Public Document Pack

# Partnerships Committee

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| **Date:** | **Wednesday, 13 January 2021** |
| **Time:** | **6.00 p.m.** |
| **Venue:** | On Microsoft Teams |


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# AGENDA

**1. WELCOME AND INTRODUCTION**

**2. APOLOGIES**

**3. MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST**

Members are asked to consider whether they have any disclosable pecuniary interests and/or any other relevant interest in connection with any item(s) on this agenda and, if so, to declare them and state the nature of the interest.

**4. MINUTES (Pages 1 - 6)**

To approve the accuracy of the minutes of the meeting held on 9 November 2020.

**5. PUBLIC AND MEMBER QUESTIONS**

5.1 **Public Questions**

Notice of questions to be given in writing or by email, by 12noon, Friday, 8 January, 2021 to the Council's Monitoring Officer and to be dealt with in accordance with Standing Order 10.

5.2 **Statements and Petitions**

Notice of representations to be given in writing or by email by 12noon, Friday, 8 January, 2021 to the Council's Monitoring Officer and to be dealt with in accordance with Standing Order 11.1.

5.3 **Questions by Members**

Questions by Members to be dealt with in accordance with Standing Orders 12.3 to 12.8.

**6. STRATEGIC DEVELOPMENTS IN THE NHS (Pages 7 - 20)**

**7. HEALTHWATCH WIRRAL - UPDATE (Pages 21 - 32)**

**8. CITIZENS ADVICE WIRRAL - UPDATE (Pages 33 - 36)**

**9. APPOINTMENTS TO THE JOINT HEALTH SCRUTINY COMMITTEE FOR CHESHIRE & MERSEYSIDE (Pages 37 - 52)**

**10. PARTNERSHIPS COMMITTEE - WORK PROGRAMME UPDATE (Pages 53 - 72)**

# PARTNERSHIPS COMMITTEE

Monday, 9 November 2020

| Present: | Councillor | C Spriggs (Chair) | |
|---|---|---|---|
| | Councillors | L Rennie | C Muspratt |
| | | T Cottier | S Spoor |
| | | J Johnson | J Walsh |
| | | I Lewis | S Whittingham |
| | | D Mitchell | |

## 1 WELCOME AND INTRODUCTION

The Chair welcomed those in attendance, stated the terms of reference and read out statement about the webcasting of the meeting.

## 2 APOLOGIES

No apologies for absence had been received.

## 3 MEMBERS' CODE OF CONDUCT - DECLARATIONS OF INTEREST

Councillor Christina Muspratt declared a personal interest in the Community Safety Strategy (minute 6) as her son was a serving police officer.

Councillor Christina Muspratt also declared an interest in the Strategic Developments in the NHS (minute 5) as she had one daughter worked as a GP and another daughter worked in the NHS.

Councillor Sarah Spoor declared a personal interest in the Strategic Developments in the NHS (minute 5) as she had a daughter who was a student nurse in NHS.

Councillor Ian Lewis declared a personal interest in the update from the Clatterbridge Cancer Centre NHS Foundation Trust (minute 8) as a voting member of Clatterbridge Cancer Centre NHS Foundation Trust.

Councillor Leslie Rennie declared a personal interest in the Community Safety Strategy (minute 6) as she was an elected Member on the Merseyside Fire and Rescue Authority.

Councillor Joe Walsh declared a personal interest in the Strategic Developments in the NHS (minute 5) as he had two daughters who worked in the NHS.

## 4 PUBLIC AND MEMBER QUESTIONS

There were no questions, statements or petitions from the public or Members.

## 5 STRATEGIC DEVELOPMENTS IN THE NHS

A report of the Chief Officer, NHS Wirral Clinical Commissioning Group and Wirral Health and Care Commissioning was considered, which provided a high-level summary of strategic developments in the NHS pertaining to the Cheshire and Merseyside Health and Care Partnership and the development of the organisation to become an Integrated Care System. It also detailed the plans to restructure commissioning and Clinical Commissioning Groups and the local influence in the health system.

Simon Banks, Chief Officer, NHS Wirral Clinical Commissioning Group and Wirral Health and Care Commissioning, presented the report and answered Members questions. Members noted that if the proposal was implemented it would create the third largest Integrated Care Systems in England by the planned amalgamation of nine Clinical Commissioning Groups into one within a timescale of 18 months.

Members were particularly interested in how local input would be retained in such a large system, although they noted that there was accountability via Councillors to the Cheshire and Wirral Partnership. Formal consultation on the changes was yet to happen and members were keen to see reports on progress.

Councillor Tony Cottier made a proposal which was seconded by Councillor Christina Muspratt and debated. It was then put to the vote and agreed.

**Resolved:**

**That the Partnerships Committee considers that local people, patient groups and other invested parties be consulted before any large scale Clinical Commissioning Group mergers are considered for Wirral. Furthermore, this Committee calls for a meeting with our counterparts from all other authorities involved in these proposals.**

## 6 COMMUNITY SAFETY STRATEGY

A report of the Director of Neighbourhood Services was submitted which outlined the development process for the statutory Community Safety Strategy which was to cover the period 2021-2025.

Mark Camborne, Assistant Director for Neighbourhood Safety and Transport introduced the report. He indicated that there was a road map for the production of the Community Safety Strategy involving a consultation process with stakeholders and the community which would culminate in a final version of the strategy being presented to the Tourism Communities Culture and Leisure Committee in 2021. It was to have input from other stakeholders

including the public, aligned with the Wirral Plan 2025 and had eight thematic areas.

Members debated the report and the scope of it to ensure that areas of focus such as New Ferry and homelessness were taken into account in the development of the strategy.

Police Superintendent Martin Earl referred to a Dashboard Tracker which showed a summary of crime in the borough.

Councillor Stuart Whittingham moved a proposal.

This was seconded by Councillor Joe Walsh and debated.

Councillor Leslie Rennie proposed an amendment to delete certain wording from the proposal so that it would read as follows:

"That the Committee note the contents of the report; and the Committee endorse the co-production approach to developing the strategy."

This was seconded by Councillor Dave Mitchell and debated.

On being put to the vote the amendment by Councillor Leslie Rennie was lost by 4 votes for and 6 against.

The proposal from Councillor Stuart Whittingham was then voted on and was carried with 6 votes for and 4 against.

**Resolved: The Committee resolved that:**

**(1) the contents of the report be noted;**

**(2) the co-production approach to developing the strategy be welcomed and endorsed;**

**(3) that further thematic specific reports as appropriate be brought to the Committee as part of the co-production process; and**

**(4) as part of the co-production process a detailed report on road safety be included on the Committee's Work Program. This report should benchmark Wirral's performance against our statistical neighbours.**

At the conclusion of this item, the Committee agreed to have a short adjournment.

## 7 CHESHIRE AND WIRRAL PARTNERSHIP DRAFT QUALITY ACCOUNT

Jo Watts, Associate Director Specialist Mental Health, All Age Disabilities, and Anushta Sivananthan, Medical Director, presented the Cheshire and Wirral Partnership (CWP) Quality Account 2019-20. They highlighted the

improvements from the previous year and the national recognition received. The CWP had a focus on continuous improvement and produced annual books of best practice and had produced an additional one for the work during the Covid pandemic.

Members asked questions in relation to a number of issues, including work undertaken to support veterans and the increased prevalence of self-harm.

**Resolved:**

**That the CWP Quality Account 2019-20 be noted.**

8 **UPDATE FROM THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

Liz Bishop, Chief Executive of Clatterbridge Cancer Centre introduced her report and slide pack detailing issues around the Centre. A new cancer hospital had opened in Liverpool in June 2020 and Clatterbridge was in the process of being refurbished.

Members queried the current situation and confirmed that transport could be arranged where patients could not access the hospital. Members were invited to visit the hospital once the work had concluded.

**Resolved:**

**That the report be noted.**

9 **PARTNERSHIPS COMMITTEE WORK PROGRAMME UPDATE**

A report of the Director of Law and Governance was submitted which included a suggested future work programme for the Committee to consider.

The Chair introduced the report and invited suggestions for issues to include in the work programme that fell within the remit of the Committee.

The Committee discussed a wide range of possible options including the possibility of inviting partners and external agencies to attend and report to future Committee Meetings. These included officers from Merseyside Fire & Rescue Service, the Northwest Ambulance Service, Social Housing providers, Network Rail, the Voluntary/Third Sector, RNLI, Better Care Fund, Utility providers, the Highways Authority and Trade Union representatives. Additionally, the Committee discussed a number of specific topics including a review of previous Motions to Council and outcomes, food security and the development of new partnerships. It was noted that the Committee had already resolved to include a detailed report on road safety as part of the Committee's Work Program.

The Chair suggested that given the breadth of ideas and options, it would be beneficial to hold a workshop to give the suggestions more consideration and it would also enable further clarification to be provided in respect to the

Committee's Terms of Reference,. She identified three key issues which she suggested could be added to the work programme pending the workshop being Road Safety, the Better Care Fund and engaging with Third Sector partners.

**Resolved:**

1) **That the following be added to the future Committee Work programme**

   **(i) Road safety**

   **(ii) Better Care Fund**

   **(iii) Engaging with Third Sector partners**

2) **That the Director of Law and Governance be requested to make the arrangements for a workshop be held to consider the role and remit of the Committee and to enable Members to give further consideration to issues that they would wish to include in the future work programme.**

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**PARTNERSHIPS COMMITTEE**

**13th JANUARY 2020**

| REPORT TITLE: | STRATEGIC DEVELOPMENTS IN THE NHS |
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| REPORT OF: | SIMON BANKS, CHIEF OFFICER, NHS WIRRAL CLINICAL COMMISSIONING GROUP AND WIRRAL HEALTH AND CARE COMMISSIONING |

**REPORT SUMMARY**

On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. The document was intended to open up a discussion with the NHS and its partners about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance. Decisions on legislation will be for Government and Parliament to make. This paper summarises the proposals set out in *Integrating Care: Next steps to building strong and effective integrated care systems across England*.

**RECOMMENDATION**

It is recommended that the Partnerships Committee notes this report.

## SUPPORTING INFORMATION

### 1.0 REASON FOR RECOMMENDATION

1.1 This report is for the information of the Partnership Committee. It is therefore recommended that the Partnership Committee notes the report.

### 2.0 OTHER OPTIONS CONSIDERED

2.1 This is a report for information and therefore does not present options for consideration or recommendation.

### 3.0 BACKGROUND INFORMATION

### 3.1 Introduction

3.1.1 On 26th November 2020 NHS England/Improvement (NHSE/I) published *Integrating Care: Next steps to building strong and effective integrated care systems across England*, subsequently referred to as *Integrating Care: Next steps*. This document set out proposals for legislative reform and focused on the operational direction of travel for the NHS from 2021/22 onwards. The document was intended to open up a discussion with the NHS and its partners about how Integrated Care Systems (ICSs) could be embedded in legislation or guidance. Decisions on legislation will be for Government and Parliament to make.

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

3.1.3 *Integrating Care: Next steps* details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective ICS and reflecting on what a range of local leaders have told NHSE/I about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

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

- Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic commissioning through systems with a focus on population health outcomes;

- The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This means that the Cheshire and Merseyside Health and Care Partnership (HCP) is now working on an authorisation process to become an ICS by April 2021.

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

3.1.6 NHS England and NHS Improvement invited views on these proposed options from all interested individuals and organisations by Friday 8th January 2021. This paper provides an overview of the key proposals in *Integrating Care: Next steps.*

### 3.2 *Integrating Care: Next Steps* – Key practical changes

3.2.1 *Integrating Care: Next steps* sets out a series of practical changes that will be in place by April 2022. The preparatory work for the implementation of these changes during 2021/22 will be supported by further guidance for ICSs and by the *NHS Operational Planning Guidance for 2021/22*. These key practical changes are summarised below.

3.2.2 There will be **devolution of national and regional functions** and resources to ICSs. ICSs will be required to work together across partners to determine:

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

3.2.3 The **future health and care system will be built upon "*place*"**, which is defined as the local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). Within each *place*, services will be joined up through primary care networks (PCNs) integrating care in neighbourhoods. The ambition is to create an offer to the local population of each *place*, to ensure that in that *place* everyone is able to:

- access clear advice on staying well;
- access a range of preventative services;
- access simple, joined-up care and treatment when they need it;

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

3.2.4 There will be **provider collaboration at scale** for services where people will have more complex or acute needs, require specialist expertise which can only be planned and organised effectively over a larger area than *place*. Some services such as hospital, specialist mental health and ambulance will be organised through provider collaboration that operates at a whole-ICS footprint – or more widely where required. To support this there will be the need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

3.2.5 By April 2022 **all NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions. These collaboratives will help the ICS to set system priorities and allocate resources. Joining up the provision of services will happen in two main ways:

- *within places* (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships ('vertical integration'); and
- *between places* at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

3.2.6 There is an expectation that there will be **strong and effective *place*-based partnerships** between sectors. These will have the full involvement of all partners who contribute to the *place's* health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards. There will be a *place* leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);

- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

This will be supported by ICSs who will need to ensure that each *place* has appropriate resources, autonomy and decision-making capabilities to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include *places* taking on delegated budgets. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

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

3.2.7 ICSs will be asked to embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including primary care network representation. Primary care clinical leadership will take place through critical leadership roles including:

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

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

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

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

3.2.8 ICSs will be required to put in place **firmer governance and decision-making arrangements** for 2021/22. As part of this, each system should define:

- '*Place*' leadership arrangements.
- Provider collaborative leadership arrangements
- Individual organisation accountability within the system governance framework.

These governance arrangements will seek to minimise levels of decision-making and set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

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

ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. *Integrating Care: Next steps* sets out options for changes in guidance and legislation, as described below.

During 2021/22, every ICS will be required to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

3.2.9 There will be a **"single pot' of NHS financial resources for each ICS**, organised at ICS level with allocative decisions being made by local leaders. ICSs will need to

- distribute resources in line with national rules, including adhering to mental health and community services investment guarantees, and locally-agreed strategies for health and care.
- deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.
- delegate significant budgets to *place* level, which might include resources for general practice, other primary care, community services, and continuing healthcare.
- move away from episodic or activity-based payment, rolling out a blended payment model for secondary care services. This is intended to greater certainty about the resources available to providers to run certain groups of services and

meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics.

- agree and codify how financial risk will be managed across places and between provider collaboratives.

Through active involvement at ICS and *place* level, providers will have a greater say in how funding is deployed; particularly as new lead provider models emerge. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

3.2.10 **Data and digital technology** have played a vital role helping the NHS and care respond to the pandemic. *Integrating Care: Next steps* places data and digital technology at the heart of creating effective local systems. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, ICSs will need to:

- build smart digital and data foundations – each ICS will have a Board level lead, three year digital transformation plan and will invest in workforce digital and data literacy and infrastructure to support this.
- connect health and care services – this will include developing or joining a shared care record across all health and social care settings to improve care and underpin population health and system management.
- use digital and data to transform care – this will support real time decision making by frontline teams and more effective workforce, finance, quality and performance planning.
- put the citizen at the centre of their care – this will involve improving access to personalised advice on staying well, enabling citizen's to access to their own data, and triage to appropriate health and care services. There will also be increased utilisation of remote monitoring to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

3.2.11 *Integrating Care: Next steps* proposes **changes to regulation and oversight** in the NHS which includes:

- subject to legislation, formally merging NHS England and NHS Improvement into a single body.
- Working with the Care Quality Commission (CQC) to embed a requirement for strong participation in ICS and provider collaborative arrangements in the Well Led assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate.
- ensuring foundation trust directors' and governors' duties to the public support system working.
- introducing new measures and metrics to support system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level and an integration index for use by all systems.

- rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition. There is also a recommendation that regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*.

The future System Oversight Framework will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks, potentially through a proposed future Intensive Recovery Support Programme.

3.2.12 There will be **changes in commissioning**, with a clearer focus on population-level health outcomes and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of Clinical Commissioning Groups (CCGs) will need to change, with either a single CCG being established or CCGs being abolished, subject to legislation, and their functions being delivered through an ICS. The latter is NHSE/I's preferred option.

The activities, capacity and resources for commissioning will change in three significant ways in the future:

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

Commissioning functions will have to be coterminous with ICS boundaries before April 2022. However, with the spread of *place*-based partnerships backed by

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

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

### 3.3 *Integrating Care: Next Steps* – Legislative Changes

3.3.1 In September 2019, NHS E/I made a number of recommendations for an NHS Bill. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership. These recommendations, which remain relevant in the context of *Integrating Care: Next steps*, included:

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

3.3.2 *Integrating Care: Next steps* proposes that ICSs should become statutory bodies. The document sets outs two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

- Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.
- Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

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

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

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

3.3.6 While both models would drive increased system collaboration and achieve the vision and aims of NHS E/I for ICSs in the immediate term, NHS E/I believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. They suggest that it also provides a clearer statutory vehicle for deepening integration across health and local government over time. Additionally NHS E/I also believe that this provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England (NHS E)[1] but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

## 3.4 Implications and Next Steps

3.4.1 Appendix 2 sets out the detail of the implications for the NHS following the proposals in *Integrating Care: Next steps*.

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

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

3.4.4 To support all of the above, all systems should agree development plans with their NHS E/I Regional Director that clearly set out:

[1] NHS England and NHS Improvement have a shared management structure but are legally distinct organisations under the Health and Social Care Act 2012. Commissioning functions and regulation legally reside with NHS England, provider development and regulation with NHS Improvement.

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

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

3.4.6 The legislative proposals set out in *Integrating Care: Next steps* go beyond NHS E/I's original legislative recommendations to the Government. This is why NHS E/I published the document with the intention of seeking views on the proposed options from all interested individuals and organisations. These views will help inform future system design work and that of Government should they take forward the recommendations for legislative change in a future Bill. The closing date for the submission of views was set as Friday 8th January 2020.

3.4.7 In *Integrating Care: Next steps* NHS E/I sought views on four specific questions:

- Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?
- Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?
- Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?
- Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

## 4.0 FINANCIAL IMPLICATIONS

4.1 None as a result of this report.

## 5.0 LEGAL IMPLICATIONS

5.1 It is likely that, in 2021, primary legislation will be introduced by Her Majesty's Government to further support the implementation of the NHS Long Term plan and to give ICSs statutory roles.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There is a direct impact of these changes on staff employed by NHS Wirral CCG. It is anticipated that there will be a human resources framework within which these proposed changes will be managed.

## 7.0 RELEVANT RISKS

7.1 The system changes outlined in this report will have risk management frameworks as part of their implementation.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 Engagement will need to take place in regard to the system changes outlined in this report.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information and no EIA is required.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 None as a result of this report.

**REPORT AUTHOR:** **Simon Banks**
Chief Officer, NHS Wirral CCG and Wirral Health and Care Commissioning
telephone: 0151 651 0011
email: simon.banks1@nhs.net

## APPENDICES

Appendix 1 Legislative Options for Integrated Care Systems
Appendix 2 Implications of *Integrating Care: Next Steps*

## BACKGROUND PAPERS

- NHS Five Year Forward View, https://www.england.nhs.uk/five-year-forward-view/
- NHS Long Term Plan, https://www.longtermplan.nhs.uk/
- NHS Planning Guidance, https://www.england.nhs.uk/publication/delivering-the-forward-view-nhs-planning-guidance-201617-202021/
- NHS England/Improvement, Designing Integrated Care Systems (ICSs) in England, https://www.england.nhs.uk/wp-content/uploads/2019/06/designing-integrated-care-systems-in-england.pdf
- Integrating Care: Next steps to building strong and effective integrated care systems across England, https://www.england.nhs.uk/wp-content/uploads/2020/11/261120-item-5-integrating-care-next-steps-for-integrated-care-systems.pdf

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
| --- | --- |

**PARTNERSHIPS COMMITTEE**
**Wednesday, 13 January 2021**

| REPORT TITLE: | HEALTHWATCH - UPDATE |
|---|---|
| REPORT OF: | DIRECTOR OF LAW AND GOVERNANCE |

**REPORT SUMMARY**

Following a discussion held at a workshop in December 2020, the chair and spokes of the Partnerships Committee requested an update from Healthwatch Wirral.

The core purpose of Healthwatch is to be the consumer champion for health and care service users .They involve patients, service users and the public in shaping local health and care services; and raise awareness of their views and experiences in relation to those services amongst those in charge of services including commissioners and providers.

Their vision is to ensure that the voice of the individual is heard and services are responsive to their needs; that everyone has the opportunity to have their say and understands how and when to access their local health and social care services.

**RECOMMENDATION/S**

The Partnerships Committee are requested to:

1. Note and comment on the presentation from Healthwatch

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report is to support the presentation supplied by Healthwatch will inform the Partnerships Committee on work being undertaken by Healthwatch and highlight any key issues within the borough, Therefore, Members may wish to comment on or make suggestions to add to the work programme.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 Members of the Committee requested that Healthwatch present an update to the committee on their work and key issues found within the borough. Therefore, no other options have been considered.

## 3.0 BACKGROUND INFORMATION

3.1 This report was requested as part of work programming by the Partnerships Committee and is a result of a request for more collaboration with partner organisations and the 3rd Sector.

## 4.0 FINANCIAL IMPLICATIONS

4.1 This report is for information purposes only and there are no financial implications.

## 5.0 LEGAL IMPLICATIONS

5.1 This report is for information purposes only and there are no legal implications.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 This report is for information purposes only and there are no legal implications.

## 7.0 RELEVANT RISKS

7.1 Members of the Partnerships Committee are keen to collaborate with partner agencies in Wirral, as well as 3rd sector organisations. This is to ensure that Members are able to gain an oversight of the issues faced by residents across the borough. Failure to do this would increase the risks caused by lack of oversight or scrutiny.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 The Partnership Committee are committed to engagement and consultation with Wirral Council partners to ensure that it’s scrutiny obligations can be discharged effectively.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information purposes only and the content will be supplied by a partner agency. The Partnerships Committee are committed to ensure that the work it does has equality at its heart and does not discriminate against anyone. Any associated actions may require an EIA

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no direct environment or climate implications as result of this report. However, Wirral Council and its Committees will consider the Climate Emergency declaration within all the work it does and will continue to incorporate this into their work programme and hold all partnerships to account.

**REPORT AUTHOR:** **Anna Perret**
(Anna Perret, Scrutiny Officer)

email: annaperret@wirral.gov.uk

## APPENDICES

Appendix 1 – Health Watch Wirral Update
Appendix 2
Appendix 3

## BACKGROUND PAPERS

Wirral Council – Partnerships Committee terms of reference.

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| **Partnerships committee** | **9 November 2020** |

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Update for Partnerships Committee
January 2021

healthwatch wirral

Healthwatch is an independent organisation with statutory duties and responsibilities to listen to people, about their experiences and views, with the purpose of influencing how our health and care is provided.

Beside our powers of entering and viewing heath and/or care services, we raise the public voice at the highest levels by being part of the strategic and operational structures within our health and care system; we also provide Free Independent Advocacy Support for people who want to make an NHS Complaint. The information that we share, with commissioners and providers, has no bias or politics and is representative, as much as possible, of Wirral residents. Tackling system inequalities runs through everything we do.

HW Wirral has a strong relationship with CQC and we raise issues with one another when inspections or visit are taking place.

Some examples of where we represent the public view locally:-

- Humanitarian Cell
- Health & Social Care Cell – Strategic Command
- Winter Planning Group
- Comms Cell
- Discharge Cell – and Patient Experience Sub-Group (daily at 3 or 4pm)
- Flu Vaccine Cell
- Covid Vaccination Cell
- Mass Testing Roll out to Care Homes Group (pilot)
- Partnership (3rd Sector) meeting, Link Forum and 'Community Of Practice' (COP) which is a grass roots community groups coming together to discuss and share ongoing activities, events and locally driven initiatives
- Healthy Wirral Partners Board
- Community Advisory Group (CAG) run by the Police
- Health Care Partnership Assembly (C&M)
- Primary Care Commissioning (operational and strategic committees)
- Health & Care Imp Group
- Winter Planning Group
- Out of Hospital Board
- Patient Quality Safety Board (WUTHFT)
- System Improvement Board (NHSE/I and CQC and all system leaders)
- Community Trust Governing Body
- Mental Health System Board
- Crisis Care Concordat
- Care Home Collaborative
- Pressure Ulcer Collaborative
- Quality Surveillance C&M
- Inequalities Board

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- BAME Sub Group
- Treat Me Well Group- The campaign has been set up by the learning disability charity 'Mencap'- led by Wirral Mencap
- Discharge Cell (and Discharge sub-group*)
- Winter Planning*
- Urgent Care Development Group*

*all of these groups are working towards an 8 point plan which has been co-designed with the Commissioners and Providers on Wirral, and NHSI and ECIST. Healthwatch, AgeUK, NHSE and ECIST have worked together to produce the para below – we are asking all Boards, Groups and Committees to embrace this para, by adding to ToR, so that, through every step, the public are at the heart of all plans and actions:-

"Foundations of Quality Improvement should always have what patients tell us about their treatment and care at the heart of everything we plan and do, as a system. We must be able to evidence that all actions and decisions made come back to this, making certain that everyone feels respected, involved and valued at each and every part of the journey. We should all feel confident that we are either giving or receiving quality care."

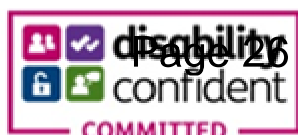
Our Annual report explains about what we have achieved so far and also lays out our plans for the coming year and you can view this by following this link:- https://healthwatchwirral.co.uk/wp-content/uploads/2020/06/HW-Annual-Report-20192020-Final.pdf

Based on information gathered through our community outreach and the relationships with the 3rd Sector and public sector our priorities this year include:-

- Mental health
- Communications and Listening even more- Outreach where possible and safe to do so
- Work closer with CQC to ensure we receive quality care in our communities and in our hospitals
- Increase Public (street level) awareness of the role of Healthwatch- this has already gained traction over 2020.

Of course, it is vital that we work with our local public sector partners on the Healthy Wirral Programme the priorities being:-

- Alcohol Misuse
- Smoking
- Self care
- Health inequalities



And the transformation programmes that underpin these priorities are:

- planned care
- Unplanned care
- Mental health
- Learning disabilities and Autism
- Women and Children and families
- Medicine optimisation

Although Covid-19 has resulted in some deviation from the plans, Healthwatch is involved in all aspects of the Healthy Wirral priorities.

Communications, Listening and Outreach

It has never been more important than now to Spare 5 for someone to help them feel less isolated. We have been working hard on making sure that we give authenticated clear information and to try to find new and better ways to communicate with people. For example; Virtual Bridge Forum, HWW Bulletin, fb/twitter and our new feedback centre (Speak Out Page).
https://healthwatchwirral.co.uk/feedback-centre/

People have felt fearful, anxious and lacking in confidence on what to do when they need help. Our aim is to provide a vehicle for people to freely give information and feedback on their experiences (our Speak Out page on our website) and also to be a "go to" for reliable sources of information.

We had a very "soft sell" survey on our website – asking people to tell us about their thoughts, feelings and experiences during Covid-19. We wanted to do this to see if we could follow what was happening to people during these difficult weeks. It was no surprise to discover that 85% of those who had responded told us that their mental health had, in some way, been affected.

**New Feedback Centre**

The Feedback Centre is like a TripAdvisor. There are 52 Healthwatch already using this style to capture feedback and the beauty of this way of doing things is that we can capture trends and themes and produce reports at the touch of a button. Thus supporting, with real time information, the System Planning (including Winter plans).

We use twitter and facebook, daily, and circulate a full e-bulletin as widely as possible once per month and these can be found on this link :

https://us7.campaign-archive.com/home/?u=9c71482cca3b44ae11b32bd67&id=6abb93330a

Update for Partnerships Committee
January 2021

**Virtual Bridge Forum**- Bridging Resources Information and Direction for Everyone (BRIDGE) Forum

This is a Forum that used to meet physically. It was important that we adapted to the virtual world and look at how we engage more frequently. At BRIDGE all involved are encouraged to think about how services here on Wirral can learn lessons and lock in the benefits of things that have gone well in recent months. As well as updating on their own activities and offers- sharing good practice and how we can work together to improve outcomes for all.

**Enter and View**

- Virtual tours using staff within the Trust, Home, GP practice etc. We have trialled this way of working with Autism Together - a report of the findings will be available on our website soon https://healthwatchwirral.co.uk/reports/

**#Spare 5 Campaign**

The Spare 5 campaign is exactly what it says on the tin. It is to encourage people in our communities to talk to each other and inspiring everyone to Spare 5 mins for themselves and the people they may come into contact with - either in work, at home or by coincidence.

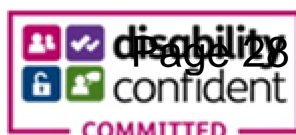
The programme of work for Spare 5 was in full swing prior to CV19; and this included a lot of face to face activity. So, we will be driving the campaign through our Bridge Forum, online, fb, twitter (and face to face as soon as possible.) We have asked WUTHFT if we can have a slot on the Staff Inductions to tell them the value and importance of Sparing 5 as we believe we need to embed this into everyone's thinking at every opportunity.

WUTHFT have also included a Healthwatch Section within their staff bulletins and on in their intranet. There are several benefits to this including:-

- It encourages everyone to Spare 5
- It helps Healthwatch share information about the 3rd Sector and the non-clinical support that can be accessed (supporting hospital avoidance)
- it prompts staff to engage with patients and encourages positive feedback about care

Discharge from hospital

Its obvious that getting people successfully discharged from hospital is vital to getting our "normal" services back on track and also to ensure there is sufficient provision in the system.



Update for Partnerships Committee
January 2021

healthwatch wirral

The #BecauseWeAllCare Campaign (a partnership between CQC and Healthwatch England) encouraged the public to share experiences, both good and bad, to help improve services. Particularly focussing on Discharge from hospital. As well as promoting the benefits of giving feedback and why it's so important, the campaign is also an opportunity to collect people's views on key local issues, such as Dementia, Mental Health.

Healthwatch are also part of the Multi Agency Discharge Cell (which meets 7 days a week). During meetings, as well as challenging the blocks in the system, such as - swab delays, Packages of Care, care Home places, Healthwatch are phoning all patients discharged on pathway 0. Pathway 0 patients are people who do not appear to require any extra support on leaving hospital – apart from maybe a follow up appointment with their GP.

We are asking how the discharge process had worked for them - for example, were you given an Estimated Discharge Date (EDD)? Did you go home when you were supposed to? (If not – what happened?) and do you care for someone at home?

During the call we may find out that they do in fact need extra support. HWW has a good knowledge of the non-clinical and clinical support that is available across Wirral, including the 3rd Sector non-clinical community support, we also #Spare5 to either signpost or support people to get that extra bit of help - to prevent re-admission and/or preventable attendances at GPs or A&E.

We have recorded what people told us and there are no real surprises eg. poor communication, waiting for meds, waiting for the consultant

However, new learning has shown that –

- patients didn't know if they had received a Discharge Pack,
- patients didn't know when they should expect to go home and there was a lack of recording this on patients records
- didn't know if they could contact their GP or even if their GP knew they were out of hospital,
- e-consult hasn't been the best experience for some patients.
- everyone appeared extremely grateful for the follow up call from Healthwatch

On the second day of carrying out this work we were able to prevent 3 people from going to A&E by sourcing community non-clinical support - but it was through our relationships rather than good processes

A quick example were the system could have done better:-

*A gentleman, who had been discharged 5 days previously, had been in extreme pain and trauma with a catheter following a stay in hospital – he had tried his*



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Spare 5 Spare time to connect

*GP multiple times – but was in so much pain he ended up going to A&E and being re-admitted - and this may have been preventable.*

A Discharge Cell sub-group was set up to bring findings together from the Pathway 0 calls and the calls being undertaken by Wirral Community Heath and Care Trust to patients on Pathways 1 and 2.

We also looked at the Discharge Pack for patients. On first viewing it was unclear who the intended recipient was – eg. the professional or the patient. We know that there are some legal requirements for the Discharge Pack but, we queried whether it was necessary to have information about DNAR or words like Trusted Assessor within it; which would be inappropriate for a lot of patients – and even alarming.

HWW raised this with WUTHFT and there are some plans in progress to have another look at the Discharge Pack -and maybe even rename it to “During my stay – and going home” and include Ward Phone Number as well as the SPA (Single Point of Access) number. Also, to give the discharge pack out much earlier in the stay – when the patient has been given an Estimated Date of Discharge. This would encourage staff to talk patients through the pack (#Spare 5 mins) so they know what the contents are and feel more supported; rather than feeling that they have just fallen off a cliff when they leave hospital!

Healthwatch have also worked with a small team to ensure WUTHFTs Discharge policy reflects that discharge is about a “’person’ who is leaving hospital after being unwell”. This was a very successful piece of work and now includes the “Foundation of quality” para mentioned earlier.

Finally, as a result of an unprecedented year, people continued to talk to us about their individual concerns which we were able to signpost/support. However, the main points raised this year were:-

Primary Care
There appeared a lack of understanding whether GPs were open for business. Although HWW were aware of the contribution of some GPs through their presence at strategic meetings, it was not as transparent to the public who could not get to see their GP or access websites because of IT issues.

Acute care
During the height of Covid-19 patients appeared not to want to go to A&E or indeed any care setting. They did not understand whether they should attend appointments or if they could visit family members. Now, December 2020, patients and families appear to be flouting the rules eg. inpatient went for a cigarette and was observed meeting family outside in the car park.

Community Care

Update for Partnerships Committee
January 2021

Screening and immunisations were on hold during Covid-19 but Breast and Cervical Screening has begun again and feedback has been good. Flu Vaccination feedback has also been good. Although there some supply issues early on.

Care Homes and Domiciliary Care
There has not been much feedback in relation to experiences of people using Dom Care but HWW observed that, in relation to other care workers, Dom Care staff appeared to be tested for Covid-19 the least.

Visits to Care Homes has been the primary concern for members of the public. Although the Council and a multi agency team worked hard to fulfil the brief from Government, to support care home visits, it was very difficult to impose. Some Care homes, within the pilot, appeared to work with the Council well whilst others were influenced by their Owners/Agencies who had multiple homes across the Country.

In general, the public were in a very grateful frame of mind during Covid-19, until September when we started to see an increase in concerns relating to Dentists, Cancer diagnosis and treatment and general support with prescriptions and supplies for those who were shielded.

Thank you for inviting me to share some of the work that Healthwatch are currently involved in, and supporting, and if you have any questions or comments please do not hesitate to contact me.

You can find our Annual Report at https://healthwatchwirral.co.uk/wp-content/uploads/2020/06/HW-Annual-Report-20192020-Final.pdf

Stay well

Karen Prior

(karen.prior@healthwatchwirral.co.uk)

End.

Karen Prior
CEO, Healthwatch Wirral – 22 December 2020

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**PARTNERSHIPS COMMITTEE**

**Wednesday, 13 January 2021**

| REPORT TITLE: | CITIZENS ADVICE WIRRAL - UPDATE |
| --- | --- |
| REPORT OF: | DIRECTOR OF LAW AND GOVERNANCE |

**REPORT SUMMARY**

Following a discussion held at a workshop in December 2020, the Chair and Spokes of the Partnerships Committee requested an update and presentation from Citizens Advice Wirral.

Citizens Advice Wirral is a local charity providing advice, information, advocacy and representation across Wirral. They have provided free, impartial and confidential advice to Wirral residents since 1939 and were formerly known as Wirral Citizens Advice Bureau. They are members of the national Citizens Advice charity but are independent from them.

Their services include general advice, specialist debt advice and specialist primary care mental health advice and advocacy. Pension wise, a specialist pension advice service, and a Financial Capability advice service are also delivered at Citizens Advice Wirral by other local Citizens Advice organisations.

Citizens Advice Wirral actively works for change in the policies and practices of organisations that impact on the lives of our clients.

**RECOMMENDATION/S**

The Partnerships Committee are requested to:

1. Note and comment on the presentation by Citizens Advice Wirral.

## SUPPORTING INFORMATION

## 1.0 REASON/S FOR RECOMMENDATION/S

1.1 This report is to support the presentation supplied by Citizens Advice Wirral and will inform the Partnerships Committee on work being undertaken by Citizens Advice Wirral and highlight any key issues within the borough, Therefore, Members may wish to comment on or make suggestions to add to the work programme.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 Members of the Committee requested that Citizens Advice Wirral present an update to the Committee on their work and key issues found within the borough. Therefore, no other options have been considered.

## 3.0 BACKGROUND INFORMATION

3.1 This report was requested as part of work programming by the Partnerships Committee and is a result of a request for more collaboration with partner organisations and the 3rd Sector.

## 4.0 FINANCIAL IMPLICATIONS

4.1 This report is for information purposes only and there are no financial implications.

## 5.0 LEGAL IMPLICATIONS

5.1 This report is for information purposes only and there are no legal implications.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 This report is for information purposes only and there are no legal implications.

## 7.0 RELEVANT RISKS

7.1 Members of the Partnerships committee are keen to collaborate with partner agencies in Wirral, as well as 3rd sector organisations. This is to ensure that Members are able to gain an oversight of the issues faced by residents across the borough. Failure to do this would increase the risks caused by lack of oversight or scrutiny.

## 8.0 ENGAGEMENT/CONSULTATION

8.1 The Partnership Committee are committed to engagement and consultation with Wirral Council Partners to ensure that it’s scrutiny obligations can be discharged effectively.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information purposes only and the content will be supplied by a partner agency. The partnerships committee are committed to ensure that the work it does has equality at its heart and does not discriminate against anyone. Any associated actions may need an EIA

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 There are no direct environment or climate implications as result of this report. However, Wirral Council and its Committees will consider the Climate Emergency Declaration within all the work it does and will continue to incorporate this into their work programme and hold all partnerships to account.

**REPORT AUTHOR:** **Anna Perret**
(Senior Democratic Services Officer)

email: annaperret@wirral.gov.uk

## APPENDICES

None – a presentation will be presented at committee

## BACKGROUND PAPERS

Wirral Council – Partnerships Committee terms of reference.

## SUBJECT HISTORY (last 3 years)

| Council Meeting | Date |
|---|---|
| **Partnerships Committee** | **9 November 2020** |

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## PARTNERSHIPS COMMITTEE

**Wednesday 13th January 2020**

| REPORT TITLE: | APPOINTMENTS TO THE JOINT HEALTH SCRUTINY COMMITTEE FOR CHESHIRE & MERSEYSIDE |
|---|---|
| REPORT OF: | DIRECTOR OF LAW AND GOVERNANCE |

**REPORT SUMMARY**

In accordance with the protocol established as the framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside, the Partnerships Committee is requested to nominate Members to sit on the Joint Health Scrutiny Committee.

The protocol stipulates that each participating local authority should ensure that those Councillors it nominates to a joint health overview and scrutiny committee reflect its own political balance. However, overall political balance requirements may be waived with the agreement of all participating local authorities.

Depending on the issue to be scrutinised, meetings will be attended by either 2 or 3 Members (see section 6.3.2 of the protocol attached at Appendix 1).

In this instance there is a need to appoint three Members, in which case in order to meet the political balance requirements three Members should be appointed as follows:

Labour: 2
Conservative: 1

Should the meeting of the Joint Health Scrutiny Committee only require attendance by two Members, then only one Labour Member will be required to attend along with one Conservative Member.

**RECOMMENDATION/S**

The Partnerships Committee is requested to appoint three members to the Joint Health Scrutiny Committee in accordance with the political balance requirements.

**SUPPORTING INFORMATION**

## 1.0 REASON/S FOR RECOMMENDATION

1.1 To ensure that Members of Wirral Council are represented on the Joint Health Scrutiny Committee.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 As a result of the need to make the appointments, no further options have been considered.

## 3.0 BACKGROUND INFORMATION

3.1 The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 came into effect on 1 April 2013 revising existing legislation regarding health scrutiny.

3.2 Ultimately the regulations place a requirement on relevant scrutiny authorities to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area, or instead, that the proposal should be referred to the Secretary of State for Health. Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not. The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. As a result a protocol has been established to deal with the proposed operation of such arrangements for the local authorities of Cheshire and Merseyside and is attached at Appendix 1 to the report.

3.3 The protocol further details the role of the Joint Committee, its powers and how the Membership is constituted. The role is also further outlined under Part 3, Section B – Partnerships Committee (Section 9.4 *Joint Health Scrutiny Committee*)

## 4.0 FINANCIAL IMPLICATIONS

4.1 Appointment to the Joint Scrutiny Committee does not include entitlement to a Special Responsibility Allowance but travel and subsistence is covered by the Members' Allowances Scheme.

## 5.0 LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct implications to staffing, ICT or Assets.

## 7.0 RELEVANT RISKS

7.1 By not appointing Members to the Joint Health Scrutiny Committee, the views of Wirral Council and its residents will not be represented.

## 8.1 ENGAGEMENT/CONSULTATION

8.1 Not applicable.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

9.2 This report requires Members to make an appointment and as such there are no direct equality Implications.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 This report is for information to Members and there are no direct environment and climate implications.

**REPORT AUTHOR:**

**Steve Fox**
**Head of Democratic and Member Services**
telephone: 0151 691 8145
email: stevefox@wirral.gov.uk

**APPENDICES**

Appendix 1: Protocol For Establishment Of Joint Health Scrutiny Arrangements For Cheshire And Merseyside

**BACKGROUND PAPERS**

The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| Wirral & Cheshire West Joint Health Scrutiny Committee | 11 December 2018 |

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**PROTOCOL FOR ESTABLISHMENT OF JOINT HEALTH SCRUTINY ARRANGEMENTS FOR CHESHIRE AND MERSEYSIDE**

## 1. INTRODUCTION

1.1 This protocol has been developed as a framework for the operation of joint health scrutiny arrangements across the local authorities of Cheshire and Merseyside. It allows for:

- scrutiny of substantial developments and variations of the health service; and,
- discretionary scrutiny of local health services

1.2 The protocol provides a framework for health scrutiny arrangements which operate on a joint basis only. Each constituent local authority should have its own local arrangements in place for carrying out health scrutiny activity individually.

## 2. BACKGROUND

2.1 The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 came into effect on 1 April 2013 revising existing legislation regarding health scrutiny.

2.2 In summary, the revised statutory framework authorises local authorities to:

- review and scrutinise any matter relating to the planning, provision and operation of the health service; and,
- consider consultations by a relevant NHS body or provider of NHS-funded services on any proposal for a substantial development or variation to the health service in the local authority's area.

2.3 Ultimately the regulations place a requirement on relevant scrutiny arrangements to reach a view on whether they are satisfied that any proposal that is deemed to be a substantial development or variation is in the interests of the health service in that area, or instead, that the proposal should be referred to the Secretary of State for Health. In instances where a proposal impacts on the residents of one local authority area exclusively, this responsibility lays with that authority's health scrutiny arrangements alone.

2.4 Where such proposals impact on more than one local authority area, each authority's health scrutiny arrangements must consider whether the proposals constitute a substantial development or variation or not. The regulations place a requirement on those local authorities that agree that a proposal is substantial to establish, in each instance, a joint overview and scrutiny committee for the purposes of considering it. This protocol deals with the

proposed operation of such arrangements for the local authorities of Cheshire and Merseyside.

## 3. PURPOSE OF THE PROTOCOL

3.1 This protocol sets out the framework for the operation of joint scrutiny arrangements where:

a) an NHS body or health service provider consults with more than one local authority on any proposal it has under consideration, for a substantial development/variation of the health service;

b) joint scrutiny activity is being carried out on a discretionary basis into the planning, provision and operation of the health service

3.2 The protocol covers the local authorities of Cheshire and Merseyside including:

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

3.3 Whilst this protocol deals with arrangements within the boundaries of Cheshire and Merseyside, it is recognised that there may be occasions when consultations/discretionary activity may affect adjoining regions/ areas. Arrangements to deal with such circumstances would have to be determined and agreed separately, as and when appropriate.

## 4. PRINCIPLES FOR JOINT HEALTH SCRUTINY

4.1 The fundamental principle underpinning joint health scrutiny will be co-operation and partnership with a mutual understanding of the following aims:

- To improve the health of local people and to tackle health inequalities;

- To represent the views of local people and ensure that these views are identified and integrated into local health service plans, services and commissioning;

- To scrutinise whether all parts of the community are able to access health services and whether the outcomes of health services are equally good for all sections of the community; and,

- To work with NHS bodies and local health providers to ensure that their health services are planned and provided in the best interests of the communities they serve.

## 5. SUBSTANTIAL DEVELOPMENT/VARIATION TO SERVICES

### 5.1 Requirements to consult

5.1.1 All relevant NHS bodies and providers of NHS-funded services[1] are required to consult local authorities when they have a proposal for a substantial development or substantial variation to the health service.

5.1.2 A substantial development or variation is not defined in legislation. Guidance has suggested that the key feature is that it should involve a major impact on the services experienced by patients and/or future patients.

5.1.3 Where a substantial development or variation impacts on the residents within one local authority area boundary, only the relevant local authority health scrutiny function shall be consulted on the proposal.

5.1.4 Where a proposal impacts on residents across more than one local authority boundary, the NHS body/health service provider is obliged to consult all those authorities whose residents are affected by the proposals in order to determine whether the proposal represents a substantial development or variation.

5.1.5 Those authorities that agree that any such proposal does constitute a substantial development or variation are obliged to form a joint health overview and scrutiny committee for the purpose of formal consultation by the proposer of the development or variation.

5.1.6 Whilst each local authority must decide individually whether a proposal represents a substantial development/variation, it is only the statutory joint health scrutiny committee which can formally comment on the proposals if more than one authority agrees that the proposed change is "substantial".

5.1.7 Determining that a proposal is not a substantial development/variation removes the ability of an individual local authority to comment formally on the proposal and exercise other powers, such as the power to refer to the Secretary of State. Once such decisions are made, the ongoing obligation on the proposer to consult formally on a proposal relates only to those authorities

[1] This includes the NHS England, any Clinical Commissioning Group providing services to the residents of Cheshire and Merseyside, an NHS Trust, an NHS Foundation Trust and any other relevant provider of NHS funded services which provides health services to those residents, including public health.

that have deemed the proposed change to be “substantial” and this must be done through the vehicle of the joint committee. Furthermore the proposer will not be obliged to provide updates or report back on proposals to individual authorities that have not deemed them to be “substantial”.

**5.2 Process for considering proposals for a substantial development/variation**

5.2.1 In consulting with the local authority in the first instance to determine whether the change is considered substantial, the NHS body/ provider of NHS-funded service is required to:

- Provide the proposed date by which it requires comments on the proposals
- Provide the proposed date by which it intends to make a final decision as to whether to implement the proposal
- Publish the dates specified above
- Inform the local authority if the dates change[2]

5.2.3 NHS bodies and local health service providers are not required to consult with local authorities where certain ‘emergency’ decisions have been taken. All exemptions to consult are set out within regulations.[3]

5.2.4 In considering whether a proposal is substantial, all local authorities are encouraged to consider the following criteria:

- *Changes in accessibility of services:* any proposal which involves the withdrawal or change of patient or diagnostic facilities for one or more speciality from the same location.

- *Impact on the wider community and other services:* This could include economic impact, transport, regeneration issues.

- *Patients affected:* changes may affect the whole population, or a small group. If changes affect a small group, the proposal may still be regarded as substantial, particularly if patients need to continue accessing that service for many years.

- *Methods of service delivery:* altering the way a service is delivered may be a substantial change, for example moving a particular service into community settings rather than being entirely hospital based.

- *Potential level of public interest:* proposals that are likely to generate a significant level of public interest in view of their likely impact.

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[2] Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013
[3] Section 24 *ibid*

5.2.5. This criteria will assist in ensuring that there is a consistent approach applied by each authority in making their respective decisions on whether a proposal is “substantial” or not. In making the decision, each authority will focus on how the proposals impacts on its own area/ residents.

## 6. OPERATION OF A STATUTORY JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

### 6.1 General

6.1.1 A joint health overview and scrutiny committee will be made up of each of the constituent local authorities that deem a proposal to be a substantial development or variation. This joint committee will be formally consulted on the proposal and have the opportunity to comment. It will also be able to refer to the Secretary of State for Health if any such proposal is not considered to be in the interests of the health service.

6.1.2 A decision as to whether the proposal is deemed substantial shall be taken within a reasonable timeframe and in accordance with any deadline set by the lead local authority, following consultation with the other participating authorities.

### 6.2 Powers

6.2.1 In dealing with substantial development/variations, any statutory joint health overview and scrutiny committee that is established can:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make comments on the subject proposal by a date provided by the NHS body/local health service provider
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations
- carry out further negotiations with the relevant NHS body where it is proposing not to agree to a substantial variation proposal; and
- where agreement cannot be reached, to notify the NHS body of the date by which it intends to make the formal referral to the Secretary of State

6.2.2 A joint health overview and scrutiny committee has the power to refer a proposal to the Secretary of State if:

- the committee is not satisfied that consultation with the relevant health scrutiny arrangements on any proposal has been adequate
- it is not satisfied that reasons for an ‘emergency’ decision that removes the need for formal consultation with health scrutiny are adequate

- it does not consider that the proposal would be in the interests of the health service in its area

6.2.3 Where a committee has made a recommendation to a NHS body/local health service provider regarding a proposal and the NHS body/provider disagrees with the recommendation, the local health service provider/NHS body is required to inform the joint committee and attempt to enter into negotiation to try and reach an agreement. In this circumstance, a joint committee has the power to report to the Secretary of State if:

- relevant steps have been taken to try to reach agreement in relation to the subject of the recommendation, but agreement has not been reached within a reasonable period of time; or,
- There has been no attempt to reach agreement within a reasonable timeframe.

6.2.4 Where a committee disagrees with a substantial variation and has either made comments (without recommendations) or chosen not to provide any comments, it can report to the Secretary of State only if it has:

- Informed the NHS body/local health service provider of its decision to disagree with the substantial variation and report to the Secretary of State; or,
- Provided indication to the NHS body/local health service provider of the date by which it intends to make a referral.

6.2.5 In any circumstance where a committee disagrees with a proposal for a substantial variation, there will be an expectation that negotiations will be entered into with the NHS body/local health service provider in order to attempt to reach agreement.

6.2.6 Where local authorities have agreed that the proposals represent substantial developments or variations to services and agreed to enter into joint arrangements, it is only the joint health overview and scrutiny committee which may exercise these powers.

6.2.7 A statutory joint health overview and scrutiny committee established under the terms of this protocol may only exercise the powers set out in 6.2.1 to 6.2.3 above in relation to the statutory consultation for which it was originally established. Its existence is time-limited to the course of the specified consultation and it may not otherwise carry out any other activity.

### 6.3 Membership

6.3.1 Each participating local authority should ensure that those Councillors it nominates to a joint health overview and scrutiny committee reflect its own political balance.[4] However, overall political balance requirements may be waived with the agreement of all participating local authorities.

[4] Localism Act 2011, Schedule 2 9FA, 6 (b)

6.3.2 A joint committee will be composed of Councillors from each of the participating authorities within Cheshire and Merseyside in the following ways:

- where 4 or more local authorities deem the proposed change to be substantial, each authority will nominate 2 elected members
- where 3 or less local authorities deem the proposed change to be substantial, then each participating authority will nominate 3 elected members.

  (Note: In making their nominations, each participating authority will be asked to ensure that their representatives have the experience and expertise to contribute effectively to a health scrutiny process)

| Local authorities who consider change to be 'substantial' | No' of elected members to be nominated from each authority |
|---|---|
| 4 or more | 2 members |
| 3 or less | 3 members |

6.3.3 Each local authority will be obliged to nominate elected members through their own relevant internal processes and provide notification of those members to the lead local administrative authority at the earliest opportunity.

6.3.4 To avoid inordinate delays in the establishment of a relevant joint committee, it is suggested that constituent authorities arrange for delegated decision making arrangements to be put in place to deal with such nominations at the earliest opportunity.

**6.5 Quorum**

6.5.1 The quorum of the meetings of a joint committee shall be one quarter of the full membership of any Joint Committee, subject to the quorum being, in each instance, no less than 3.

6.5.2 There will be an expectation for there to be representation from each authority at a meeting of any joint committee established. The lead local authority will attempt to ensure that this representation is achieved.

**6.6 Identifying a lead local authority**

6.6.1 A lead local authority should be identified from one of the participating authorities to take the lead in terms of administering and organising a joint committee in relation to a specific proposal.

6.6.2 Selection of a lead authority should, where possible, be chosen by mutual agreement by the participating authorities and take into account both capacity

to service a joint health scrutiny committee and available resources. The application of the following criteria should also guide determination of the lead authority:

- The local authority within whose area the service being changed is based; or
- The local authority within whose area the lead commissioner or provider leading the consultation is based.

6.6.3 Lead local authority support should include a specific contact point for communication regarding the administration of the joint committee. There will be an obligation on the key lead authority officer to liaise appropriately with officers from each participating authority to ensure the smooth running of the joint committee.

6.6.4 Each participating local authority will have the discretion to provide whatever support it may deem appropriate to their own representative(s) to allow them to make a full contribution to the work of a joint committee.

**6.7 Nomination of Chair/ Vice-Chair**

The chair/ vice-chair of the joint health overview and scrutiny committee will be nominated and agreed at the committee's first meeting. It might be expected that consideration would be given to the chair being nominated from the representative(s) from the lead authority.

**6.8 Meetings of a Joint Committee**

6.8.1 At the first meeting of any joint committee established to consider a proposal for a substantial development or variation, the committee will also consider and agree:

- The joint committee's terms of reference;
- The procedural rules for the operation of the joint committee;
- The process/ timeline for dealing formally with the consultation, including:
    - the number of sessions required to consider the proposal; and,
    - the date by which the joint committee will make a decision as to whether to refer the proposal to the Secretary of State for Health – which should be in advance of the proposed date by which the NHS body/service provider intends to make the decision.

6.8.2 All other meetings of the joint committee will be determined in line with the proposed approach for dealing with the consultation. Different approaches may be taken for each consultation and could include gathering evidence from:

- NHS bodies and local service providers;
- patients and the public;

- voluntary sector and community organisations; and
- NHS regulatory bodies.

### 6.9 Reports of a Joint Committee

6.9.1 A joint committee is entitled to produce a written report which may include recommendations. As a minimum, the report will include:

- An explanation of why the matter was reviewed or scrutinised
- A summary of the evidence considered
- A list of the participants involved in the review
- An explanation of any recommendations on the matter reviewed or scrutinised

The lead authority will be responsible for the drafting of a report for consideration by the joint committee.

6.9.2 Reports shall be agreed by the majority of members of a joint committee and submitted to the relevant NHS body/health service provider or the Secretary of State as applicable.

6.9.3 Where a member of a joint health scrutiny committee does not agree with the content of the committee's report, they may produce a report setting out their findings and recommendations which will be attached as an appendix to the joint health scrutiny committee's main report.

## 7. DISCRETIONARY HEALTH SCRUTINY

7.1 More generally, the Health and Social Care Act 2012 and the 2013 Health Scrutiny Regulations provide for local authority health scrutiny arrangements to scrutinise the planning, provision and operation of health services.

7.2 In this respect, two or more local authorities may appoint a joint committee for the purposes of scrutinising the planning, provision and operation of health services which impact on a wider footprint than that of an individual authority's area.

7.3 Any such committee will have the power to:

- require relevant NHS bodies and health service providers to provide information to and attend before meetings of the committee to answer questions
- make reports and recommendations to relevant NHS bodies/local health providers
- require relevant NHS bodies/local health service providers to respond within a fixed timescale to reports or recommendations

7.4 A discretionary joint committee will not have the power to refer an issue to the Secretary of State for Health.

7.5 In establishing a joint committee for the purposes of discretionary joint scrutiny activity, the constituent local authorities should determine the committee's role and remit. This should include consideration as to whether the committee operates as a standing arrangement for the purposes of considering all of the planning, provision and operation of health services within a particular area or whether it is being established for the purposes of considering the operation of one particular health service with a view to making recommendations for its improvement. In the case of the latter, the committee must disband once its specific scrutiny activity is complete.

7.6 In administering any such committee, the proposed approach identified in sections 6.3 – 6.9 (disregarding any power to refer to the Secretary of State) of this protocol should be followed, as appropriate.

## 8. CONCLUSION

8.1 The local authorities of Cheshire and Merseyside have adopted this protocol as a means of governing the operation of joint health scrutiny arrangements both mandatory and discretionary. The protocol is intended to support effective consultation with NHS bodies or local health service providers on any proposal for a substantial development of or variation in health services. The protocol also supports the establishment of a joint health overview and scrutiny committee where discretionary health scrutiny activity is deemed appropriate.

8.2 The protocol will be reviewed regularly, and at least on an annual basis to ensure that it complies with all current legislation and any guidance published by the Department of Health.

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**PARTNERSHIPS COMMITTEE**

**Monday 9th November 2020**

| REPORT TITLE: | PARTNERSHIPS COMMITTEE WORK PROGRAMME UPDATE |
| --- | --- |
| REPORT OF: | DIRECTOR OF LAW AND GOVERNANCE |

**REPORT SUMMARY**

The Partnerships Committee, in co-operation with the Policy and Service Committees, is responsible for proposing and delivering an annual committee work programme.

The Council has a number of statutory scrutiny functions including matters relating to the health of the authority's population, the activities of those responsible for crime and disorder strategies, as embodied by the Safer Wirral Partnership, under the Police and Justice Act 2006 and flood risk management and coastal erosion management functions which may affect the local authority's area. These overview and scrutiny functions are to be carried out by the Partnerships Committee, which will also scrutinise the functions and responsibilities undertaken by other public bodies within the Borough.

It is envisaged that the work programme will be formed from a combination of standing items and requested officer reports. This report provides the Committee with an opportunity to plan and regularly review its work across the municipal year. The work programme for the Partnerships Committee is attached as Appendix 1 to this report.

**RECOMMENDATION/S**

Members are invited to note and comment on the proposed Partnerships Committee work programme for the remainder of the 2020/21 municipal year.

**SUPPORTING INFORMATION**

## 1.0 REASON/S FOR RECOMMENDATION

1.1 To ensure Members of the Partnerships Committee have the opportunity to contribute to the delivery of the annual work programme.

## 2.0 OTHER OPTIONS CONSIDERED

2.1 A number of workplan formats were explored, with the current framework open to amendment to match the requirements of the Committee.

## 3.0 BACKGROUND INFORMATION

3.1 The work programme should align with the priorities of the Council and its partners. The programme will be informed by:

- The Council Plan
- The Council's transformation programme
- The Council's Forward Plan
- Service performance information
- Risk management information
- Public or service user feedback
- Referrals from Council

### 3.2 Terms of Reference

3.3 The principal role of the Partnerships Committee is to look outwards to the Council's functions as the area's democratically elected local government, representing the people and businesses of the Borough. In terms of reviewing the decisions of relevant partner authorities on health service provision, on crime and disorder and on flood risk management, this role extends to include a statutory role and powers given by Parliament to the Council. The Committee can produce reports to which a relevant partner authority must have regard in the exercise of its functions.

3.4 The Committee is established by Council to fulfil those functions as an overview and scrutiny committee, not undertaken by the Decision Review Committee, provided under Part 3 of the 2012 Local Authorities (Committee System) (England) Regulations. The Committee is charged by full Council to:

(a) undertake reviews and make recommendations on services or activities carried out by external organisations which affect the Borough of Wirral or any of its inhabitants, including the review and monitoring of the contractual and operational performance of shared service partnerships, joint ventures and outside organisations to which the Council makes a resource contribution, focussing on examination of the benefits of the Council's contribution and the extent to which the body concerned makes a contribution to achievement of the Council's priorities;

(b) consider and implement mechanisms to encourage and enhance community participation in the development of policy options and to investigate, take evidence and consult upon issues within their remit;

(c) undertake responsibility for the Council's responsibilities for scrutiny as stated in the Police and Justice Act 2006, the Health and Social Care Act 2006 as amended, the Local Government Act 2000 as amended, the Localism Act 2011 and the subsequent Local Authority (Committee System) (England) Regulations 2012, which includes

(d) in respect of the Health and Social Care Act 2006, the functions to:

(i) investigate major health issues identified by, or of concern to, the local population.
(ii) consult, be consulted on and respond to substantial changes to local health service provision, including assessing the impact on the local community and health service users.
(iii) scrutinise the impact of interventions on the health of local inhabitants, particularly socially excluded and other minority groups, with the aim of reducing health inequalities.
(iv) maintain an overview of health service delivery against national and local targets, particularly those that improve the public's health.
(v) receive and consider referrals from local Healthwatch on health matters.

(e) in respect of the Police and Justice Act 2006, the functions to:

(i) review or scrutinise decisions made or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions; and

(ii) make reports or recommendations to the local authority with respect to the discharge of those functions

(f) in respect of Section 9JB of the Local Government Act 2000, the functions to review and scrutinise the exercise by risk management authorities of flood risk management and of coastal erosion management functions which may affect the local authority's area; and

(g) undertake responsibility for those overview and scrutiny functions provided for under Part 3 of the 2012 Local Authorities (Committee System) (England) Regulations. not otherwise fulfilled.

**4.0 FINANCIAL IMPLICATIONS**

4.1 This report is for information and planning purposes only, therefore there are no direct financial implication arising. However, there may be financial implications arising as a result of work programme items

**5.0 LEGAL IMPLICATIONS**

5.1 There are no direct legal implications arising from this report. However, there may be legal implications arising as a result of work programme items.

## 6.0 RESOURCE IMPLICATIONS: STAFFING, ICT AND ASSETS

6.1 There are no direct implications to staffing, ICT or Assets.

## 7.0 RELEVANT RISKS

7.1 The Committee's ability to review decisions made by relevant partner authorities and the performance of these organisations may be compromised if it does not have the opportunity to plan and regularly review its work across the municipal year.

## 8.1 ENGAGEMENT/CONSULTATION

8.1 Not applicable.

## 9.0 EQUALITY IMPLICATIONS

9.1 Wirral Council has a legal requirement to make sure its policies, and the way it carries out its work, do not discriminate against anyone. An Equality Impact Assessment is a tool to help council services identify steps they can take to ensure equality for anyone who might be affected by a particular policy, decision or activity.

This report is for information to Members and there are no direct equality Implications.

## 10.0 ENVIRONMENT AND CLIMATE IMPLICATIONS

10.1 This report is for information to Members and there are no direct environment and climate implications.

**REPORT AUTHOR:**

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## APPENDICES

Appendix 1: Partnerships Committee workshop report

## BACKGROUND PAPERS

http://democracy.wirral.gov.uk/ieListDocuments.aspx?CId=123&MId=8578

**SUBJECT HISTORY (last 3 years)**

| Council Meeting | Date |
|---|---|
| **Partnerships committee** | **9th November 2020** |

# Partnerships Committee Workshop report

## A report produced by the Partnerships Committee

**January 2021 Final Report**

# 1. Governance

In October 2019, Wirral Council agreed to a move from the Leader and Cabinet Executive arrangements to a Committee System form of governance arrangements. These changes have taken effect from the first Annual Council Meeting on 28th September 2020.

The Council has a number of statutory scrutiny functions including matters relating to the health of the authority's population and the power to scrutinise the activities of those responsible for crime and disorder strategies, as embodied by the Safer Wirral Partnership, under the Police and Justice Act 2006

The Council has determined, through its governance working group, that these overview and scrutiny functions are to be carried out by the Partnerships Committee, which will also scrutinise the functions and responsibilities undertaken by other public bodies within the Borough. The Partnerships Committee will be an 'outward looking' committee composed of 11 Council Members who will be assigned subject to political proportionality – with its principal role to review decisions made by relevant partner authorities and the performance of these organisations. Overview and scrutiny as an approach, meaning the review of implementation of policies and develop of future policy, will be undertaken by the Policy & Resources Committee.

The Partnerships Committee has been established primarily to implement the authority's overview and scrutiny functions as set out in Part 3 of the Local Authority (Committee System) (England) Regulations 2012 (b) Functions. The Partnerships Committee will review and scrutinise matters which affect the Borough and its residents, including carrying out the Council's statutory responsibilities in relation to decisions made or action taken in connection with;

- the discharge by the Wirral Community Safety Partnership of their crime and disorder functions under the Police and Justice Act 2006;
- matters relating to the planning, provision and operation of health services in the Borough, including significant change to service provision and those jointly commissioned or delivered by the council under the Health and Social Care Act 2006;
- the review and scrutiny of the flood and coastal erosion risk management functions under the Flood and Water Management Act 2010.

The Partnerships Committee does not have a direct Council budget that it is responsible for, but rather acts as a scrutiny body to review the financial and performance data of external partners and offer comment.

### 1.1 Terms of Reference

**Composition:**

Eleven (11) Members of the Council, subject to proportionality, which may be altered to accommodate the overall political balance calculation.

**Terms of Reference**

The principal role of the Partnerships Committee is to look outwards to the Council's functions as the area's democratically elected local government, representing the people and businesses of the Borough. In terms of reviewing the decisions of relevant partner authorities on health service provision, on crime and disorder and on flood risk management, this role extends to include a statutory role and powers given by Parliament to the Council. The Committee can produce reports to which a relevant partner authority must have regard in the exercise of its functions.

The Committee is established by Council to fulfil those functions as an overview and scrutiny committee, not undertaken by the Decision Review Committee, provided under Part 3 of the 2012 Local Authorities (Committee System) (England) Regulations.

The Committee is charged by full Council to:-

(a) undertake reviews and make recommendations on services or activities carried out by external organisations which affect the Borough of Wirral or any of its inhabitants, including the review and monitoring of the contractual and operational performance of shared service partnerships, joint ventures and outside organisations to which the Council makes a resource contribution, focussing on examination of the benefits of the Council's contribution and the extent to which the body concerned makes a contribution to achievement of the Council's priorities;

(b) consider and implement mechanisms to encourage and enhance community participation in the development of policy options and to investigate, take evidence and consult upon issues within their remit;

(c) undertake responsibility for the Council's responsibilities for scrutiny as stated in the Police and Justice Act 2006, the Health and Social Care Act 2006 as amended, the Local Government Act 2000 as amended, the Localism Act 2011 and the subsequent Local Authority (Committee System) (England) Regulations 2012, which includes

(d) in respect of the Health and Social Care Act 2006, the functions to:

    (i) investigate major health issues identified by, or of concern to, the local population.
    (ii) consult, be consulted on and respond to substantial changes to local health service provision, including assessing the impact on the local community and health service users.

    (iii) scrutinise the impact of interventions on the health of local inhabitants, particularly socially excluded and other minority groups, with the aim of reducing health inequalities.

(iv) maintain an overview of health service delivery against national and local targets, particularly those that improve the public's health.

(v) receive and consider referrals from local Healthwatch on health matters.

(e) in respect of the Police and Justice Act 2006, the functions to:

(i) review or scrutinise decisions made or other action taken, in connection with the discharge by the responsible authorities of their crime and disorder functions; and

(ii) make reports or recommendations to the local authority with respect to the discharge of those functions

(f) in respect of Section 9JB of the Local Government Act 2000, the functions to review and scrutinise the exercise by risk management authorities of flood risk management and of coastal erosion management functions which may affect the local authority's area; and

(g) undertake responsibility for those overview and scrutiny functions provided for under Part 3 of the 2012 Local Authorities (Committee System) (England) Regulations. not otherwise fulfilled.

**1.2 Methodology**

The process and meetings of the Committee in carrying out will be conducted in accordance with the Overview and Scrutiny Procedure Rules set out in Part 4(4) of this Constitution.

**1.3 Joint Health Scrutiny Committee**

A Joint Health Scrutiny Committees has been established under Regulations made under the Health and Social Care Act 2001 and directions issued by the Secretary of State for Health. These committees comprise representatives of the authorities in the area affected and are appointed to examine proposals by NHS Trusts and commissioners that affect more than one local authority area. They are authorised formally by the local authorities to scrutinise and report on the proposals and to consider whether, in the light of the decision of the NHS Board(s), the consultation process was flawed or that the decision is not in the interest of the residents and health needs in the area and, in either case, whether to refer the matter to the Secretary of State for Health.

Procedures at meetings of Joint Health Scrutiny Committees will be as decided by the Joint Committee and in accordance with the Memorandum of Understanding agreed by the respective authorities [dated xx], except where otherwise prescribed by legislation.

## 2. Overview and Scrutiny: Statutory Guidance

May 2019, the Ministry for Housing Communities and Local Government published a statutory document on Overview & Scrutiny in local government. Authorities with a scrutiny arrangement have an obligation to hold the guidance in regard when exercising their scrutiny function, although it is nationally recognised that each authority is best placed to determine its own scrutiny arrangements.
The guidance seeks to ensure local authorities and combined authorities are aware of the purpose of overview and scrutiny, what effective scrutiny looks like, how to conduct it effectively and the benefits it can bring.

### 2.1 Culture

A crucial area of focus within the guidance was the idea of a strong organisational culture which recognises the value of scrutiny. In addition, the paper states that early engagement between the Executive and Scrutiny is key, and that Scrutiny Members are supported to have an independent mindset and a high profile within the organisation.

### 2.2 Resourcing

As referenced in the guidance, 'effectively resourced scrutiny adds value to the authority, improves ability to meet the needs of local people and can help policy formulation.' The designation of a Statutory Scrutiny Officer is required, alongside a team of Democratic Services officers who are structurally independent from those areas they scrutinise, in order to ensure impartiality of advice. Wirral currently delivers all aspects of best practice regarding resourcing, with a statutory scrutiny officer and a team of officers in place.

### 2.3 Selecting Committee Members

The paper states that selecting Members for scrutiny committees with the right skills and commitment is essential, and effective induction and training should be ensured. Outside expertise in the form of co-option of individuals and technical advisors can also be useful.

At Wirral, Partnership Committee members are selected based on their knowledge, experience and dedication to the remit of the Committee. There is a corporate Member Development programme in place, with scrutiny-specific training and development often arranged by Democratic Services.

Scrutiny Members should be able to access any information that they require and receive it in good time, with care taken not to limit or refuse information unless necessary. Committees in Wirral make use of closed scrutiny sessions if requested information is financially or commercially sensitive although Members were keen that, where possible, information is presented to the Committee to keep discussion open and transparent.

**Parliamentary Select Committees**

Parliamentary Select Committees are groups of MPs or members of the House of Lords that are set up to investigate a specific issue in detail or to perform a specific scrutiny role. They may call in officials and experts for questioning and can demand information from the government. Select committees publish their findings in a report and the government is expected to respond to any recommendations that are made.

In British politics, parliamentary select committees can be appointed from the House of Commons, like the Foreign Affairs Select Committee or from the House of Lords, like the Delegated Powers and Regulatory Reform Committee.

In regard Local Government Overview and Scrutiny there been the acceleration in the development of formal and informal partnership working at local level, since 2020.

This has led to a more outward-looking approach to scrutiny work, with councillors looking at issues as they affect local people rather than carrying out oversight of the council as an institution. The potential expansion of scrutiny's role has led to some challenges in prioritisation, and the management of resources, to ensure that the function is investigating the right issues at the right time, and in the right way.

The Francis inquiry into the Stafford Hospital scandal revealed that concerns expressed to the local scrutiny committee with responsibility for health issues had not been taken up and investigated. The inquiry report suggested that scrutiny needed to be properly supported to carry out a central role in a more robust accountability framework within the NHS, to prevent those events recurring.

The statutory guidance, and this guidance, reflects the “four principles” of good scrutiny developed by CfPS in 2003 and which remain vital and relevant today. These are that effective overview and scrutiny should:

- Provide constructive “critical friend” challenge;
- Amplify the voices and concerns of the public;
- Be led by independent people who take responsibility for their role;
- Drive improvement in public services.

CfPS thinks that there are three further components of good scrutiny and good governance which support and reinforce these principles. These components are necessary in order for democracy at a local level to be participative; they are necessary for good scrutiny to thrive. These are:

- Accountability – an environment where responsibility for services and decisions is clear and where those holding responsibility can and are answerable for success and failure;
- Transparency – the publication, proactively, of information relating to services and decisions to allow local people, and others, to hold policymakers and decision-makers to account.
- Involvement – rules, principles and processes whereby a wide range of stakeholders (including elected representatives) can play active roles in holding to account and influencing and directing the development of policy.
- These principles and components rely on the presence of a strong and supportive political and organisational culture; one in which forensic and robust scrutiny can develop and thrive.

## 3. Work Planning and Considerations for Work Programmes

The guidance suggests that O&S Committees draw up long-term work programmes, making them flexible enough to accommodate any urgent issues that arise during the year. In addition, it is suggested that work is prioritised, with emphasis given to subjects that are involve risk, finance or partnership working, and that partners, stakeholders and executive Members are engaged with.

This includes use of a set of principles for prioritisation – a clear list of criteria to ensure that the most significant topics are prioritised. Alongside this initial planning session, the agenda for each meeting is reviewed throughout the year to allow urgent issues to be addressed and the work programme to remain as flexible as possible.

**Evidence Sessions**

The publication advocates the use of evidence sessions in informing the recommendations of O&S Committees. These sessions can include workshops or task and finish groups, and should have clear objectives to start, and evaluation of evidence presented.

At Committee on 9th November 2020, Committee discussed the work programme and a wide range of possible options including the possibility of inviting partners and external agencies to attend and report to future Committee Meetings.
These included:

- Officers from Merseyside Fire & Rescue Service,
- the Northwest Ambulance Service,
- Social Housing providers,
- Network Rail,
- the Voluntary/Third Sector,
- RNLI,
- Better Care Fund,
- Utility providers,
- the Highways Authority and
- Trade Union representatives
- Notices of Motion
- Food security
- Partnerships
- Road safety

## 4. Workshop Summary

In December 2020, a workshop was held for members of the Partnerships Committee with a view to setting out the committee priorities for the next municipal year and beyond. It was agreed by Members and Officers that the new governance arrangements, committee system and disaggregation of scrutiny between the policy and service committees gives the partnerships committee a unique opportunity to shape the work programme.

After updates from the Heads of Legal Services and Democratic & Member Services, the Chair opened up discussions from Members of the Committee as to the work programme and priorities moving forward.

After some discussion there was a general consensus that the Committee should continue to focus on health scrutiny moving forward, with additional focus and collaboration with partner organisations.

Members were also keen to avoid duplication of work with other Committees and agreed that some items such as road safety would be best served by the policy and service committees. However, it was also agreed that collaboration between the Committees should be maintained and matters for further scrutiny could be referred to the Partnerships Committee for consideration

It was agreed that a list of agenda items should be sent via Democratic Services to collate agenda subjects for prioritisation by the Chair and Group spokes.

Members of the Committee were asked to rank items in order of priority and were also requested to note how the items should be scrutinised, i.e. Committee report, workshop or working group etc.

Below are the collated responses.

| **Topic in rank order of interest** | **Suggested Format of Scrutiny Approach** | **Internal/ External/ Combination** |
|---|---|---|
| 1. Voluntary/Third Sector | Committee report/ Presentation | Combination |
| 2. Better Care Fund | Committee report/ Presentation | Combination |
| 3. Merseyside Fire & Rescue Service | Committee report/Presentation | External |
| 4. RNLI | Committee report/ Presentation | External |
| 5. Northwest Ambulance Service | Committee report/ Presentation | External |
| 6. Network Rail | Committee report or workshop | External |
| 7.Trade Union representatives | Committee report or workshop | External |
| 8.Utility providers | Committee report/ Presentation | External |
| 9. Food security | Workshop | Combination |
| 10. Notices of Motion | Officer research/Workshop | Internal |

| | | |
|---|---|---|
| 11. Social Housing providers | Refer to Housing committee | Combination |
| 12. Highways Authority | Refer to Environment Committee | Internal |
| 13. Road safety | Refer to Environment Committee | Combination |

| HEALTH | |
|---|---|
| **Wirral Health and Care Commissioning (Wirral CCG)** | |
| ***Key Officer*** | ***Role*** |
| Simon Banks (PA Karen Duckworth) | Chief Officer |
| Dr Paula Cowan | Chair |
| Lorna Quigley | Director of Quality and Patient Safety |
| Nesta Hawker | Director of Commissioning |
| Wirral University Teaching Hospital NHS Foundation Trust | |
| Janelle Holmes (PA Nigel McLeod) | Chief Executive |
| Anthony Middleton | Chief Operating Officer |
| Paul Moore | Director of Governance and Quality Improvement |
| Hazel Richards | Chief Nurse |
| Wirral Community Health and Care NHS Foundation Trust | |
| Karen Howell (PA Denise Powell) | Chief Executive |
| Mark Greatrex | Deputy Chief Executive |
| Val McGee | Chief Operating Officer |
| Paula Simpson | Director of Nursing |
| Cheshire and Wirral Partnership NHS Foundation Trust | |
| Sheena Cumiskey | Chief Executive |
| Suzanne Edwards | Director of Operations |
| Clatterbridge Cancer Centre NHS Foundation Trust | |
| Dr Liz Bishop | Chief Executive |
| Dr Sheena Khanduri | Medical Director |

| COMMUNITY SAFETY | |
|---|---|
| Wirral Community Safety Partnership : co-ordinated by Mark Camborne, AD - Safer Wirral Service | |
| ***Key Officer*** | ***Role*** |
| Clive Howarth | Police Crime Commissioner's Office |
| Gary O'Rourke | Merseyside Police |
| Simon Banks | Wirral CCG |
| TBC | National Probation Service |
| TBC | Merseytravel |
| TBC | Merseyside Community Rehabilitation Company |
| Phil Garrigan | Mersey Fire and Rescue Service |

| FLOODING AND FLOOD RISK MANAGEMENT |
|---|
| Wirral Flood and Water Management Partnership : co-ordinated by Neil Thomas, Flood and Coastal Risk Manager |
| Environment Agency |
| United Utilities |
| Welsh Water |
| WBC Highways Authority |

## 5.COMMITTEE MEMBERSHIP AND MEETING SCHEDULE

The draft Council Calendar of Meetings 2020/21 and Committee Memberships will be confirmed at the Annual Council meeting on 28th September 2020.

| **11 Members** | | | |
|---|---|---|---|
| **Labour** | **Conservative** | **Liberal Democrat** | **Independent** |
| Cllr Christine Spriggs (Chair)<br>Cllr Tony Cottier<br>Cllr Christina Muspratt<br>Cllr Sarah Spoor<br>Cllr Joe Walsh<br>Cllr Stuart Whittingham | Cllr Leslie Rennie (Vice-Chair)<br>Cllr Jenny Johnson<br>Cllr Ian Lewis | Cllr Dave Mitchell | Cllr Mike Sullivan |

Meeting Schedule

Formal Committee meetings are scheduled for the following dates during the 2020/22 municipal year:

- 9th November 2020
- 13th January 2021

Meetings normally commence at 6.00pm

Head of Member and Democratic Services/Statutory Scrutiny Officer
Steve Fox
✉ stevefox@wirral.gov.uk

Principal Democratic Services Officer
Michael Jones
✉ michaeljones1@wirral.gov.uk

Senior Democratic Services Officer
Alexandra Davidson
✉ alexandradavidson@wirral.gov.uk

# PARTNERSHIPS COMMITTEE

**WORK PROGRAMME 2020/21**

**Contact Officer/s:** Mike Jones
Alex Davidson

**PROPOSED AGENDA FOR PARTNERSHIPS COMMITTEE**
**13th January 2021**

| Item | Lead Departmental Officer | Wirral Plan Priority |
|---|---|---|
| Strategic Developments in the NHS | Simon Banks | Healthy and active lives |
| Healthwatch Wirral | Karen Prior | Healthy and active lives |
| Citizens Advice Wirral Update report | Citizens Advice Wirral | Healthy and active lives |
| Appointments to joint health scrutiny for Cheshire and Merseyside | Steve Fox | Healthy and active lives |
| Work Programme update | Anna Perrett | Healthy and active lives |

**ADDITIONAL AGENDA ITEMS – WAITING TO BE SCHEDULED**

| Item | Approximate timescale | Lead Departmental Officer |
|---|---|---|
| Community Safety Strategy Update | 2020/21 | Mark Camborne |
| WUTH CQC Improvement Plan | 2020/21 | Janelle Holmes/Paul Moore (WUTH) |
| *Liverpool & Wirral Coroner Annual Report 2019* | 2020/21 | *Rachelle Nield (Chief Clerk - H.M. Coroner's Court)* |

**Committee Priorities – waiting to be scheduled**

| Topic in rank order of interest | Suggested Format of Scrutiny Approach | Internal/ External/ Combination |
|---|---|---|
| 1. Voluntary/Third Sector | Committee report/ Presentation | Combination |
| 2. Better Care Fund | Committee report/ Presentation | Combination |
| 3. Merseyside Fire & Rescue Service | Committee report/Presentation | External |
| 4. RNLI | Committee report/ Presentation | External |
| 5. Northwest Ambulance Service | Committee report/ Presentation | External |
| 6. Network Rail | Committee report or workshop | External |
| 7.Trade Union representatives | Committee report or workshop | External |
| 8.Utility providers | Committee report/ Presentation | External |
| 9. Food security | Workshop | Combination |
| 10. Notices of Motion | Officer research/Workshop | Internal |
| 11. Social Housing providers | Refer to Housing committee | Combination |
| 12. Highways Authority | Refer to Environment Committee | Internal |
| 13. Road safety | Refer to Environment Committee | Combination |

**STANDING ITEMS AND MONITORING REPORTS**

| Item | Reporting Frequency | Lead Departmental Officer |
|---|---|---|
| Liverpool City Region Combined Authority Updates | Bi-Annually | Rose Boylan |
| Flood Risk Management Annual Report | Annually – March | Neil Thomas |
| NHS Trust Quality Accounts | Annually - May | Alex Davidson |
| Adult Safeguarding Annual Report | TBC | Lorna Quigley |
| Public questions | Each meeting | |

**WORK PROGRAMME ACTIVITIES OUTSIDE COMMITTEE**

| Item | Format | Timescale | Lead Officer | Progress |
|---|---|---|---|---|
| **Working Groups/ Sub Committees** | | | | |
| | | | | |
| **Task and Finish work** | | | | |
| NHS Trust Quality Accounts | Task & Finish | May 2022 | Alex Davidson | |
| **Spotlight sessions / workshops** | | | | |
| | | | | |
| | | | | |
| | | | | |
| **Corporate scrutiny / Other** | | | | |
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