Mid and South Essex Health and Care Partnership

Attachment C2

Memorandum of Understanding & Ways of Working

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Foreword

Since the creation of our Partnership, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 1.2 million people living in our area. We have recently published our 5-Year Strategy and Delivery Plan which outlines our vision and ambitions and refreshes our commitment to working together for the benefit of our residents.

As a Partnership we have a number of lines of accountability – to each other, as partners, to our residents and service users and, for NHS partners, to government through NHS England and NHS Improvement. Through that route, two key expectations for systems have been identified:

- That we will work together to agree and deliver a coordinated programme of transformational change, to secure the long-term sustainability, ensure local delivery of the NHS Long Term Plan (LTP) and to support transformation of health and care at System, Place and Locality.

- That we will collectively manage system performance, noting that individual organisations retain individual statutory accountabilities.

The challenge for the Partnership is to manage these expectations while also working together as equal partners. This document sets out how we will do this. We have aimed to:

- Put people at the heart of our approach, and not organisations.
- Honour the principle of subsidiarity
- Be respectful of the statutory functions and accountabilities of individual organisations
- Be as "light touch" as possible, while recognising the requirements placed upon us as outlined above, and that collectively, we are stewards of public services and funding.

We have agreed to develop this Memorandum of Understanding (MoU) to strengthen existing joint working arrangements and support our future development. This document is in two parts:

1. Memorandum of Understanding – that provides an overview of the Partnership, its vision and priorities, principles for integrated working and a description of the functions at System, Place and Locality/Primary Care Network
2. Ways of working - that provides an overview of the governance arrangements and expectations for mutual accountability and collective agreement.

The Covid-19 emergency has accelerated transformational change across the system. We have learned just how much can be done when led from the front line. The emergency has led to even closer working between organisations and sectors at place level and we realise that there is thereby still greater potential for change which is beneficial to all.

While we have made great strides, we know there is a lot more to do. The health and care system will continue to be under significant pressure, and we must address health inequalities. We all agree that working more closely together at System, Place and Locality level will enable us to tackle these challenges and achieve our ambitions. This MoU demonstrates our clear commitment to do this.

Professor Michael Thorne CBE
Independent Chair
Mid & South Essex Health and Care Partnership

Part 1: Memorandum of Understanding

Overarching Principles:

This MoU:

- Is based on an ethos that the Partnership is a servant of the people in Mid and South Essex.
- Seeks to ensure collective decision-making to improve the health and wellbeing of our residents.
- Has a central principle of subsidiarity.
- Commits to supporting Place as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services.
- Recognises the pivotal role of our Health and Wellbeing Boards in setting joint health and wellbeing strategies to reduce health inequalities.
- Recognises the central role of Local Authority Health Overview and Scrutiny arrangements with responsibilities for holding health and care organisations to account and for scrutinizing major service changes
- Recognises the regulatory functions of the NHS.

This MoU 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 MoU.
- Intended to replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Local Authorities.

1. Parties to the Memorandum

1.1 The members of the Mid and South Essex Health and Care Partnership (the Partnership), and parties to this Memorandum of Understanding (MoU), are:

Local Authorities

- Essex County Council* #
- Southend-on-Sea Borough Council #
- Thurrock Council #

NHS Commissioners

- NHS Basildon & Brentwood CCG
- NHS Castle Point & Rochford CCG
- NHS Mid-Essex CCG
- NHS Southend CCG
- NHS Thurrock CCG

NHS Service Providers

- East of England Ambulance Services Trust *
- Essex Partnership University NHS Foundation Trust *
- North East London NHS Foundation Trust *
- Mid & South Essex NHS Foundation Trust
- Provide CIC *

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other Partners

- Healthwatch Essex*
- Healthwatch Southend
- Healthwatch Thurrock
- Community & Voluntary Sector Network
- University College London Partners (UCLP)*
- Eastern Academic Health Science Network*

* These organisations are also part of neighbouring Integrated Care Systems.

\# The policy agenda and priorities for Local Authorities are set out by democratically elected councilors and cabinet and these are subject to scrutiny alongside management of finance and performance.

1.2 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 accountability arrangements set out in this MoU.

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

Definitions and Interpretation

1, 4 This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5 This MoU shall commence on the date of signature of the Partners. It shall be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the Partnership as an Integrated Care System. It shall thereafter be subject to an annual review of the arrangements by the Partnership Board.

2. Purpose

2.1. The purpose of this MoU is to formalise and build on our existing partnership arrangements and relationships. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.2. The MOU defines an agreed governance framework that specifies the functions that will be delivered at:

- Locality (ie. Sub-place footprint/Primary Care Network) level.
- Place (ie. The four places linked to respective Health and Wellbeing Boards)
- System (ie. Health & Care Partnership/Mid and South Essex) level

2.3. The MoU also outlines how partners will discharge the two key roles for the Integrated Care System, as defined by NHS England and Improvement. These are to;

- Work together to agree and deliver a coordinated programme of transformational change, to secure the long-term sustainability of the system, ensure local delivery of the LTP and to support transformation of delivery of health and care at System, Place and Locality.

- Collectively manage system performance, including the overall NHS financial and operational performance of the system, noting that individual organisations retain individual (and statutory) accountabilities

2.4. Partners to this MoU recognise that the system needs to move from a transactional model of commissioning /provision to a model of collaboration between health and care providers based on population health outcomes; and to transform healthcare services from a focus purely on treatment to one that also prevents ill health from occurring and has a strengths-based approach.

2.5. Our 5-year Strategy and Delivery Plan has outlined how we will take a Population Health System approach by working together to a common set of health and wellbeing outcomes.

2.6. We wish this MOU to provide pragmatic solutions to integration and partnership working and to avoid adding extra unnecessary layers of governance, bureaucracy or complexity. We aim to avoid creating rigid long term structures that are unable to evolve over time or which undermine the existing governance and statutory responsibilities of our individual organisations.

2.7. The MoU 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 MoU. It is a formal understanding between all of the Partners who have each entered into this MoU intending to honour all their obligations under it.

2.8. Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the MoU, constitute a Partner as the agent of another, nor

authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

3. Our Vision & Ambitions

3.1 We have worked together to develop a shared vision for health and care services across Mid and South Essex. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

"A health and care partnership working for a better quality of life in a thriving Mid and South Essex, with every resident making informed choices in a strengthened health and care system"

We are committed to supporting:

Healthy Start – helping every child to have the best start in life
- Supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.
- Supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.
- creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – spring from participation
- making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives
- Helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home
- From advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

3.2 Our priorities for improving health outcomes, joining up care locally, and living within our financial means were set out in our 5-year Strategy & Delivery Plan and this MoU should be read in conjunction with the Strategy.

3.3 We have agreed through our 5-Year Strategy that our focus as a partnership should be to reduce health inequalities by seeking to shift resources to address the "inverse care law". We will do this by:

4 Principles for integrated working

This MOU, and more widely the way we plan, commission and deliver a Population Health System through an ICS is based on the following principles which all signatories to this MOU agree to:

1. Prevention. We will transform services from ones that react to health and care need, to ones that play a proactive part in keeping our residents as healthy and independent for as long as possible. We will intervene earlier to help people remain well. We recognise that this approach is both good for our population's health and wellbeing, and saves money in the longer term.

2. Partnership. *Progress occurs at the speed of trust.* We will ensure that future transformation and integration builds upon the strong relationships and partnerships at System, Place and Locality/PCN level and see to protect and nurture these relationships. We will ensure that future partnership arrangements include the widest possible range of stakeholders. As partners, at every level we will act for the benefit of the population we serve, and not for organisational self-interest. We will ensure that our residents are engaged as equal partners in decision making on future transformation activity at the most appropriate level.

3. Whole Systems Thinking. We recognise the value of coordinated action across all providers at each level of the system, as the best way to address the health and wellbeing challenges that our residents face. We have developed a single outcomes framework that operates across System, Place and Locality footprints. We seek to define population outcomes based contracts that coordinate action across multiple providers to ensure our system becomes sustainable over the long term.

4. Strengths and Asset Based Approach. We believe in a 'strengths and solutions' based approach. We see the individual as a whole person with differing needs and wants, not a passive recipient of "top down" services. We will harness and empower individuals to solve their own problems, with service providers support to 'fill the gaps'. We will leverage existing community and third sector assets in care delivery, connecting individuals with support outside of traditional NHS or Social Care interventions. This strengths based approach to delivering care will generate positive and varied solutions tailored to the wider wellbeing needs of each resident, not a 'one size fits all' option.

5. Subsidiarity. We believe in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities. We recognise that PCNs and localities are the building blocks around which integration best occurs. We will devolve planning and delivery down to the lowest possible level where it makes sense to do so. Our starting point for service delivery, transformation and integration will be locality/sub locality level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

6. Empowering front line staff to do the right thing. We believe in 'distributed leadership'; harnessing the creativity and energy of staff. We will move from a transactional model of commissioning to an approach that focuses on outcomes.

7. Pragmatic Pluralism. We recognise that across the system and our places there is a considerable heterogeneity of need between populations. We recognise that there are some actions that it makes sense to do once at system level, whilst others that need to be done differently in different places and localities. We will respect this diversity and develop pragmatic solutions that respond to it.

8. Leverage Health Intelligence and the evidence base. We recognise the importance of health intelligence and published evidence to fully understand and then best respond to ensure a high quality of care. We will use our JSNA programmes to understand the needs of our residents and improve their outcomes. We will look for opportunities for joint working between the three Public Health teams on shared health intelligence products. We know that different population groups have different care needs and we will use Population Health Management techniques like risk stratification and predictive modelling developed from our integrated health and care record system to identify and segment 'at risk' cohorts in our population and design targeted, tailored and proactive evidence based interventions to keep people well.

9. Innovation. Transforming the way we work means trying new and innovative approaches. To make process we will try and test new approaches, evaluating as we go, keeping the best and not admonishing ourselves where we fail and not being afraid to stop things that have not worked.

5. Expected Functions at Locality, Place & System Level

Subsidiarity is our guiding principle as a Partnership and everything we do together aims to ensure this. The following section describes the functions that may be carried out at each level in the system – at locality/PCN level, at Place and at System. The functions listed are not exhaustive. Annex 4 provides a high level description of the spectrum of relationships between the various sectors and partners, and the functions that will be delivered within each.

Locality / Primary Care Network Level

5.1 Localities are the footprint upon which we can ensure that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents.

5.2 We recognise the critical and increasing importance of localities and PCNs and support the principle of *subsidiarity;* that the starting point for planning, transforming and delivering services should be at the most local level practicable.

5.3 We have an aspiration to deliver Community-Led Commissioning/Resource prioritisation. We wish to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process.

5.4 At Locality / PCN level we commit to the following where practicable:

- Forming locality/PCN based Steering Boards to manage development and implementation of new models of integrated care within each locality
- Devolving the maximum number of programmes possible to create a coherent and integrated locality offer, moving services closer to communities.
- Empowering front-line staff to design and deliver a service offer that responds to local need and engages the third sector and residents in the wellbeing agenda.
- Through the Better Care Fund, identifying and protecting a local locality budget
- Developing locality-based commissioning arrangements where partners agree it makes sense to do so (eg locality/PCN based contracts for long-term condition case finding/management, LES services with GP, voluntary sector services)
- Delivery of locality based healthy lifestyle services (eg. self-care/patient education, smoking cessation, sexual health (spoke services), cervical screening, weight management)
- Supporting service delivery with a mixed skill workforce including integration of community healthcare, mental health, and social care.
- Delivery of a wider range of services closer to people's homes. This may include, but is not limited to:
    - Minor operations coordinated across GP practices (eg. lumps and bumps, vasectomy services)
    - Phlebotomy services
    - Long Term Conditions case-finding programmes including hypertension, AF and depression screening.

- Support for carers
- End of Life care
- Delivery of dental care and improved oral health programmes
- Delivery of MSK services
- Wound Care
- Single, integrated 'one stop shop' clinics for the management of diabetes, cardio-vascular disease and respiratory long-term conditions with input from secondary care consultants.
- New model of care for Common Mental Health Disorders and some mental health services for patients with SMI including IAPT, Dementia and Psychiatric Nursing
- Clinical models including diagnostics (eg. 24 hour blood pressure monitoring) and some secondary care outpatient clinic provision
- Consultant-led integrated primary/secondary care specialist clinical provision (eg. gerontology, community paediatrics, diabetes, neurology/epilepsy, community cardiology)
- Proactive clinical outreach to residential care homes
- Adult Social Care assessment/fieldwork services
- Social Prescribing
- Asset Based Community Development approaches including community assets and community resilience building
- Locality housing and employment support
- The Schools Wellbeing Service (defining a school as a community)
- Children's Centres – a wide range of services and support for families with young children.

Place (Integrated Care Partnership) Level

5.5 We have four defined Places across the system and will form four Integrated Care Partnership Boards with representation from all key local authority, NHS, Healthwatch, and community and voluntary sector stakeholders, aligned to the relevant Health and Wellbeing Board(s). These are:

- An Integrated Care Partnership for Thurrock encompassing the geographical footprint of Thurrock Council, Thurrock CCG ,Thurrock Joint Health and Wellbeing Board, Thurrock Healthwatch and Thurrock CVS
- An Integrated Care Partnership for South East Essex encompassing the geographical footprint of Southend-on-Sea Borough Council, part of Essex County Council, Castle Point Borough Council, Rochford District Council, Castle Point and Rochford CCG, and Southend CCG, linking to both Southend Health and Wellbeing Board and Essex Health and Wellbeing Board.
- An Integrated Care Partnership covering for Mid Essex encompassing the geographical footprint of Mid Essex CCG, Chelmsford City Council, Maldon District Council, Braintree District Council and part of Essex County Council, linking to Essex Health and Wellbeing Board.
- An Integrated Care Partnership for Basildon and Brentwood encompassing the geographical footprint of Basildon and Brentwood CCG, Basildon District Council,

Brentwood Borough Council, part of Essex County Council and linking to Essex Health and Wellbeing Board.

5.6 The work within each Place will reflect local priorities and relationships, and provide a greater focus on population health management, integration of services around the individual's needs, and a focus on care provided in primary and community settings.

5.7 We recognise *Place* as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services. We also recognise the Kings Fund Research finding that 70% of integration activity occurs at Place or Locality level.

5.8 Appropriate resources will be made available to ensure our places can deliver agreed transformation programmes.

5.9 We acknowledge the pivotal role of Local Authorities in delivering integrated care and population health through their functions to address the wider determinants of health including housing, employment and economic growth, education, planning, regeneration and transport, their role in commissioning of primary and secondary prevention activity from the Public Health Grant, and their responsibility to commission and deliver Adult and Children's Social Care.

5.10 We further recognise the statutory role of the three Health and Wellbeing Boards, with responsibility for joint strategic needs assessments, and setting joint health and wellbeing strategies to reduce health inequalities. The Health and Wellbeing Boards also hold a requirement to approve plans for the Better Care Fund.

5.11 We also acknowledge the key roles of local Healthwatch in representing the views of patients and the community and voluntary sector in delivering wider health and wellbeing programmes.

5.12 Each place will have formal arrangements for engaging with local communities.

5.13 Political leadership for each ICP will be provided through the relevant Health and Wellbeing Board.

5.14 Each ICP will be accountable to the Health and Wellbeing Board for delivery of its locally agreed plan.

5.15 Each ICP will also have a line of accountability to the System (Partnership Board) for delivery of agreed system transformation, finance, quality and performance priorities.

5.16 We recognise the statutory role of Health Overview and Scrutiny Committees., with responsibilities for holding health and care organisations to account and for scrutinizing major service changes. Political scrutiny of proposals and decisions made at all levels of the system will be undertaken through Essex, Thurrock and Southend Health Overview and Scrutiny Committees and Cabinets. For some issues that have system-wide implications a Joint Overview and Scrutiny Committee will be established.

5.17 At each Integrated Care Partnership we commit to the following:

- Developing and leading delivery of an Integrated Care Partnership Population Health Strategy and outcomes framework aligned to wider Health and Wellbeing Strategies and the agreed system Outcomes Framework.
- Developing a single ICP Integrated Care Alliance Contract between all health and care stakeholders including the third sector with arrangements for sharing population health outcome metrics, and (where relevant) budgets and mechanisms to share financial risk and reward.
- Gathering the views of our residents and engaging them in re-design of services and commissioning decisions through Healthwatch and other consultation mechanisms.
- Leading capital regeneration programmes that impact on health and wellbeing and that are distinct to each ICP geography
- Integrating planning and regeneration strategic programmes that impact positively on wellbeing and wider determinants
- Developing and implementing new models of integrated preventative care encompassing NHS, adult and children's social care, education, housing, health improvement and prevention, community safety and third sector services/community assets.
- Where appropriate, integrating Health and Social Care commissioning in a single function, managed through the Better Care Fund as the financial delivery mechanism for integrated out of hospital health and care services.
- Development and strategic leadership of local prevention programmes eg tobacco control, smoking cessation, weight management.
- Delivery of integrated Frailty Pathways between hospital, community and primary healthcare, adult social care and the third sector.
- Discharge planning from secondary to adult social care including programmes to reduce/eliminate Delayed Transfers of Care
- Delivery of planned care activity including Continuing Health Care.

In addition, and depending on the footprint of the ICP, they may also undertake:

- A Joint Strategic Needs Assessment and Healthcare Public Health Offer to assess need/demand/supply and drive commissioning priorities
- Management of integrated contracts / agreements between providers eg. Section 75
- Commissioning ICP wide primary prevention services as appropriate, including local stop smoking, weight management, services that promote physical activity, services that improve nutrition, drug and alcohol treatment services, sexual and reproductive health services, public health nursing
- Strategic commissioning Adult and Children's Social Care where provision is borough wide

System (ie. Mid and South Essex) level

5.18 We recognise that there are some tasks and integration activity that it makes sense to do once, at scale, at *System* level for our 1.2m population. We also recognise the planning footprint of Mid and South Essex will become increasingly more important as the geography recognised by NHS England & Improvement for strategic financial and planning activity in their oversight of the NHS Long Term Plan implementation.

5.19 At System level, we commit to:

- Keep up to date our Strategy & Delivery Plan
- Agree and monitor a set of high level population health outcomes meaningful to the population of Mid and South Essex.
- Plan for and secure the right workforce.
- Use digital technology to drive change and ensure systems are inter-operable, including the development of the integrated shared care record.
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the strategic capital and estates plans across Mid and South Essex.
- Develop a shared information, data, and intelligence function to drive system-wide change.
- Operate as an Integrated Care System and progressively to build population health management capabilities required to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services.
- Manage our financial resources within a shared financial framework for the NHS across the constituent CCGs and provider organisations to maximise system-wide efficiencies necessary to manage within the NHS financial control total. (See Annex 1 for organisations subject to the NHS control total)
- Allocate resources in line with the need to address health inequalities, re-investing savings in areas where this will have the largest impact for residents.
- Strengthen strategic planning and commissioning arrangements for the system.
- Own and resolve system-wide challenges (to be agreed between partners) through partnership working.
- Integrate, over time, the regulatory functions that have historically sat with NHSE/I as part of a single ICS.

Greater Essex

5.20 It is recognised that some services are planned, commissioned and delivered at the Greater Essex level – for example mental health and learning disability services. Nothing in this MoU seeks to undermine these arrangements.

NHS Region /National

5.21 It is recognised that some specialised NHS services are planned, commissioned and delivered at regional or supra-regional level. Nothing in this MoU seeks to undermine these arrangements.

Part 2: Ways of Working

This section of the document describes in more detail the ways of working and governance groups that exist.

6. Partnership Governance

6.1. 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.

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

6.3 A schematic of our governance and accountability relationships is provided at Annex 3 and terms of reference of the Partnership Board, System Leadership Executive, System Finance Leaders Group and Clinical & Professional Forum will be developed separately.

Partnership Board

6.4. A Partnership Board is in place to provide the formal leadership for the Partnership. The Partnership Board is responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to reach collective agreement as Partners which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

6.5. The Partnership Board is made up of the chairs of each organisation (NHS and upper tier Health & Wellbeing Board chairs), the Executive Lead for the Partnership (who is also the Joint Accountable Officer for the 5 CCGs), Chief Executive Officers of NHS provider organisations, lead officers for the three Local Authorities, Place-based leads, representatives from Healthwatch, Public Health, Community and Voluntary Sector organisations and the Local Medical Committee. Over time, membership will evolve to include identified system leaders for specific programmes eg. workforce, quality, performance.

The Partnership Board is independently chaired. It will meet at least 4 times each year in public.

6.6 The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national NHS bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive Group

6.7 The System Leadership Executive (SLE) Group comprises Chief Executive Officers and Accountable Officers of NHS organisations and lead officers from the Local Authorities. It is responsible for:

- Overseeing delivery of the Partnership's strategy, receiving reports from the Transformation Programme Delivery Group on priority programmes and agreeing action to resolve any issues arising.
- Taking advice from the System Finance Leaders Group and the Clinical and Professional Forum as appropriate.
- Regularly reviewing a dashboard of key performance, quality, finance and transformation metrics and taking appropriate action where required.
- Building leadership and collective responsibility for our shared objectives.
- Act as the interface with NHS regulators on system performance and assurance on behalf of the Partnership.

6.8. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

Clinical & Professional Forum

6.9. Clinical and professional leadership is central to all of the work we do. Clinical and professional leadership is built into each of our work programmes and governance groups.

6.10 The purpose of the Clinical & Professional Forum is to drive clinical and professional leadership and provide support, advice, guidance and challenge to the Partnership, and to assist the Partnership in both setting and achieving its stated priorities.

6.11 The Clinical & Professional Forum ensures that the voice of professionals from across the range of partner organisations, drives the development of new models and proposals for the transformation of services. It also takes an overview of system performance on quality.

System Finance Leaders Group

6.12 Financial stewardship is key to the Partnership's work. The purpose of the System Finance Leaders Group is to provide financial support, advice and guidance to the Partnership and to assist the Partnership Board by providing collaborative financial leadership for all programmes.

6.13 The System Finance Leaders Group will develop a system-wide governance framework and work towards the system control total for NHS Partners, support the development of data analytics and financial modelling for the system, ensure financial plans are up to date, and develop a financial investment process to include the operation of an investment advisory group.

Transformation Programme Delivery Group

6.14 Delivery and transformation programmes have been established to enable the Partnership to achieve its agreed priorities. Cross-system programmes are overseen by a central Programme Management Office to ensure a consistent methodology of managing complex programmes.

6.15 Each programme has a Senior Responsible Owner, typically at executive level, and has a structure that builds in clinical and other stakeholder input, representation from each of our

four places and each relevant service sector. All programmes will adopt the agreed system Design Principles and Target Operating Model described at Annex 2.

6.16 The Transformation Programme Delivery Group will comprise programme leads. It will meet bi-monthly to track progress of agreed priority programmes, manage risk and ensure interdependencies are managed. Programmes will provide regular updates to the System Leadership Executive.

Other governance arrangements between Partners

6.17 The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, providers, local authorities) that support the way it works.

The Joint Committee of Clinical Commissioning Groups

6.18 The five CCGs in Mid and South Essex are continuing to develop closer working arrangements within each of the four Places that make up our Partnership.

6.19 The CCGs established a Joint Committee in 2017, which has delegated authority to take decisions collectively on matters relating to:

- Acute hospital services
- NHS 111 services
- Ambulance services
- Patient transport services
- Acute mental health services

The Joint Committee comprises representatives from each CCG and has one lay member. To make sure that decision making is open and transparent, the Committee meets in public on a bi-monthly basis. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

6.20 The CCGs have commenced work to engage with partners on a formal merger.

6.21 The Joint Committee is a committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the Mid and South Essex programmes of work that have been expressly delegated to it by the CCGs.

Mid & South Essex NHS Foundation Trust

6.22 The three acute hospital trusts in Mid and South Essex have been working closely together for several years and formally merged in April 2020 to become the Mid & South Essex NHS Foundation Trust.

Essex Partnership University NHS Foundation Trust (EPUT)

6.23 EPUT provides adult mental health and learning disability services across mid and south Essex. EPUT also provides Community services in south east Essex. For the purposes of NHS planning,

EPUT aligns with the Mid and South Essex footprint. EPUT provides services across three STPs/ICS in Essex and is part of the New Models of Care Provider Collaborative with other mental health trusts for specialist mental health services in the region.

North East London NHS Foundation Trust

6.24 NELFT provide adult community services in south west Essex and children's community services across the footprint and children's mental health services across greater Essex. For the purposes of planning, NELFT aligns with north east London.

Provide CiC

6.25 Provide is a community interest company (social enterprise), providing health and care community services across the East region.

Joint Approach

6.26 NELFT, Provide and EPUT are currently exploring opportunities for joint working, sharing best practice and integration of services to achieve better outcomes for residents. This work is on-going with a view to a potential joint venture contract arrangement. NHS commissioners have indicated that they wish to pursue a single contract with the three providers.

Local Government

6.27 The Partnership includes three upper tier local authorities. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions. At Place level, the district councils of Basildon, Brentwood, Castle Point, Rochford, Rayleigh, Maldon, Chelmsford and Braintree play a key role.

6.28 Within the Partnership, NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

6.29 The four Places have accountability to the upper tier Health and Wellbeing Boards for delivery of locally agreed plans.

6.30 Local Authorities are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime, certain aspects of these arrangements will not apply - most significantly, Local Authority partners would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this MoU, Local Authorities agree to align with the spirit of joint planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councilors will continue to hold the partner organisations accountable through their formal Scrutiny powers. It is recognised that Essex County Council interacts with three ICS' and therefore must take a pragmatic approach to its interactions with each.

Current statutory requirements

6.31 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.

6.32 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.

6.33 NHS England and NHS Improvement are working more closely together and expect, over time, to merge. This means that NHS regulators will increasingly be taking a joined up approach to regulation of NHS partners, taking a "system first" approach. Our Partnership needs to be able to respond to this while respecting that non-NHS partners have separate lines of accountability.

7. A new model of mutual accountability

7.1. Through this MoU the Partners agree to take a collaborative approach to, and collective responsibility for, managing performance, resources and the totality of population health.

7.2 This MoU has no direct impact on the roles and respective responsibilities of the Partners which all retain their full statutory duties and powers.

7.3 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 supporting the spread and adoption of innovation and best practice between Partners.

7.4. 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.

7.5. System oversight will including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress and areas for improvement;
- Identifying the need for improvement support through education, sharing of best practice and peer review;
- Agreeing the need for more formal action or intervention on behalf of the Partnership; and
- Consideration of regulatory powers or functions.

7.6. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a coordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking Action

7.7. The SLE will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal support and intervention when needed. These may include:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- the appointment of external support where required; and
- restrictions on access to discretionary funding and financial incentives.

7.8 Where financial performance is not consistent with plan, the System Finance Leaders Group will make recommendations to the SLE on a range of support and, where required, intervention, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- enhanced controls for deployment of transformation/capital funding held at Place

7.9 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 require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies – Support, Oversight and Escalation

7.10 As part of the development of the Partnership and the collaborative working between the Partners under the terms of this MoU, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in Mid and South Essex in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of providers, commissioners and Places in accordance with the terms of this MoU;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, outcomes and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual provider and commissioner 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 SLE and work through the Partnership Board to seek a resolution prior to making an intervention with the Partner.

7.11. To support Partnership development as an Integrated Care System there will be a process of aligning resources from Arms Length Bodies to support delivery and establish an integrated single assurance and regulation approach.

7.12. National capability and capacity will be available to support Mid and South Essex 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.

8. Collective Arrangements & Resolving Issues

8.1 We aim to make collective decisions as a partnership, respectful of the statutory obligations of each partner. Our approach to collective decision-making arrangements will follow the principle of subsidiarity and will be in line with our shared values and behaviours. We commit to taking all reasonable steps to reach a mutually acceptable resolution to any issue that arises.

8.2 Both the Partnership Board and SLE have no formal powers delegated by any Partner. However, they will increasingly take on responsibility for coordinating agreements, based on a "Best for Mid and South Essex" basis. The Partnership Board will initially have responsibility for reaching agreement on:

- The objectives of priority work programmes and work streams
- The apportionment of transformation monies from national NHS bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

8.3 The Partnership Board will receive recommendations on the above from the SLE. The SLE will aim to reach agreement by consensus. If agreement cannot be reached, then the matter may be referred to the Partnership Board for wider discussion and resolution.

8.4 In respect of priorities for NHS capital investment or apportionment of transformation funding, if a consensus cannot be reached at the SLE meeting to agree this then 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.

8.5 The Partners understand any decision about service change that requires consultation will be undertaken in accordance with the relevant statutory obligations of partners.

Issue resolution

8.6 Partners will attempt to resolve in good faith any issues between them in respect of Partnership-related matters, in line with the principles set out in this MoU.

8.7 The Partnership will apply an issue resolution process to resolve any issues which cannot otherwise be agreed through these arrangements.

8.8 Subsidiarity will be the overarching principle when resolving issues. Therefore, where appropriate, Place-based arrangements will be used to resolve any issues which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

8.9. As agreements 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 issue resolution process.

8.10. The key stages of the issue resolution process are

1. The SLE will discuss issues openly and transparently and seek to find resolution to the mutual satisfaction of each of the affected parties. The SLE will take appropriate advice from the System Finance Leaders Group, the Clinical and Professional Forum, Place/Alliances and other relevant groups in pursuit of a resolution.
2. The SLE will come to a majority decision (ie. a majority of eligible Partners participating in the meeting who are affected by the matter under discussion, determined by the scope of applicable issues set out in Annex 1) on how best to resolve the issue through applying the principles of this MoU and taking account of the objectives of the Partnership. SLE will advise the Partners of its decision in writing.
3. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the issue, the matter can be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the issue in accordance with the terms of this MoU.
4. In the unlikely event that the independent facilitator cannot resolve the issue, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the issue in accordance with the terms of this MoU and advise the parties of its decision.

9. Financial Framework

9.1. All Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

9.2. A set of financial principles have been agreed. They confirm that we will:

- aim to live within our means, and develop, for the NHS, system financial governance and risk management arrangements to deliver the system control total.
- develop a Mid and South Essex system efficiency plan in response to the financial challenges we face; and
- develop a shared approach to investment, including the establishment of an Investment Advisory Group
- develop payment and risk share models that support a system response rather than work against it.

9.3. We will collectively manage resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to ensure financial sustainability.

Living within our means and management of risk

9.4. Through this MoU the collective leaders at System level and in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include

establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective partners involved.

9.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks at System level and in each Place, leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

9.6. NHS partners are committed to continuing the adoption of payment models which are better suited to whole system collaborative working and are outcome focused. The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

9.7. The Partners intend that any transformation funds made available to the Partnership will be allocated through collective agreement by the Partnership, in line with agreed priorities. The method of allocation may vary according to agreed priorities – for example, funds may be allocated on an equitable basis in order to address the inverse care law. Any savings accrued through demand management functions will be re-invested where they can have maximum impacts for the population. Decisions will be guided by the Partnership population health management work.

9.8 Funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the partners have agreed that they will deliver the maximum leverage for change and address financial risk.

9.9. The funding provided to Places (through formula agreed by the partners) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all partners that the resource has been deployed to deliver maximum transformational impact, address financial risk, and to meet efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and Partnership Board, and be subject to on-going monitoring and assurance.

9.10. Funding provided to the Programmes will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant partners.

Allocation of ICS capital

9.11. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;

- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this MoU.

Allocation of Provider and Commissioner Incentive Funding (Financial Recovery Funding)

9.12. The approach to managing additional funds set out by NHS planning guidance and business rules is not part of this MoU. A common approach to this will be agreed by the Partnership as part of annual financial planning.

10. Variations

10.1. This MoU, including the Schedules, may only be varied by written agreement of all the Partners.

11. Charges and liabilities

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

11.2. By separate agreement, the Parties have agreed to share specific costs and expenses arising in respect of the Partnership between them in accordance with a "Contributions Schedule", developed by the Partnership and approved by the Partnership Board.

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

12. Information Sharing

12.1 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 Mid and South Essex" basis.

12.2. 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.

13. Confidential Information

13.1. 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 unauthorized 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 MoU 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.

13.2. 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.

13.3. The Parties agree to procure, 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 MoU.

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

14. Additional Partners

14.1. If appropriate to achieve the agreed 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 MoU if required.

14.2. The Partners intend that any organisation who is to be a partner to this MoU (including themselves) shall commit to the principles, governance arrangements and ways of working.

15. Signatures

15.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same document.

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

15.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

Signed: Print:	Position	Organisation	Date
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Schedule 1 - Definitions and Interpretation

1. The headings in this MoU 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.

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers*	Councils	NHSE & NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Collective agreement and issue resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
NHS financial framework – risk management	✓	✓		✓		
Financial framework – Allocation of NHS capital and transformation funds	✓	✓		✓		
National and regional support	✓	✓	✓	✓		

*All elements of the financial framework for Mid & South Essex, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs. Provide CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Design Principles & Target Operating Model

Design Principle	Description

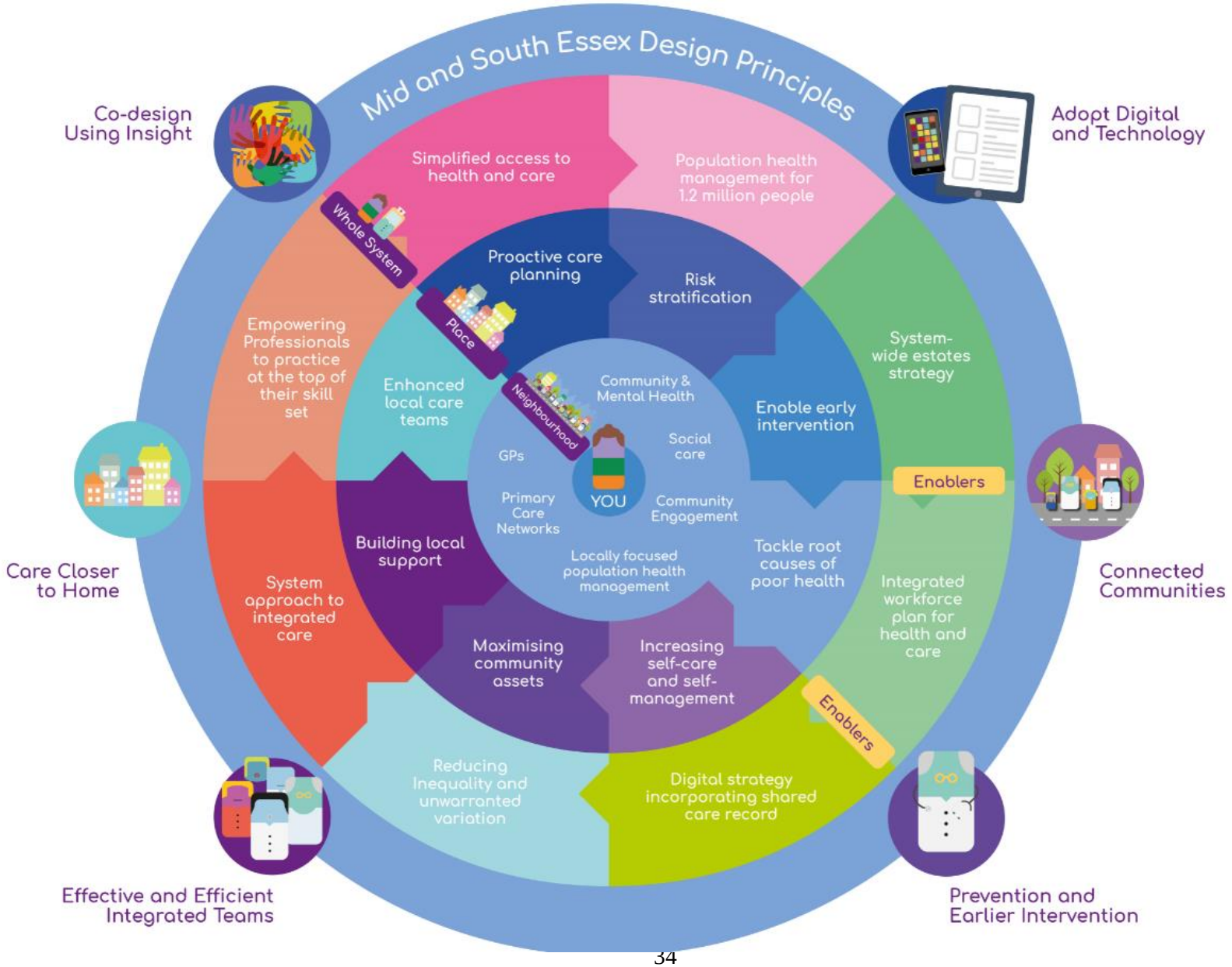
We will co-design with insights and intelligence, putting residents at the centre 	// We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement driven by a feedback culture.
	// We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity.
	// We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.

We will connect people together, delivering integrated care in the community 	// Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
We will support people to stay well through prevention, self-care and independence thus building resilient communities 	// A shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.

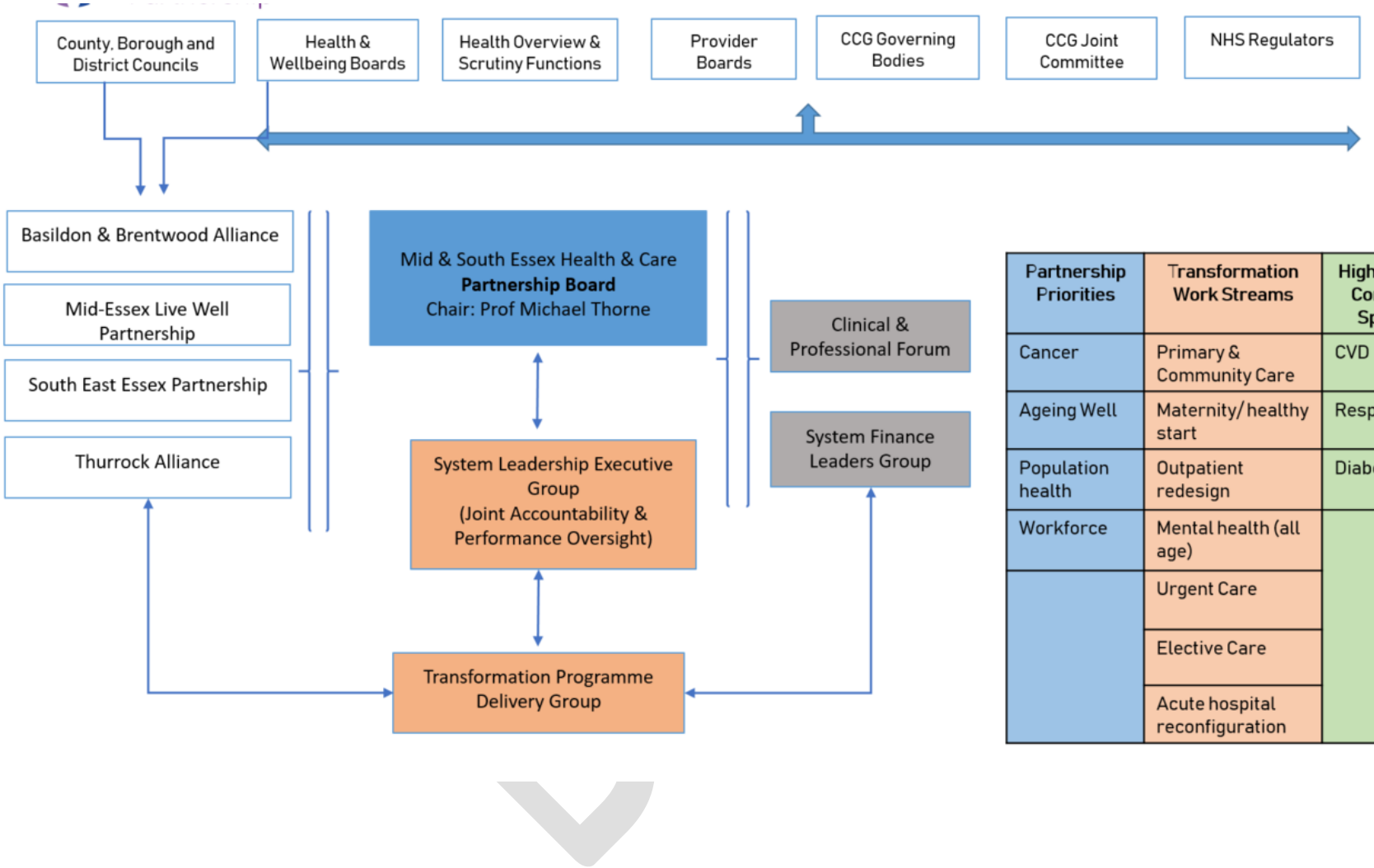
We will adopt digital and technology by default 	// Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions.
	// Other channels will remain available but used only when most appropriate.
	// Staff and residents are supported to adapt to new ways of working and champion innovation.

We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce 	// Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset.
	// Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services.
	// We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.

 We will deliver services as close to the home as possible	// Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs; including online.

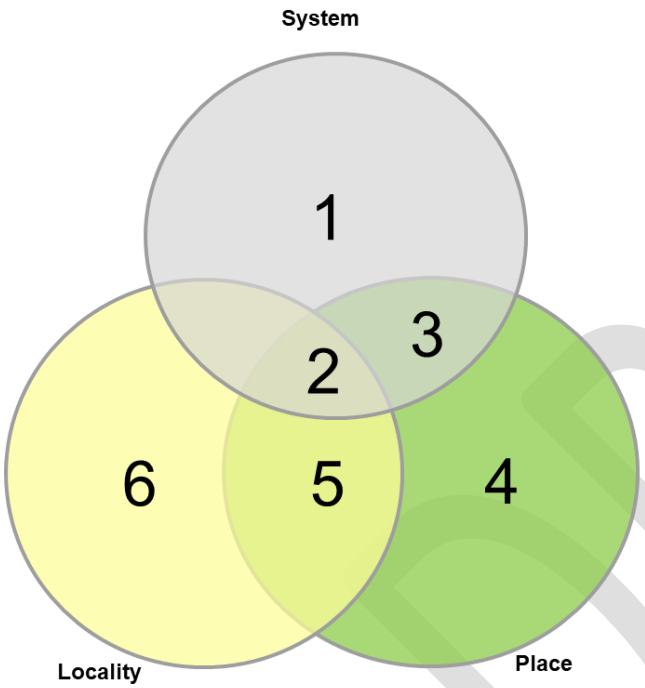

Mid and South Essex Design Principles
Co-design Using Insight
Adopt Digital and Technology
Care Closer to Home
Connected Communities
Effective and Efficient Integrated Teams
Prevention and Earlier Intervention
Simplified access to health and care
Population health management for 1.2 million people
Whole System
Proactive care planning
Risk stratification
Place
Empowering Professionals to practice at the top of their skill set
Enhanced local care teams
Neighbourhood
Community & Mental Health
Social care
GPs
YOU
Primary Care Networks
Community Engagement
Locally focused population health management
Enable early intervention
System-wide estates strategy
Enablers
Building local support
Tackle root causes of poor health
System approach to integrated care
Integrated workforce plan for health and care
Maximising community assets
Increasing self-care and self-management
Enablers
Reducing Inequality and unwarranted variation
Digital strategy incorporating shared care record

Annex 3 – Partnership Overview



Partnership Priorities	Transformation Work Streams	High-Impact Condition Specific	Enabling Programmes
Cancer	Primary & Community Care	CVD	Digital
Ageing Well	Maternity/ healthy start	Respiratory	Innovation & Improvement
Population health	Outpatient redesign	Diabetes	Communications & Engagement
Workforce	Mental health (all age)		Estates & Capital
	Urgent Care		Business functions
	Elective Care		
	Acute hospital reconfiguration		

Annex 4 – Spectrum of Relationships



1

Shared vision and purpose for Population Health

System wide health intelligence

Population Health Outcomes Framework

Integrated Data Solution procurement/management

Workforce

Owning and resolving system wide challenges e.g. A&E

NHS Capital Programme

System wide population health activity e.g. Ottawa stop smoking model within hospitals

Single ICS contract for activity that it makes sense to do once at system level:

- Primary Care contracting and performance management
- Secondary Healthcare commissioning across more than one hospital site
- NHS Specialist commissioning
- System wide MH commissioning including inpatients, crisis care, ANLS, suicide prevention, RAID

Strategic oversight of STP Primary Care Strategy

2

Allocation of system wide finance/resources based on need/inequality
Use of integrated data
Local planning/implementation to support system wide priorities

3

Frailty Care pathway
Planned care commissioning
Secondary care implementation of prevention programmes

4

Integrated Care Partnership of all key stakeholder agencies with a single Alliance Contract and outcomes framework aligned to wider Health and Wellbeing Strategies, single capitated budget and mechanisms for risk/reward share between partners

Joint Strategic Needs Assessment to drive commissioning priorities

Engaging resident views in re-design of services through Healthwatch

Capital regeneration programmes that impact on Health and Wellbeing

Developing and strategic oversight of integrated care models

Integrating planning/regeneration and housing functions to impact positively on wellbeing

Integrating Health and Social Care commissioning managed through the BCF as the financial deliver mechanism for integrated out of hospital health and care

Strategic leadership of prevention programmes including Tobacco Control, Whole Systems Obesity, children and young people's wellbeing, public mental health

Management of integrated contracts/agreements between providers e.g. Section 75

Commissioning of lifestyle modification services including smoking cessation, weight management and drug/alcohol treatment

Commissioning planned care including continuing care

Minor Injuries

5

Developing single integrated population outcome based contracts encompassing LTC case finding/clinical management, PH lifestyle services, LESs, NHSE dental, PCN contracts, and provision of MH and community services
Single locality budget within BCF
Devolution of current place based services to locality level e.g. Community Led Solutions
Market development of locality based services

6

Formation of Local Based Steering Boards to manage implementation/delivery
Empowering front line staff in service re-design
Co-commissioning with residents
Implementation of integrated locality contracts care models including lifestyle modification, mixed skill clinical workforce, minor ops, LTC case finding/management, end of life care, wound care, CMHDs, IMC clinical models, proactive outreach to care homes, wellbeing teams, ASC fieldwork, social prescribing, community hubs/development, children's centres, edge of care services, locality housing offices