



Report Cover Sheet

Report to:	Trust Board	
Date of the Meeting:	24 February 2021	
Agenda Item:	P1-029-21	
Title:	Cheshire and Merseyside Partnership Memorandum of Understanding	
Report prepared by:	Angela Wendzicha	
Executive Lead:	Liz Bishop, Chief Executive	
Status of the Report:	Public	Private
	X	

Paper previously considered by:	Not Applicable
Date & Decision:	Not Applicable

Purpose of the Paper/Key Points for Discussion:	<p>During December 2020, discussion and engagement was carried out in by Cheshire and Merseyside Health and Care Partnership in relation to a proposed Partnership Memorandum of Understanding. This also coincided with the consultation published by NHSI/E on Integrated Care Systems.</p> <p>The attached documentation and Memorandum of Understanding has been provided for discussion and with a recommendation the Trust supports the adoption of the updated Memorandum of Understanding as proposed by the Cheshire and Merseyside Health and Care Partnership.</p>
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Action Required:	Discuss	X
	Approve	X
	For Information/Noting	

Next steps required	
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The paper links to the following strategic priorities (please tick)

Deliver outstanding care locally		Collaborative system leadership to deliver better patient care	x
Retain and develop outstanding staff		Be enterprising	
Invest in research & innovation to deliver excellent patient care in the future		Maintain excellent quality, operational and financial performance	

The paper relates to the following Board Assurance Framework (BAF) Risks

BAF Risk	Please Tick
1. If we do not optimise quality outcomes we will not be able to provide outstanding care	
2. If we do not prioritise the costs of the delivering the Transforming Cancer Care Programme we will not be able to maintain our long-term financial strength and make appropriate strategic investments.	
3. If we do not have the right infrastructure (estate, communication & engagement, information and technology) we will be unable to deliver care close to home.	
4. If we do not have the right innovative workforce solutions including education and development, we will not have the right skills, in the right place, at the right time to deliver the outstanding care.	
5. If we do not have an organisational culture that promotes positive staff engagement and excellent health and well-being we will not be able to retain and attract the right workforce.	
6. If we fail to implement and optimise digital technology we will not deliver optimal patient outcomes and operational effectiveness.	
7. If we fail to position the organisation as a credible research partner we will limit patient access to clinical trials and affect our reputation as a specialist centre delivering excellent patient care in the future.	
8. If we do not retain system-side leadership, for example, SRO for Cancer Alliance and influence the National Cancer Policy, we will not have the right influence on the strategic direction to deliver outstanding cancer services for the population of Cheshire & Merseyside.	X
9. If we do not support and invest in entrepreneurial ideas and adapt to changes in national priorities and market conditions we will stifle innovative cancer services for the future.	
10. If we do not continually support, lead and prioritise improved quality, operational and financial performance, we will not provide safe, efficient and effective cancer services.	

Equality & Diversity Impact Assessment		
Are there concerns that the policy/service could have an adverse impact on:	YES	NO
Age		X
Disability		X
Gender		X
Race		X
Sexual Orientation		X
Gender Reassignment		X
Religion/Belief		X
Pregnancy and Maternity		X

If YES to one or more of the above please add further detail and identify if a full impact assessment is required.

Date: 2 February 2021

Dear Colleagues,

Partnership Memorandum of Understanding (MoU)

You will recall I wrote to you in early December inviting discussion, engagement and feedback on our draft MoU. I want to thank all of you for your largely positive and constructive engagement in this dialogue.

Our review of the Partnership's MoU coincided with the publication of NHSE/I consultation on Integrated Care Systems. The MoU is not designed to respond to the points raised in the NHSE/I consultation which provide us with a number of discussion points and areas to explore, together, over the coming period. Our MoU provides a foundation and shared understanding from which to start this exploration.

By adopting the MoU we aim to:

- Document the Partnership's current arrangements
- Provide clarity on our starting point and a foundation to those engaged within the Partnership but also our stakeholders
- Set out the Partnership's vision, mission, aims and values
- Detail the Partnership's developing governance arrangements
- Provide assurance to partners and NHS oversight bodies on our direction of travel and intentions

We discussed the MoU and feedback at our Board meeting on 27 January. To support wide engagement and full understanding of the issues raised, considered and the suggested way forward I have provided you with a copy of the paperwork we considered.

A number of significant points of note were put forward through our engagement on the MoU and during our preparation for ICS designation. It is unlikely the MoU will ever be the right vehicle for addressing all such points. I have therefore enclosed an annex which sets out a number of areas of work and describes how the Partnership will progress these areas or support dialogue. My expectation is that this approach will provide you with clarity on the way forward and identify where it is not possible to provide definitive answers, now, while also retaining the clarity and purpose of the MoU.

A smaller number of points warrant fuller explanation and clarification on the way forward as follows:

- The Partnership committed to reviewing the MoU after a period of not more than 6 months into the next financial year
- Discussions will continue on the best way to secure appropriate Primary Care representation and engagement at the Partnership Board. However following feedback and discussion at the Board we propose that to support the importance of effective representation Primary Care will, going forward as now, have two positions on the Board when nominated or elected
- It is recognised that the membership of the Partnership Board - set out at Annex 6 of the MoU - describes our aspiration and expectation over time for Board membership as the Partnership moves towards ICS statutory responsibilities. Discussions will take place with CCGs, shortly, to explore and define appropriate transition arrangements covering the year ahead. Recognising the current statutory roles and responsibilities within our system. Discussions will also commence with Local Authority colleagues about how and when we establish the proposed political representation on the Board
- We have sought to enhance the wording of the MoU to reflect our commitment to social value and social responsibility, our carbon reduction intent and references to inequalities and the breadth of linkages across the partnership (housing and education etc).

My hope is that you will receive this correspondence and provide your support by adopting the updated MoU. In doing so I know you will recognise the status and intent of the MoU as a platform to build from, acknowledge the complimentary but distinct work that will be initiated by the Partnership to support the wider development of how we work together.

I propose that the March Board receive an update on the intention of partners in respect of approval of the MoU and I would therefore ask for notification of your intention and progress within your organisation by no later than 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.

Our system is interwoven, mutually dependent and complex. Through alignment and a tight focus on priorities in *Place* together with working at scale when it benefits the public we can make a genuine positive difference to everyone in Cheshire and Merseyside having a great start in life, and getting the support they need to stay healthy and live longer.

Finally, let me direct your attention to Partnership microsite:

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

Regards



Alan Yates
Chair, Cheshire and Merseyside Health and Care Partnership

Enc:

- Annex one – Summary of actions, commitments or offers from the Partnership
- HCP Board Report – Memorandum of Understanding – Comments from partners
- MoU v8

Annex one

Summary of actions, commitments or offers from the Partnership

Further to discussions at the Partnership Board on 27 January 2021 the below sets out how a number of important matters will be developed as the Partnership matures as an emerging ICS primarily relating to engagement, development or interactions across Cheshire and Merseyside.

The areas detailed are not included in the MoU because this is either not the right place for such matters to be recorded, as work needs to take place across the partnership in some areas, or because we are not yet sufficiently clear on the statutory frameworks we may have to work within.

Accordingly a number of areas of work will be initiated by the Partnerships' executive, alongside partners, as follows:

1. The Partnership's Development Plan through 2021/22 will include work to define, develop and explore implementation of:
 - ICS Architecture: Assurance & Transformation which may include further development of mutual accountability in practice in Cheshire and Merseyside
 - System governance
 - A refreshed approach to programme delivery – including a focus on outcomes and clarity of objectives
 - Consistent ambition and progress in Place / ICP Development
 - Leadership Capacity & Capability – ensuring leadership across all areas of vertical and horizontal integration and developing and embedding assurance capability
 - Streamlined Commissioning – Establishing a fully functioning JCCCG and the expected integration between collaboratives and the Partnership
 - System Plans – Maximising alignment between place and system plans. Ensuring critical enabling infrastructure plans are well developed in areas such as Estates, Capital and Digital
 - Provider collaboratives – Delivering our roadmap for establishment of provider collaboratives detailing the purpose, form, leadership and governance requirements
 - Partnership working and collaboration (especially with local government colleagues)
 - HCP communications and engagement
 - Delivering NHS performance and assurance oversight

- Workforce Transformation and Planning
2. Development of terms of reference, for HCP groups or forums, which will provide more clarity on their interrelationship and accountabilities. This piece of work will include the redefinition of the role of the Partnership Coordination Group no later than August 2021
 3. That definitions and arrangements for clinical leadership in new systems and ways of working form an early piece of work to be considered by both the emerging Provider Collaborative and our ICP Forum
 4. That our ICP Forum consider whether any specific measures or steps are needed to maximise the role, value and contribution of Health and Wellbeing Boards, consistently, in our systems
 5. That a number of related potential roles or expectations for ICP or Places be explored via our ICP Forum or ICP's themselves:
 - Use and applicability of VCS Compact
 - How place delegations will be exercised / granted and how escalations should occur to the Partnership Board. In keeping with a response to our engagement we recognise the outcome of this work will likely have an influence on who and which organisations need to be represented in which forums and groups
 6. That discussions continue with partners on the basis of developing a Political Assembly a part of the Partnership's established governance
 7. The Partnership has formally recorded a number of legitimate queries and areas requiring exploration on how statutory arrangements and interlinkages might work in future – while we can discuss this and like issues we recognise we may only fully know the requirements we will need to work toward when and if legislation is brought forward. The same position is true around how and when an ICS, once established, might be required to trigger action plans or manage any disputes.

Memorandum of Understanding

Comments received from partners

Report To:	Cheshire and Merseyside Health and Care Partnership Board
Date of Report:	27/01/21
Report Author(s):	Ben Vinter
Purpose:	<p>Provide the Board with:</p> <ul style="list-style-type: none"> • An update on feedback from consultation on the MoU with partners • Recommendations on the approach to this feedback • Opportunity for the Board to provide guidance on the next steps and timescales
Recommendation(s):	<p>That the Board give consideration to the points raised in response to the circulated MoU and support the recommendations for response or progress of actions as detailed in section 3. Noting the recommendations fall into two broad categories:</p> <ul style="list-style-type: none"> • Imminent action / amendment supporting final drafting • Medium / longer term actions which may be incorporated in future versions of the MoU <p>The Board support and propose the adoption of MoU by the Partnership as an accurate and timely description of the Partnership and its present ambition.</p>

1. Context

In drafting the Memorandum of Understanding (MoU) the aim was to respond to the challenge set by the Partnership Assembly in autumn 2020 to provide:

- Clarity on the way the partnership works and aspires to work in the future - striking the balance of achieving strategic vision while remaining in touch with local variation
- Enhanced recognition of Place including providing a framework for an increased proportion of Local Authority membership,
- Clarity on the role of the Partnership – a convenor of the Cheshire and Merseyside health and care system.



When drafting and discussing the MoU the Board and the majority of our partners recognised that the Partnership is, currently, at a particular point in its development. From here there is more for us to do in describing our arrangements, for example, over the next immediate period developing terms of reference but also over a longer timeframe and with more complex engagement to continue our development and co-production. This means some of the work we now need to do and our response to some feedback will continue through 2021/22, and beyond, as we agree the arrangements that will work for our system.

This version of MoU and its hopeful adoption, imminently, is the start of this discussion and journey, not the end point.

Accordingly, at this time, the MoU's ambition was deliberately limited to:

- Documenting the Partnership's current arrangements
- Providing clarity on our starting point and a foundation to those engaged within the Partnership but also our stakeholders
- Setting out the Partnership's vision, mission, aims and values
- Detailing the Partnership's developing governance arrangements
- Providing assurance to partners and NHS oversight bodies on our direction of travel and intentions

The recent publication by NHSE/I of its consultation – Integrating Care: The next steps to building strong and effective integrated care systems across England – coincided with our circulation of the MoU which had been sometime in the drafting. To some extent this was fortuitous as the publication began to describe a set out options and choices that will shape our future direction of travel. However the publication of an NHSE/I consultation should not be confused with the value, purpose or intent of the MoU. The MoU is not designed to respond to the points raised in the NHSE/I consultation rather their publication starts a description of supplementary choices and challenges we now need to work through, together, for which our MoU provides a foundation and shared understanding from which to start.

At the time this work was initiated and through discussion with the Partnership Board in November and December you recognised and agreed that the MoU represented a first step, that it would iterate both from this draft following consultation but also that it would need to evolve and develop through 2021/22 as, for example, we define what common expectations we have for Places or as our Providers explore what provider collaboration means within a Cheshire and Merseyside context.

2. Feedback

General

A broad range of partners particularly from local authorities, providers and the voluntary sector saw value in the MoU as providing a foundation and in setting out our ambition, aims and values clearly stating the ethos of collaboration and partnership, and the significant emphasis on primacy of Place.

NHSE/I consultation and potential future changes

A number of partners recognised that as NHSE/I thinking evolves and policy develops, over the coming period, there will be more clarity that the Partnership and in turn the MoU or other system frameworks need to explore with stakeholders and ultimately define by agreement.

More definition and detail on next stage developments – governance, assurance and system architecture

A number of Partners, in particular Place representatives, requested further clarification on areas we know represent a programme of work that needs to be progressed, together, through 2021/22 namely more detail and definition of:

- Governance arrangements and linkages between groups both at a Partnership level and throughout the partnership
- Accountability and any relevant performance frameworks
- How Place fits within and works with the ICS

A number of responses, particularly from local authorities and NHS providers, sought clarification on the scope and nature of streamlined commissioning and the way in which one CCG will work in our system. This line of enquiry is understood but the Board is reminded that the CCGs in Cheshire and Merseyside have begun to define the issues they see current value in working together on, at scale, from a commissioning perspective and that more details on the way forward are likely to emerge from the outcome of NHSE/I's consultation in due course.

Representation

A number of colleagues requested clarification on representation and membership of groups including HCP Board representation. The Board will recall that we were clear in the MoU that this is an area of work, across the Partnership's apparatus, that we need to initiate during quarter four of 2020/21 and it should welcome recognition that this work now needs to be progressed. A number of responses also requested greater detail on the scope and membership of the Partnership Assembly.

The Board will be aware that work is ongoing among providers across our system to define and scope their work whether this be through Provider Collaboratives or the emerging Primary Care Network Forum. The Board will recognise that one of the outputs of this work will be to reflect these groups equally critical role in the work of the Partnership including through representation.

Clinical Leadership

A number of colleagues also fed back on the need to be clearer on the role and place for clinical leadership and involvement. The Board should recognise this is work that needs to be done and to an extent, at a Partnership Board level, this will link to and be influenced by the work referred to directly above. However the system must also await NHSE/I proposals in respect of the future of CCGs and how and if membership is specified.

The significant value of local and Place based working for clinical voice, across all professions, but also democratic input already commonly secured should also be acknowledged.

Delivery and outcomes

Some responses requested more detail on what the Partnership will deliver and how. The importance of this task is understood and needs to be worked on, together, across the Partnership but there remains a question of if an MoU is the best place to describe such detailed areas of work.

The Partnership's Development Plan defines, at a high level, a number of significant areas of work which HCP and partners need to progress, together, this includes a focus on ICS level programmes but also a number of areas related to system plans and capability as called for by partners in their responses. Such work should include clearer definition of outcomes,

maximise common understanding of the Partnership's aims and metrics where appropriate in line with the feedback provided by partners.

Health and Wellbeing Boards

A number of colleagues called out the role of Health and Well Being Boards (HWB). The MoU sought to recognise this role and the Partnership is committed to Place based working including current forms of partnership working, collaboration and oversight. The Board should be conscious that matters such as linkages between Place based arrangements and their development with or through HWBs needs to be co-created across the partnership, link to thinking on the role and development of Integrated Care Partnerships and to an extent be proposed by the convenors of those Boards.

Local Authorities

Some responses queried the notion of a local authority lead role in the Partnership. While the Board will recognise there is more to work to do in this area, not least in respect of any legislation that may be brought forward by the government, the Board has previously been clear that the role and nature of an ICS requires a fundamentally different way of working. Local authorities alongside all system partners should and do have lead roles in ICS working.

In response to the request for feedback on the MoU a number of local authorities responded and took opportunity to advise the Partnership of the Liverpool City Region view on the NHSE/I consultation calling for:

- *A new statutory reciprocal duty of collaboration to improve population health and address health inequalities on all NHS organisations and local authorities;*
- *A legal requirement on ICSs to involve Health and Wellbeing Boards (HWBs) in the development of plans and to devolve the development of place or locality plans to HWBs;*
- *A new power for HWBs to “sign off” on all ICS plans;*
- *Arrangements for commissioning to continue to have a strong place-based focus, with a strong and proactive role in HWBs in approving commissioning plans; and,*
- *A statutory duty on ICSs to be accountable to their local communities through existing democratic processes.*

The DASS perspective to the NHSE/I proposals was also shared with us and provided feedback in the following areas:

- *Primacy of Place is paramount; “place” being each local authority area;*
- *Each local authority “place” must be represented in future governance arrangements for the Cheshire and Merseyside ICS;*
- *The agreed governance for Cheshire and Merseyside at “system” and at “place” level must address historic democratic deficits in NHS governance;*
- *There should be formal recognition of Health and Wellbeing Boards as the strategic decision-making bodies for ICPs in each “place”, given that they are already best positioned to support improved outcomes in the wider determinants of population health; and,*
- *There should be formal assurance that budgets will be devolved to “place”, and that any and all residual budgets to be retained at Cheshire and Merseyside level will be agreed in advance by each “place”.*

The above points are interesting areas of debate and discussion but are not matters that can all be addressed by the MoU. The Partnership makes a continued commitment to work



inclusively, collaboratively and to co-create solutions that work for Cheshire and Merseyside. We also acknowledge that the Partnership is not, at this time, a statutory body and we await NHSE/I feedback to its consultation. However the Board will recognise the challenge put forward and feels strongly about local representation and connections across systems. To that extent proposals are contained within the recommendations section which seek to provide for enhanced and clearer representation responding to the ambition described.

Since the time when the MoU was circulated the Chair and Chief Officer have been continuing their engagement with local authorities and discussing the role a Political Assembly, elected representatives and local authorities can and should play through the partnership and at a Partnership Board level. These points are addressed in the recommendations section.

Patient and Public Engagement

Some suggestions have been received that the Partnership can and should place greater emphasis on patient and resident engagement. In particular there was a suggestion that we should place the patient and public at the centre of 'our integrated, system approach to collaboration'. It is suggested that the Board support this welcome emphasis.

Feedback has also suggested that the MoU should make greater recognition of the way the Partnership either does or aspires to engage with patients and the public. It is suggested given the current status of the ICS that the current balance, described between existing statutory organisations and the Partnership, is appropriate. The Board may, however, wish to encourage even stronger emphasis in this area, to ensure patient and public engagement forms a core part of the system's development plan and will wish to remain mindful on both the legislation and the right thing to do in this area as and if changes are brought forward.

Health inequalities and wider determinants of health

A number of comments received related to the extent to which the Partnership can address matters beyond what might traditionally be considered the focus of health and care. Suggestions and emphasis on these points get right to the very heart of what the Partnership hopes and expects to achieve:

- Tackling health inequalities and improving lives needs new partnerships that 'liberate the potential' in people. It will be important the Partnership is not just co-ordinating existing health and social care organisational support e.g. education, housing, business, industry and enterprise
- Social responsibility, the response to inequalities and the role of anchor institutions could be more explicit in the MOU
- The wider role of other partners in achieving health and wellbeing outcomes that look at a 'whole person approach' could be described in the MOU

Innovation

It was suggested that the MoU should reference the Partnership's potential to innovate.

Climate Change

It was suggested that the MoU should reference the Partnership's contribution and commitment to tackling climate change.

Digital and data

It was suggested that the MoU should reference the Partnership's contribution and need for system level work programmes to address the health and wellbeing needs of the C&M population, which are data led, using data intelligence and associated measurement will need to inform the Partnership level programme prioritisation and determine progress.

3. Recommendations

In response to the themes summarised above and the significant amount of feedback that was received in response to the request for engagement in the Partnership's Memorandum of Understanding it is recommended that the Board:

- A. Recognise and acknowledge the broadly positive nature of the responses supplied
- B. Thank all system contributors for their engagement
- C. Acknowledge the status, place and timing of the MoU as a foundation in the Partnership's development. Agreeing that it is not, was not intended to be and cannot expect to be the complete word on partnership working, system integration, or Cheshire and Merseyside health and care
- D. Acknowledge that over the next quarter work will be progressed, in partnership, which begins to define some of the issues raised through this engagement. For example, terms of reference and the redefinition of the role of the Partnership Coordination Group which it may be appropriate to be appended to future versions of the MoU. However other, more significant bodies of work, such as ICP development or programme design and delivery will need to be developed and potentially referenced in future versions of this document but may never appropriately form part of it
- E. Commit to a full review of the MoU being initiated by 31/3/22 or following the implementation of any legislation by government related to integrated care systems

Turning to the more specific themes arising from the consultation it is recommended that the Board:

- F. Recognise and acknowledge the areas of work that will be progressed, collaboratively, and which form part of the Partnership's Development Plan through 2021/22 covering the following areas:
 - Developing and enhancing ICS Architecture: Assurance & Transformation
 - Review and refine system governance
 - Implement a refreshed approach to programme delivery
 - Support consistent ambition and progress in Place / ICP Development
 - Leadership Capacity & Capability – ensuring leadership across all areas of vertical and horizontal integration and developing and embedding assurance capability
 - Streamlining Commissioning – Establishing a fully functioning JCCCG and the expected integration between collaboratives and the Partnership
 - System Plans – Maximising alignment between place and system plans. Ensuring critical enabling infrastructure plans are well developed in areas such as Estates, Capital and Digital
 - Provider collaboratives – Delivering our roadmap for establishment of provider collaboratives detailing the purpose, form, leadership and governance requirements.
 - Partnership working and Collaboration (especially with local government colleagues)
 - Communications and Engagement
 - Delivering NHS performance and assurance oversight
 - Workforce Transformation and Planning

- 
- G. Given the stage of the Partnerships development, the extent of engagement that has been undertaken during the preceding 9 months and the feedback that has been received in response to the MoU it is proposed that the Board consider amendments to its membership reflecting, proportionate, system orientated participation and representation as follows:
- i. A representative from each of our nine Local Authority area within the ICS footprint. We understand it is the intention of system leaders that these representatives will be political representatives
 - 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. A Primary Care Network representative. Assumed to be the Chair of 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.
- H. In response to the need for greater clarity on clinical leadership that this be identified and form an early piece of work to be considered by both the emerging Provider Collaborative and our ICP development forum
- I. That our ICP forum consider whether any specific measures or steps are needed to maximise the role, value and contribution of Health and Wellbeing Boards in our systems
- J. That in addition to recognising and supporting the proposal for Local Authority representation on the Partnership Board that discussions continue with partners on the basis of developing a Political Assembly a part of the Partnership's established governance
- K. Supports amendments to the MoU to reflect proposals made in respect of:
- i. Placing patients and residents at the centre of 'our integrated, system approach to collaboration'
 - ii. Tackling health inequalities and improving lives needs new partnerships that 'liberate the potential' in people. It will be important the Partnership is not just co-ordinating existing health and social care organisational support e.g. education, housing, business, industry and enterprise
 - iii. Social responsibility, the response to inequalities and the role of anchor institutions could be more explicit in the MOU
 - iv. The wider role of other partners in achieving health and wellbeing outcomes that look at a 'whole person approach' could be described in the MOU
 - v. Innovation
 - vi. Climate Change
 - vii. Digital and data



Responders

- Cheshire West and Chester Council
- Halton MBC
- Knowsley MBC

- Alder Hey Children's NHS FT
- Cheshire and Wirral Partnership NHS FT
- Liverpool University Hospitals NHS FT
- Liverpool Women's NHS FT
- Mersey Care NHS FT
- NW Boroughs Partnership NHS FT
- The Walton Centre NHS FT
- Warrington and Halton Hospitals NHS FT
- Wirral Community Health and Care NHS FT

- NHS Cheshire
- NHS Liverpool
- NHS South Sefton
- NHS Southport and Formby
- NHS St Helens

- Healthy Wirral – incorporating all partners
- Cheshire West Integrated Care Partnership – a representative
- VCFSE representatives

Pre consultation responders:

- St Helens MBC
- Warrington Borough Council

Our thanks is recorded to all those responding. Any omissions are not deliberate and can be corrected.



**Cheshire and
Merseyside**
Health and Care Partnership

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 received.

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

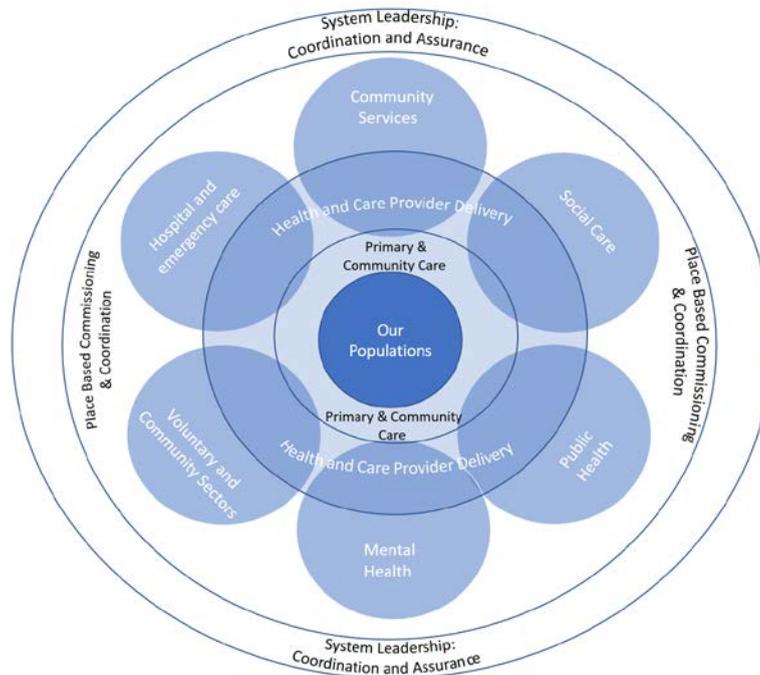
The purpose of this Memorandum is to formalise our partnership arrangements. We do not seek to introduce a hierarchical model; rather provide clarity through a framework, based on the principle of subsidiarity, to ensure collective ownership and coordination of delivery. This approach also provides the basis for a refreshed relationship with national NHS oversight bodies¹, 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.

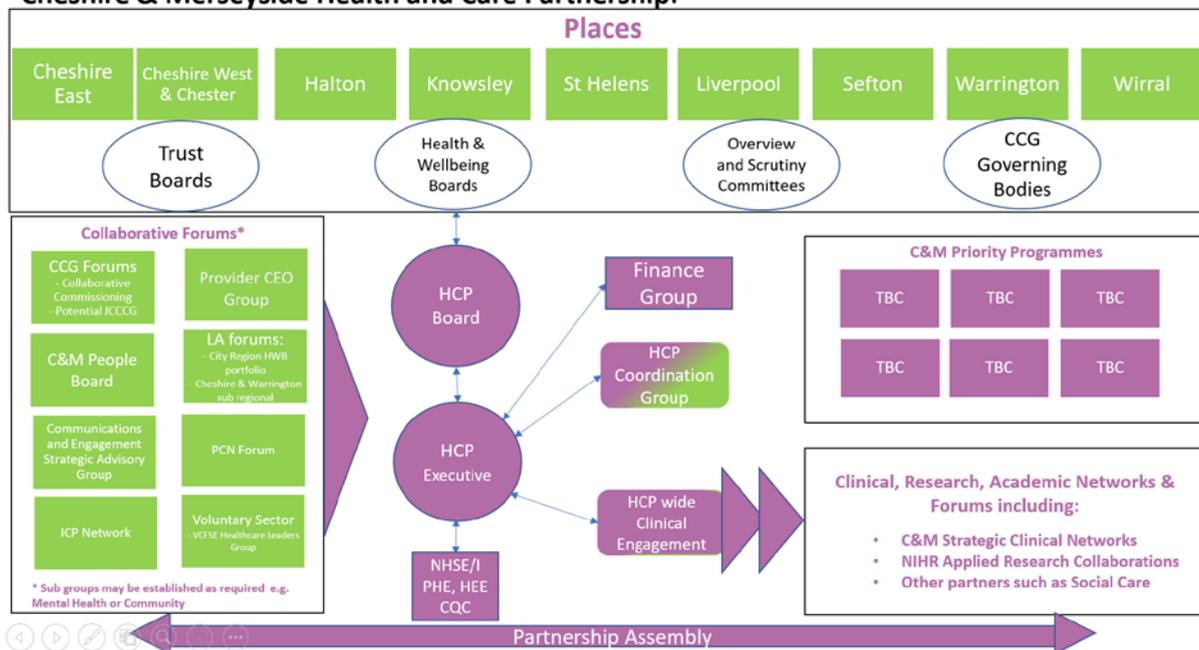
4. Partnership Governance

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.

Cheshire & Merseyside Health and Care Partnership:



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 accountability² 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 coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

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

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

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:

Health Regulator and Oversight Bodies

- NHS England and NHS Improvement

Other National Bodies

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

Other Local Bodies

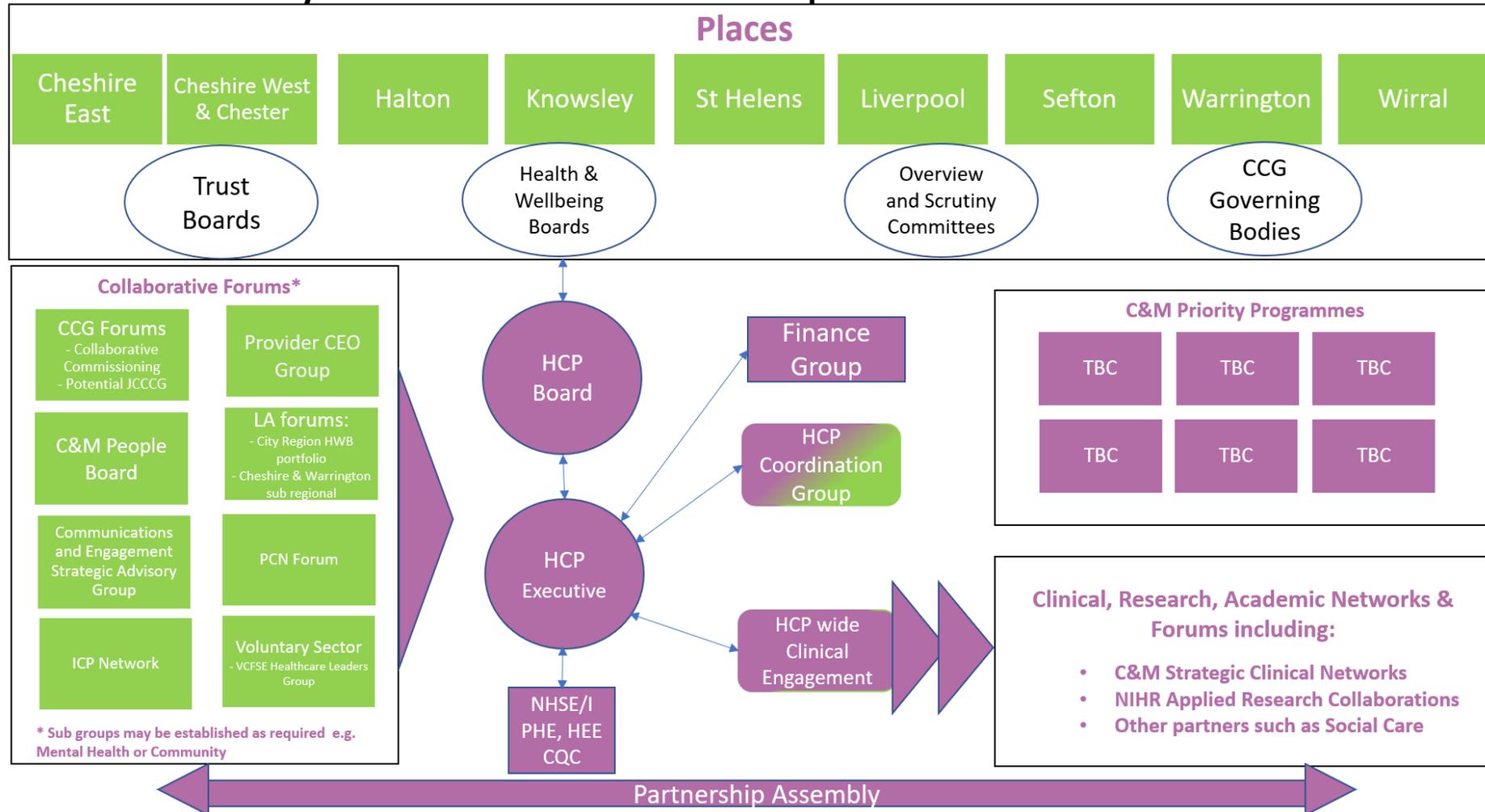
- Fire
- Police
- Probation
- Others, where relevant

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: <ul style="list-style-type: none"> • Financial risk management • Allocation of capital and transformation 	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

Annex 2 – Schematic of Governance and Accountability Arrangements

Cheshire & Merseyside Health and Care Partnership:



Annex 4 – Mutual Accountability Arrangements

A single consistent approach for assurance and accountability³ 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 coordinating decisions relating to regulatory and oversight functions currently exercised from outside the system and will look to reach recommendations and any decisions on a *Best for Cheshire and Merseyside* basis.

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

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

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 in writing.
- 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.