AGENDA PAPERS FOR

HEALTH AND WELLBEING BOARD

Date: Friday, 29 January 2021

Time: 10.00 a.m.

Place: Virtual Meeting
The meeting will be streamed live at
https://www.youtube.com/channel/UCjwbIOW5x0NSe38sgFU8bKg

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including officers, and any apologies for absence.

2. **TERMS OF REFERENCE** 1 - 2

To note the Terms of Reference of the Board for the 2020/21 Municipal Year as agreed at the Annual Council Meeting 25 November 2020.

3. **BOARD MEMBERSHIP 2020/21** 3 - 4

To note the membership of the Board for the 2020/21 Municipal Year as agreed at the Annual Council Meeting held 25 November 2020.

4. **MINUTES** 5 - 14

To receive and if so determined, to approve as a correct record the Minutes of the meeting held on 16 October 2020.

5. **QUESTIONS FROM THE PUBLIC**

A maximum of 15 minutes will be allocated to public questions submitted in writing to Democratic Services (democratic.services@trafford.gov.uk) by 4 p.m. on the working day prior to the meeting. Questions must be relevant to items appearing on the agenda and will be submitted in the order in which they were received.

6. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

7. **REFRESHING THE HEALTH AND WELLBEING BOARD STRATEGY IN THE LIGHT OF:** 15 - 16

To receive a report from the Director of Public Health.

(a) **PUBLIC HEALTH ANNUAL REPORT** (Pages 17 - 20) 17 - 20
To receive a report from the Director of Public Health.

(b) **EQUALITIES STRATEGY** (Pages 21 - 56) 21 - 56
To receive a report from the Director of Public Health.

(c) **UPDATE ON CCG SYSTEM** (Pages 57 - 126) 57 - 126
To receive a presentation from the Accountable Officer for Trafford CCG.

8. **URGENT BUSINESS (IF ANY)**

Any other item or items which by reason of special circumstances (to be specified) the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

SARA TODD
Chief Executive

Membership of the Committee

S. Johnston (Vice-Chair), Councillor J. Brophy, Councillor L. Blackburn, Councillor J. Harding, Councillor C. Hynes, Councillor J. Slater (Chair), M. Bailey, C. Davidson, D. Eaton, H. Fairfield, Dr. M. Jarvis, M. Noble, E. Roaf, M. Roe, R. Spearing, A. Worthington, P. Duggan, S. Radcliffe, Rooney, J. Wareing, Hemingway, S. Donnellan, D. Evans, M. Hill, M. Pritchard, A. Seabourne, J. McGregor, M. Gallagher and Coulton.

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray, Governance Officer,
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Email: alexander.murray@trafford.gov.uk

This agenda was issued on Thursday 21 January 2021 by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH

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HEALTH AND WELLBEING BOARD

Terms of Reference

1. To provide strong leadership and direction of the health and wellbeing agenda by agreeing priority outcomes for health and wellbeing.

2. To develop a shared understanding of the needs of the local population and lead the statutory Joint Strategic Needs Assessment (JSNA).

3. To seek to meet those needs by producing a Joint Health and Wellbeing Strategy for Trafford and ensure that it drives commissioning of relevant services.

4. To drive a genuine collaborative approach to commissioning of improved health and care services which improve the health and wellbeing of local people and reduces health inequalities.

5. To promote joined–up commissioning plans across the NHS, social care and public health.

6. To have oversight of local Clinical Commissioning Group (CCG) and local authority commissioning plans.

7. To operate as a thematic partnership within the context of the Sustainable Community Strategy Trafford 2021 and align its work to the Trafford Partnership in that capacity.

8. To improve local democratic accountability and engage with the Health and Wellbeing Forum which includes Trafford residents, service providers and other key stakeholders to understand health and wellbeing needs in Trafford.

9. To monitor and review the delivery of health and wellbeing improvements and outcomes through robust performance monitoring.

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TRAFFORD COUNCIL

MEMBERSHIP OF COMMITTEES 2020/21

Notes on Membership:

(1) The Council Membership is nominated by the Leader of the Council.

(2) The Chair for the Health and Wellbeing Board will rotate on an annual basis between Trafford Council and NHS Trafford Clinical Commissioning Group.

(3) * Denotes that this position must be represented on the HWB as per the Health and Social Care Act 2012 (Note: at least one Councillor, one member of each relevant CCG, a representative of the local Healthwatch organisation plus any other members considered appropriate by the Council, must be appointed.)

COMMITTEE	NO. OF MEMBERS
HEALTH AND WELLBEING BOARD	5 (plus *Corporate Director of Children Services, Corporate Director of Adult Services, *Director of Public Health and 16 External Partners)

LABOUR GROUP	CONSERVATIVE GROUP	LIBERAL DEMOCRAT GROUP	GREEN PARTY GROUP
Councillors:	Councillors:	Councillors:	Councillors:
Executive Member for Health, Wellbeing and Equalities Executive Member for Adult Social Care Executive Member for Children's Services	Shadow Executive Member for Health, Wellbeing and Equalities	Jane Brophy	
TOTAL 3	**1**	**1**	**0**

Membership of the Health and Wellbeing Board shall also comprise of:

- NHS Trafford Clinical Commissioning Group (3 representatives: Chair, Chief Operating Officer and Clinical Director/Representative)
- Chair of Health Watch
- Third Sector (2 representatives)
- Independent Chair Local Safeguarding Board
- Chair of the Safer Trafford Partnership - GMP
- Chair of the Trafford Sports and Physical Activity Partnership
- Chief Executive Officers of health care providers (2): (Manchester University NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust)
- Greater Manchester Fire and Rescue Service Representative
- Greater Manchester Health and Social Care Partner Representative

HEALTH AND WELLBEING BOARD

16 OCTOBER 2020

PRESENT

Councillor J. Slater (in the Chair).
Dr. S. Johnston (Vice-Chair), Councillor J. Brophy, Councillor L. Blackburn, D. Eaton, H. Fairfield, Councillor J. Holden, Dr. M. Jarvis, M. Noble, E. Roaf, D. Evans and M. Pritchard

In attendance

Johna Wareing	Manchester NHS Foundaton Trust
Rebecca Horton	Mental Health Lead for Traffrod Housing Trust
Tom Maloney	Health & Social Care Programme Director
Alexander Murray	Givernanec Officer

APOLOGIES

Apologies for absence were received from Councillor J. Harding, Councillor C. Hynes, M. Bailey, P. Duggan, S. Radcliffe, Hemingway, M. Hill and J. McGregor

15. MINUTES

RESOLVED: That the minutes of the meeting held 14 August 2020 be agreed as an accurate record.

16. DECLARATIONS OF INTEREST

No additional declarations were made.

17. QUESTIONS FROM THE PUBLIC

No questions were received.

18. COVID 19 OUTBREAK PLAN

The Director of Public Health presented the COVID 19 figures across Trafford. Trafford had high levels of testing and 12.5% of tests were coming back positive. Feedback received showed that the majority of people who were receiving tests said that they had symptoms. All of Trafford's figures were well above the England average but the positive aspect was that there were low rates among school aged children. The highest rates of infection were amongst 18 and 19 year olds and the most worrying aspect was that there had been a rise in cases among the over 60 population, who were of the highest risk from COVID 19. The second highest rates of infection were among 45 – 64 population and then the 34 – 44 population. Spread among these ages groups was concerning as they were more likely to come into contact with the older population.

Although many cases had been linked to schools it was believed that these were due to community transmissions and it appeared as though there was very little spread within schools. There had been some outbreaks in care homes but it appeared that the measures taken to protect care home residents were working could change. The main message was the importance of self-isolation if you have been contact with someone who had COVID 19.

The public health team had divided their work into sections which was reflected within the plan. Trafford had increased the levels of testing available, the local test and trace system was working and supporting the national system, and the team had been working closely with care homes and businesses to make them COVID safe. There had also been an increased focus on community engagement to find out what people were struggling with to ensure there was adequate messaging and support available. Following the introduction Board Members were given the opportunity to ask questions.

Councillor Blackburn noted that if one child tested positive then their whole bubble was sent home but their siblings were still able to go to school and asked the Director of Public Health to explain that approach. The Director of Public Health explained that in early years if a pupil or teacher tested positive then the whole bubble was sent home. In secondary schools it was just the close contacts who had to isolate. The practice was one step of separation between anyone who had been infected and those who were required to isolate. So if a child or teacher tested positive anyone who had direct contact needed to isolate but the siblings of those who had been in contact with the infected person would not need to isolate.

Councillor Blackburn noted that a testing facility was to be set up at the Soccer Dome in Trafford Park and asked what publicity and signage was in place. The Director of Public Health responded that publicity and signage was due to be set up as soon as the facility was running.

The Vice Chair raised concerns about the health impacts of the restrictions on the public's health due to people not seeking medical advice and mental health due to increased isolation. The Chair responded that those concerns had been picked up within messaging going out to the public. The Director of Public Health added that there was a need for more positive messaging about what you were able to do such as going out to meet friends and family as long as they arrange to do so safely.

The Corporate Director for Adult Services then gave an overview of the Winter Plan which had been circulated with the Agenda. This year's Winter Plan was longer than in previous years as it covered the NHS Wave Three Guidance in addition to the Adult Social Care Winter Plan and both parts needed to be completed for submission by the 31st October. The plan covered a number of core issues including the flue, increased admissions, falls, and respiratory problems.

The Outbreak Management Plan covered Trafford's response to the second wave of COVID 19. Modelling had been completed utilising data on activity since the first outbreak to identify the likely impact of the second wave. There was a single plan for Trafford bringing all aspects of Health and Social Care together. The plan

detailed the pathways that had been refreshed from the lessons learned over the course of the pandemic. The pathways covered discharges from hospital, respiratory support, support into homes, support into care homes, end of life support, and the long term impacts of COVID 19. The recovery and reform group were tracking the work and all partners across the health and care sectors were involved in bringing the plan to fruition. The operating model for the system was in place and had been enhanced in line with the most recent guidance. The Hospital discharge guidance was still in operation which required patients be discharged within three hours of becoming fit to leave and to be tested prior to discharge to a care home. The Urgent Care Control room tracked all patients who were discharged and ensured that follow up support was put in place.

The Corporate Director for Adult Services informed the Board that a different pattern was emerging in the second wave. In the first wave the majority of those who were admitted to hospital were very ill and it was between six to eight weeks before they were ready to be discharged. In the second wave the people being admitted were younger and were recovering faster. In response to this the government had released new guidance on having a designated site for anyone who was COVID positive and an agreement had been reached to have joint provision between Manchester and Trafford.

Discharge to assess beds had been utilised throughout the pandemic and the Council were renewing those contracts. The rapid discharge homecare services were also being renewed for the next phase along with the therapy provision to support discharges into the community. The required capacity was being tracked on a daily basis to enable action to be taken swiftly if additional capacity was required. Digital support was being used to deliver as much support as possible. The latest guidance switched the sourcing of PPE equipment to a national portal, which was to be free to both registered and unregistered services. The hub that had been set up by Trafford and Manchester would continue for the foreseeable future to support the national process and act as a back-up option if required.

All care homes were contacted twice a week which would continue throughout the winter period. All outbreaks were being tracked and the infection control team responded quickly to any outbreaks. Weekly testing was in pace for Care Home staff with monthly testing for residents. There were an increased number of risks during the winter months and the Director of Adult Services was confident that the risks had been identified and with plans in place. The main risk was the cost of the second wave which would put all services under significant pressure. There had been a change in the funding of support with the NHS providing funding for the first six weeks following discharge then the cost would move to social care and place additional strain on the Council's budgets. The financial impact was being monitored and work was ongoing nationally to manage those risks.

Following the overview Board Members were given the opportunity to ask questions. The Mental Health Lead for Trafford Housing Trust informed the Board that there had been some issues with accessing therapy provision at the One Stop Resource Centre and asked when it was likely to go back to normal levels. The Corporate Director of Adult Services responded that this had been discussed at the Local Care Alliance and guidance was due to be reissued across the system in

relation to the contact and service offer for all services. The Corporate Director of Adult Services requested that the details of any particular service issues be sent to her so they could be addressed.

The Chair of the Trafford Strategic Safeguarding Partnership welcomed the information and assurance provided by the Corporate Director of Adult Services but raised concerns around Children's Services especially around mental health support in the wake of the pandemic. The Chair of Health Watch Trafford responded that some deep dive exercises on children's services had been conducted by the Quality, Finance, and Performance Board and an update was due in December.

The Mental Health Lead for Trafford Housing Trust raised that a lot of the outdoor play equipment was in need of maintenance across Trafford. The Chair responded that she was aware that work was ongoing at Longford Park following an accident. The Chair assured the Board that the One Trafford Partnership were working on improving the outdoor play facilities across the Borough. The Chair asked that people contact Councillor Patel with the details of any specific issues so that she was aware and could address them.

RESOLVED:

1) That the COVID 19 update be noted.
2) That the Winter Plan be noted.
3) That the COVID 19 Outbreak plan be noted.

19. LOCAL CARE ALLIANCE: HEALTH AND SOCIAL CARE RECOVERY AND REFORM

The Corporate Director of Adult Services went through the presentation which had been circulated with the agenda and covered Items 8a, 8b, 8c, and item 11. The programme for recovery and reform for health and social care services was up and running and aligned with the Trafford Locality Plan. The programme was split into four key projects. The first was living well in my community which had been developed and delivered well with the voluntary sector throughout the pandemic. The key work streams were the development of place based working, the creation of a partnership wide information and advice offer, the reduction of inequalities, and to create a strong sustainable voluntary sector in Trafford. The Board were shown a set of actions which were to be completed as part of the project by the end of December 2020.

The Health & Social Care Programme Director informed the Board that there were four Strategic Design Groups, one for each of the four key projects. There were around eighteen different partners involved within the Living Well in My Community Strategic Design Group. A partnership approach was being to the creation of the priorities for each group with co-production being utilised where possible. The presentation showed the defined set of priorities for each of the strategic design groups, the joint chairs of the groups, and a roadmap for the next twelve weeks of work. The Health & Social Care Programme Director explained

that the programme took a whole system approach with the wider determinants of health, sustainability, and prevention all being consider by the Strategic Design Groups. The Corporate Director of Adults Services added that there was a very detailed Communications and Engagement Strategy that had been developed to support this programme of work which ensured that people's views were being captured. There was also a performance framework that sat behind the programme to monitor the impact it was having and to ensure it was meeting the desired outcomes.

The Health & Social Care Programme Director then moved the slides on to the point that provided detail around the communications and engagement plan and the performance framework. The full Communications and engagement strategy had been circulated to the Board and the slides provided a short overview. The strategy had been designed to function as the sole communications strategy for the COVID 19 response and for the development of the service for the future. The slides contained the core components of the strategy such as partnership working and governance. Each component had a commitment such as to always work collaboratively and consider the wider determinants of health, and ensuring that key forums are kept up to date regarding communication and engagement. All of the commitments had been developed by the programme steering group which had representation from around nineteen partner organisations. The slides also included the system connectivity structure for the strategy which showed how all the Boards, Groups, and Organisations across the Trafford system linked into the strategy. The communications strategy detailed the mediums and methods that would be utilised in order to measure the performance and the impact of the programme of work. The list included google analytics, feedback from focus groups, telephone interviews, and event feedback.

The end of the presentation included an update on the #FutureTrafford campaign. The Health & Social Care Programme Director explained that #FutureTrafford campaign was to run over four weeks and had four focuses of Employment and skills, Business Recovery, Children and Young People, and Living well in the Community. The campaign linked in with the work of the Strategic Design Groups with Trafford Housing Trust leading on the development and the Council leading on the campaign management. The campaign aimed to engage as many people as possible across the borough so that their views could help to shape the area going forward. The Health & Social Care Programme Director asked all Board Members to spread word of the campaign to their respective networks and to support the campaign over the coming weeks.

The end of the presentation focused upon the Measurement Framework. The Health & Social Care Programme Director informed the Board that there was a wide array of information available and the framework looked to increase understanding of the whole system by bringing all the information into a central place. That information would then be used to commission differently, deliver differently, and develop differently. The framework would aid in identifying where changes were needed to pathways, whether different or new services needed to be commissioned, or if money need to be redirected within the system.

The Board were shown an outline of the framework which included sections that linked to the work of the four Strategic Design Groups. Once populated the framework was being sent to the November meeting of the Trafford Local Care Alliance Board. The framework would show the impact on reducing health inequalities, whether the area was showing signs of recovery, and the progress in reform of the system. The framework also captured information relating to the workforce and whether they were happy and productive as well as the financial picture and the value of the Trafford pound. Over the course of the next few weeks the team would create a single dashboard for the whole system based around neighbourhood profiles linked to the JSNA. The Health & Social Care Programme Director ended by stating that he would like to bring back the populated framework towards the end of the year.

Following the presentation the Chair of the Trafford Strategic Safeguarding Partnership noted the strong focus on health and social care and asked where the wider determinants were captured within the programme. The Health & Social Care Programme Director responded that a wide range of information had been captured from residents across the borough from various organisations utilising I Statements to understand their views on what was important. That data was in the process of being analysed and would inform the approach going forward. The strategic design groups were committed to addressing the wider determinants of health and this would become more apparent as the programme progressed. The Health & Social Care Programme Director spoke about a presentation on the eight sources of learning from the COVID period which was to be shared with Board Members for information. The Chair of the Trafford Strategic Safeguarding Partnership thanked the Health & Social Care Programme Director for the response and added that the role and impact of schools within the programme should be made more visible within the documentation.

Councillor Blackburn asked whether there was a glossary of acronyms available so that Board Members could understand what they meant without having to ask questions after each presentation. The Health & Social Care Programme Director assured the Board that a glossary was being developed and that it would be shared once it had been completed.

The Health & Social Care Programme Director made the Board aware that the NHS and care in Trafford social media page (https://www.facebook.com/NHSandCareinTrafford/) had gone live which would be used as a shared platform to messages out to the public and was accessible to a wide range of partners.

The Chair of the Trafford Strategic Safeguarding Partnership reminded the Board that the 16th to the 23rd of November was safeguarding adults' week and that while COVID had disrupted the preparations a wide range of resources were available for everyone including professionals, members of the public, and politicians. The Chair asked that the Health & Social Care Programme Director share that information on the NHS and Care Facebook page.

RESOLVED:

1) That the Recovery and Reform: Strategic Design Group Highlight Report be noted.
2) That the Measurement Framework be noted
3) That the Communications and Engagement Strategy Report be noted.
4) That the overview of the #Future Trafford Campaign be noted.
5) That the Measurement Framework is to come to the Board before the end of the year.
6) That the presentation on the eight sources of learning from the COVID 19 period be circulated to Board Members.
7) That the glossary of acronyms be shared with Board Members once completed.
8) That the Health & Social Care Programme Director share that information of safeguarding adults' week on the NHS and Care Facebook page.

20. CDOP REPORT

The Director of Public Health introduced the report and explained that the Child Death Overview Panel (CDOP) reviewed the death of any child or young person between birth and eighteen years old. CDOPs had been in place for the last decade and a wealth of data had been gathered during that time. The aim was to capture any learning that could be taken from a child's death to improve practice, to identify any patterns, and to identify preventative measures. With terminal illnesses the information is not about preventing death but to improve how services support children and their families. The report requested that the Health and Wellbeing Board support a change in Trafford's approach to managing the recording and sharing of the information available to the CDOP. The changes included the appointment of an Independent Chair for the Panel and to set up the ECDOP System.

Following the introduction the Chair of the Trafford Strategic Safeguarding Partnership asked whether she would be able to meet and discuss the changes with the Director of Public Health to ensure that they aligned with the work of the Trafford Strategic Safeguarding Board. The Director of Public Health responded that she would be happy to meet after the meeting and assured the Chair of the Trafford Strategic Safeguarding Partnership that the new arrangements would improve the relationship between the Partnership and the Panel.

The Changes were then moved by the Chair and agreed by the Board.

RESOLVED:

1) That the report be noted.
2) That the changes listed within the report be agreed by the Board.
3) That the Chair of the Trafford Strategic Safeguarding Partnership and the Director of Public Health are to meet to discuss the

changes to the CDOP and how it linked to the Trafford Strategic Safeguarding Partnership.

21. UPDATE ON THE STRATEGIC OBJECTIVES AND CURRENT OUTCOMES FOR THE HEALTH AND WELLBEING BOARD

The Director of Public Health introduced the presentation which had been circulated with the agenda. During the pandemic the main focus of the Board had been on tackling the issues created by COVID 19 but now was the time to begin to look at the recovery following the pandemic and what the Board's priorities would be. Prior to the pandemic the Board had been focused on reducing inequalities in healthy life expectancy across the borough and the presentation provided the latest data available. The Director of Public Health then introduced the Public Health Intelligence Analyst who had been working on Trafford's data sets.

The Public Health Intelligence Analyst then went through the slides. The Healthy life expectancy was increasing for both men and women and was among the highest nationally, although work needed to be done with Trafford CCG to measure the difference between different areas of the Borough. Trafford had seen a reduction in the number of smokers and there had been a large reduction in smoking among routine and manual workers. For alcohol related hospitalisation and premature mortality rates due to liver disease Trafford were worse than the national average and the worst out of their statistical neighbours. Between 2015 and 2018 Trafford had started to see a reduction in premature mortality for liver disease.

Trafford performed well against the national average for the prevalence of overweight and obesity. Trafford was statistically similar to the national average for physical inactivity in 2018/19 and Trafford had seen reductions since 2015. Prevalence of obesity amongst year six children showed that those in the most deprived quintile were twice as likely to be obese as children in the least obese quintile. In the reception years those in the most deprived quintile were still twice as likely to be obese as those in the least deprived quintile.

Trafford performed very well in terms of cervical screening both nationally and against statistical neighbours. Trafford mortality rates for preventable cancers had been steadily declining since 2001. Trafford had a lower rate of suicide than the national average and also performed well against their statistical neighbours. However, people with severe mental health issues in Trafford were five times more likely to die prematurely than the general population. The rate of employment for people in contact with a secondary mental health service had dropped from 71% in 2015/16 to 67.7% in 2017/18.

The Director of Public Health noted the improvement in the reduction in smoking was great news and now had to do some work to in due the reason for those reductions and to see how COVID had impacted those figures. There was increased concern around alcohol abuse and levels of inactivity given the impact of COVID. The improvement around rates of cervical screening was positive news as this was something that the public health team had been working on with

colleagues from Trafford CCG and it appeared as though the work was having an impact. The inequalities information was still of great concern and need to concentrate on reducing the inequalities that were shown in the data and to investigate the impact of inequality in the other areas. While the levels of premature death for people suffering from mental health issues had reduced there was still a very large gap between them and the general population.

Following the presentation Councillor Blackburn asked whether the smoking figures included electronic cigarettes. The Director of Public Health responded that the figure were for cigarette smoking and did not include electronic cigarettes. Councillor Blackburn followed up by asking whether it was known what was in electronic cigarette liquid and whether it was regulated. The Director for Public Health responded that the electronic cigarettes that were used in the stop smoking campaign were controlled and while she did not know all of the substances in the electronic cigarette liquid all the data showed that it was far safer than smoking although it may have its own risks and should be used as an aid to quitting rather than an alternative.
The Chair of Health Watch Trafford was particularly concerned by the statistics around mental health especially as this was very likely to be exacerbated by the pandemic. The Director of Public Health responded that even before the pandemic the UK had some of the worst mental health in Europe and the team were continuing to focus on ways to improve the wellbeing of those with mental health issues which included aiding in the development of the mental health strategy.

The Chair of the Trafford Strategic Safeguarding Board then asked about the statistics on mental health, what was considered as serious mental health issues, and how was Trafford looking to support those people. The Director of Public Health Confirmed that serious was defined as severe and enduring and that was where the differences in education, employment, and life expectancy were being seen. It was an ambition of the Health and Wellbeing Board to reduce the impact of having a severe mental illness and while it was hoped that Trafford could reduce the prevalence of severe mental health conditions the data showed that the prevalence was increasing.

RESOLVED:

1) That the update be noted.

The meeting commenced at 10.00 am and finished at 11.45 am

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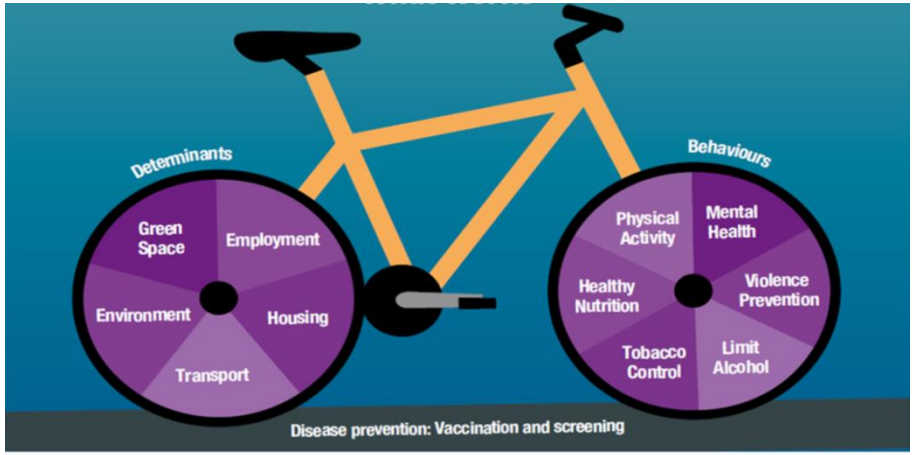
Trafford Health and Wellbeing Strategy 2019-29

The Trafford Health and Wellbeing Board exists to improve population health outcomes. It does this through strategy development, improving partnership working, and using our knowledge of local needs from our Joint Strategic Needs Assessment to improve our services. In Trafford we are focussing on using the HWBB to increase the number of years people spend in good health. This is measured by *Healthy life expectancy (HLE)*. This is a good pointer to the population's general health and gives an idea of the population's need for health and social care services. The variation across the borough for this indicator is greater than for life expectancy, and in general communities in the north of the borough fare much worse than those in the south, putting additional burdens on these communities.

In Trafford we have a 16 year inequality or difference gap between our most affluent and most deprived communities[1]. To improve HLE, we are focussing on preventing poor health and on promoting wellbeing, as this will reduce health and social care costs, and enhance resilience, employment and social outcomes. The actions required must address the 'wider determinants' of health such as clean air, housing, transport, employment and the environment we live in, as all of these have a role in driving our behaviours, as can be seen in the diagram below. We also need to ensure that our actions help reduce the borough's carbon footprint, and reduce the impact of climate change on our population

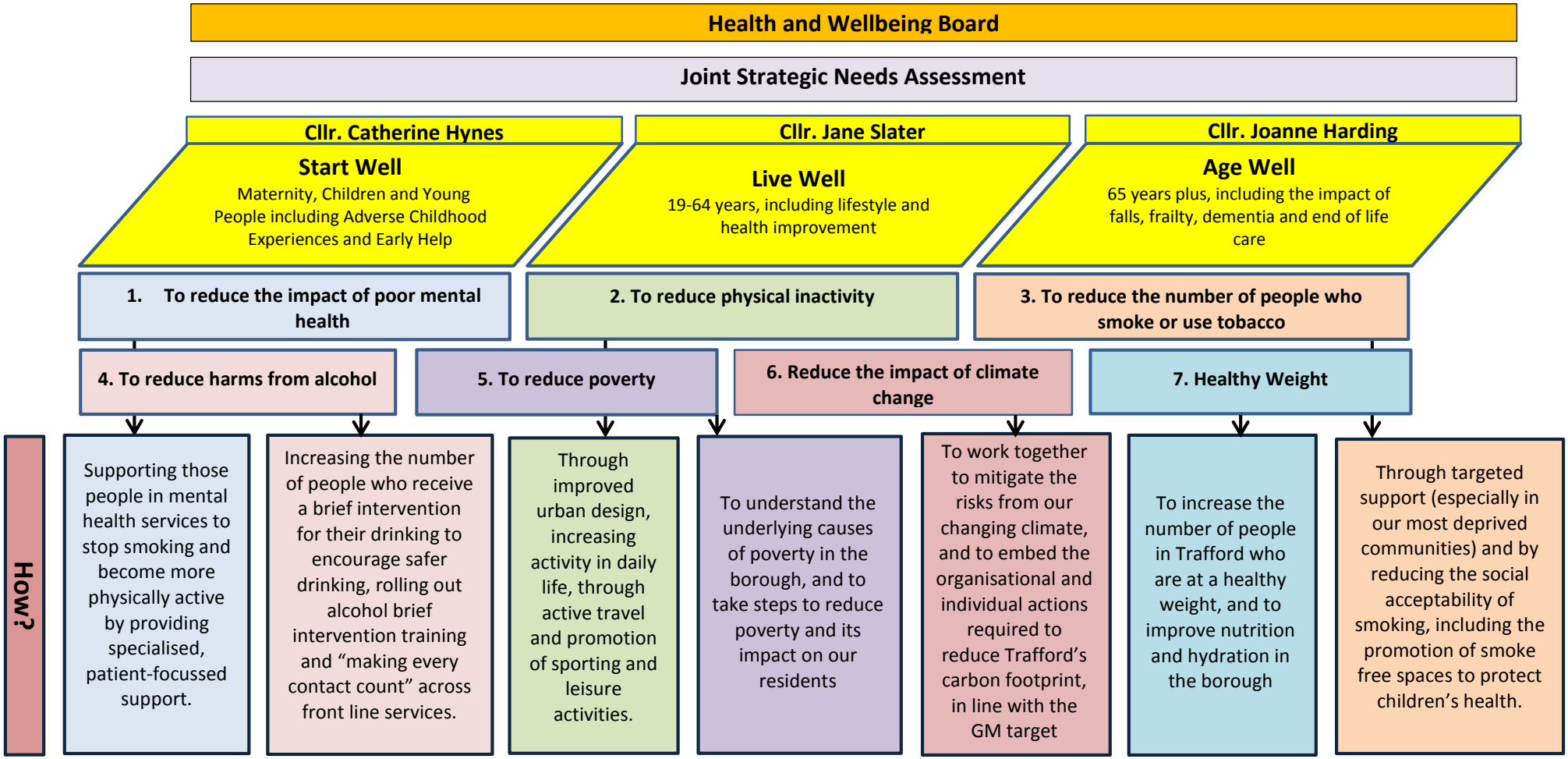
How?

The Health and Wellbeing Board is focussed on our residents' journeys through life, taking a life course approach that reflects the public health needs of that age group. We aim to improve outcomes at each stage while ensuring that seven overarching priorities are considered, and ensuring interventions are evidence based, measurable and add value.



Source: WHO (2013a).

[1] *PHE, (2017) Slope Index of Inequality in HLE, 2009-13 pooled data, https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/*



How will we know we have made a difference?

Multiagency Boards will oversee each life course area, and have partnership action plans, focusing on the priority areas. We have produced a performance dashboard for our key indicators so that we measure our progress, monitoring improvements in Healthy Life Expectancy overall (from a baseline of 2013-15) but also the Slope Index of Inequality (SII) in healthy life expectancy (from a baseline of 2009-13) which is a measure of inequality or how much healthy life expectancy in Trafford varies with deprivation.

We will only achieve the desired outcomes by working with our population and with partners in Trafford and across Greater Manchester and measuring the difference we make. Members of the Board are responsible for ensuring that actions and approaches agreed by the Board are delivered in their own organisations.

Lead:

Eleanor Roaf, *Director of Public Health (Interim)*

PHAR 2019: Combatting Climate Change

All ensuing actions to be led through the Trafford Climate Emergency and Air Quailty Group

Recommendation	Action	Group Progressing	Lead	Timescale
1 Understand your carbon footprint and think about the actions that you can take to reduce this while improving your life, health and bank balance. Use the WWF carbon calculator or similar for this, also Mike Berners Lee's book How Bad Are Bananas helps with understanding the impact of everyday items				
2 Refuse, reduce, re-use, repurpose and recycle – in that order				
3 Create a demand for national and local policies that help reduce climate change – so policies on good housing design and standards, good public transport, energy efficiency, improving the food system, responsible fashion. Supporting these polices will help politicians take action.				
4 Active travel (walking, cycling and using public transport) increases physical activity which has a huge impact on health, reducing falls, CVD and some cancers, It also improves air quality, again improving health outcomes				
5 Don't drive if you can avoid it. Try walking for journeys of less than one mile, and cycling or using public transport for journeys of 3-5 miles. Cycling is generally quicker than driving for urban journeys up to 5 miles, especially in the rush hour, and it saves money too.				
6 Fly less, and if you have to fly, use the most direct routes. Always fly economy – travelling first class triples your carbon footprint.				
7 Food choices. Shopping and growing local improves social cohesion, food quality, and reduces food waste. Eating less processed food reduces CVD and cancer risk.				

8 Improve energy efficiency. Ensure all houses are energy efficient to EPC C standard, and any new buildings should display DEC certificates and be insulated.

9 Insulate your home. Better insulated homes are warmer, which reduces childhood asthma and hospitalisations of older people. It also saves money so reduces fuel poverty.

Undertake the Greater Manchester big clean switch programme https://bigcleanswitch.org/gm

Buy fewer, higher quality clothes or buy second hand. Consider the production costs, including worker conditions as well as the materials used.

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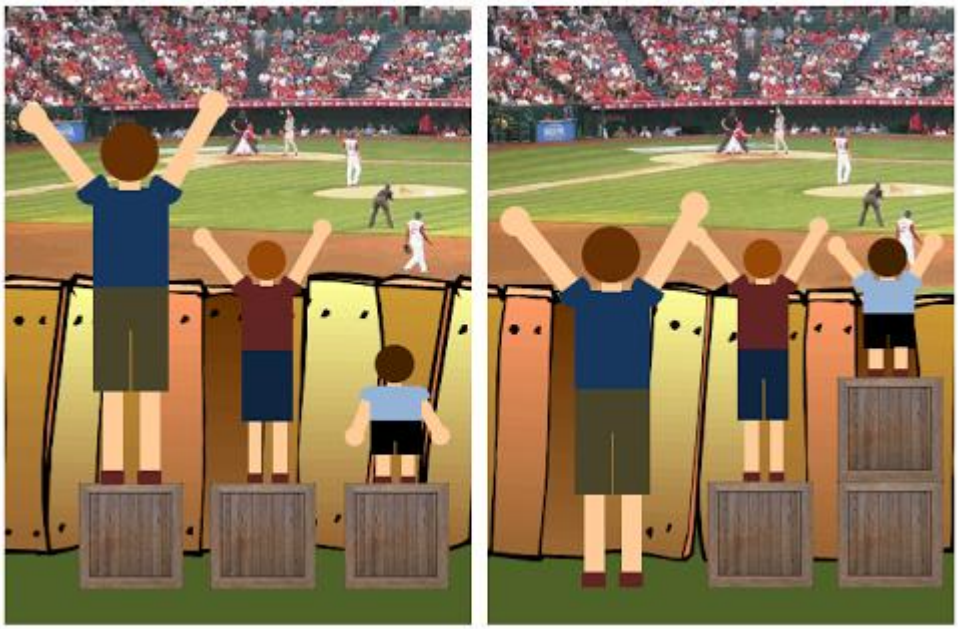
TRAFFORD COUNCIL

NHS Trafford Clinical Commissioning Group

Corporate Equality Strategy

2021 to 2025



This strategy can be made available in a range of languages and formats on request, such as Easy Read, Braille, Urdu, Polish etc. As a provider we have a contracted translation and interpretation service available for face-to-face and written communications with our customers.

Foreword by Councillor Jane Slater – Executive Member Health, Wellbeing and Equalities

I am extremely pleased that we are now able to bring forward our joint Equality Strategy for the next four years. Trafford is a diverse and vibrant borough where we celebrate all of our communities. Our workforce should fully reflect our diverse communities to enable us to delivery first class services to residents.

The events of 2020 have driven home the inequality that exists across the country. We want to make Trafford Council and the CCG exemplars of good practice, beacons in these difficult times and service providers that are committed to changing and improving to support all our residents. I look forward to continually reviewing our strategy as it evolves and looking at our progress in 2025.

Councillor Jane Slater

Joint Foreword by Sara Todd – Chief Executive for Trafford Council

and

Martyn Pritchard - Trafford CCG Accountable Officer

It gives us great pleasure to share our Corporate Equality Strategy with our residents, colleagues and partners. Improving equality across everything we do is a key priority for us and the unequal impact of Covid.19 has shone a light on areas where inequalities need to be tackled urgently. At home and abroad, there has been growing recognition that too many people and communities in our society face systemic inequalities that need to be addressed. This, along with the evident disparities in health outcomes for some communities, has reinforced the need for us to work harder to address those inequalities.

As employers, we strive to be inclusive and we are committed to creating an environment that values and respects the diversity and richness that differences bring. By being inclusive, we can then better understand our residents and businesses and, in turn, serve them better.

This strategy outlines the steps we are taking to become more inclusive employers and to deliver high quality services that recognise the different needs of our residents, as well as promoting community cohesion in our diverse neighbourhoods in Trafford. We very much look forward to working with everyone who has a stake in our Borough to bring it to life.

Sara Todd

Trafford Council

Martyn Pritchard

Trafford CCG

Contents Page No.

Executive Summary for Corporate Equality Strategy 2021 to 2025

Welcome to our Corporate Equality Strategy for Trafford Council and Trafford Clinical Commissioning Group (CCG).

As two of the largest employers locally, and providers and commissioners of a wide range of services for our residents, Trafford Council and Trafford CCG are committed to challenging inequality, discrimination and disadvantage. We are working hard to ensure that equality and inclusion good practice is implemented and embedded in all areas of our working practices in relation to policies, service delivery, employment, community engagement and partnership working.

The Strategy outlines how we are doing as a Provider, Commissioner, Employer, Regulator and Partner. In particular, our key Equality Objectives are:

- Inclusive and Informed Leadership
- Improving our Workforce Data Collection
- Reducing Health Inequalities
- Reducing Hate Crime.

Our Strategy shows how we are working to meet our Public Duty within the Equality Act 2010 with regard to people in the nine protected characteristics which are: disability, race, age, religion or belief, sex, sexual orientation, gender reassignment, pregnancy and maternity marriage and civil partnership. It is important to note that while we are working to serve our employees and customers/clients within protected characteristics, we are also mindful of the needs of other groups such as: carers, people who are homeless, ex-military personnel, people who live in poverty as well as other non-protected characteristics.

This Strategy should be read in conjunction with the Trafford's Poverty Strategy which specifically focuses on how we are working to mitigate the impact of poverty in Trafford.

We have included a snapshot of the data we hold on our population in relation to our geographical localities i.e. North, South, West and Central Trafford which helps us ensure that our services can be tailored to meet access, cultural and identity needs as required.

We are keen to be accountable and evidence our commitment to promoting equality so we have an Equality Action Plan that supports this Strategy detailing the specific areas where we will endeavour to make significant improvements over the next four years. Below are some of the outcomes which we hope to achieve.

Joint outcomes that the Council and the CCG will aim for as Leaders:

- An accountability framework, so our leaders are aware of their roles and responsibilities around EDHR (Equality, Diversity and Human Rights).
- Senior leaders regularly meet with and support our equality staff groups.

Joint outcomes that the Council and the CCG will aim for Employers:

- Improving the quality of the staff protected characteristic data collected by encouraging staff to update their electronic staff records
- The CCG will support the Council to embed the principles of the mandated and non-mandated NHS equality standards e.g. Workforce Race Equality Standard, Workforce Disability Equality Standard, and the Equality Delivery System.

Health outcomes Trafford Council will aim for:

- To reduce the impact of poor mental health
- To reduce physical inactivity
- To reduce the number of people who smoke or use tobacco
- To reduce harms from alcohol
- To improve cancer prevention and screening.
- To improve healthy weight

Health outcomes Trafford CCG will aim for include:

- We will hold comprehensive and up to date demographic data, from a wide variety of sources, including patient information, to inform the provision of services to the Trafford community
- The CCG will seek assurances from providers, through contract monitoring, that screening, vaccination, health promotions and other commissioned health services benefit all local communities, including people from protected/vulnerable groups.

Outcomes for Reducing Hate Crime that Trafford Council will aim for:

- Keeping People Safe
- Reducing Harm & Offending
- Strengthening Communities & Places

Community Cohesion

Trafford Council and Trafford CCG are committed to promoting community cohesion amongst the diverse communities we work with; and to valuing and including the skills, talents and local knowledge of our voluntary community sector in order to enhance the provision of services wherever possible for the residents of Trafford.

The Impact of Covid-19 and Inequalities.

Work started on the Corporate Equality Strategy prior to the onset of Covid-19 in the UK. Since then the Council and the CCG have been working hard to respond to Trafford residents' needs during the pandemic. Both organisations will be capturing information about the impact of Covid-19 on people in all the protected characteristic groups and making plans to mitigate the effects and improve services in the future from lessons learnt.

1. Introduction

This Corporate Equality Strategy for Trafford Council and Trafford CCG outlines the steps we will take to promote equality, diversity and inclusion in all of our work. We are committed to reducing inequalities through adopting the highest standard of service delivery and employment practice. Despite this, we know we have some way to go to realise our ambition. Through this strategy we will take the steps needed to address inequality in the workplace, in the development of our physical infrastructure and in relation to access to services and outcomes.

Within our strategy we are reviewing our roles as leaders, regulators, commissioners, providers, and employers to ensure that we are addressing inequality consistently and across everything we do. Our strategy is underpinned by our equality policies for human resources as well as our approach to commissioning, spatial planning, partnership working and community cohesion. A Corporate Equality Steering Group has been established to steer the work programme with representatives at Director and Senior Management level from both Trafford Council and Trafford CCG.

The Equalities Steering Group has identified leadership, the workforce, reducing hate crime and tackling health inequalities as being the key areas of focus.

This strategy is supported by an action plan, detailing the work that our organisations and the directorates within them will deliver over the next three years to reduce inequalities and improve our population's outcomes.

1.1 Equality Mission Statement

As two of the largest employers locally, commissioners and providers of a wide range of services for our residents, Trafford Council and Trafford CCG are committed to challenging inequality, discrimination and disadvantage. Equality of opportunity for all sections of the community is an integral part of our commitment. We know that the diversity of our population is one of our greatest strengths and assets but currently some groups are at systemic disadvantage and we must do more to address this.

1.2 Accountability

The work of our Equality Strategy is overseen by the Corporate Equality Strategy Steering Group which reports to the Joint Leadership Team for the Council and the CCG which, in turn, reports to the Council's Elected Members and the CGG Governing Body.

2. Meeting Our Public Duty: understanding the legal framework and using underpinning policy and guidance

2.1 Trafford Council and Trafford CCG's Legal Duty under the Equality Act 2010

The Corporate Equality Strategy outlines how Trafford Council and Trafford CCG are working to ensure that they meet their statutory obligations in the Equality Act 2010 to the benefit of their employees, residents and services users.

The Act refers to a series of 'Protected Characteristics' and we ensure that we give consideration to those groups who share the protected characteristics. The protected characteristics are:

- Race
- Disability
- Age
- Religion or belief
- Sex
- Sexual orientation
- Gender reassignment (Transgender)
- Pregnancy and maternity
- Marriage and civil partnership

We know that there are other groups in our population that can also suffer significant disadvantage and this can be a cause of poverty and health inequality.
We will be mindful of their particular needs when designing and delivering services, and in our day to day operations. These groups include but are not restricted to:

- People who are homeless
- People who are ex-military personnel
- People who live in poverty
- People who are long-term unemployed
- People with substances misuse dependences
- People with limited family or social networks
- People who are geographically isolated
- People who are carers

It is important to recognise that being in more than one of the protected groups, or having additional barriers such as living in poverty, may exacerbate the inequalities that people experience.

The Public Sector Equality Duty 2011 (PSED) (Section 149 of the Equality Act 2010) (https://www.legislation.gov.uk/ukpga/2010/15/contents) applies to public bodies delivering public services. The duty requires local authorities and public bodies to

consider employees and service users in all the protected groups. This means that in the exercise of our functions we must have due regard to the duty to:

1. Eliminate unlawful discrimination, harassment, victimisation and other prohibited conduct
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

There are a number of other legal duties in relation to equality that the Council and the CCG must meet. These are detailed in Appendix 1 which contains links to our internal policies relating to reducing inequality.

3. Our Equality Objectives for 2021-25

Working together, the Council and the CCG have chosen the following equality objectives for 2021-25:

- Inclusive and Informed Leadership
- Improving our workforce data collection
- Reducing health inequalities
- Reducing hate crime

Further details of the Council objectives can be found here.
https://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/our-equality-objectives.aspx

3.1 Equality Objective 1: Inclusive Leadership - Equality is Everybody's Business

This objective is to ensure that senior leaders use their influence to promote equality, diversity and human rights and are effective in the delivery of this agenda across the Council and the CCG. Without senior managers showing consistent leadership, we will not see the changes we need.

Promotion of the message 'Equality is Everybody's Business' will ensure that everyone takes ownership to promote equality in all aspects of service delivery. The ~~s~~trategy will be championed by Elected Members, the CCG Governing Body Members, Corporate and Senior Leadership Teams, as well as all managers and staff.

Success measures:

- Uptake of training on mandatory Equality, Diversity & Inclusion (EDI) course ' Equality as a Leader'
- Uptake of training on mandatory EDI course, 'Equality is Everybody's Business for all staff
- Uptake of training on Human Rights by CCG staff and CCG Governing Body.
- Uptake of mandatory training on EPIC Manager - Equality, Diversity and Inclusion.

3.2 Equality Objective 2: Improving Equality Workforce Data Collection and improving the representativeness of our workforce

- To embed effective equalities working practices in all our employment and service delivery
- To address the need to improve recruitment, selection, training and promotion opportunities for all protected groups, and in particular for the disabled and BAME (Black and Minority Ethnic) members of our workforce.

The Council and the CCG are required to hold data on the protected characteristics of their workforces. Having complete and accurate information is vital if we are to understand inequalities within our workforce, and to take effective steps to address these. We recognise that some members of staff have concerns about sharing this information, and so we need to do more to understand and allay these concerns. To this end we are raising awareness of the importance of this data through adverts on the Staff Intranet page and our Staff Networks and asking managers to encourage their staff teams to keep their equality profile information up-to-date and complete.

Success measures

- Increase in successful applicants from protected groups
- Increase in uptake of mandatory equality and diversity in recruitment training for managers and directors.
- Increase in recording of all protected characteristics
- Diversity in interview panels.

3.3 Equality Objective 3: Reducing Health Inequalities

Addressing health inequalities is a key objective for the Council and the CCG because of the large gap in life expectancy between residents living in different areas of Trafford. Healthy Life Expectancy (that is, the number of years lived in good health) in the most deprived 10% of areas in Trafford is around 16 years lower than in the least deprived 10%.

Areas of deprivation tend to see the highest rates of illness, and deprivation levels are higher in many of our protected groups. The steps we take to reduce the impact of deprivation will support us to deliver our many Equalities objectives, and more details of these steps are included in our Poverty Strategy. The Health and

Wellbeing Strategy's overarching goal is to reduce Trafford's inequality in healthy life expectancy, through education and work in the following priority areas:

- To reduce the impact of poor mental health
- To reduce physical inactivity
- To reduce the number of people who smoke or use tobacco
- To reduce harms from alcohol
- To reduce the impact of poverty
- To improve healthy weight
- To tackle climate emergency
- To tackle domestic violence.

By ensuring that we include monitoring of improvements for our protected groups as well as for our more deprived populations, we will start to narrow the existing gaps in outcomes for a number of causes of premature mortality in Trafford, such as cancer and cardio vascular diseases. The Trafford Joint Strategic Needs Assessment (JSNA) states that, "over 30% of circulatory disease and many cancers could be avoided by stopping smoking, improving diet and increasing levels of physical exercise".

Success measures

- Accurate recording of protected characteristics by services (including primary care)
- Narrowing the gap in uptake of key preventative services such as screening and immunisation
- Reduced gap in premature mortality including for people with serious mental illness
- Reduced gap in relation to smoking, physical activity and obesity.

Source for above: http://www.traffordjsna.org.uk/Trafford-JSNA.aspx

3.4 Equality Objective 4: Reducing Hate Crime

Trafford has a diverse community, with many faiths and cultures across our borough. We have strong community relations, and Trafford is the safest borough in Greater Manchester. However, we recognise that more could be done to improve social inclusion of isolated and vulnerable residents, reduce hate crime, prevent radicalisation, and ensure people with different faith and cultures live together positively and without fear. Trafford's Hate Crime Action Plan is aligned with the Greater Manchester Standing Together Plan with a local focus on the following priorities.

Keeping People Safe – Partnership approach (working with Greater Manchester Police and the Voluntary Community Sector) to reduce hate crime incidents includes: awareness-raising in communities, promoting services to keep people safe, staff training, referrals for support.

Reducing Harm & Offending - Ensuring an effective responsive where hate crime occurs with victim support, early intervention with perpetrators to prevent escalation and swift enforcement where appropriate.

Strengthening Communities & Places - Community Cohesion work, support for grass roots community groups through grant funding, work with schools, supporting community and faith groups around the issue of hate crime

The GM Standing Together Plan can be found at:

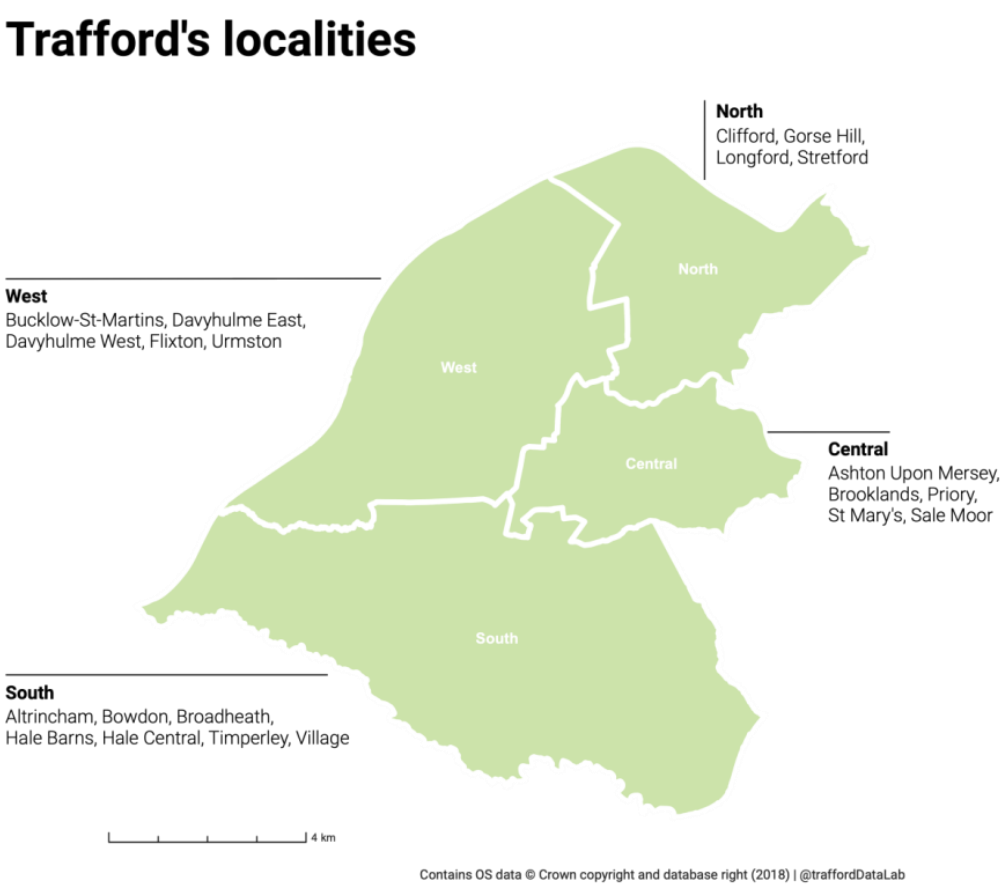
https://www.greatermanchester-ca.gov.uk/media/1268/police-and-crime-plan-standing-together.pdf

4. Our Population

4.1 Trafford population and deprivation

Trafford Council and Trafford CCG provide services for a population of approximately (at mid-2019) 237,354 residents. Trafford has a number of distinct neighbourhoods, often with quite different populations and needs.

For much of our service delivery, we divide the borough into four ‘neighbourhoods’: North, South, West and Central, as the map below shows and the associated electoral wards for each.



By national standards, Trafford is average in terms of deprivation, which means that it is more affluent than almost every other borough in the North West. However, this hides huge inequalities throughout the borough. For example, the proportion of children 0-15 living in deprived households was 39% in Bucklow St Martins compared to 4.3% in Timperley[i].

Locality	Electoral Wards	Population Estimates
North	Stretford, Longford, Gorse Hill & Clifford	48,205
South	Hale Central, Timperley, Hale Barns, Altrincham, Bowdon, Broadheath & Village	78,602
Central	Ashton upon Mersey, Brooklands, Priory, St Mary's & Sale Moor	56,076
West	Davyhulme, Urmston, Flixton and Bucklow St Martins	5,610

People living in areas of deprivation sometimes experience the higher levels of illness because of differences in the 'wider determinants' of health, such as housing, education and employment. Therefore, it is important that we understand the health outcomes for our protected groups as this helps us to design services that can reduce the negative impact for these groups.

4.2 Understanding our protected groups in Trafford

The potential negative impact of being a member of a protected group can be increased for people either by belonging to more than one of the groups, or by having other characteristics that increase any negative impacts. For example, the experience of being black, female and pregnant will be very different if you are on a low income compared to being in a well-paid professional job: although there will be some common aspects. In addition, people's protected characteristics can change over time.

4.3 Age and Sex

The resident population of Trafford at mid-2019 is estimated at 237,354. This is made up of:

- 60,956 people aged 0-19 years (25.7% of the total population)
- 135,215 people aged 20-64 years (57% of total)
- 41,183 people aged 65 or more years (17.4% of total).

Source for above: (http://www.traffordjsna.org.uk/About-Trafford/Key-demographics/Population-estimates.aspx).

The mid-2019 population estimates for Trafford residents by gender are: Females: 121,276 and Males: 116,078. Source: https://www.nomisweb.co.uk/datasets/pestsyoala

4.4 Ethnicity

At the last Census in 2011, 14.5% of the Trafford resident population (or 32,744 people) reported belonging to a BAME group, very similar to England as a whole (14.6%). However, there is wide variation within Trafford in the proportion of the population belonging to BAME communities.

In addition, the BAME population in Trafford has a younger age structure than the population as a whole. Among children and young people aged under 20 more than 1 in 5 (21.9%) belongs to a BAME group, compared to around 1 in 20 (4.8%) among those aged 65 years and over.

A small number of our BAME population do not speak English as their first language. Overall, 94.5% of people living in Trafford speak English, but it is estimated that we have a further 62 languages spoken, including Polish, Urdu, and Gujarati, (Trafford Census Demographics). Supporting children to be bilingual in English and their mother tongue has been shown to deliver both social and educational advantages, so maintaining this language diversity is of huge benefit. However, we also need to ensure that everyone living in Trafford (whether from a BAME background or not) is well supported to develop their English language skills, as this will both help them socially and also to achieve high quality employment.

4.5 Disability

There are 38,603 disabled residents in Trafford (17%), as defined by those who have a health (including mental health) problem or a physical, cognitive or sensory impairment which limits their day-to-day activities. Determining the exact number of Trafford residents living with a disability is difficult and often based on national prevalence. For example:

- 1 in 20 children have an impairment
- Estimates show that 1.1% of the general population will have an autistic spectrum condition
- 4,288 adults have a learning disability
- In 2015/16**,** 530 adults were receiving long–term support from Trafford Council because of a learning disability
- As at mid- 2016/17, 944 individuals were on a GP learning disability register
- A third of people with a learning disability will have a dual diagnosis of autism

According to results from the Annual Population Survey for the year ending March 2019 it is estimated that the number of disabled people in work is:

- EA core (current disability) or work-limiting disabled people: 27,000
- EA core disabled (current disability): 24,800
- Work-limiting disabled people: 20,200

EA Core disabled includes those who have a long-term disability which substantially limits their day-to-day activities. Work-limiting disabled includes those who have a long-term disability which affects the kind or amount of work they might do. Sources for the above are:

http://www.infotrafford.org.uk/lab/jsna/about-trafford/overview

https://www.surreyi.gov.uk/dataset/annual-population-survey-economic-activity-by

4.6 Religion

According to the 2011 census, of those people who declared their religion, 143,639 residents (87.4%) stated they were Christian. The second largest religious group were Muslims with 12,994 residents (7.9%). The dominant religious group in all wards is Christian except for Clifford where Muslims form the largest faith group 48%). There is also a significant minority of Muslim residents in Longford ward (30.1%) and Jewish residents in Hale Barns (13.2%).

4.7 Other protected groups

Sexual orientation – capturing accurate data is problematic as we need to develop people's confidence in disclosing their sexuality, however, we do have the following data, and we can extrapolate from this to estimate figures for Trafford.

Greater Manchester is home to an estimated 215,000 LGBT people - https://lgbt.foundation/actionplan

In 2018, there were an estimated 1.2 million people aged 16 years and over identifying as LGBT. Men (2.5%) were more likely to identify as LGBT than women (2.0%) in 2018. Source - https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2018#sexual-orientation-data

Gender reassignment – we recognise that this is a data gap and we will work with partners to develop our knowledge and get the best data available

Pregnancy and maternity – Data on this is well collected for our staff and it is included in decision making as relevant and in accordance with the law e.g. taking into account the needs of young parents and our staff who may be pregnant and / or on maternity leave. Part time and flexible working opportunities are offered to men and women as well as shared paternity/maternity leave.

Success measure

- higher take-up by men of maternity leave

Marriage and civil partnership – for the year, April 2019 to March 2020 there were 112 religious marriages, 429 civil marriages and 11 civil partnership formations.

Source: Trafford Council Registration Service (BDM – Birth, Death, Marriages)

4.8 Other groups at known disadvantage

Carers

According to the 2011 Census, 23,509 (10.4%) people were providing care in Trafford. The JSNA[i] states that: 'there is evidence that many carers are "hidden" from services. For example the JSNA shows that,

- Only 2,900 people are recorded by their GP practice as a carer
- Around 5,000 carers are known to Adult Social Care and around the same to Trafford Carer's Centre
- 2,300 are claiming carer's allowance.

4.9 Summary – what the make-up of our population tells us

Using data and other sources to understand our population helps us ensure that our services can be tailored to meet cultural and identity needs. It is recognised that there is a need to remove barriers to accessing services for disabled people and ensuring prompt support is available and offered to carers. It is also clear that there is a need to prepare for the increase in numbers of older people needing adult social care in the future, and to adapt some of these services so that they meet the needs of a more diverse population than at present. Furthermore our Poverty Strategy aims to reduce the impacts and harms of poverty on health and equality.

5. Leadership actions

5.1 Trafford Partnership

The Trafford Partnership enables the Council, its partners and communities, to achieve better outcomes than would be achieved by working alone. It works to develop positive and mutually beneficial engagement between residents, voluntary and community organisations, businesses and public services, and promote and celebrate activity and success through our communication channels.

For further information please see http://www.traffordpartnership.org/thematic-partnerships/Docs/TP-Annual-Report-2019web.pdf

5.2 Role of the Trafford Partnership Board

The Board brings together leaders from across sectors and themes which form three strategic boards for: Health and Wellbeing, Strong Communities and Inclusive Growth together with the Public Service Reform Board. This enables a dynamic set of voices, to provide advice, support and constructive challenge to strategic delivery, as well as overseeing progress and the 'state of Trafford'; what it's like to live and work in Trafford and its diverse communities. Part of the Partnership Board's role is to assure that the priorities are being achieved in all neighbourhoods and communities, reduce inequality and maximise local strengths. For further details, please see:

http://www.traffordpartnership.org/partnership-board/Trafford-Partnership-Board.aspx

As part of the Partnership, the Joint Council and CCG Leadership Forum are responsible for the Equality Strategy. The CCG have an Equality Steering Group. The Council's elected members and non-executive board members have a strong community advocacy and influencing role. Councillor Jane Slater is our Executive Member for Health, Wellbeing and Equalities and Councillor Barry Winstanley leads the Elected Members' Disability Task and Finish Group. We also have staff equality groups each of which have a senior responsible officer from the Corporate Leadership Team.

5.3 Role of the Council Corporate Leadership Team

Trafford Council's Corporate Leadership Team operates in accordance with Article 13 of the Council's Constitution which states that all decisions of the Council will be made in accordance with the following principles:

- Respect for human rights
- The public sector equality duty and general equality duties.

5.4 Role of the CCG Primary Commissioning Committee

Trafford CCG Primary Care Commissioning Committee's Terms of Reference state that the CCG has duties with regard to reducing inequalities as set out in Section 14T); Chapter A2 of the NHS Act which are to:

(a) Reduce inequalities between patients with respect to their ability to access health services, and
(b) Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

The CCG also delivers the following actions as part of the equality, diversity and inclusion work programme:

- Produce an Equality and Inclusion annual report in line with the Public Sector Equality Duty
- Produce an Accessible Information Standard report annually
- Distribute a monthly Equality and Diversity awareness bulletin to staff.

The Committee receives and reviews regular reports on developments, performance and the quality of primary care services from the CCG Primary care team.

It ensures that all proposed changes and developments are supported by Equality Impact Assessments and support all reviews of service delivery and monitors all initiatives to improve service outcomes for individuals and groups with protected characteristics.

6. Our role as an employer: Workforce

Both the Council and the CCG hold data on the protected characteristics of their workforces but are aware that we have to work to improve some incomplete datasets s mentioned above in our Equality Objective 3: 'Improving Equality Workforce Data Collection'.

We are keen to work to improve recruitment, retention, promotion and training opportunities for the disabled staff and the Council has an additional focus for improvement for the BAME members of its workforce.

6.1 Trafford Council Equality Monitoring, Facts & Figures

The table below show the data the Council hold for Black and Minority Ethnic and Disabled employees in senior positions as a proportion of Trafford residents.

Trafford Council Equality Monitoring, Facts & Figures Total Staff Headcount as of 31 March 2020 – 2469					
No of BAME Staff	**No. BAME Staff in Senior Positions**	**No BAME Residents in Borough**	**No of Disabled Staff**	**No Disabled Staff in Senior Positions**	**No Disabled Residents**
9.44% (27.18% prefer not to state)	3% in Top 5% Salaries	32,744 residents in Trafford (14.5%)*	3.93% of those declared (36.98% not known)	4%	*38,603 residents in Trafford (17%) *Census 2011

Source: https://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/facts-and-figures.aspx

6.2 Trafford Council's People Strategy

Trafford Council's People Strategy 'EPIC YOU – Building a Winning Culture 2020 to 2022' outlines the values and behaviours which showing how:

- We **Empower** – we inspire and trust our people to deliver the best outcomes for our customers, communities and colleagues.
- We are **People Centred** – we value all people, within and external to the organisation and give those around us respect.
- We are **Inclusive** – we are committed to creating an environment that values and respects the diversity and richness that differences bring.
- We **Collaborate** – we build relationships, collaborate; treat people as equal partners and work together to make things happen.

Source: http://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/docs/People-Strategy.pdf

6.3 Trafford CCG Equality Monitoring, Facts & Figures

Trafford CCG Equality Monitoring, Facts & Figures Total Staff Headcount as of 31 March 2020 – 133					
% of BAME Staff	**%. BAME Staff in Senior Positions**	**% BAME Residents in Borough**	**% of Disabled Staff**	**% Disabled Staff in Senior Positions**	**% Disabled Residents**
19.62% 0.9% prefer not to state)	20% in Top 5% Salaries	32,744 residents in Trafford (14.5%)*	6.5% (10.2% prefer not to say)	0% in top 5% of salaries	*38,603 residents in Trafford (17%) *Census 2011

6.4 CCG values & behaviours

- Compassion: We will treat everyone fairly with compassion, dignity and respect.
- Support: we will value and support each other to be the best we can.
- Integrity and openness: We will be transparent in our actions and decision-making.
- Partnership: we will work with patients, their families, our communities and partners to improve the health of our population.

For full details of the CCG values & behaviours please see Appendix 3.

Joint HR Success Measures for the Council and the CCG

- Ensure we fully understand the composition and needs of our diverse workforces starting by improving the quality of the staff protected characteristic data collected by encouraging staff to update their electronic staff records

- The CCG will support the Council to embed the principles of the mandated and non-mandated NHS equality standards e.g. Workforce Race Equality Standard, Workforce Disability Equality Standard, and the Equality Delivery System.

6.5 Greater Manchester's Good Employment Charter

We support Greater Manchester's Good Employment Charter which details seven 'Good Employment Principles' which have an equality and inclusion thread running through them. They are:

- Extending secure work
- Extending flexible work
- Working towards paying a Real Living Wage
- Improving workplace engagement and voice
- Developing excellent recruitment and progression
- Improving people management
- Developing a productive and healthy workplace

6.6 Staff Networks

The Council has four staff networks: the BAME (Black, Asian and minority ethnic) Staff Network, Staff Disability Group, Carers' Support Group, and the LGBT (Lesbian, Gay, Bisexual and Transgender) Staff Network. They all meet according to the needs of each group and have sponsors from the Trafford Council Corporate Leadership Team. CCG employees are supported by their Senior Leadership Team to join the staff networks if they wish. All groups meet within work time, as agreed by the Corporate Leadership Team.

The networks connect employees who have a common identity and experience and enable their voices to be heard to inform the organisation. The staff groups work with

directors of HR, the head of health and safety and the trade unions, to address and improve employment practices. This joint working has taken place during the Council's and CCG's response to COVID-19, to support staff working from home and inform the organisation's plans for the safe return of staff to the workplace.

Success Measures

- Implementation of agreed actions suggested by the staff forums
- Confidence in the approaches to reducing inequalities as fed back by staff groups

7. Our role as a Commissioner of Services

Trafford CCG and Trafford Council are committed to providing, commissioning and procuring cost effective services that improve outcomes for all of our diverse population. This requires monitoring of the services provided and the development of service specification and design to reduce inequality.

Trafford Together for Health and Social Care is our combined approach for the Council and Trafford CCG to deliver a holistic person-centred health and social care service to our residents.

Trafford CCG and Trafford Council are responsible for the design and improvement of services. Our commissioning decisions are informed by the needs of individuals and groups in our communities, defined by population, locality, and by protected characteristic or shared interest. This enables us to design services which are truly based on supporting residents to live healthy lives.

We also commission using the principles of asset-based working and co-production, using local people and communities' skills, knowledge, and understanding of their needs to design our health and social care services. Asset based commissioning relies on understanding what local communities can do for themselves, need help with, and what they want statutory bodies to provide for them. This approach starts to shift power through working with local people and groups and having devolved budgets to local people and communities. The ultimate aim is communities controlling their own resources

Data quality remains an issue for some services and improving our data collection is a key action for all.

Success Measures

- Monitoring of uptake of services by protected groups
- Explore ways to monitor the outcomes by different groups for the various services they receive.

8. Our role as a Provider of Services

8.1 Access Trafford & Libraries

Trafford Council's Contact Centre takes calls from residents Monday – Friday in line with corporate opening times dealing with queries, relating to council tax, benefits, adult social care, planning and building control, pest control, elections and blue badges applications. The Contact Centre receives around 5,000 calls per year.

Some staff are bilingual, but all staff have access to an interpreting service if required.

There are 11 libraries in Trafford and 99% of the population is within 2 miles of a library. There is no age restriction to people joining the library and all libraries have disabled access. Work over the next year will ensure libraries become Autism friendly. All libraries are open Monday to Friday, and on Saturday. Please see link below for opening times.
http://www.trafford.gov.uk/residents/SearchResults.aspx?search_keywords=library%20opening%20times

There are computers in all libraries that are free to use and have free Wi-Fi.

We commission Age UK Trafford to provide a Home Library Service which delivers books to residents who may find it hard to get to a library; and to carers who may have difficulties accessing a library due to their caring responsibilities. Also, our Talking Book service posts talking books out to customers who may have difficulty reading print due to a sight or other impairment and is free of charge via Royal Mail.

Success Measure

- Feedback from customer surveys

8.2 Adult Social Care

Trafford Council's Adult Services Directorate provides assessment, advice and guidance to all adults, and their carers who request an assessment or may be perceived to have care and support needs (as defined by the Care Act, 2014 - http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted). We currently have four integrated Neighbourhoods (North, West, Central & South) and a collaborative partnership with our health colleagues in Trafford Local Care Organisation (TLCO) within Manchester Foundation Trust (MFT) to ensure that our responses are localised, proportionate and timely.

We also offer several specialist Borough wide Services which include: Complex Need Adults (Learning Disabilities), Safeguarding and the Deprivation of Liberty Safeguards (DoLS) teams.

8.3 Adult Social Care and Equalities – key objectives, approach and training

Our social care provision for adults considers a wide range of access needs for people with physical and mental disabilities, sensory impairments, religious and cultural needs. Personalisation helps formulate individual tailor-made care plans together with developments geographically located to be in the centre of our localities with our Extra Care Provision at: Limelight in Old Trafford, Elkin Court at Partington, Fiona Gardens at Sale and New Haven in Timperley. There is more work to be done to reach out to and support our Black and Minority Ethnic (BAME) clients in order to capture information about their diverse needs with regard to faith and culture to ensure they receive the quality tailored social care suited to their individual needs.

Success measures

- Engagement of voluntary sector and faith groups to support BAME service users and their families
- Council able to offer support to more carers especially those likely to be linked to BAME communities.
- Focus on meeting faith/cultural needs of all individuals at assessment as these are often excluded
- Improved Advocacy/translator services especially in North Trafford
- Improved data collection of equality profile of adult social care clients to enable improved tailored provision of care to meet needs especially with regard to identity, ethnicity, religion etc.
- Improve our knowledge of social care clients experiencing hate crime and exploitation.

8.4 Early Help & Children's Social Care

Social Work England sets the professional standards for social workers, (see Appendix 2) and standard 1 specifically addresses equality and diversity as follows:

Professional standard Number 1 is 'Promote the rights, strengths and wellbeing of people, families and communities' states that as social workers and all other professionals working in children's social care will:

1.1 Value each person as an individual, recognising their strengths and abilities.

1.2 Respect and promote the human rights, views, wishes and feelings of the people I work with, balancing rights and risks and enabling access to advice, advocacy, support and services.

1.3 Work in partnership with people to promote their wellbeing and achieve best outcomes, recognising them as experts in their own lives.

1.4 Value the importance of family and community systems and work in partnership with people to identify and harness the assets of those systems.

1.5 Recognise differences across diverse communities and challenge the impact of disadvantage and discrimination on people and their families and communities.

1.6 Promote social justice, helping to confront and resolve issues of inequality and inclusion.

1.7 Recognise and use responsibly, the power and authority I have when working with people, ensuring that my interventions are always necessary, the least intrusive, proportionate, and in people's best interests.

Success Measures

- Evidence against the seven standards above
- Feedback from children and families
- Fostering and adoption outcomes for diverse groups
- Improved data collection of equality profile of children in social care to enable improved tailored provision of care to meet needs especially with regard to identity, ethnicity, religion etc.
- Improve our knowledge of social care clients experiencing hate crime and exploitation such as CCE, trafficking and modern day slavery**.**

8.5 Education & Young People

Trafford's education system is performing well with 96% of schools being rated 'Good' and 'Outstanding' and high educational outcomes for children. 'Closing the gap', particularly for disadvantaged pupils and young people with Special Educational Needs has been, and remains, an area of focus at all levels. Areas for improvement are addressed through the following:

- The Education Strategy and the work of the Education Board

The Education Strategy has helped to unify the system and use resources as effectively as possible. Effective team working throughout the Education Department enables combined intelligence to be utilised to identify schools that require support.

- The Special Educational Needs Action Plan

The purpose of the SEND (Special Education Needs and Disabilities) Strategy is to ensure there is a well-planned provision that meets the needs of children and young people with SEND and their families. Integrated services across education, health and social care will work closely with parents and carers, to ensure that individual needs are met. It also means a strong commitment to early intervention and prevention so that early help is provided in a timely way

- The 0-5 Strategic Plan

The work of the 0-5 Multi-Agency Strategic Board is to increase the proportion of children who are ready for school at the end of the Early Years Foundation Stage and narrow the gap for the most disadvantaged children.

Success Measures

- All Trafford children and young people attend settings and schools which are good or better by Ofsted and they are educated in the provision best suits their needs.
- The aspiration of all children and young people with a particular focus on the most vulnerable pupils is raised, so that they have the skills and confidence to lead successful lives so that the attainment gap between disadvantaged pupils and their peers is reduced at all milestones.
- Children with Special Educational Needs achieve strong outcomes as evidenced in attainment outcomes which are above national expectations and there are reduced numbers of school exclusions

8.6 Place Services – Equalities

Place-based services carry out a number of activities that support the Council's equalities agenda. These include:

- Working with disability groups to improve the accessibility of our town centres
- When determining planning applications, ensuring the Council's duties under the Equalities Act 2010 are discharged
- The emerging Design Guide will include guidance on improving accessibility in developments for all the community
- The Head of Service is a committee member of Women in Planning North West – which seeks to promote diversity and inclusivity in planning and to ensure that women's voices are heard
- Older Person's Housing Strategy developed to address the needs of older people in Trafford
- Supported Housing Strategy being developed to identify the housing and support needs of people with a learning disability and/or autism; people living with mental health; people with substances dependencies; people with a physical/sensory impairment; young people (aged under 18) including Care Leavers and offenders
- Homelessness Strategy incorporates all residents of Trafford who are homeless or threatened with becoming homeless.

Success Measures

- All town centres are accessible
- Monitor access to housing by protected group
- Reduce homelessness

9. Regulatory Services and Environmental Health

Trafford has a flourishing and diverse range of restaurants and takeaways which contributes to the richness and attraction of our town centres. In order to ensure that all business operators understand the environmental health requirements we have published these requirements in ~~to~~ a range of languages.

The Safer Food Better Business manual commonly used by the food businesses, is available on the Food Standards Agency's website in alternative languages (www.food.gov.uk). Officers from Regulatory Services make available to businesses detailed allergens guidance which has been translated into 13 languages commonly spoken in Trafford.
Success Measures

- Cleanliness standards in restaurants/takeaways by area
- Enforcement re allergens

9.1 Licensing

Taxis – Wheelchair accessible vehicles

Whilst it is a requirement in Trafford that all hackney carriage vehicles, licensed by the Council, must be wheelchair accessible there are far more licensed private hire vehicles to which this requirement does not apply.

We aim to amend a range of policies around regulation of the taxi trade in Trafford. We will implement the provisions of section 167 of the Equality Act 2010. This gives the local authority the power to make publicly available lists of wheelchair accessible vehicles ("designated vehicles"). Once designated, the drivers of those vehicles are legally obliged to carry passengers in wheelchairs, provide assistance to those passengers and are prohibited from imposing any extra charges. Drivers are also be conditioned by licence to carry a passenger's assistance animal and allow it to remain with the passenger in the vehicle (travelling in the front foot well if trained to do so) and not make any charge for doing so.

Success Measures

- Feedback on Council webpage and for the list of accessible vehicles from customers
- Feedback from survey with the public and disabled groups on other information about accessibility

9.2 Trading Standards

Trading Standards – Support for vulnerable residents and those with additional needs.

Trafford iCAN system is a messaging system that is intended for residents who would like to be made aware of the latest cons and scams. Trading Standards' iCAN alerts are included in Trafford's Talking Newspaper for visually impaired residents. Regular awareness raising sessions are delivered with Henshaws, the charity that supports visually impaired people of all ages. In addition a regular programme of talks to social groups and sheltered accommodation schemes goes on every year for older residents and Trading Standards have established links into the Social Services' safeguarding system along with Greater Manchester Police (GMP) who refer the most vulnerable of scam victims through to Trading Standards.

9.3 Building Control

The Building Control service ensure that both residential and non-residential new build, or extended and altered existing commercial buildings, meet the Building Regulations requirements relating to access and facilities for disabled persons to access buildings. The service also applies design standards for people with disabilities to large commercial buildings and sports facilities.

9.4 Bins & Recycling

We offer an assisted collection service to any resident who are unable to place their bins ~~out~~ for collection and return. All communications will have a pictorial element to reduce any language or literacy barriers.

Households needing further support to recycle will be visited by advisors. We have found that engaging with householders on the doorstep and the pictorial leaflets enable communities to better understand the recycling service.

Success Measures

- Feedback from users
- Monitoring for satisfaction by different protected groups
- A reduction in the amount of recycling rejected at the tipping hall

9.5 Interpretation and translation

For all our service delivery we provide a full language interpretation and translation service through an approved provider to our customers as requested. This includes, language interpretation, transcriptions, British Sign Language and other alternative formats. In the past year, (April 2019 – March 2020) our most frequent requests have been for the following languages: Punjabi, Mandarin, French and Arabic.

10. Trafford Community Engagement

Trafford Partnerships Team lead on projects such as the Trafford Poverty Strategy, Trafford Together Locality Plan, healthy weight, school readiness, period poverty and the Working Well Early Help Programme.

Examples of active community engagement are:

- Trafford's Sport & Physical Activity Strategy
- Trafford's Armed Forces Covenant
- Voluntary Community Service Engagement (VCSE) sector
- Delivery of the Inclusive Neighbourhood Grants scheme and supporting small VCSE organisations to deliver projects and events in their communities
- Leading on community engagement across the borough through networks such as Vision 31, town centre partnerships and the Old Trafford Conversation
- Supporting community initiatives such as Partington Women's Group, The Bread and Butter Thing, Ear4U Centre and Our Sale West.

Success Measures

- Development and implementation of the Trafford Poverty Strategy
- Delivery of Trafford's Armed Forces Covenant and commitments
- Monitoring the delivery of projects and events through community grant schemes to demonstrate positive impact
- Sustainability of VCSE organisations through capacity building and emergence of new VCSE organisations
- Increased level of resident and partner engagement in community initiatives and partnership networks supported by the team
- Sustainability of the Community Response Hubs and the creation of neighbourhood networks connected to these Hubs

11. Community Cohesion

Trafford Council has established a Community Cohesion Forum. The resident-led forum brings together representatives from local voluntary and community organisations, faith groups and youth groups alongside partner agencies, to understand cohesion in the borough and join up the efforts to tackle challenges and take opportunities to work more effectively in partnership. The Forum meets quarterly and is currently co-chaired by the Mayor and a Trafford resident. For 2020/2021, the Forum is focusing efforts to tackle knife and hate crime in the communities.

12. Our Response to COVID-19

At the time of writing this document we encountered the COVID-19 global pandemic. Changes were made to services and policies to support Trafford's most vulnerable groups through our service delivery, for example, in our care homes and through our community hubs. Information has been available in alternative formats and in other languages so that everyone has access to the information that they need. In terms of employment there has been a focus on staff health and wellbeing and supporting staff through the change in physical work environment and shift in job role in response to urgent priorities throughout the NHS and local authorities.

Success Measures

- Reach of messaging into communities
- Uptake of support by population group

13. George Floyd and Black Lives Matter

As a result of the murder of George Floyd there has been a global, national and local response to the need to address the structural racism and inequality that exists in our society and institutions. In response, Trafford Council and CCG are committed to strengthening the dialogue with all communities and exploring together ways of reducing race inequality.

It is important to keep the conversation going as the fight for justice continues which is why we wanted to share a short but very informative rap about why black lives matter by Fleur East, (who is of mixed-heritage) and a former runner-up of the X Factor. Please see the link below.

https://planetradio.co.uk/hits-radio/entertainment/celebrity/fleur-east-rap-roulette-black-lives-matter/

14. Conclusion

Trafford is committed to equality, diversity, inclusion and human rights for all. We recognise we still have some way to go to achieve our equality goals but we have set out in this Strategy our plans for making progress. We would very much welcome comments on the Strategy from our residents, staff and partners going forward and we will continually consult, respond and implement improvements as our Strategy will evolve as our communities and their needs evolve.

We will conduct an equality review working with external equality specialists who will help us shape our action plan to achieve this Strategy

We will continually report on the action plan through our various governance processes and to our Joint Leadership Team

Appendix 1

Additional Legal duties and meeting Mandated Equality Requirements

In addition to the Equality Act 2010 Trafford Council and the CCG are also subject to other legal and mandated requirements. These include:

The Health and Social Care Act 2012

CCG's must in the exercise of their functions have due regard to the need to:

- Reduce inequalities between patients with respect to their ability to access health services and
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

The Act also requires the Council and CCG to follow the Accessible Information Standard. This Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information communication needs of patients, service users, carers and parents with a disability, impairment or sensory loss, and ensure they receive the following:

- 'Accessible information' (information which can be read or received and understood by the individual or group for which it is intended) and
- 'Communication support' (support which is needed to enable effective, accurate dialogue between a professional and a service user to take place).

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is within the NHS standard contract. It focuses on race equality as a priority area and follows published research which has highlighted disparities in the number of Black, Asian and Minority Ethnic (BAME) people in senior leadership positions across the NHS, as well as lower levels of wellbeing and satisfaction amongst BAME staff. The CCG publishes its results annually along with an action plan and is responsible for ensuring that providers of commissioned services provide their results.

Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) enables NHS organisations to compare the experience of disabled and non-disabled staff. Like the WRES, an annual action plan is required to enable progress to be demonstrated. The WDES also seeks to improve the representation of disabled people at Board level. Currently the CCG is not required to complete the WDES, but it does need to ensure that providers of commissioned services provide evidence of their results including an annual action plan. It does this through quarterly meetings with large providers such as Manchester Foundation Trust and Greater Manchester Mental Health Trust and with smaller service providers through contract management arrangements.

The Equality Delivery System (EDS)

The Equality Delivery System (EDS) is a tool that helps NHS organisations improve the services they provide for the local community and better working environments, free from discrimination, for those who work for the NHS. It outlines requirements in health outcomes, improved patient experience, a diverse workforce and inclusive leadership.

Equality Impact Assessments (EIA's)

Under the Public Sector Equality Duty within the Equality Act 2010, the Council has to show that it has given 'due regard' or consideration to the impact that a decision or change in policy has on groups that share a protected characteristic. One method of doing this is to carry out an equality impact assessment (EIA). This helps us to ensure that the different needs of people are taken into account as far as possible and that any potential negative impact on people is mitigated where possible.

Trafford Council carries out EIAs on a wide range of policies, functions and procedures to ensure that equality is taken into consideration in every area of our work. For further information on EIAs please visit our website: https://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/equality-impact-assessments.aspx

The CCG use a similar process which is referred to as an Equality Impact and Risk Assessment (EIRA). This process provides a framework for undertaking a robust equality risk and human rights impact assessment and is the primary source for demonstrating how the CCG has considered its legal duties, including the Equality Act 2010, the PSED, and the Human Rights Act 1998. Assessments are carried out for the following:

- Change in service-commissioning or decommissioning
- Policy development or review
- Strategy development
- Change in work practices.

Progress on EIRAs is included in our Equality and Inclusion annual report and EIAs are available on request.

All staff in Early Help & Children's Social Care work to the six agreed professional standards of Social Work England which can be found here:

https://www.socialworkengland.org.uk/media/1640/1227_socialworkengland_standards_prof_standards_final-aw.pdf)

Appendix 2

Internal policies to support Equality and Diversity

Trafford Council has an overarching Equality and Diversity in Employment Policy Statement which details our vision to ensure that everyone has equal opportunity to succeed. This can be found on our website. (http://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/equality-and-diversity.aspx

Trafford Council has a Service Delivery Policy Statement to demonstrate our commitment to providing services to local people that respond to the diverse needs of service users and this can be found at: http://www.trafford.gov.uk/about-your-council/strategies-plans-and-policies/equality-and-diversity/service-delivery-policy-statement.aspx

Appendix 3

NHS Trafford CCG Values & Behaviours

Compassion: We will treat everyone fairly with compassion, dignity and respect

- We will always find the time to listen and value the views of others
- We will be polite and respectful of our colleagues and team mates
- We will not bully, discount or ignore anyone
- We will always consider our colleagues' feelings and think of our impact on others

Support: We will value and support each other to be the best we can

- We will be someone that colleagues can rely on, whoever they are and whatever their role
- We will respect other people's time as being as valuable our own
- We will contribute to a safe and tidy work environment and won't expect others to tidy up after us
- We will constantly strive to simplify processes and eliminate waste, whilst always improving quality

Integrity and Openness: We will be transparent in our actions and decision making

- We will involve colleagues in the work we do with, or for them, so they know what's happening
- We will ask open questions and keep people informed
- We will speak up for and defend our standards when others don't follow them, and appreciate them when they do
- We will take responsibility for our action

Partnership: We will work with patients, their families, our communities and our partners to improve the health of our population

- We will work with others to innovate and solve frustrations
- We will make the best use of available resources
- We will always look and behave appropriately for our audiences

You can see our values… in how we behave every day

Compassion: We will treat everyone fairly with compassion, dignity and respect

- I will always find the time to listen and value the views of others
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- We will work with you to innovate and solve frustrations
- We will make the best use of available resources
- We will always look and behave appropriately for you and our audiences

Our values and behaviours- for colleagues - As a commissioning organisation, our values and behaviours are key to help us deliver an effective service

Appendix 4

For details about the Women in Planning Committee please see:

https://www.womeninplanning.org/north-west

Trafford Integrating Care

Next steps to building strong and effective integrated care systems

Trafford CCG Programme Board Presentation

January 2021

Integrating Care: Background and Context

Working with partners we will aim to:

- ❑ Understand the future in terms of role and functions in Trafford and Greater Manchester
- ❑ Understand future accountability and governance
- ❑ Agree a form which will deliver the functions for Trafford based on our locality working
- ❑ Work towards a positive and proactive future for Trafford residents and Trafford colleagues

Our vision will remain: **Trafford Together: People, Place and Partnership**

Our frame of reference will be a locality health and social care integrated system, within which we will focus on our Locality Plan, the Local Care Alliance and the Local Care Organisation.

Work will be within the construct of 'place' which for us in Trafford is:

- ❑ **1** Locality, **4** Neighbourhoods, **6** Community Hubs and **5** Primary Care Networks

The CCG has formed a Programme Board to drive forward the work, which is made up of Senior Leadership from the CCG and Council

Integrating Care: Learning from our journey

"**To improve health and wellbeing for the people of Trafford**, maximising available resources through system wide collaboration"

"An acknowledgement that **integrated care cannot be delivered by organisations working alone or in isolation**, it must be delivered through collaborative working"

"That the development of very different **relationships is at the heart of integrated care**, with professionals from different organisations, professional groups and teams understanding one another and developing mutually respectful and collaborative relationships with those who require their professional expertise"

(Local Care Alliance Memorandum of Understanding, July 2020)

Integrating Care: Learning from our journey

- H&SC Strategic Vision – Trafford Recovery / Locality Plan
- Integrated Neighbourhood Working
- Integrated Commissioning
- System Connectivity
- Positive Relationships
- Values / Behaviours / Principles
- Performance and Measurement
- Co-Design and Co-Production
- Local communities hold the key

Integrating Care: The GM Response to the NHS Engagement Exercise

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.

Consensus in Greater Manchester to pursue 'Option 2'

- ❑ Provides for a clearer structure which will minimise the potential or unnecessarily complicated governance
- ❑ A more streamlined arrangement to progress the commissioning and delivery of system level services
- ❑ A clearer opportunity to reduce or remove the commissioner/provider separation at the system level
- ❑ Ability to establish local governance and financial flows which similarly reduces the transactional burden of the commissioner provider split

- Conditional on implementation of financial, governance and staffing arrangements which would provide for accountability at Trafford level

Integrating Care: Trafford Engagement Exercise Response

There were 4 questions to be answered as part of the guidance and below is Trafford CCG's Governing Body response to those questions:

1. We agree that giving Integrated Care System a statutory footing in 2022 alongside other legislative proposals gives the right foundation for the NHS over the next decade.

2. We agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability cross the systems, to Parliament and most importantly to patients.

3. We 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 population needs.

4. We agree subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to Integrated Care System bodies.

Integrating Care: Pillar Work Streams

Engagement

Engagement

Trafford System Place Board

Trafford Local Care Organisation Scope

Trafford Provider Collaborative

Trafford Clinical and Profession Leadership

Transition

Programme Approach

Engagement

Engagement

Integrating Care: System Connectivity and Engagement

Meeting	January 21	February 21	March 21	April 1	September 21	April 22
CCG Governing Body	5 January	N/A	30 March	Tbc	Tbc	Go Live for new system. (CCG Final Accounts June 22)
CCG Council of Members	N/A	N/A	10 March	Tbc	Tbc	
Joint Leadership Team (Council and CCG)	27 January	24 February	24 March	Tbc	Tbc	
Joint Commissioning Board (Council and CCG)	N/A	8 February	Tbc (decision on shadow)	Tbc (Place Board in shadow)	Tbc (shadow phase)	
Trafford Local Care Alliance	14th January	11th February	11th March	15th April	9th September	

Forum	Frequency
SLT Programme Board	Weekly
SLT Update	Weekly
HSC R&RB Updates	Bi-weekly
Colleague Engagement	Colleague Forum: Fortnightly / Kitchen Briefing: Weekly / Colleague Briefing: Weekly

Integrating Care: System Place Board

Workstream Group:
Sara Radcliffe, Gareth James, Zoe Mellon, Ian Tomlinson

Trafford TOGETHER

System Place Board: Initial Thoughts on Scope up to April 2021

Workstream to:

- ❑ Outline the initial design of a System Place Board for Trafford – function and form
- ❑ Agree the initial design with the Trafford Joint Commissioning Board and partners
- ❑ Enable the board to be in shadow form for April 21
- ❑ Design the April 21-April 22 process that leads to full establishment for April 22

System Place Board: Initial questions to be answered……..

What are the functions that the place based board needs to undertake ?	→	Leading integrated health and social care strategy, commissioning, governance including delegated responsibilities and overall system performance
Who are the people/roles that need to be on the board to fulfil the functions	→	Place Leader, Health Watch, Public Health as stated and then ……
Is it a Senior Officer Group which reports into a wider governance structure	→	This would seem appropriate for the functions as described and could then place it into the wider governance for scrutiny
Does the current JCB fulfil this role	→	Not at present, a new design is needed
Is the wider governance currently fit for purpose to scrutinise this form of board	→	Not at present, a new emphasis is needed
What is the process that we would need to go to constitute the Board	→	Guidance may outline this or we may need to explore wat has previously happened with joint committees

Integrating Care: Financial Framework

Understanding financial arrangements and financial flows is essential to the development of integrated care. There remains uncertainty, but what we do know is:

NHSE&I engagement on Integrating Care:

- The intention is to **"delegate significant budgets to 'place' level"**
- Encourage **"allocative decisions in the hands of local leaders"**

NHSE&I priorities for winter and 2021/22:

- We won't know financial settlement until close to March '21
- Funding will continue at a system level (GM)
- Based on previously published CCG allocations; adjusted for impacts of 20/21

Key actions and milestones:

- Agree budgets and contracts from April '21
- Continue to agree local alignment of Trafford budgets
- Influence GM financial framework discussions

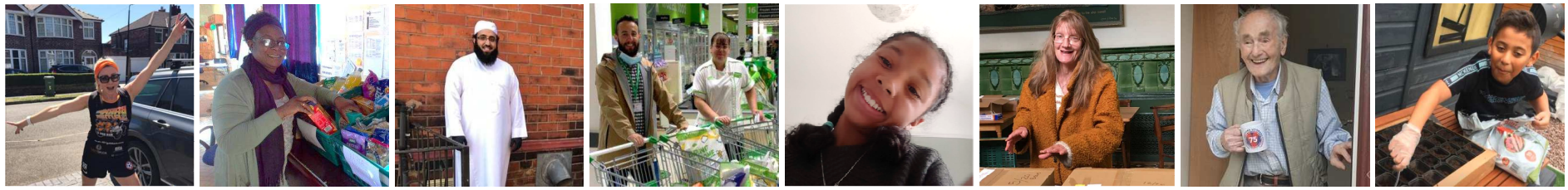
Integrating Care: Provider Collaborative

Workstream Group
Naomi Ledwith, Thomas Maloney, Paul James, Julie Flanagan

Trafford TOGETHER

Provider Collaborative: Initial Thoughts……..

GM Level	**Partnership** GM Provider Assembly	**Delivery** GM Provider Collaboration
Trafford Level	**Partnership** Trafford Locality Provider Assembly	**Delivery** Trafford Locality Provider Delivery Vehicle



Trafford TOGETHER

Provider Collaborative: Trafford Locality Provider Assembly

The 'Engine Room' of the System Board

'Proposed Purpose' Initial Thoughts:

- A wide ranging **strategic partnership** of all providers in Trafford
- Oversees **joint planning** at the most appropriate spatial level for the subject matter
- **Use of data** to strategically plan and design health and care services to meet needs of population
- Continue to redress the balance of care to move it **closer to home**
- Use of data to **identify inequalities** (outcomes and access, within Trafford and in comparison to GM and statistical neighbours) to propose programmes of work that close unacceptable gaps.
- Support organisations to improve their capabilities and capacity to **tackle unwarranted variation and performance challenges** – look to embed consistent 'continuous improvement' methodology
- Identify and **develop innovations**, validate and replicate where appropriate
- **Align work with GM bodies**, such as the ICS (GMHSCP), Universities, HINM to advance the collaborative' s purpose, including the education and research imperatives
- Oversee the necessary **recruitment, training and development of the required workforce** to deliver against the breadth of the Trafford Together H&SC Locality Plan
- Ensure effective **Public Engagement and Co-Production**
- Maximise the '**Trafford Pound**' – securing positive return on investment and value for money
- Exercise its '**Financial Responsibilities**' – to work within a system financial envelope

Trafford Locality Provider Assembly Membership

Trafford Locality Provider Assembly has a wide ranging membership to include:

- Local Care Organisation
- Trafford Primary Care Networks
- Trafford Council
- Greater Manchester Mental Health NHS Foundation Trust
- Manchester University NHS Foundation Trust - in particular WTWA, CSS
- Trafford Community Collective (VCFSE Representative)
- Wider Primary Care - Pharmacy, Dentistry, Optometry
- GP OOH
- Social Care Providers
- Independent Sector (Health)

- ❑ **Parity of esteem** amongst the membership in the 'Assembly'
- ❑ Integration needs to be **authentic and promote equality** amongst partners
- ❑ Supported by a **programme approach**

Trafford Provider Deliver Vehicle:

'Proposed Purpose' Initial Thoughts and Questions:

Trafford Locality Provider Delivery Vehicle:

- Scope of service and operating model to be wider than current LCO including strong working relationships between the provider assembly members, alongside the means to connect to housing, education, criminal justice etc
- We create our own route map guiding these changes, with some partners being organisationally integrated, some contractually and some aligned through partnership agreements
- We need to understand should the model be all age?

The Delivery Vehicle could:

- Act as a means to enable the neighbourhood model, working with communities to empower change
- In addition to operational delivery could also be responsible for reform ie tactical commissioning; risk stratification & case finding; lived experience and co-production; strengths based/asset based working; workforce development and blended roles
- Act as local economic contributor, delivering social value - through its employment, training, procurement and volunteering activities

As a result of the changes we will need to consider:

- New quality assurance, quality monitoring, and improvement models spanning the scope of the collaboration
- New financial framework to accelerate maturity and development
- New digital framework to ensure linkages and innovation
- The role of commissioners as Resilience and Reform

Need to recognise and protect the linkages across local and GM/specialist pathways and avoid fragmentation of care. They are not separate models but part of the same episode of care and most likely operated by a single organisation operating at both spatial levels

Integrating Care:
Local Care Organisation Scope

Workstream Group
Sara Radcliffe, Rebecca Demaine, Stephanie Whitelaw, Cathy O'Driscoll, Andrea Gallant, Louise Walpole

Trafford TOGETHER

LCO Initial Thoughts on Scope up to April 2021……..

Workstream Group to:

- Outline the initial proposed scope of the future LCO in Trafford with MFT/TLCO and partners – function and form
- Agree the initial scope and design with MFT/TLCO and partners
- Design the April 21 – September 21 process
- Design the September 21 to April 22 shadow process

LCO Scope: Initial questions to be answered……..

Who, when and how do we need to work with the TLCO – linking back into the Exec to Exec which is being put in place

→ This has to be a collaborative piece of work with MFT/TLCO from the beginning with joint and clear arrangements in place for decision making

What are the CCG functions that we would want to keep at a locality level – and therefore what are the ones that would be at an ISC level

Out of these which ones to we feel would be best in a LCO and where else may functions best go e.g. other providers such as GMMH or Council

We see the CCG as a commissioning organisation and would need to work through the functions within our directorates - including Commissioning, Finance and Contracting, corporate services, Performance and Quality Improvement, Primary Care Services, Nursing services, Integrated Health and Social Care Strategy and where they would best sit to serve the people of Trafford

Who and what would we want to facilitate being aligned to the LCO – more than in the provider collaborative, i.e. building on the PCN discussions

→ We would need to work with the Provider collaborative work stream, with the Local Care Alliance, to understand and realise the range of issues and possibilities

Integrating Care: Clinical and Practitioner Leadership

Workstream Group
Mark Jarvis, Manish Prasad, Rebecca Demaine, Jacqueline Coulton

Clinical and Practitioner Leadership: Scope up to April 2021……..

Workstream Group to:

- Identify the key clinical and practitioner stakeholders in Trafford
- Agree the appropriate representatives from stakeholders
- Organise a set of workshops with all relevant stakeholders to collectively design and agree how the future clinical decisions and pathways could be made
- Stakeholders to include but not exhaustive: GPs, Pharmacist, Practice Nursing, Nursing Community, AHP, OT, Paediatrics, Physiotherapy community, Dental, Mental Health, Optometrist, Pharmacist community, VCSFE, Public Health, Safeguarding, Social Care, Care homes, Secondary Care, Diagnostics, Ambulance, Patient Representative…….

Integrating Care: Transition

Workstream Group
Louise Walpole, Angela Beadsworth (Initial)

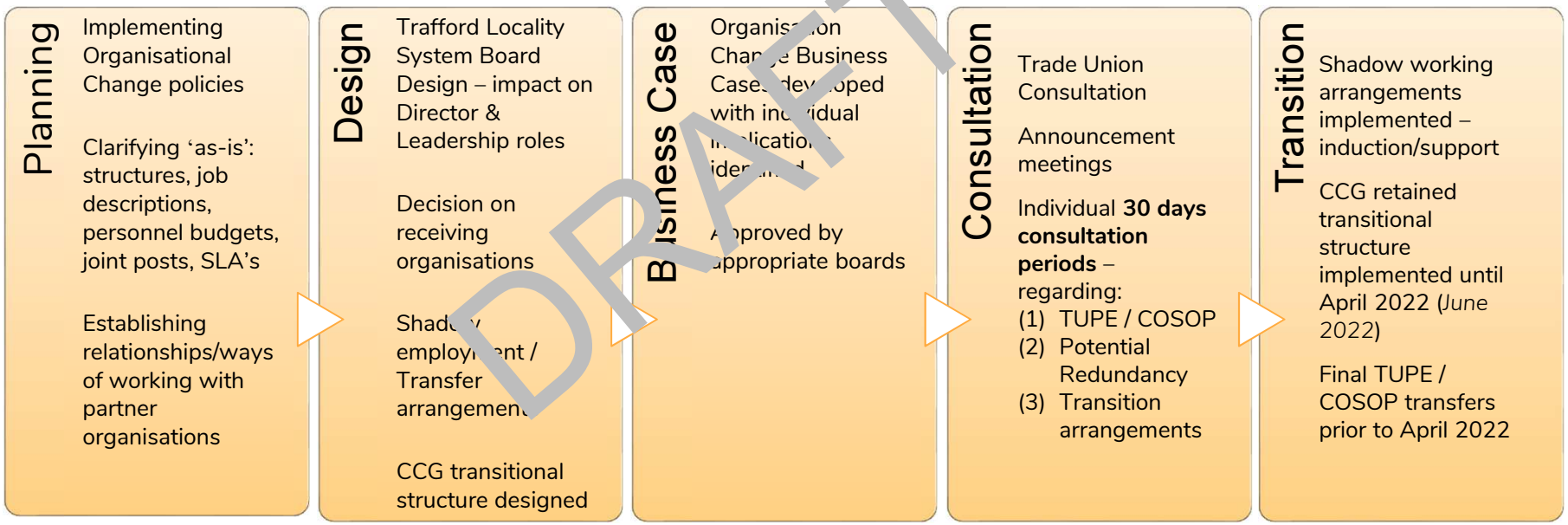
Trafford TOGETHER

Workforce Transition Approach

- This will be a complex transition requiring significant collaboration at the design phase to define a **system wide structure** that effectively accommodates the transition of CCG functions into other parts of the system in line with the principles set out by the Integrated Care System aspirations.
- **All system partners** will need to adopt a programme approach to ensure complete alignment of system design, transition and implementation.
- **Changes to structure and roles will impact receiving organisations as well as the CCG**, therefore the design and subsequent workforce implications will need to be worked through collaboratively. These developments will be fed into the **Trafford Locality Workforce Group** whose role in the transition and implementation process will be critical.
- Through this system redesign we aim to continue on our journey in achieving **one workforce across Trafford, enabling, better lives for our most vulnerable people, better wellbeing for our population and better connections through our communities.** Striving for an engaged, effective and inclusive workforce. Supporting this system redesign organisation development support will be required such as:
    - Continued development of our system leaders
    - Induction / training for colleagues impacted by the transition within the system
    - Supporting the health and wellbeing of our workforce
    - Provision of learning & development to support and embed place-based ways of working
    - Workforce diversity and inclusion strategies
    - Development of 'leaders' in selected Improvement Methodology
- At this stage Organisation Development is not mapped out, but requires significant consideration and potential investment/resource

Workforce Transition Phases - CCG

- Workforce Transition for the Trafford CCG will comply with the Organisational Change Policy.
- The high level plan below sets out a broad overview of the stages of the transition from a CCG workforce perspective – this will be built as work develops to ensure a details transition plan for all work streams.
- All receiving organisation will have redesign workforce considerations and due process to follow and collaboration will be required at all stages of the process.



Workforce Communications and Support - CCG

- Any period of Organisational Change brings uncertainty and can unsettle a workforce. We have the added challenge of leading this change through a global pandemic, which in itself brings huge workforce challenges for all in the Health and Social Care System.
- Most colleagues at the CCG will continue to work from home for during the initial months of 2021 and it is difficult to foresee when a return to ways of working prior to the pandemic will recommence.

Regular informal communication

- Kitchen briefing led by AO, Time Together sessions & Colleague Briefing updates
- Transition focused colleagues update meetings
- Updates at Colleague Forum
- Line Manager Supervision

Formal consultation

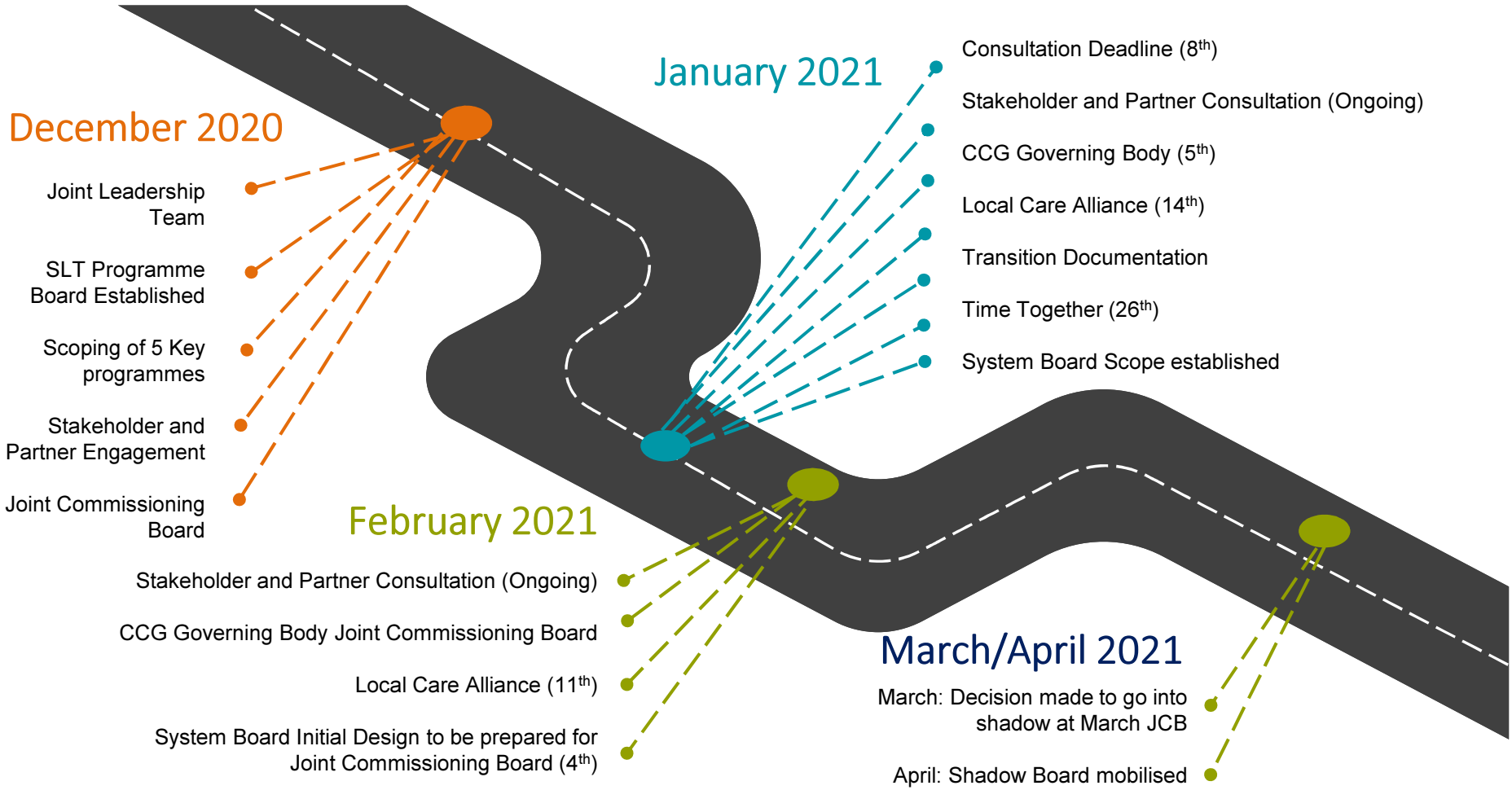
- Initial updates and dialogues with Trade Unions about proposals and progress
- Formal consultation with Trade Unions to set our proposals
- Formal Colleagues Announcement - individual 30 day consultation with 1:1s
- Published Frequently Asked Questions to support consultation process

Wellbeing support

- Underpinned by CCG's People Plan there will be a focus on supporting the workforce. This will include ensuring engagement through Colleagues Form and Kitchen Briefings; undertaking check-in's & appraisals, engaging staff groups, and continuing to listen and act on feedback (e.g. NHS Staff Survey). Online wellbeing tools will be promoted through Colleague briefing and published on the intranet.

Integrating Care: We must…….

- Embody the values and behaviours of our existing partnerships – particularly learning from the Local Care Alliance (LCA)
- Commit to conducting our business with honesty and impartiality
- Ensure that integration is authentic and promotes equality amongst partners
- Adopt evidence-based practice, recognising the unique characteristics of our locality, our neighbourhoods and our communities
- Focus on the delivery of core outcomes and expectations as well as tackling unwarranted variations across and within specific areas of Trafford – address our inequalities
- Think system finance and enact the 'financial principles' agreed through the LCA – funding flows to align with our priorities (Prevention)
- Maximise social value and encourage community wealth building approaches
- Put in place a proportionate programme management function to manage the partnerships, work programmes, system connectivity


December 2020
Joint Leadership Team
SLT Programme Board Established
Scoping of 5 Key programmes
Stakeholder and Partner Engagement
Joint Commissioning Board
January 2021
Consultation Deadline (8th)
Stakeholder and Partner Consultation (Ongoing)
CCG Governing Body (5th)
Local Care Alliance (14th)
Transition Documentation
Time Together (26th)
System Board Scope established
February 2021
Stakeholder and Partner Consultation (Ongoing)
CCG Governing Body Joint Commissioning Board
Local Care Alliance (11th)
System Board Initial Design to be prepared for Joint Commissioning Board (4th)
March/April 2021
March: Decision made to go into shadow at March JCB
April: Shadow Board mobilised

Trafford Integrating Care: Next steps to building strong and effective integrated care systems across England

The ask:

- ❑ Support the programme approach and structured work programme as outlined – particularly Provider 'Collaborative and Clinical' and 'Practitioner Leadership'
- ❑ Engage in appropriate task and finish groups as they emerge with named individuals
- ❑ Work collaboratively to confirm timeframes for each of the 5 work programmes including the establishment of the Shadow 'System Board' arrangements by April 2021
- ❑ Single partner organisation conduit to support the escalation of issues that require discussion/resolution

Questions, Comments & Next Steps

Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

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

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

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

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take effect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January 2021.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on 24 November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICSs therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

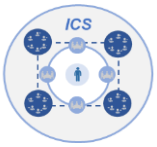
1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

Devolution of functions and resources



1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

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

"Place": an important building block for health and care integration

1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

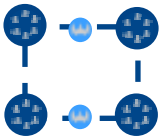
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

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

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance need to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and
- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. The NHS and local government are increasingly pressing for a more driven and comprehensive roll-out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above ('vertical integration'); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services or providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;

- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);
- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers;

- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;
- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of, improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

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

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.

- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models.

- A primary care perspective at system level.

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

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

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

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;

- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
  i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
  ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
  iii. agreed joint decision-making arrangements with local government; and
  iv. representation on the ICS board.

  They may flexibly define:
  i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
  ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
  iii. the precise governance and decision-making arrangements that exist within each place; and
  iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
  i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions; and
  ii. provider collaboratives represented on the appropriate ICS board(s).

They may flexibly define:

i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

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

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision-making by enabling decision-making joint committees of both commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizens' panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot'** which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that

each ICS has the capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three-year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.
- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.
- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common electronic patient records (EPRs).

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.
- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:
    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning; and

- the capacity and skills needed for population health management.

- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to

be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the "Well Led" assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors' and governors' duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an 'integration index' for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice

of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to Government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.

- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3, current CCG functions would subsequently be absorbed to become core ICS business.

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

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

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes-focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision-making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs, the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But during the COVID

pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012)* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and removing the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

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

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the "end state" for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by "re-purposing" CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to the ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

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

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

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

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make a difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets, they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become 'thinner' as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their 'at scale' activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

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

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

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

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

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

4.27. The legislative proposals set out in this document take us beyond our original legislative recommendations to the Government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of Government should they take forward our recommendations in a future Bill.

4.28. Please contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January 2021.

4.29. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

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