer Services and the Executive Director of Children's Social Care and Education in consultation with the Cabinet Member to complete the necessary agreements required as part of the academy conversion process as outlined in the report, be approved.

Reasons for the Decisions:

Cabinet needs to authorise appropriate officers to enter into the agreements required as part of the academy conversion process

Alternative Options Considered and Rejected:

No other options are available. The Secretary of State has the powers to direct that the academy conversion process can continue if the agreements are not signed.

110. AFGHAN MOD SCHEME

The Cabinet considered the report of the Head of Communities that outlined the Afghan MOD Scheme and the options for Sefton's participation including agreeing a pledge of numbers of people to be assisted (25 people being the recommended quota). The report also sought approval to appoint the South Sefton Housing Group (Lead organisation Bosco) to deliver the scheme on a 1 year +1+1 arrangement, and sought to delegate authority to the Head of Communities to approve the waiver and any subsequent extension periods.

The Cabinet Member for Communities and Housing, Councillor Hardy welcomed the scheme and referred to the success of the syrian refugee programme and those that had settled long term and integrated well in Sefton. Councillor Hardy extended a warm welcome to those families/individuals who would be joining Sefton.

Decision Made: That:

(1) Sefton's participation in the Afghan Ministry of Defence (MOD) Scheme from April 2021, be approved;

(2) a "pledge" of up to 25 people to be assisted in 2021/22, be approved;

(3) the appointment of the South Sefton Housing Group (lead organisation Bosco) from April 2021 to deliver the scheme on a 1 year +1+1 arrangement, be approved;

(4) the Head of Communities be authorised to seek a waiver from the Executive Director to the Contract Procedure Rules to make a direct award of the contract to South Sefton Housing Group, be approved; and

(5) any extension to the contract following the initial first year be delegated to the Head of Communities in consultation with the Cabinet Member – Communities and Housing, be approved.

Reasons for the Decisions:

To participate in a scheme that supports former MOD Afghan personnel that have suffered persecution since the British military withdrawal from Afghanistan. To agree a pledge of 25 people per year which is consistent with the similar Syrian resettlement scheme. To appoint South Sefton Housing Group (lead organisation Bosco) to deliver the scheme given their track record in the Syrian Resettlement scheme and their local knowledge and delivery partnerships. The scheme expenditure will be below the light touch threshold in relation to the Public Contract Regulations 2015 and is for a 1 year +1+1 arrangements. Delegated authority to the Head of Service to approve the waiver and to approve future extensions in consultation with the Cabinet Member – Communities and Housing will provide a seamless approval process.

Alternative Options Considered and Rejected:

The following options was considered and rejected;

1. Not to be involved in the scheme – this option was rejected as there is a moral responsibility to support the scheme which will further enrich Seftons diverse communities.

111. NEW DOMESTIC ABUSE SAFE ACCOMMODATION DUTY

The Cabinet considered the report of the Head of Communities that outlined the New Domestic Abuse Safe Accommodation Duty that the Domestic Abuse Act would introduce, the responsibilities and the work that would need to be undertaken in order to prepare for when the new duty comes into force in April 2021. The report also sought approval for the

creation of a Local Domestic Abuse Partnership Board and new governance arrangements including membership.

The Cabinet Member for Communities and Housing, Councillor Hardy thanked all Council Staff, Partner Agencies and all those providing outreach support to those individuals who have required help and support during the pandemic and who continue to require that support.

Decision Made: That:

(1) the creation of a Local Domestic Abuse Partnership Board (LPB) ensuring the membership meets the requirements of the draft statutory guidance and that the Cabinet Member for Communities and Housing, Councillor Hardy, be appointed as Chair of the LPB, be approved;

(2) the creation of a Survivor Forum that will have a representative on the LPB, be approved;

(3) the Head of Communities be requested to appoint a consultant /additional temporary member of staff to undertake a Needs Assessment and the work outlined in paragraph 5 of the report, be approved;

(4) the revision of the Sefton Domestic Abuse Strategy to reflect the outcome of the Domestic Abuse (DA) Needs Assessment which is also a requirement of the duty;

(5) the various commissioning arrangements for DA services in Sefton and bring them into a coherent timetable to ensure that the meet the recommendations of the needs assessment and DA Strategy, be noted; and

(6) the creation a range of Safe Accommodation options for DA victims/survivors in Sefton, be approved.

Reasons for the Decisions:

The Domestic Abuse Act will place a statutory obligation on Local Authorities to create a Local Domestic Abuse Partnership Board who will be responsible for giving effect to the Sefton Domestic Abuse Strategy and in particular the new Safe Accommodation duty the Act place on Local Authorities. The Act recommends membership for Local Partnership Boards, however the governance arrangements fall outside the current arrangements for the Safer Sefton Communities Partnership and will need amending and approving.

Alternative Options Considered and Rejected:

The following option was considered and rejected;

1. Not to create a Local Domestic Abuse Partnership Board – this option was rejected as there is a statutory responsibility to create the board.

112. FINANCIAL MANAGEMENT 2020/21 TO 2023/24 AND FRAMEWORK FOR CHANGE 2020 - REVENUE AND CAPITAL BUDGET UPDATE 2020/21 INCLUDING THE FINANCIAL IMPACT OF COVID-19 ON THE 2020/21 BUDGET - MARCH UPDATE

The Cabinet considered the report of the Executive Director for Corporate Resources and Customer Services and were advised of:

(1) the current estimated financial impact of COVID-19 on the 2020/21 Budget;

(2) the current forecast revenue outturn position for the Council for 2020/21;

(3) the current forecast on Council Tax and Business Rates collection for 2020/21; and

(4) the monitoring position of the Council's capital programme to the end of January 2021:

- the forecast expenditure to year end;
- variations against the approved budgets and an explanation of those variations for consideration by Members;
- updates to spending profiles and proposed amendments to capital budgets necessary to ensure the efficient delivery of capital projects are also presented for approval.

Decisions Made: That:

(A) in respect of the Revenue Budget:

(1) the current estimated impact of COVID-19 on the 2020/21 Budget together with the key issues that will influence the final position, be noted;

(2) the financial risks associated with the delivery of the 2020/21 revenue budget and the material variations that are to be expected to the current estimates contained in this report be recognised, and it be agreed subsequent reports provide updates and where appropriate remedial actions plans as appropriate;

(3) the current forecast revenue outturn position for 2020/21, be noted;

(4) it be acknowledged that the forecast outturn position will continue to be reviewed to ensure a balanced forecast outturn position and financial sustainability can be achieved;

(5) the Government Workforce Capacity Fund grant that has been received to help local authorities to boost staffing levels and which will be utilised in accordance with central government guidance, be noted;

(6) the transfer of any unspent Council resources from the Council Tax Exceptional Hardship Fund and the Emergency Limited Assistance Scheme into Earmarked Reserves to help support more residents in 2021/22. These transfers will be approved by the Section 151 officer, in consultation with the Chief Executive where applicable, in line with the Council's Financial Procedure Rules, be noted.

(B) in respect of the Capital Programme:

(1) the spending profiles across financial years for the approved capital programme (paragraph 6.1.1) be noted;

(2) the latest capital expenditure position as at 31 January 2021 of £14.572m (paragraph 6.2.1) with the latest full year forecast of £27.237m (paragraph 6.3.1) be noted;

(3) the explanations of variances to project budgets (paragraph 6.2.3) be noted;

(4) approval of a supplementary capital estimate for £0.788m for the Bootle and Southport Town hall retrofit energy saving works scheme, to be funded from a Public Sector Decarbonisation Fund (PSDF) Section 31 grant allocated by the Government. (paragraph 6.4) be approved;

(5) the Executive Director Corporate Resources and Customer Services will manage capital resources to ensure the capital programme remains fully funded and that capital funding arrangements secure the maximum financial benefit to the Council (paragraph 6.7.3), be noted.

Reasons for the Decisions:

To ensure Cabinet are informed of the forecast outturn position for the 2020/21 Revenue Budget as at the end of January 2021, including delivery of a remedial action plan, and to provide an updated forecast of the outturn position with regard to the collection of Council Tax and Business Rates.

To keep members informed of the progress of the Capital Programme against the profiled budget for 2020/21 and agreed allocations for future years.

To progress any changes that are required in order to maintain a relevant and accurate budget profile necessary for effective monitoring of the Capital Programme.

To approve any updates to funding resources so that they can be applied to capital schemes in the delivery of the Council's overall capital strategy.

Alternative Options Considered and Rejected:

None

Agenda Item 4

Report to:	Cabinet	Date of Meeting:	1 April 2021
Subject:	Strategic Integrated Care Partnership and Governance		
Report of:	Chief Executive	Wards Affected:	(All Wards);
Portfolio:	Cabinet Member Adult Social Care Cabinet Member Health and Wellbeing Cabinet Member Children, Schools and Safeguarding		
Is this a Key Decision:	Yes	Included in Forward Plan:	Yes
Exempt / Confidential Report:	No		

Summary:

1.1 This paper provides an update on the proposed arrangements for the next phase of development of the place-based approach to Integrated Health and Care in Sefton, referred to as Integrated Care Partnership (ICP)

1.2 The ICP will be underpinned by a revised governance structure and a range of task and finish groups to ensure we develop our own transformational programme.

1.3 The report has been tabled and supported at the Health and Well Being Board prior to submission to Cabinet.

Recommendation(s):

1) Note the progress made to date by the Council and its Partners in establishing the Integrated Care Partnership;

2) Cabinet Members are asked to consider and approve the recommendations contained within the report.

3) Agree the leadership and support systems to deliver the changes. It is therefore recommended that the Executive Director of Adult Social Care and Health be designated as Place Lead.

4) Agree that regular progress reports would be presented to the Health and Well Being Board and Cabinet with any Key Decisions escalated as required.

Reasons for the Recommendation(s):

Proposed legislative changes once enacted will require new arrangements to be put in place. The report sets out the infrastructure needed to achieve this.

Alternative Options Considered and Rejected: (including any Risk Implications)

Proposed legislative changes once enacted will require new arrangements to be put in place and so doing nothing is not an option.

What will it cost and how will it be financed?

(A) Revenue Costs

There are no revenue costs associated with this report at this stage

(B) Capital Costs

There are no capital costs associated with this report at this stage

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): There are no resource implications arising from this report at this stage
Legal Implications: There may be legal and policy implications for the Council contained within the proposed legislative changes that will be enacted in April 2022 and will be presented for decision as required.
Equality Implications: There are no equality implications at this stage, however any policy change will be subject to an equality impact assessment.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate confident and resilient communities: Proposals allow greater localised control and focus on the needs of the borough of Sefton in the design, delivery and review of Health and Care Services
Commission, broker and provide core services: Proposals strength the role of Strategic Commission at a Sefton borough level and encourage greater collaboration for better outcomes.
Place – leadership and influencer: proposals set out the road map for greater local control driven by the Health and Wellbeing Board.
Drivers of change and reform: Proposals allow a Sefton Health and Care system

focus on health inequalities and wider determinants of health
Facilitate sustainable economic prosperity: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Greater income for social investment: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Cleaner Greener; Proposals will allow a greater focus on wider determinants of Health

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD6338/21) and the Chief Legal and Democratic Officer (LD 4439/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Proposals build on the NHS England led national consultation Integrating care: Next steps to building strong and effective integrated care systems across England (which closed on the 8th January).

Implementation Date for the Decision

Following the expiry of the “call-in” period for the Minutes of the Cabinet Meeting

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Appendices:

The following appendices are attached to this report:

1) Strategic Report

Background Papers:

NHS England Consultation:

https://www.england.nhs.uk/publication/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems-across-england/

Health and Social Care White Paper:

Working together to improve health and social care for all - GOV.UK (www.gov.uk)

Agenda Item 4

1. Context and proposals

1.1 The development of an ICP (Integrated Care Partnership) in Sefton is in line with national policy set by NHS England/Improvement in respect of developing Integrated Care Systems (ICS) and Integrated Care Partnerships (ICP) by April 2022. This development also reflects the approach being taken at a Cheshire & Merseyside Health & Care Partnership level in terms of its own development as an ICS comprising a number of Integrated Care Partnerships (of which Sefton is one).

1.2 Organisations in Sefton have been developing stronger and more effective ways of working together to address health and wellbeing inequalities and the response to the pandemic has further strengthened these partnerships. This approach was initially developed through a Provider Alliance model, however with proposed changes around legislation contained within the White Paper there will be a requirement that system partners should now begin to formalise arrangements for an Integrated Care Partnership at Place or Borough level with "place" being the terminology used in NHS policy. Attached at Appendix 1 is a detailed strategic position which sets out the proposed approach for Sefton and reflects the current thinking around the White Paper for Health and Social Care published on the 11th February 2021.

1.3 The Sefton Integrated Care Partnership will bring together key partners from across the Sefton, recognising both the vital role of wider cross-sector partners and the central role that Primary Care Networks will play in adopting a population health management approach in Sefton. The Integrated Care Partnership will work together to deliver improved health and care outcomes for Sefton's population. The Health and Wellbeing Board and system partners have already agreed several key priority areas embodied within the Health and Wellbeing strategy which can be viewed here: https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf

1.4 As previously stated, Appendix 1 sets out the partnerships strategic position and in order to develop the position into our Integrated Care Partnership it is proposed that a review of the terms of reference of the Health and Well Being Board is undertaken. In addition, a range of task and finish groups will need to be introduced and these are set out in section 13 within Appendix 1. This phase of development will take place over the next 12 months to 31 March 2022 and the governance structure will be refreshed as part of the development of the Integrated Care Partnership.

1.5 The White Paper makes specific reference to "collaborative commissioning" and the requirement for provider organisations and commissioners to work closer in order to improve Health and Wellbeing outcomes for their Place or Borough. In Sefton we continue to make progress in this area and there continues to be ongoing focus on the integration of 'commissioning' which will support the successful delivery of the Integrated Care Partnership. The 'Place' will be led by the Executive Director of Adult Social Care and Health who will work together with all partners to deliver the strategy with governance and oversight from the HWBB.

1.6 The Accountable Officer for the CCG's has discussed the paper with the Governing Body of NHS South Sefton CCG and NHS Southport and Formby CCG who are both supportive of the approach. The report has been shared with the Cheshire and Merseyside Health Partnership and other key partners. The role and function of the Governing Body of the CCG's will be affected by the proposed legislative changes brought about by the White Paper and introduction of the ICS and so the Accountable Officer from the CCGs and the team will provide a strong steer through this period of transition. It is proposed that the Accountable Officer provides Executive Sponsorship to the Transformation and Integration programme to support the Executive Director for Adult Social Care and Health, in this interim period and supports the development of the Primary Care Networks in the Borough.

2. Conclusions

2.1 This report and the detail contained within Appendix 1 outlines the proposals to develop the Strategic Integrated Care Partnership (ICP) as the 'place' arrangements and as the next steps in our ambition for integrated Health and Care arrangements in Sefton. This is in direct response to the national proposals from NHSE/I to develop a Cheshire and Merseyside Integrated Care System (ICS) by 2022 and the requirement for 'place based' arrangements as part of this transformation agenda.

Agenda Item 4

Appendix One:

Integrating Place Making Care systems for Sefton Local Authority Area

The Sefton Integrated Care Partnership (SICP)

Integrating Place Making Care Systems for Sefton Local Authority

The Sefton Integrated Care Partnership (SICP)

1. Purpose of the report

The following is a Sefton Borough Council position statement regarding the new arrangements for NHS Integrating Care in terms of ‘place’. The report sets out what is expected and what can be defined locally in relation to place making. The report also outlines the steps we need to consider and the time scales for implementation.

2. Background

It has been recognised that the NHS has been largely organized to provide episodic treatment for acute illness to date and the fact is now, more than ever, needs to deliver joined up support for increasing numbers of older people and those living with chronic conditions. Nationally there continues to be an unacceptable inequality in the health of our population and life expectancy is stalling with the wider determinants of health being now well known but often tackled in silos. The Health Foundation (2017) suggests that as little as 10% of a populations health and wellbeing is linked to access to health care. Sefton welcomes the opportunities to work with the NHS and partners in addressing unacceptable health inequalities which sadly persist at national, Cheshire and Mersey and borough level.

The integration of health and care has the potential to drive improvements in population health by reaching beyond the NHS to involve local authorities and other agencies to tackle the wider determinants of health that drive longer term health outcomes and inequalities. Together we are better placed to promote positive health related behaviour, ensure equitable access to quality clinical and social care services. But we can also tackle those issues which influence opportunities and behaviours. These relate to our built environment and socio-economic situation.

Our Place should be bold and ambitious in tackling the wider determinants such as employment, physical environment, personal income, housing, food security, transport, education and skills as well as creating safe and nurturing communities that can flourish.

The Cheshire and Merseyside Sustainability and Transformation Partnership (STP) was established in 2016 as a fore runner of the Health Care Partnership and today includes 9 CCG’s, 9 LAs and 19 NHS Provider Trusts.

Key background papers on integration include the LGA Paper “Integrated Commissioning for better outcomes” published in April 2018 (Integrated Commissioning for Better Outcomes: a commissioning framework | Local Government Association)

clearly stated getting integration right is now more important than ever for the populations and people who use Health and Care services, and for the families that support them. This also outlines the critical role of Health and Wellbeing Boards in driving this process forward. Reiterated by the Kings Fund in November 2019 in its paper on Health and Wellbeing Boards and Integration which can be found here:

www.kingsfund.org.uk/publications/articles/health-wellbeing-boards-integrated-care-systems

Covid has demonstrated the importance of addressing equity and inequalities within our communities and we need to improve the lives of our poorest communities through transformation and integration of care and systems, but we need to draw in our wider partners to assist us with this change.

On 11 February 2021, the government published a White Paper Integration and innovation: working together to improve health and social care (DHSC, 2021), setting out a raft of proposed reforms to health and care. This was accompanied by an NHS England (NHSE, 2021) publication- Legislating for Integrated Care systems, which set out the five recommendations NHSE made to government to inform the white paper. These recommendations were set alongside some principles to guide how the Government progresses this work.

The recommendations are:

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

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

iii. The NHS ICS statutory body should be supported by a wider statutory health and care stakeholder partnership. Explicit provision should also be made for requirements about transparency.

iv. There should be maximum local flexibility as to how the ICS health and care stakeholder partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where this work well. The composition of the board of the NHS ICS statutory body itself must however be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I would approve ICS constitutions in line with national statutory guidance.

v. Provisions should enable the transfer of responsibility for primary medical, dental, ophthalmic and community pharmacy services by NHS England to the NHS ICS statutory

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

3. Context

The main vision and principles are embodied within the Health and Well Being Strategy 2020-2025 (a set of shared priorities that stretch across organisations is key requirement of the emerging models) and focus upon:

- Improving health and wellbeing outcomes for and with people and reduce inequalities.
- Creating conditions for partners to focus on single set of outcomes
- Transforming the current crisis response, demand led acute approach to prevention, to enablement and supporting people to stay well and independent in their own communities.
- Providing a single and consistent commissioning voice to providers, voluntary sector, and independent sector communities.
- Providing a place-based approach based on neighbourhoods and needs led with a focus on joint strategic needs assessment based on a focused single set of data and intelligence
- Enabling commissioning staff to work together to commission joined up services which are cost effective.
- Improving the quality and experience of all health and care services.
- Working with the Council to develop primary care networks to further develop integrated care for communities.
- Creating capacity by utilising and maximising workforce assets and skills, reducing administration to facilitate local system leadership.
- Working together on addressing the financial pressures within the system
- Creating capacity to accept delegated authority for the commissioning of other NHS England commissioned services.
- Enabling the organisation to join up areas of best practice into a single strategic overarching pathway of prevention, care and support.

Based on the most recent 2019 Index of Multiple Deprivation (IMD) Sefton is ranked 89th out of 317 local authorities. The burden of deprivation does not fall equally across the borough. Thirty-eight of Sefton's 189 Lower Super Output Areas (LSOAs) are in the most deprived 10% nationally. This equates to approximately 58,000 residents (21% of the population). Conversely only seven Sefton LSOAs fall in the least deprived 10% nationally (4% of the population and 10,000 residents).

Sefton's ranking in 2015 was 100th, indicating that Sefton has become relatively more deprived. Sefton's 2015 IMD ranking was 100 (higher is more deprived). This suggests that Sefton has become relatively more deprived, compared to other parts of the country since 2015. Sefton's 2019 rank places it in the second most deprived quintile (or fifth) of

local authorities. Despite this, *on average,* Sefton was the least deprived local authority in the Liverpool City Region according in 2019. This decline reinforces how important it is for the Borough to focus explicitly on its locality commissioning programme with an emphasis on early intervention and prevention.

The Due North report (2014) highlighted differences in health across England – people in the north had worse health when compared to people living in the south. It recommended:

- Tackling poverty and economic inequality within the North and between the North and the rest of England.
- Promoting healthy development in early childhood.
- Sharing power over resources and increase the influence that the public has on how resources are used to improve the determinants of health.
- Strengthening the role of the health sector in promoting health equity.

It also recommended tackling health inequalities by building on the strengths of a community, for example the expertise of people in the area. The report stated that the public must have a say in how resources are used to improve health and reduce health inequalities. These findings were used by Public Health England to establish a Well North programme to pilot this approach across a number of areas in the North of England. Sefton was one of the first areas selected to take part in the programme.

Health inequalities are created over time, sometimes over decades, and can take just as long to be addressed. As stated in 'Health Equity in England: The Marmot Review 10 Years On' (2020) [IV] (and he repeats this in the December review on the impact of Covid – Build Back Fairer) more work is needed to reduce the widening health inequalities gap.

The recently published Sefton Public Health report highlighted what action can be taken at a local level to address the wider determinants of health in order to reduce many of the avoidable health inequalities we have in Sefton. In line with the approach recommended by the Due North Report (2004), Well Sefton has worked hard to address inequalities by focusing on a community-led approach, building on local assets and developing community capacity. Coincidentally, the Public Health approach underpinning Well Sefton aligns closely with the recent recommendations published in the Marmot Review 10 years on. The Sefton Public Health report recommends the use of a local social value approach, investment in social, cultural and economic resources in deprived communities, a focus on early intervention and prevention, recognition of the value of engagement with local communities and a vision of community led partnerships. The Sefton Health and Wellbeing Board in its March 2020 meeting approved a report on the proposed engagement in the work to see Cheshire and Merseyside become a Marmot region and recognised its significance in delivering the Sefton Health and Wellbeing Strategy (which can be viewed here, https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf).

In 2019 Sefton's Clinical Commissioning Groups (CCGs) published the five-year strategy Sefton2gether-Shaping Sefton II, in line with the NHSE requirement following publication of the long term plan. The CCGs worked closely with the local authority that was simultaneously refreshing the Health & Wellbeing Board strategy. This document built of the earlier work of the CCGs strategic plan Shaping Sefton I and affirmed the role of the local NHS alongside the council as anchor institutions with the ability to provide much needed employment to the community adding social value. The plan strengthens the focus on tackling the wider determinants of health.

The Cheshire and Merseyside Health Care Partnership formally wrote to NHS England on the 28th January 2021 to seek approval to become recognised as an Integrated Care System citing its potential to drive improvements in population health by reaching beyond health and care to tackle wider determinants through:

- System stewardship
- Inclusive arrangements
- Engagement with Public Staff and other key Stakeholders
- Planning and establishing an approach to Finance and Performing
- Enhancing Integrated Commissioning at place/borough level
- Provider collaborative
- Responding to and embedding NHS Constitution
- Academic partnership to underpin programme evidence and evaluation.

The ICS (Integrated Care System) application from the Cheshire and Merseyside Health Care Partnership references the Local Authority as being able to provide focus through the Health and Wellbeing Board. With the fundamentals of an ICS integration being focused on an improved population health and healthcare, tackling unequal outcomes and access to services, enhancing productivity and Value for Money and Helping the NHS to support broader Social and economic development. Reflecting the priorities defined by the Sefton Health and Wellbeing Strategy. The application also highlights the need to increase networks into areas of influencing and affecting wider determinants recognised as key council focuses of deprivation, environmental degradation and the build environment including housing, as well as linking Education, employment, and service delivery at place.

4. Definitions

Within the guidance issued by the Department of Health, the role of 'Places', are defined as meaning "long-established Local Authority boundaries", at which joint strategic needs assessments, health and wellbeing strategies and commissioning approaches are developed in partnership, to deliver the following:

- Closer working with LA and VCS partners on prevention and health inequalities
- Joining up Council/ hospital/ community services
- Clinical care redesign (including simplifying and standardising care pathways)

- Forming provider partnerships and alliances (including GPs) to redesign and integrate services
- Developing new provider models
- Population health management
- covers 250-500k population (Usually Council/ Borough level)

It recommends that 'Place' should be sub divided into Neighbourhoods and should work alongside, and with Primary Care Networks (PCN) on population footprints of 30-50k

Neighbourhood aims are:

- Implementing integrated delivery models, forming Multi-Disciplinary Teams
- Forming PCNs, strengthening primary care, joining up primary & community care
- Implementing social prescribing

5. Integrated Place Based Care

The aims of integrated place base care systems are to:

a) Plan, manage and deliver services together for populations. This would enable neighbourhoods to focus on need be that a health need or a wider determinant of health need
b) Linking education, employment and service delivery in a Place/Borough to enable us to shape our workforce and build resilience and opportunity in communities
c) Linking health skills and knowledge with housing and care across our neighbourhoods to enable us to support our families in need or at risk of harm

The guidance suggests that partners should include - Primary Care Network Leads, Local Authority adult and children's social services leads, Community Health Provider, Mental Health Provider, Acute Provider(s), Public Health, Voluntary sector, Housing, Police, Education

Each area therefore must:

- Access clear advice on staying well; There is still a strong emphasis on individual responsibility and choice. The strength of a place-based approach is that we should be looking at the barriers that mean people don't act on the advice – even if it is clear and accessible. If we have prevention services – and we will need to create an environment that will help people put the advice into practice. The NHS as a huge employer can play a role here but the partners at place can take a lead.
- 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.

Delivery will be through Local Government, NHS providers, Primary Care and the voluntary sector working together in each place in ICPs, built around Primary Care Networks (PCNs) in neighbourhoods.

The Council can really influence wellbeing and prevent ill-health. We already work as

- System leaders
- Mobilise resources across a diverse work force (Covid is a good example) and partners
- See health as an asset
- The Council already take a wider and social determinants approach – roads, traffic, air quality, housing, education, community safety, etc and deliver on population interventions such as screening and vaccination programmes – get that right and we could save 100s more lives
- Picking up and optimising management of those people with long term conditions – managing high blood pressure, diabetes care. It's about finding the missing patients.
- Building prevention and early intervention into their routine work, e.g. smoking cessation and vaccine promotion in maternity care.

There is much to gain from the synergy of the 8 CCG localities with the 3 Council locality areas and work has been accelerating through the Integrated Neighbourhood teams. Through transition over the next 12 months the leadership role of the Primary Care networks (PCNs) will gather momentum. These local footprints will be the vehicle for driving the approach to population health management (PHM).

6. Integrated Care Partnerships

The Department of Health and Social Care (DHSC) recognise that every area is different, but clearly highlight that common characteristics of the most successful systems are when there is the full involvement of all partners who contribute to the Place's health and care.

The DHSC recognise that there is a critical role for local Councils to work with health partners who will play a leading role for clinical primary care leaders, through Primary Care Networks; and a clear, strategic relationship with Health and Well Being Boards.

To support the above there are already well established and recognised governance arrangements in place, underpinned by Sefton's Health and Well Being Board. The governance set out below is a way of connecting the above roles together, whilst at the

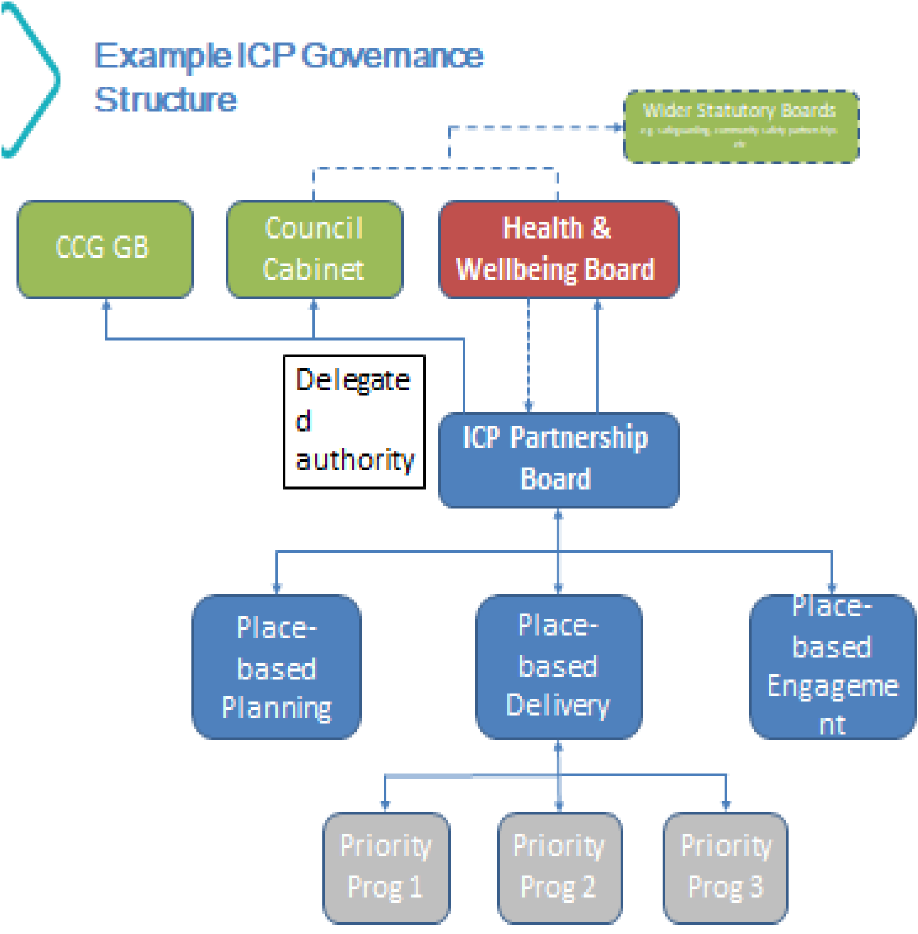
same time continuing with the adult forum, children and young people (CYP) and Special Educational Needs Board.

It is recommended that the adult forum is reviewed and developed into a fully functioning Board within the same model of the SEND and Children and Young People Boards. There will be an opportunity to shape local governance at Borough level with a focus on strengthening the Health and Wellbeing Board to support local system leadership and with a strong emphasis on improving population health.

Future transformation funding will focus on improving population health at scale across the Cheshire and Merseyside footprint and so the role of the HWBB will be pivotal. Systems of governance will change over time in line with legislative changes.

We also need to be nimbler and it is therefore also recommended that the TOR for the HWBB are reviewed with the existing CCGs, PCNs and NHS/Voluntary Sector, Healthwatch, Housing, Police and Education partners playing a pivotal role in its future development, and a memorandum of understanding is developed to ensure agreement from all partners.

As can be seen from the diagram below the C&M Partnership are beginning to consider the future governance and as can be seen from their position on place-based commissioning and integrated care it is heavily weighted to the roles and functions of Local councils and its role as system leaders in the ‘Place’.



Whilst this approach is the one recommended by the C&M Partnership it will be for the area to determine its own approach and the process is set out to achieve its own destination within the report. A key component of the success of the Integrated Care Partnership- place model is ensuring the planning and delivery function are working in a harmonious way at both strategic and operational level. Work will need to be undertaken to consider the development of a partnership plan that truly reflects this for Sefton.

7. Finance

The DHSC guidance states that 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. CCGs already receive 0.2% of their total resource allocation to support the move to place-based care and we would wish to work in partnership with the CCGs in the design of organisational structures for the future beyond 2021.

The devolved budget will include CCG Budget, PCN and majority of specialised commissioning such as mental health services, eventually devolved to place. Place leaders will have a duty to spend within the financial rules but also in line with local strategies. The white paper reinforces the focus on finance, value-for-money and capitated budgets (which aligns with PHM). As its uncertain currently what level of delegated resource Sefton may receive from the ICS, it is worth considering how this impact on pooled arrangements, specifically in relation to spend. This is important so that at ICP level there is a whole 'pathway' view taken in order to facilitate the 'left shift' in activity which will be needed to release spend from acute providers to facilitate reinvestment.

In Sefton we already have a £48M pooled budget, the ninth largest in the North West. However, it would not be described as a means of transforming the system and deliver the outcomes against the health and well-being strategy and in affect it is currently largely transactional with the main focus on the better care fund and programme.
However, with a change in focus and with more engagement and support of the NHS and other voluntary sector providers there is a significant opportunity to expand the Section 75 arrangement to cover children services, public health and housing and make this a transformation budget to deliver against the Health and Well Being strategy for the Sefton population.

Oversight will be required of the funding being made available to spend on Sefton residents Health & Social care. This resource needs to be considered in the context of outcome-based measures and potential for different and lengthier contracting mechanism e.g. Lead provider models, to move away from historical 'piecemeal' transactional methods.

8. Prescribed and Flexible elements

The DHSC guidance states that 'Place' leadership arrangements 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

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 ICP board.

The seniority of the leadership in the ICP should be commensurate with the roles and responsibilities, particularly if some of the CCG functions are to be delegated.

9. Collaborative Commissioning

The DHSC guidance states that each 'Place' must ensure there is a **single, system-wide approach to undertake collaborative strategic commissioning**.

The guidance clearly states that systems should also agree whether individual functions are best delivered at system or at Place, balancing subsidiarity with the benefits of scale working. Health Commissioners may, for example, work at Place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside Local Authorities.

Places will be expected to develop an integrated approach to commissioning between Health and the Local Authority, with shared posts, joint teams and pooled budgets to underpin and support the ICP. This role is described by C&M as place-based commissioning and co-ordination and must sit alongside the Health and Care Provider delivery parts.

The ICS will be required nationally to cultivate a strategic focus and ensure commissioning arrangements and decisions support and are aligned with system priorities in the context of shared commissioning decision making with Health and Local Authority in the ICP.

This will discharge core ICS functions at a local level through the ICP, 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
- Supporting a segmented and targeted approach to ensure we level up health inequalities
- Have contractual mechanisms for delivery
- Are able to ensure clinical input is a key part of Strategic Commissioning.

There must be minimal layers of decision making (some systems have a Joint Commissioning Board, but this is not prescribed). It must enable Integrated Commissioning arrangements for Health and Social Care, with local responsiveness

through the Health and Wellbeing Board. Whilst this already happens to various degrees in place, this is currently voluntary, but work is underway to make this legislation through the options proposed in the consultation. In 2021/22 work must be undertaken to layer residents' voices and the Voluntary Sector in the Governance process, with Health Watch involvement recommended. Involvement of Overview and Scrutiny is also referenced in proposed developments.

Within Sefton there is already a recognised commissioning structure and approach and it is believed that Sefton will be well placed to deliver against the DHSC priorities, be nimble, as well as form agreements developed with the C&M ICS.

10. Population Health Management, Digital & Quality assurance

The ICP should develop a system wide digital plan; a shared care record and a cross system Intelligence and analytical function. This needs to move from reactive business intelligence to a proactive PHM which supports the approach to early intervention and prevention and links to the system resource ensuring value for tax payer's money. This has to have strong connectivity to the CM ICS.

We have already invested heavily in shared care records and worked together in partnership, now we need to make sure this is more integrated and joined up with the Cheshire and Mersey HCP /ICS and the joint enabling programmes we wish to pursue are as follows:

- Shared networks – to enable colocation/multi agency teams
- Integrated case recording – to wrap services around customers
- Including Data protection requirements
- Joint approach to TECS strategy and priorities
- Digital inclusion strategy and connectivity
- A combined BI function would allow us to fulfil the requirement of the ICS to ensure that decisions and spending is predicated on evidence base and a inclusive and fully reflective needs assessment of the population of Sefton.
- Fulfil the requirement to have collective systems of management and performance at a place level.

In the ICP we have to fully utilise the capability of Combined Intelligence for Population Health Action (CIPHA) functionality and use it to understand population health needs and drive the change in delivery required to improve health outcomes and reduce health inequalities in Sefton.

The ICP will also need to develop a new quality assurance framework that will be to accommodate the elements of local authority work and previous functions of the CCG at a local level.

11. Place based leadership

The DHSC states that there should be a recognised and identified Place leadership to undertake the following tasks:

- 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;
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.
- to focus on the wider determinates of health across the population
- to support and develop Primary Care Networks (PCNs) which join up primary and community services across local neighbourhoods; and
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);

Based upon the above it is clear that in partnership with the existing CCGs, PCNs, NHS providers, Voluntary sector providers, Healthwatch, Police, Housing, Education, that the Local Authority should take the leadership role in local ‘place’ making arrangements and in January 2020 the Council introduced a new Executive lead for Adult Social Care and Health. This model is an accepted and recognised approach as the existing Cheshire and Merseyside state they recognise “the lead role of the Local authority in the integration of care and system design is recognised”; “place at the Local authority level is the primary building block for integration between health and care and other sectors of the system.”

This role extends the role of the DASS set out in the 2006 legal framework and reflects the emerging national position on NHS policy. Key to this role are the following:

- Assessing local need.
- Delivering an integrated whole system approach to support local community inclusion and wellbeing.
- Ensuring that the role of DASS delivers to Council responsibility for assessing planning commissioning wellbeing provision and promoting social inclusion.
- Systems leadership and making sure the voice of social care social work and the social model is heard, particularly by working with NHS partners, the police, providers, voluntary organisations, the wider council and members of the community.
- Shaping care and health and wider public services in the area.
- Promote the inclusion and rights of disabled and older people.

Cheshire and Merseyside in their application to become an ICS make it clear they expect a lead role from the Local Authority in the integration of Care and System design and that

political engagement and democratic input will bring legitimacy to the current transformation.

The DASS role will ensure that the focus is not just on adult social care and a wider system leadership approach is undertaken with all Council areas and wider partners. It is also of note that Sefton is the only Place in Cheshire and Mersey that has split CCGs, this is highlighted in the ICS application and supports the need to provide LA based leadership to the place of Sefton.

It is therefore recommended that the Executive Director of ASC and Health be designated Place Leader, work alongside the existing CCGs, PCNs, other NHS, Council Officers and partner agencies to develop our strategic approach, policies and structures which should complement the existing Health and Well-Being Strategy 2020-2025. Any new responsibilities emerging will be discussed and agreed with the wider C&M ICS.

In moving from CCGs to the new ICP the knowledge and experiences of clinicians, which has been at the forefront of CCGs must not be lost. Clinical leadership and engagement is key to the continued success of the future ICP. Thought should be given to how current forums can be used to support the ICP going forward. There is a real opportunity and energy to take forward alignment of staff from the CCGs and local authority team to deliver our ambitions in Sefton.

12. Timeframe and Next steps

In 2021/22 there will be a requirement for the system to begin planning its recovery, performance, delivery and development in each of its 9 places, with an eventual requirement for firm 5-year plans. The partnership proposes to work with 2 or 3 places to as initial development areas to help define what good looks like the outcome being an agreed work plan, Development plan and Organisational Development plan. This work will begin in March 2021. This report therefore has set out its strategic approach towards this plan.

The Cheshire and Merseyside Health Care Partnership highlights emerging need to develop public engagement in planning and decision making, development plans to places taken us up to 2022, further clarity of place functions, efficacy plans for each place, enabling place to support challenged organisation and address systemic issues, design expectations and goals for system, place and neighbourhood integration. This will need to be considered as part of a task and finish programme management approach.

It is understood that ‘shadow’ arrangements must be in place by April 2021 and by September 2021 plans are expected of how this will be delivered in full by April 2022. The Local Authority is keen that their position is clearly outlined at the earliest possible stage and subject to discussions with CCG and other partner leaders it is proposed that a similar report will be presented to the HWBB on 10 March 2021.

Dependent upon the feedback by HWBB members the Council would intend presenting a report to Cabinet on the 1st April 2021 and this decision would be taken nearer the time,

as discussions about other partner Boards take place. In addition, there is an opportunity to scrutinise any further detail proposals on 22 June 2021 at the Health and Adult social care Overview & Scrutiny Committee. Subject to discussions and agreement the proposal is to seek full agreement with the wider C&M ICS in September 2021.

Work has begun on a high-level programme plan that has been formulated subject to governance approval. The workforce issues will be addressed concurrently following HWBB on 10 March 2021 and before September 2021.

13. Next steps

It is recommended that partners consider the strategic report and proposed ICP governance. From there the ICP Governance is considered by all key partners in February March / April / May at their decision-making forums and engagement with C&M ICS.

A communication and engagement plan and organisational development plan will need to be developed and regular reports to HWBB with a clear programme and timetable.

In order to facilitate the required work from now until April 2022 it is proposed to establish a strategic task and finish group. Its remit will be as follows:-

- Strategic leadership and oversight of the Place ICP – reporting to Informal Cabinet, other Boards and the Health and Wellbeing Board
- Oversees delivery of programme to establish place making at Borough level
- Approves the organisational development strategy and action plan for the Place ICP
- Approve system wide outcome measures
- Evaluates risk in relation to system change proposals
- Approves the communications and engagement strategy and action plan for the ICP
- Holds to account the Programme Delivery Group and System Resources Group – Primary Care Networks (PCNs)
- Oversees enabling systems and infrastructure workstreams
- Seeks the views of other Forums – Cabinet and the Health and Adult Social Care and Children Overview & Scrutiny Committees

With its membership drawn from the following; -

- Cabinet Member Health to Chair
- Leader and relevant Cllr Cabinet Members
- 4 x PCN Clinical Directors and CCG senior reps
- Director Public Health
- VCS/Education/Police/Healthwatch Rep
- NWB Rep/Acute/Mersey Care Rep
- Housing representative

- Council Chief Executive
- Exec Directors - to be confirmed
- Heads of Service – to be confirmed

Membership to be reviewed and developed as and when the priorities of the ICP change

This will be supported by two sub groups, namely: - the programme delivery group and the system resource group whose remits are described below: -

Programme Delivery Group remit

- Develop proposals for change to the delivery of services for the key priority areas identified by the ICS that will improve quality, outcomes and/ or sustainability of all services
- Resource delivery of the ICS Plan as advised by System Resources Group
- Ensure programmes are delivered through neighbourhood working
- Establish and agree the remit of working groups to focus on key priority areas
- Feedback and report to the ICP T&F Board in respect of the key priority areas
- Develop system wide outcome measures for collective performance reporting
- Report on progress to the ICP T&F Board

Membership

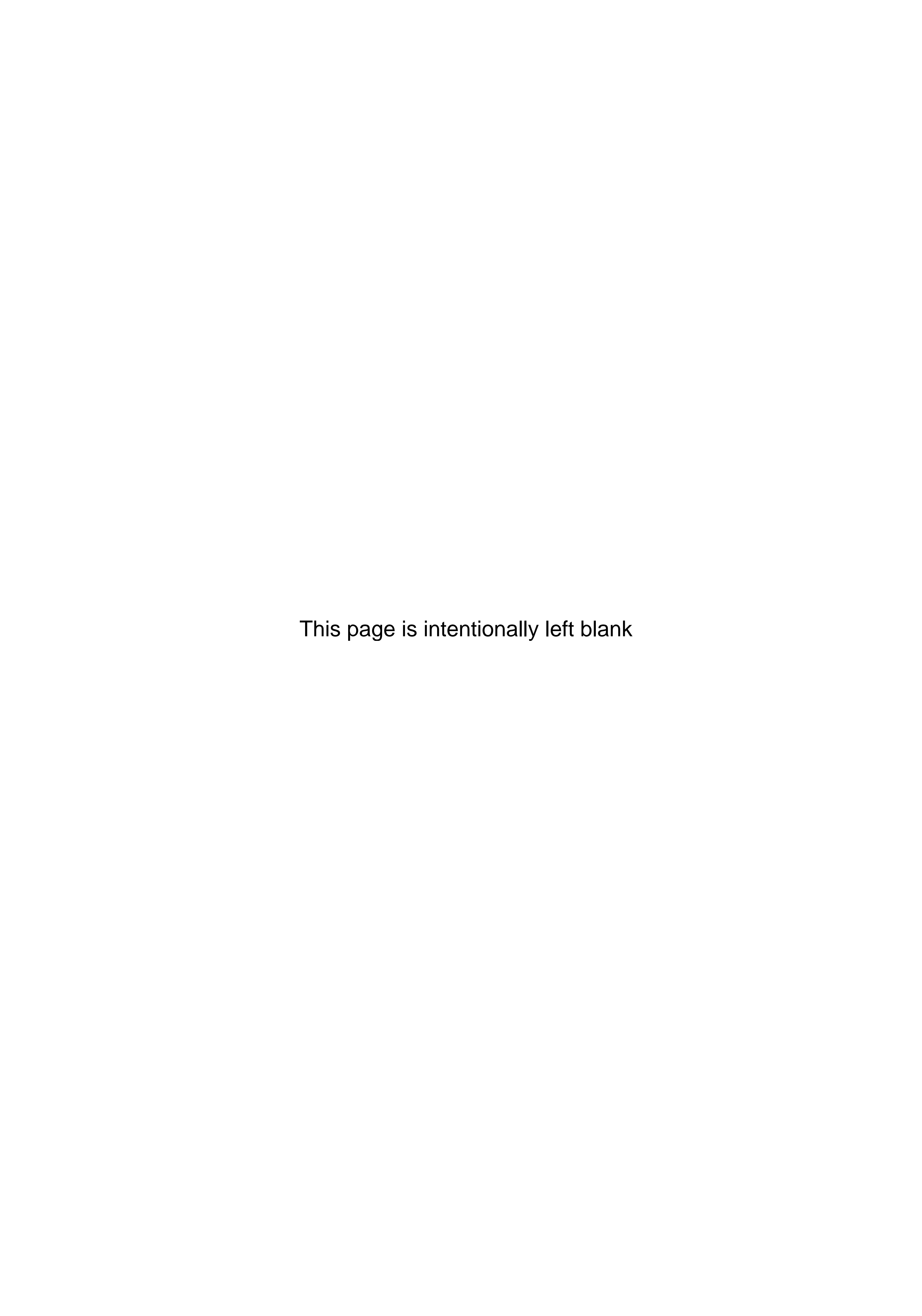
- CCGs and Council Commissioners / provider representation including PCNs / VCS Rep / Locality Leads / Stakeholder Forum Rep
- 1 x Rep from each PCN
- Strategic Estates Group rep
- Heads of Service
- Director of Public Health
- Executive Directors and senior CCG reps
- Mersey Care and NWB/Acute Rep
- Housing Rep
- VCS/Education/Healthwatch/Police
- Transformation support team

System Resources Group remit

- Strategic oversight of the collective resources of the Partners in Sefton
- Advises the ICP Task and Finish (T&F) Board to support effective and efficient decision making
- Reports on performance, financial and other resource risk across the ICS, including monitoring the system performance dashboard and recommending mitigating actions
- Identifies opportunities to shift/release resources – effective use of Sefton's £ and resources to further the ICS Plan, using population health intelligence and horizon scanning
- Advises on the development of mechanisms for risk/gain share amongst ICS Partners
- Makes recommendations to Programme Delivery Group on financial, performance and contractual implications of proposals before they go to the ICP T&F Board
- Feed into decisions to be made by the ICP T&F group, Health and Wellbeing Board which have a material impact on the resources of the ICP or any ICP partners

Membership

- Director of Finance/Chief Finance Officer CCG
- Council Executive Directors and CCG senior reps
- PCN Rep(s)
- Possibly Business Intelligence/Performance Reps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Report to:	Cabinet	Date of Meeting:	1 April 2021
Subject:	Cheshire and Merseyside Health Care Partnership Draft Memorandum of Understanding		
Report of:	Executive Director of Adult Social Care and Health	Wards Affected:	(All Wards);
Portfolio:	Cabinet Member - Health and Wellbeing		
Is this a Key Decision:	Yes	Included in Forward Plan:	Yes
Exempt / Confidential Report:	No		

Summary:

The report offers a review of the latest version of the Cheshire and Merseyside Health and Care Partnership Memorandum of Understanding (MoU) and asks Cabinet for their intention to sign the final version of the MoU once formally submitted to the Council. Cabinet is asked to delegate this to the Cabinet member for Health and Wellbeing.

Recommendations:

(1) Cabinet welcomes the latest version of the Cheshire and Merseyside Health and Care Partnership Memorandum of Understanding (MOU) subject to the comments upon the same expressed by the Leader and the Cabinet Member for Health and Wellbeing in their joint letter of 2nd March 2021, which is included as appendix 3 to the report and notes that it may be revised further: and

(2) Cabinet delegates authority to sign the final version of the MOU to the Cabinet Member for Health and Wellbeing.

Reasons for the Recommendation(s):

Support the implementation of the Governance of the Memorandum of Understanding for the Cheshire and Merseyside Integrated Care System.

Alternative Options Considered and Rejected: (including any Risk Implications)

Proposed legislative changes once enacted will require new arrangements to be put in place and so doing nothing is not an option.

What will it cost and how will it be financed?

(A) Revenue Costs

None identified at this time

(B) Capital Costs

None identified at this time

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): None identified at this time
Legal Implications: As identified in the report and appendices.
Equality Implications: There are no equality implications.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate confident and resilient communities: Proposals allow greater localised control and focus on the needs of the borough of Sefton in the design, delivery and review of Health and Care Services
Commission, broker and provide core services: Proposals strength the role of Strategic Commission at a Sefton borough level and encourage greater collaboration for better outcomes.
Place – leadership and influencer: proposals set out the road map for greater local control driven by the Health and Wellbeing Board.
Drivers of change and reform: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate sustainable economic prosperity: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Greater income for social investment: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Cleaner Greener; Proposals will allow a greater focus on wider determinants of Health

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.6344/21) and the Chief Legal and Democratic Officer (LD.4545/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Proposals build on the NHS England led national consultation Integrating care: Next steps to building strong and effective integrated care systems across England (which closed on the 8th January). The consultation on the development of the MoU has been led by the Cheshire and Merseyside Health Care Partnership which Sefton has engaged in to date

Implementation Date for the Decision

Following the expiry of the “call-in” period for the Minutes of the Cabinet Meeting

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Appendices:

The following appendices are attached to this report:

1. The latest version of the MoU for a response
2. Letter from Chair of HCP
3. Letter from Councillor Ian Moncur and Councillor Ian Maher providing a response.

Background Papers:

There are no background papers available for inspection.

1. Introduction:

1.1 Following the Government White Paper “Working together to improve Health and Social Care for All” on proposed legislative changes an MoU (Memorandum of Understanding) has been developed by the Cheshire and Merseyside Health Care Partnership to outline the governance arrangements across all nine local authority footprints regarding working with the emerging Integrated Care System.

1.2 The MoU and the work of the Health Care Partnership will be critical to the development of an Integrated Care System in Cheshire and Merseyside and the Integrated Care Partnership in Sefton. Once proposed legislation regarding integration has been enacted this will require new arrangements to be put in

place. The new arrangements will affect the way in which the Health and Care system works in an integrated way. This MoU will assist in establishing governance arrangements during this planning phase.

2. Development of the MoU:

2.1 On the 2nd February 2021 Alan Yates, Chair of Cheshire & Merseyside Health and Care Partnership wrote to all partners with a revised version of the MoU which is appended. The Cheshire and Merseyside Health Care Partnership are now asking for formal consideration of the latest version of the Memorandum of Understanding relating to the governance arrangement for the Integrated Care System by the 12th March 2021.

2.2 In advance of this deadline Cabinet Members for Adult Social Care, Health and Wellbeing, Children's Social Care and Education met to consider a response and this was sent to the Cheshire and Merseyside Health Care Partnership.

2.3 The latest version of the MoU has strengthened the position of Council scrutiny and clarified that democratically elected Councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers. The MOU has now addressed specific issues raised by the Council notably the representation at board extended to all 9 Councils across the Cheshire and Mersey footprint. Full detail of the points can be found in the appendix.

3. Conclusion:

In conclusion, the Cabinet on behalf of the Council is recommended to support the principles laid out in the latest draft of the Cheshire and Merseyside Health Care Partnership MoU however, continued support from Sefton Council is contingent on having full engagement in the emerging new arrangements.

Memorandum of Understanding

V8

January 2021

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1. 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

2. 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:

- Primary Care Networks
- Specialist community service providers
- GP Federations
- 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, community engagement and determination of the most appropriate location for care to be recieved.

2.1 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 to 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.

3. 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.

3.1 Purpose

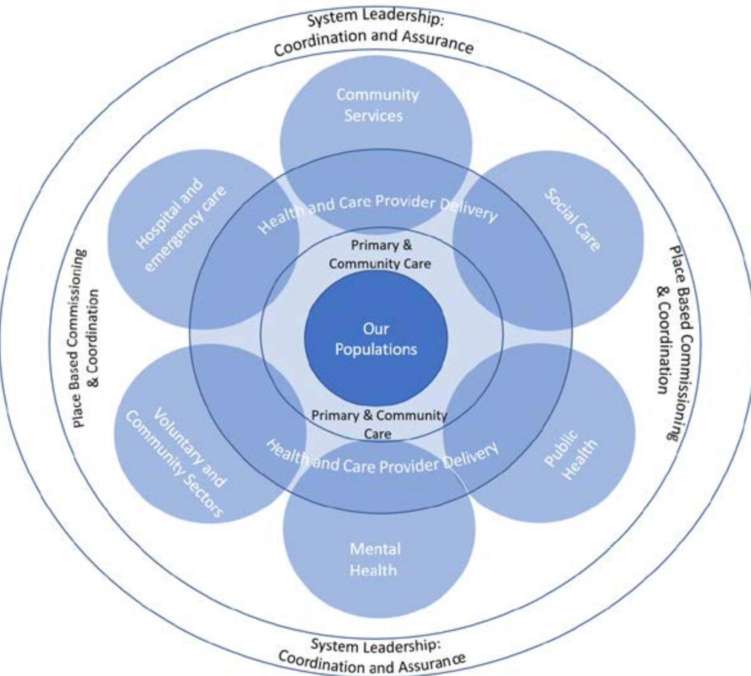
The purpose of this Memorandum is to formalise our partnership arrangements. We do not seek to introduce a hierarchical model; rather provide clarity through a framework, based on the principle of subsidiarity, to ensure collective ownership and coordination of delivery. This approach also provides the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

3.2 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).

3.2.1 How we are moving forward in Cheshire and Merseyside

3.2.1.1 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.

3.2.1.2 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**

3.2.1.3 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

3.2.1.4 Active members of our communities

We recognise that a number of our partners consider themselves to be and act as *Anchor Institutions*. Through having sizeable assets that can be used to support local community wealth building and development *anchors* can advance the welfare of the populations they serve.

The Partnership takes its' and our partner's responsibilities and potential for social responsibility and social action seriously. Differing from what has preceded we hope and expect the Partnership, as a truly integrated care system, can impact on the wider determinants of health and care including in education, housing, business, industry, enterprise and ultimately the whole person approach to health and well-being. It is through this way of working that we expect to be able to have most impact on equity and health inequalities.

Furthermore, as a core part of its social responsibility, the Partnership is supporting organisations to develop Green Plans and meet new NHS Net Zero Carbon Plan targets. As a Social Value Accelerator Site, we're dedicated to embedding social value across anchor institutions, building capabilities across environmental, economic and social factors.

In progressing our aims and initiatives we will support and champion innovation and the use of data and technology to provide insight and guide our delivery and focus.

3.2.1.5 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, through which a significant number of partners will interact will similarly focus on and track outcomes.

3.2.1.6 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.

3.2.1.7 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.

3.3 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.

3.4 Term

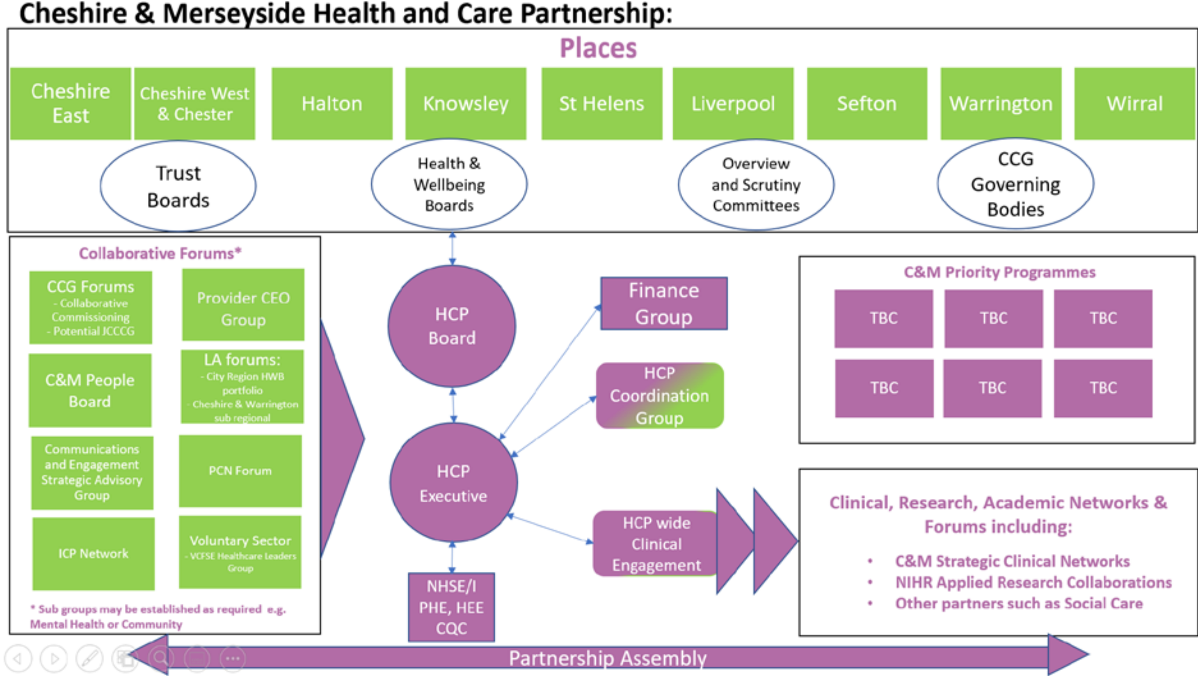
This Memorandum is a dynamic document and is intended to reflect where the partnership is at the date of adoption. As the system, collaboration and any responsibilities or delegations are developed or assumed this document will be reviewed and updated. When we become a full Integrated Care System the governance arrangements will be subject to review.

4. 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.



4.1 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).

4.2 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.

Current proposed Board membership is detailed in Annex 6.

4.3 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

4.4 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

4.5 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

4.6 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.

4.7 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.

4.7.1 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.

4.7.2 Provider Collaborative

The nineteen NHS 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.

4.7.3 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.

4.7.4 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.

4.7.5 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.

4.7.6 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.

4.7.7 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

4.7.8 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. As identified by NHSE/I these may take the form of or link with Place based Provider Collaboratives. Such 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.

5. 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

5.1 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.

5.2 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 co-ordinating 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.

5.3 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.

6. 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.

7. Variations

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

7.1 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.

7.2 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.

7.2.1 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.

7.3 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.

7.4 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 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,
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 Ambulance Service NHS Trust
- 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 Health and Care 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

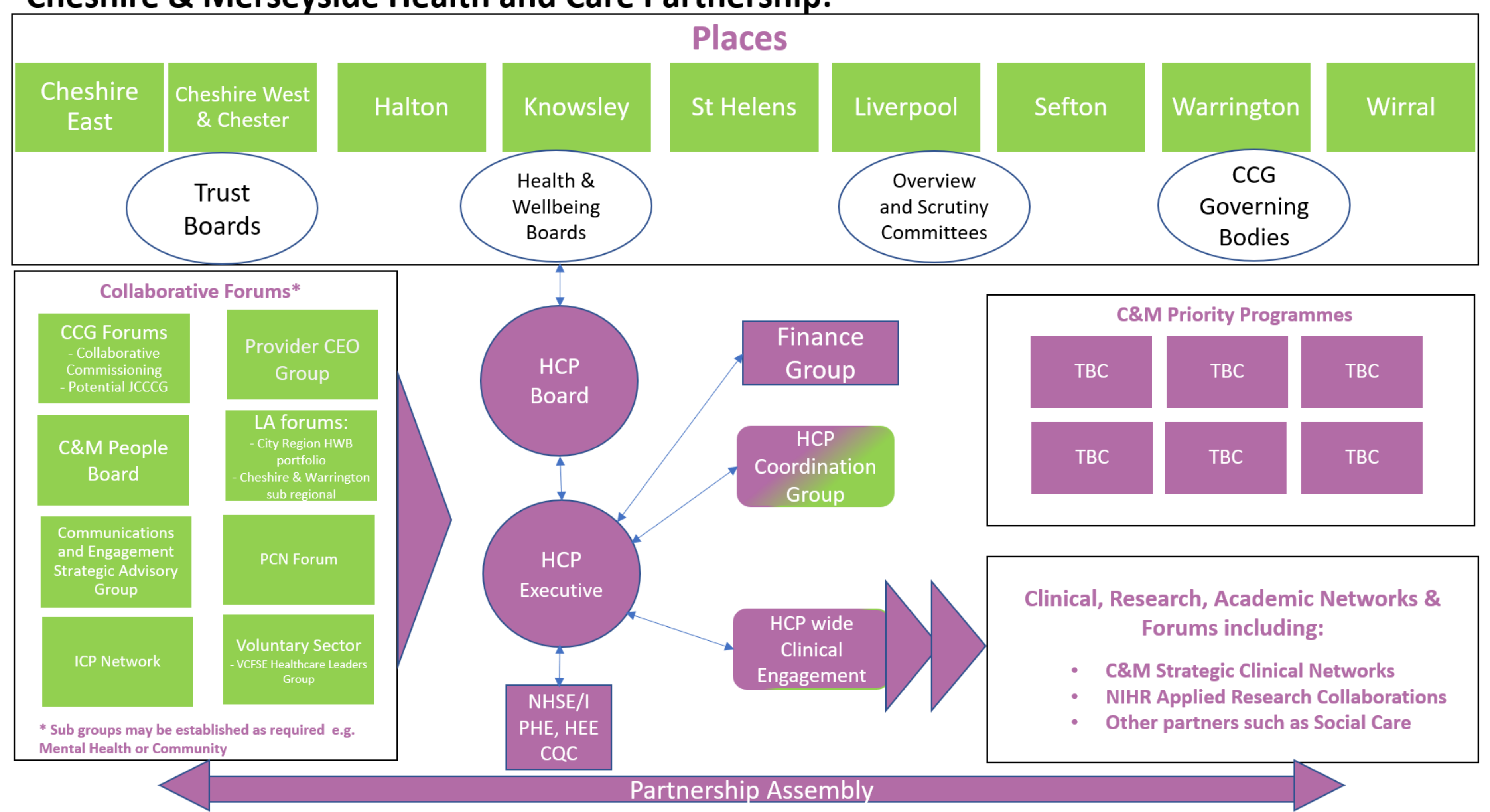
Other Local Bodies

- 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



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.

1. 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.

2. 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.

3. 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.

4. 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

5. 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.

6. 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.

7. 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.

8. 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 co-ordinating 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.

9. 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 and Rescue Service	Edge Hill University
Cheshire Police	Merseyside Fire and Rescue Service
Cheshire West Voluntary Action	Merseyside Police
Healthwatch Cheshire	CPS Mersey-Cheshire
Manchester Metropolitan University	NW 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	

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

Annex 6 – Partnership Board Membership

i. A representative from each of our nine Local Authority areas within the ICS footprint.

ii. A CEO and a Chair representing acute providers

iii. A CEO and a Chair representing mental health and community providers

iv. A CEO and a Chair representing specialist providers

v. Two Primary Care Network representatives. Assumed elected or nominated via the Primary Care Network Forum

vi. A CCG Accountable Officer

vii. A CCG Clinical Chair

viii. A Public Health representative

ix. A VCSE representative

x. An NHSE/I representative

xi. From the Partnership, itself, it is proposed that the Chair, Chief Officer and up to 3 executive director posts will be full or voting members of the Board. Other directors will attend.

The above Partnership Board membership provides for the envisaged future form reflecting when the ICS has assumed statutory powers.

The Partnership is progressing dialogue with CCG's regarding representation, through 2021/22, reflecting an anticipated transition year.

Date: 02 March 2021

Dear Colleagues,

Partnership Memorandum of Understanding (MoU)

You will know I wrote to you early last month to update you on the outputs of our MoU engagement through December and January and informing you of the recommendations and next steps agreed at our January Partnership Board meeting.

One of the actions we committed to taking forward and defining in the short term was appropriate transition arrangements covering the year ahead. In particular, for CCGs, recognising the current statutory roles and responsibilities within our system.

Following positive discussions, I want to update you on the conclusion of this dialogue and the agreements reached by the Partnership Board, in supporting the 2021/22 transition year, at its meeting on 24 February:

- Extend membership to all CCG Chairs - Responding to the need for greater local NHS perspectives in our discussions. A development which will also assist the Board by providing for some lay/independent involvement and a wider clinical voice
- Maintaining the current position of a Chair and Accountable Officer representative of CCGs
- That in keeping with the commitment provided in January these arrangements will be reviewed within six months of their introduction
- The Board agreed to introduce these arrangements from 1st June. This will support a smooth transition but will also follow local government elections now confirmed for 6th May.

All of the above has reference to and provides for some small supplementary updates to our MoU, as we committed to do, at Appendix 6 only. Accordingly, I have provided an updated Appendix 6 attached to this correspondence should you wish to make an addendum to the document already circulated. You will note that we alluded to this change in version 8 of the MoU as circulated and which, I know, is already in the process of being signed up to.

I have confidence that these arrangements will support and assist the partnership, making best use of our shared knowledge and experience during this transition year, as we respond to the challenges and system development needs that have now been described in the Government's White Paper and which include projections that we will need to develop both a Partnership and an NHS Board for Cheshire and Merseyside.

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As we prepare to embark on the next step of this shared journey, I want to place on record my thanks and gratitude to the outgoing Board, both for their contributions but also for supporting this proposal.

I also want to recognise and thank those of you that have been feeding back and providing commitment to or directly signing up to the MoU. I look forward to hearing from all of you on your progress by 12 March.

Should you wish to discuss this further Ben Vinter remains available as a resource to support your discussions and Jackie Bene and Alan Yates also remain available to discuss with senior leaders as needed.

Finally, let me direct your attention to Partnership microsite:

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

Regards

Alan

Alan Yates
Chair, Cheshire and Merseyside Health and Care Partnership

Enc:

- Updated – MoU Annex 6

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Annex 6 – Partnership Board Membership

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iv. A CEO and a Chair representing specialist providers

v. Two Primary Care Network representatives. Assumed elected or nominated via the Primary Care Network Forum

vi. A CCG Accountable Officer

vii. A CCG Clinical Chair

viii. The Chairs of each system CCG providing community, place and clinical perspective

ix. A Public Health representative

x. A VCSE representative

xi. An NHSE/I representative

xii. From the Partnership, itself, it is proposed that the Chair, Chief Officer and up to 3 executive director posts will be full or voting members of the Board. Other directors will attend.

The above Partnership Board membership provides for both the envisaged future form reflecting when the ICS has assumed statutory powers and acts as a bridge, through 2021/22, reflecting an anticipated transition year.

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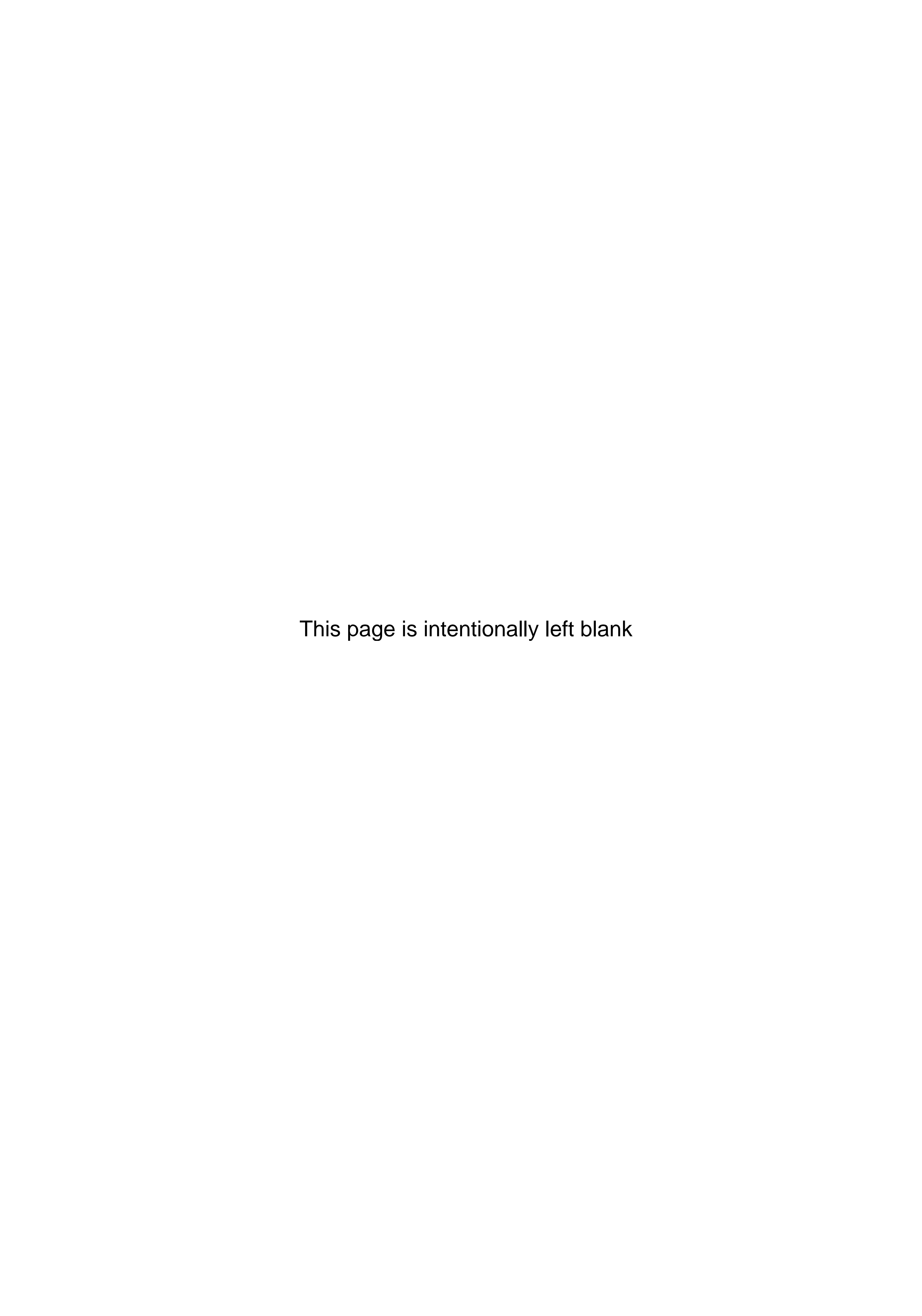
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Councillor Ian Maher
Councillor Ian Moncur
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L20 7AE
0151 934 3361
ian.maher@sefton.gov.uk
ian.moncur@sefton.gov.uk
Date: 2nd March 2021
Our Ref: IM/LP/MOU

Ben Vinter (NHS NEL CSU)

Via email: ben.vinter@nhs.net

Re: Cheshire and Merseyside Health Care Partnership Response to the updated Draft Memorandum of Understanding

Thank you for communicating the updated draft Memorandum of Understanding on the 2nd February 2021. We understand that the March board of the Health Care Partnership wish to receive an update on the intention of partners in respect of approval of the MOU, and that you require notification of intention and progress within our organisation by no later than 12th March.

The next available Cabinet meeting where there will be an opportunity to have a formal discussion on the MOU will be held on the 1st April 2021.

In advance of the 1st April, Cabinet Members have met to discuss the latest draft and we can confirm that Cabinet will be recommended to support the latest iteration of the MOU and in addition we wish to stress that ongoing support will be contingent on the following:

- The commitment to a six-month review of the MOU and confirmed Board membership for each of the 9 local government elected representatives is welcomed. However, we would wish to see a commitment to a further review at 12 months aligned to the introduction of the proposed legislative changes and the demise of the Clinical Commissioning Groups. This is because the structural and policy impact is significant and we feel a further review, as the new system starts to embed, is necessary to offer assurance to the Council.

- The Council would also wish to request further consideration is given to the issue of voting rights on the Board. It is noted that the proposed MOU states that voting rights be applicable to 3 members only, the Council would wish to express that the Partnership consider full voting rights for all members.

We would like to request clarification on the following legal issues: -

- Although the MOU recognises the role of Overview and Scrutiny Committee function, it does not detail how this will be taken forward. Further information on regular reporting mechanisms is required.
- The Assembly is referenced as a 'democratic forum'; however, this is misleading as it is not constituted as such. We would recommend that the terminology is clarified or indeed reviewed.
- Page 26 of the document refers to the Europeans Communities Act 1972 which has been repealed. This will require amendment.

In conclusion, the Cabinet on behalf of the Council will be recommended to support the principles laid out in the MOU and will expect full engagement in the emerging new arrangements. As stated, the Council's ongoing support is subject to the clarifications outlined above. We also wish to reinforce the importance on our Sefton Borough, and the opportunity to work together to improve the Health and Wellbeing of Sefton resident.

Yours sincerely,

Councillor Ian Maher
Leader of Sefton Council

Councillor Ian Moncur
Cabinet Member for Health and Wellbeing

sefton.gov.uk

Search 'Sefton Council'

Report to:	Cabinet	Date of Meeting:	1 April 2021
Subject:	Southport Town Deal – Heads of Terms		
Report of:	Executive Director (Place)	Wards Affected:	Ainsdale; Birkdale; Cambridge; Dukes; Kew; Meols; Norwood;
Portfolio:	Cabinet Member - Regeneration and Skills		
Is this a Key Decision:	Yes	Included in Forward Plan:	Yes
Exempt / Confidential Report:	No		

Summary:

Report to update Cabinet on the Southport Town Deal, and the Town Investment Plan which was submitted to government at the end of October 2020, and to seek approval for Sefton Council to agree non-binding Heads of Terms in advance of business case development for the projects identified therein.

Recommendation(s):

Cabinet is recommended to:

(1) approve finalisation of the non-binding Heads of Terms, as accountable body for the Town Deal;

(2) delegate agreement of those Heads of Terms, once finalised by the Town Deal board, to the Chief Executive, in consultation with the Cabinet Member for Regeneration and Skills;

(3) note the time scales and next steps for project confirmation and business case development;

(4) delegate business case development for the projects to the Executive Director (Place), in consultation with the Cabinet Member for Regeneration and Skills; and

(5) note that business case approval for each of the projects taken forward will be brought for Cabinet and Council approval on a project-by-project basis, in accordance with the Councils Financial Procedure Rules.

Reasons for the Recommendation(s):

Southport was one of 101 towns identified as potential recipients of Town Deal funding, for which a bid submission and Town Investment Plan (TIP) was required. The process requires leadership of a Town Deal Board, with a private sector Chair, but the Council is required to undertake the role of Accountable Body for the bid, and for the subsequent

negotiation of Heads of Terms, agreement of the Town Deal, and to be the organisation through which funding will flow.

These recommendations enable finalisation of those Heads of Terms with government, in advance of the detailed project development process.

Alternative Options Considered and Rejected: (including any Risk Implications)

The alternative of not agreeing to the Heads of Terms, and not undertaking the role of Accountable Body for the Town Deal is rejected given the significance of the funding, the quality and quantity of projects identified and the importance of such funding to economic recovery in Southport given the impact of the COVID-19 pandemic on the town and its economy.

What will it cost and how will it be financed?

(A) Revenue Costs

No revenue costs are anticipated with the agreement of Heads of Terms. Project costs will be brought to Cabinet in accordance with Council financial procedure rules.

(B) Capital Costs

No capital costs are associated with the agreement of Heads of Terms. Project costs will be brought to Cabinet in accordance with Council financial procedure rules.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): Currently resource (people) implications are being managed within the current Council resource envelope and prioritising work as required. When required due to capacity shortfall external resources are considered and used, with external expertise procured where beneficial to the Town Deal board. Upon completion of negotiations and agreement of a final set of projects all revenue and capital financial implications will be reported to future meetings of Cabinet and Council in accordance with the Councils Financial Procedure Rules.
Legal Implications: There are no legal implications associated with agreement to the non-binding Heads of Terms.
Equality Implications: There are no equality implications associated with agreement to the non-binding Heads of Terms. The Town Deal process has consulted and communicated widely in advance of, and since, the bid, and all projects developed will ensure equality and accessibility for all. Details will be provided within the individual project business cases.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Given the impact of Covid-19 on Southport's economy and its key sectors, the Town Deal should support recovery and projects that deliver the creation of new employment opportunities across the town.
Facilitate confident and resilient communities: The Town Investment Plan is community focussed and the way forward being substantiated by extensive local community consultation, including the voice of the youth gathered in collaboration with local schools and colleges. The Projects are driven to enhance the community and the town as a place to live and work.
Commission, broker and provide core services: The Town Deal and associated TIP will support the core value of providing core services in the optimum way, making best use of digital now and future proofing with services at the front of delivery.
Place – leadership and influencer: The Council will directly contribute to an improved visitor destination creating further confidence in Southport that could lead to further private sector investment.
Drivers of change and reform: Providing a long-term sustainable future for Southport creating a new diverse use meeting the expectations of residents and visitors. Making Southport an increasingly attractive place to live and work and embrace the needs of current and future residents and visitors.
Facilitate sustainable economic prosperity: The proposals will support new business start-ups, and help established businesses to create additional employment and sustainable business growth.
Greater income for social investment: The Town Deal will support the generation of income that can support the delivery and enhancement of positive social impact.
Cleaner Greener: All projects in the Town Investment Plan will establish the best accepted build criteria and follow current best guidance and standards and will contribute to Sefton's objectives in respect of environmental sustainability.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director Corporate Resources and Customer Services (FD.6347/21) and Chief Legal and Democratic Officer (LD.4548/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Extensive external consultation and engagement took place throughout the bid development process, in line with the advice from of Sefton's Public Engagement and Consultation Panel. Digital and online communications and engagement has successfully been maximised in light of the restrictions posed by Covid-19 on face-to-

face engagement.

Implementation Date for the Decision

Following the expiry of the "call-in" period for the Minutes of the Cabinet Meeting

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Appendices:

There are no appendices to this report.

Background Papers:

The following background papers, which are not available elsewhere on the Internet can be accessed on the Council website:

http://smbc-modgov-03/mgCommitteeDetails.aspx?ID=881

1. Introduction and Background

1.1 Southport is one of 101 towns across the country that was invited to bid for up to £50 million in funding as part of the Government's Towns Fund. To secure a share of this funding, in line with the guidance, a Town Deal Board has been established and a Town Investment Plan (TIP) was submitted in October 2020.

1.2 The TIP provides a long-term vision for Southport to 2050, identifying potential projects that will help to improve the town in the short, medium and long term and support the delivery of innovative regeneration plans,

1.3 The objective of the Town Deal Fund is to drive the economic regeneration of towns to deliver long term economic and productivity growth through:

- Urban regeneration, planning and land use
- Skills and enterprise infrastructure
- Connectivity

1.4 The cabinet report approved in October 2020 set out in detail the steps taken by the council and the Town Deal Board up to the point of the submission of the Town Investment Plan. As recommended in that report the submission of the bid and Town Investment Plan was delegated to the Cabinet Member for Regeneration and Skills, and the Executive Director (Place), for submission at the end of October 2020 on behalf of the Town Deal Board.

2. Funding Announcement and Heads of Terms

2.1 In the government's budget, published on 3rd March 2021 it was confirmed that Southport has been offered a Town Deal up to the value of £37.5 million. MHCLG have advised that the higher funding offer (above £25 million) is in recognition of the case that Southport has made for the regional and national significance of its proposals.

2.2 An offer letter for the Town Deal were also issued on 3rd March, with a requirement to be signed and returned by 17th March 2020. The signatories of the letter are the Chair of the Town Deal Board, Chief Executive of the council and the MHCLG Secretary of State.

2.3 The Heads of Terms are not contractually binding, and the offer is subject to certain conditions being met. The Heads of Terms, to be finalised by 10th May 2021, set out the following:

The commitment:

- The Heads of Terms will act as a Memorandum of Understanding for the future development and delivery of Southport's Town Investment Plan and project proposals. It sets out joint expectations as Southport enters the business case development phase (a 12-month phase.)
- That we will prioritise the projects included in the TIP within the funding envelope being offered.
- Funding for individual projects will be subject to successfully completing Phase 2 of the Towns Fund process. This includes detailed project

development and business case assurance at local level.

Process, governance and assurance:

- Local partners will work with government to demonstrate the feasibility, viability and value for money of their projects by developing and submitting the Town Deal Summary Document which will include:
    - A list of agreed projects
    - Details of business case assurance processes followed for each project
    - An update on actions taken in relation to the Heads of Terms key conditions and requirements
    - A Delivery Plan (including details of the team, working arrangements and agreements with stakeholders)
    - A Monitoring and Evaluation Plan
    - Confirmation of funding arrangements and financial profiles for each project
    - Undertaking Public Sector Equalities Duty analysis
    - Approval from the Town Deal Board and Lead Council

2.4. The Heads of Terms state that we should confirm in writing the projects being taken forward within two months of accepting the offer (by 10th May 2021).

2.5 Business cases must then be completed and a summary document submitted, within 12 months of the deal being agreed. Once approved by MHCLG and assuming the conditions have been met, the funding will be released.

2.6 The assurance process for business case and project approval will be in line with Sefton Council's assurance process, with oversight from the Town Deal Board. Project Business cases will be Green Book compliant.

2.7 If the town wishes to alter or change the projects being developed or make other changes on the conditions set out in the Terms then it must be presented to the Towns Hub partners, with clear justification and evidence.

3.0 Management and governance

3.1 The management, governance and delivery of Southport's Town Investment Plan will require the ongoing oversight provided by the Town Deal Board. As the accountable body, Sefton Council will retain responsibility for the delivery of the programme. Project management and delivery will continue to be provided by the Council. Specific project business cases will be brought to Cabinet as required in accordance with Council financial procedure rules.