Partnership Board
Wednesday 26th May 2021
15:00am to 17:00pm
Agenda

AGENDA NO.	ITEM	LEAD	ACTION
PB/21/39 15:00 - 15:04	Welcome, Introductions and Apologies	Alan Yates	Oral
PB/21/40 15:04 - 15:05	Declarations of Interest	All	Oral
PB/21/41 15:05 - 15:06	• Minutes of the last meeting 28th April 2021 • Minutes of Partnership Co-ordination Board – for review	Alan Yates (to note)	Paper Paper
PB/21/42 15:06 - 15:10	Chief Officer's Update	Jackie Bene	Oral
PB/21/43 15:10 – 15:45	ICS Planning: our workforce, finance and activity plans	Keith Griffiths	Paper
PB/21/44 15:45 – 16:20	Commissioning: • Joint Committee of CCGs – development and work plan • Commissioning Function Review - ICS and Place responsibilities and next steps • Establishing an NHS Board	Clare Watson Sarah O'Brien Chair	Paper Paper Discussion
PB/21/45 16:20 – 16:35	Finance Briefing – 20/21 year end	Keith Griffiths	Paper
PB/21/46 16:35 – 16:55	ICS Population Health Management – Next Steps	Sarah O'Brien	Presentation
PB/21/47 16:55 – 17:00	Review of the meeting and communications from it	Alan Yates	Oral
Date and time of next meeting: Wednesday 30th June 2021, 15.00pm to 17.00pm			

MEMBERSHIP – PARTNERSHIP BOARD

Chair
Alan Yates (AY) – Chair, Cheshire & Merseyside Health & Care Partnership

Executive Team
Jackie Bene (JB) – Chief Officer
Dave Sweeney (DS) – Implementation Director
Kieran Murphy (KM) – Clinical Lead
Marie Boles (MB) – Director of Nursing
Christine Hughes (CH) – Director of Communications & Engagement
Keith Griffiths (KG) – Director of Finance
Sarah O'Brien (SOB) – Director of Strategy & System Developemnt

Local Authorities
Professor Steven Broomhead (SBr) – Chief Executive, Warrington Borough Council
Kath O'Dwyer (KO) – Chief Executive, St Helens Council

Voluntary, Community and Social Enterprise (VCSE)
Warren Escadale (WE) – Chief Executive, Voluntary Sector North West

NHS Providers
Simon Barber (SBa) - Chief Executive, North West Boroughs Healthcare NHS FT
Ann Marr (AM) – Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust
Sheena Cumiskey (SC) – Chief Executive, Cheshire and Wirral Partnership NHS FT
Joe Rafferty (JR) – Chief Executive – Mersey Care NHS FT

NHS Commissioners
Mark Palethorpe (MPt) – Chief Officer, NHS St Helens CCG
Jan Ledward (JL) – Chief Officer, NHS Liverpool CCG
Clare Watson (CW) - Chief Officer, Cheshire CCG

NHS North West
Linda Buckley (LB) – Director of Strategic Transformation and Locality Lead (C&M)

Advisory Members
Gerald Meehan (GM) – C&M Health and Care Partnership Advisor

NWAS
Daren Mochrie DM) - Chief Executive Officer

Primary Care
Dr Jonathan Griffiths (JG) - GP/Primary Care Advisor
Dr Raj Kumar (RK) - General Medical Practitioner - Eric Moore Partnership Medical Practice, Warrington and Clinical Director & Responsible Officer - NHS Digital

Public Health
Eileen O'Meara (EO) - C&M Population Health Clinical Lead/Director of Public Health and Public Protection Halton and Warrington LA

Cheshire and Merseyside Partnership Board
28th April 2021, 15.00-17.00
MS teams – Virtual

DRAFT MINUTES

Present:

Alan Yates (AY)	Chair	Cheshire and Merseyside Health and Care Partnership
Jackie Bene (JB)	Chief Officer	Cheshire and Merseyside Health and Care Partnership
Raj Kumar (RK)	GP Representative	Cheshire and Merseyside Health and Care Partnership
Christine Hughes (CH)	Director of Communications and Engagement	Cheshire and Merseyside Health and Care Partnership
Keith Griffiths (KG)	Director of Finance	Cheshire and Merseyside Health and Care Partnership
Dave Sweeney (DS)	Partnerships Lead	Cheshire and Merseyside Health and Care Partnership
Kieran Murphy (KM)	Clinical Lead (NHSI/E Advisor to the Executive Team)	NHSE/I
Sarah O'Brien (SO)	Executive Director of Strategy & System Development	Cheshire and Merseyside Health and Care Partnership
Mark Palethorpe (MP)	Chief Officer	NHS St Helens CCG
Marie Boles (MB)	Director of Nursing (NHSI/E Advisor to the Executive Team)	NHSE/I
Steven Broomhead (SB)	Chief Executive	Warrington Borough Council
Gerald Meehan (GM	Local Authority Advisor to the Executive Team	Cheshire and Merseyside Health and Care Partnership
Maxine Power (MP)	Director of Quality, Innovation & Improvement	North West Ambulance Service (NWAS)
Jan Ledward (JL)	Chief Officer	NHS Liverpool CCG
Eileen O'Meara (EO)	C&M Population Health Clinical Lead & Director of Public Health and Public Protection	Cheshire and Merseyside Public Health Collaborative
Warren Escadale (WE)	Chief Executive	Voluntary Sector North West

Clare Watson (CW)	Accountable Officer	NHS Cheshire CCG
Kath O'Dwyer (KO)	Chief Executive	St Helens Council
Chris Samosa (CS)	Director of Workforce	Cheshire and Merseyside Health and Care Partnership

In Attendance

Jennie Bennett (JBe)	Executive Assistant (Minutes)	Cheshire and Merseyside Health and Care Partnership
Matthew Atkinson (MA)	Specialty Registrar in Public Health	Halton Council
Jonathan Griffiths (JG)	GP/Primary Care Advisor	Cheshire and Merseyside Health and Care Partnership
Ben Vinter (BV)	ICS Planning	Cheshire and Merseyside Health and Care Partnership

Apologies

Joe Rafferty	Chief Executive	Merseycare
Ann Marr	Chief Executive	St Helens & Knowsley
Sheena Cumiskey	Chief Executive	Cheshire & Wirral Partnership

Agenda No	Item	Action
PB/21/25	**Welcome, Introductions and Apologies**	**AY**
	AY welcomed all to the meeting and apologies were recorded as detailed. Given the apologies provided it was noted that the meeting was quorate and therefore able to go ahead. AY advised that the new board membership arrangements will start from June 2021.	
PB/21/26	**Declarations of Interest**	**AY**
	There were no declarations of interest.	
PB/21/27	**Minutes of the Last meeting - 31st March 2021**	**AY**
	The minutes of the Cheshire and Merseyside Partnership Board held on 31st March 2021 were accepted as a true and accurate record of the meeting. **Minutes of Partnership Co-ordination Board – for review** The minutes of the Partnership Co-ordination Board contained within the meeting pack were noted for information purposes.	
PB/21/28	**Chief Officers Update**	**JB**
	JB reported that much of what had been progressed during the last month focussed on discussions around Place, particularly with local authorities exploring preparations and shared understanding. To support Place development a review has been commissioned to secure an independent baseline assessment of each Place. This will support development of a set of local priorities enabling development of organisational forms, provision, commissioning and relationships. Hill Dickinson are assisting with this and will provide a unique legal perspective on the frameworks that may need to be developed as statutory bodies form during the next year. The ICS has also been responding to the NHS Planning guidance, bringing all system partners together, to support the development and descriptions of plans for the rest of the year and will need to be signed off as a system, when ready, at the next Board meeting.	
PB/21/29	**Transformation Programmes Governance**	**JB**
	JB discussed the paper contained within the meeting pack and the proposals for programme governance. Progress and approach has been discussed at a number of recent Board meetings which had included reviewing existing Partnership programmes through the lens of the ICS priorities and where investment could most affect change. One round of reviewing submissions had been undertaken and will be undertaken again, following reframing, to ensure all submissions describe the required alignment, provide suitable detail on timelines, outputs and quality. Governance of programmes moving forward was discussed; there needs to be an architecture that provides assurance from the delivery of programmes that they are reaching their milestones focused on the priorities set by the Partnership particularly	3

	around improving population health and reducing inequalities. As the approach described is embedded it will need to develop and encompass NHSE/I programmes, some of which are well established and have been in place for several years, and any new programmes which are defined and supported. A Programme Board will be set up at the beginning of June which JB will chair and will run monthly, providing bimonthly exception reports to the Partnership Board. All present at the meeting were in agreement with this proposal. MP asked if there was any more information on Urgent and Emergency Care oversight. JB advised that there were two old programmes that it had been agreed would not continue as transformation programmes as they represented business as usual. Within this context the Hospital Cell has initiated an elective care programme it is likely that work in this area will continue through the provider collaborative's as they develop. JB identified that the Urgent Care Network needed developing further, accordingly it was proposed that Cheshire and Merseyside would establish a system wide Urgent and Emergency Care Board which can operate at system level and in tandem with locally focused A&E Delivery Boards which now need to be re-established following the pandemic. Such an approach will ensure that the work is overseen as a system and support any formal requirements for reporting to the region and NHSE/I in addition to any Gold and winter responses as required. JB will ensure that MP is engaged in the system board. MP asked if reducing avoidable hospital admissions may become a focus of work to these groups. JB confirmed the issue will receive focus, however, it will form part of the Out of Hospital Cell work as it moves forward.	
PB/21/30	**Transition of Partnership Co-ordination Group to a Partnership Development Advisory Group**	JB
	JB provided an overview of the Partnership Co-ordination Group which has provided a valuable supporting function to the Partnership Board and was set up at the beginning of the pandemic to co-ordinate the activities of both the NHS and the care sector. The landscape and activity was complex in April 2020 meaning value was sought in reducing duplication. Latterly, its focus had supported learning and development from best practice. The proposals reflect that it would be useful for the group to become an Advisory Group, supporting the development of the ICS and Partnership as it responds to the changes over the next period including development into its NHS Body and Partnership Board. The group's purpose is thought to be time limited to approximately a year, until the ICS is statutory, and would focus on engagement with wider partners. KO asked if the wording could be changed to make it clear that some CCG representatives are also the Place lead. JB agreed to the amendment. SB asked JB if the NHS Board is to be the Board responsible for day to day operations of the NHS service, assuming commissioning functions from CCG's and whether there will be local government representation. JB agreed and outlined that the White Paper alludes to the NHS Board and Partnership Board both having local government representation on it. The value of such an approach is recognised locally and will be the aim. AY noted a comment in the chat box from KO – "*Section 6 - Membership, refers to The Cheshire and Merseyside ICS Development Group - I assume it should be the Transformation Programme Board?"* SO acknowledged the comment and will amend	

	the proposal. AY thanked JB for progress on this piece of work and advised that point five in the paper recommends formal endorsement and approval with the governance framework and approach and draft terms of reference for the Transformation Programme Board and recommended a starting date of June 2021 for the first meeting. All present at the meeting were in agreement with this proposal.	
PB/21/31	**Preparing for a New Board**	AY
	AY invited a discussion around the new Board, designed to support the ICS' transition during 2021/22, noting that new arrangements will start on 1st June 2021. It is envisaged that the newly constituted Board will first meet towards the end of June conducting business on the basis of the principles signed up to within the Partnership's Memorandum of Understanding. There will be approximately seven people from the current board who will move on to the new Board. AY identified that there will need to be some form of induction covering the challenges facing the Partnership needs to respond too and the progress made to date. In response to the suggestion of conducting an induction meeting for the new Board, it was agreed that there would be value in the membership meeting to achieve orientation, meet each other and recognise the different constituencies before first meeting as a Board. KO advised that she has onboarded a new senior team virtually during lockdown; and felt that the following priorities and the purpose would help; a governance structure chart including what groups links where, including wider partner organisations. Structure charts around the core team. KO also felt it would be best to have one meeting together rather than two or more meetings with two different cohorts. CW also felt it would be good to have a joint meeting; to support integration, supplemented with governance information details on reporting into Place and where Place aligns to Cheshire and Merseyside priorities, along with the white paper summary and local government summary. CW felt it would be helpful to have the induction pack on the website as a repository of information. SB asked for a comprehensive but succinct and relevant induction pack as the NHS and local government can often provide too much information. SB felt that one meeting would be appropriate with one or two current members as advisors. SB offered to be available as an advisor. AY identified that a CCG AO would also be a helpful advisor. AY discussed the local government elections and the potential process to identify the Health and Wellbeing Board Chairs and representatives. Following a request for details on anticipated timescale SB identified that most local councils have their Annual General Meeting towards the third week of May and at that point decisions are made on outside bodies and Council Committees, meaning that the first or second week in June would work well. AY explained that he has received a request to run an NHS trust non-exec director assembly, akin to the recently established Political Assembly. AY has also met on a regular basis with lay members of CCG's and indicated to the Board that he would	

	also seek to establish one of each of these meetings in June. AY noted that the first meeting of the Primary Care Providers Group had taken place last week, AY felt it was a productive and helpful meeting. RK gave an overview of the meeting and identified that it had been a worthwhile challenge to secure appropriate and full representation on the group. A forum of eighteen members met to ask key questions that is of relevance to the Board. Agenda items and outputs will be shared to allow proactive participation within the agenda of the ICS. A formal nomination process will take place to elect two members to sit on the ICS Board over the next two months.	
PB/21/32	**Rapid Health Needs Assessment for Cheshire and Merseyside**	EO
	EO provided an update on the Rapid Health Needs Assessment for Cheshire and Merseyside. EO introduced Dr Matt Atkinson who presented to the meeting, a copy of which was provided in the meeting pack. AY thanked MA for the very informative presentation and opened up questions to the group. SO identified that there are a number of ways for this work to be built into and embedded within the system including the Population Health Programme that EO is leading. Some of the prevention work will be picked up in the Cardiovascular Disease Programme. In addition all programmes have been asked to focus on their impact on health inequalities. The presentation pulled out that these are challenges at a Place level and Joint Service Needs Assessments (JSNA's) and Health and Wellbeing Boards in Place will be focusing on this. Programmes and Place will focus on these issues. RK thanked MA for an excellent presentation and noted that the facts provided a stark reminder of the work that lay ahead, RK identified that in Cheshire and Merseyside there is a fifteen year average lifespan gap between some areas. RK appreciated that Primary Care is spread right across the spectrum of screening and dealing with health conditions. MP repeated thanks to MA, and noted that the link to poverty is key to this and discussed how employment, housing, skills, infrastructure and transport will influence the long term impact on some of the most deprived communities and the balance that needs to be struck between the clinical treatments and wider determinants of health. MP gave an example of Salford having taken an approach where the whole council would deliver on things such as reducing homelessness, digital, transport which will make a difference for the population. Close working with the Local Authority, NHS and at Place will start to make a difference. SB identified that most of the nine Places will be looking to refresh Health and Well Being Board Terms of Reference and their plans and strategies, the work that MA has produced will help as evidence for this group and for the Partnership collectively. Health and Wellbeing Boards should be asked to look at their terms of reference and their plans and strategies and start to develop new strategies through JSNA's and build a model up from the bottom. KO discussed the number of meetings local authorities had led and participated in, during the pandemic, through Merseyside Resilience Forum and the Health and Social Care Recovery Cell. Work now moved from a response to a recovery phase. Recovery is about addressing inequalities and this data is exceptionally helpful to do this. MA identified that this is not just about recovery, it is about planning for the next pandemic	

	as there are much poorer health outcomes for people who already have underlying health conditions, some of which are preventable. KG felt that this presentation needed to go to the Provider Collaborative as well as Trust Boards so that there is visibility on this message to non-exec directors. There is an opportunity through the Community Diagnostic Hub programme to give consideration to where they are placed. KG noted from the presentation that there was a 25% deterioration in prostate cancer over ten years and was the only one on the chart that went up, and asked MA what where the drivers around this? MA advised that prostate cancer is mostly a disease of age and not one that is, necessarily, preventable through public health intervention which is why it has increased on the list as a relative cause of disability and the aging population with people less likely to die of other causes. EO reiterated that it is very sobering looking at the figures and identified that life expectancy progress has stalled over the last ten years, this is the first time this has happened since the 1900's. It is hoped that the commitment to the Marmot work will help shape work with the wider determinants of health and best practice examples.	
PB/21/33	**Improving Health and Wellbeing in Cheshire and Merseyside Strategy**	SO
	SO advised that the paper in the meeting pack was attached for noting and the helpful comments from the last meeting had been reflected in the circulated content. The strategy in the pack was formally launched on the website last week. SO's requested the Board and its membership use the Strategy and make sure that Places and partners know it, use it across programmes and make sure organisations embed the principles within their own plans. We have signed up to this as a five-year overarching strategy to drive reduction in health inequalities. RK identified that there was no mention of Primary Care within the strategy. AY agreed that this would be looked into.	
PB/21/34	**MOU Update**	BV
	BV discussed the final push for sign up to the MoU; of the thirty-seven organisations, thirty-three have now committed. Of the four that have not committed, Liverpool City Council are working on this at present. Southport and Ormskirk are also working on it at present and it is due at their Board next Wednesday. Cheshire West and Chester Council are also in the same position. BV is still waiting to hear from Liverpool CCG. JL advised that Liverpool CCG had a development session with the Board has been set on 11th May and it is on the agenda. JL will be able to advise the outcome post this meeting. AY advised that the Partnership Board needs to draw on the authority from everyone being signed up to the MOU. When it becomes a statutory body this may change, however, for the coming year, it is on the basis of this agreement between us.	
PB/21/35	**Draft Forward Plan**	BV
	BV discussed the paper provided in the meeting pack. The purpose of the paper is to engage the current board, secure input and thoughts on possible structures recognising that it is a transition year and that there are some things to work through.	

	The content begins to describe potential different roles that the Partnership and NHS Board may form going forward. The draft forward plan is set out in two parts recognising there is likely to be a shadow board requirements in quarter three and a new membership may take on a number of activities. KO identified on slide 100 the split of responsibilities and the activity between the partnership and the NHS board, and understood why strategic commissioning is within the NHS board, but asked would it be tactical to be in both? BV recognised that there is a lot more thinking of interplay between the two boards. AY identified that a few of the lines could have NHS in front of them to make it clear and explicit. AY asked for continued thinking and comments to be passed on to BV to build a comprehensive list.	
PB/21/36	**End of 20/21 Year Finance Update**	KG
	KG gave an overview of the paper provided in the meeting pack and explained the context of the approach that the finance community are taking in the run up to the year end and the linkages to regional and national strategies and protecting the interests of Cheshire and Mersey into 21/22. National policies and strategies and some of the accounting arrangements that would normally apply between commissioners and providers have been altered significantly due to the pandemic. From a Partnership perspective the programs have not spent as expected because capacity has been diverted to Covid and the additional resources came in late in the year to support vaccination. Some resources will need to be required to fund ongoing programs of work in 21/22. On face value this means there has been an underspend in the Partnership. The summary financial position of the NHS organisations within the system is looking likely to outturn as a gross overspend of £11m. There were changes in terms of the national stance on how it would like the NHS to end 20/21 and to support discussions with the Treasury for funding allocations for 21/22. Locally the decision was taken to ensure the deficit of £11m sits across our providers and CCGs collectively. Some overspend in providers are as a result of the changing national policy on how certain elements within the accounting regime should be deployed in 20/21. KG acknowledged the efforts undertaken by CFO and DOF colleagues to work in a very difficult regime.	
PB/21/37	**Update on ICS Development Programme**	SO
	SO gave a headline of the process for the Development Plan which was undertaken as a part of the ICS designation submission and used the framework that identified gaps. All ICS's need an updated development plan by the end of quarter one. Ours is in development and takes its foundations from the existing development plan and aligning the current and more actions to the six sections that are going to be in the framework. SO & BV have worked with a draft NHSE development tool and with the executive team and are identifying actions. Additionally an ICS Implementation Plan is required to ensure we get from where we are now to where we need to be in April 2022. SO expects that this ready well ahead of the end of Quarter once which will be brought back to the Board. SO gave a headline update on each of the key sections, a lot of progress has been made on programme delivery with a plan for governance. All programmes have been reviewed with a refocus on equalities. Good progress has been made on Places and	

	integrated care partnership delivery. JB & SO have been meeting with all of the Local Authority Chief Executives and have also met with all of the Place Leads to talk through the slides and principles to work through what they need to do at place. Each Place needs to be able to articulate to NHS England what the place arrangements and leadership will be. To progress ICS preparations on commissioning has been supported by a functions review, the initial work around this is complete supported by two overarching workshops, two task and finish groups and discussion with quality leads around what things when CCG's dissolve will be done at Place and what will be done at a system level. The workshops went well and reached a consensus, through the task and finish groups, in principle of what can be done where. There will be a paper coming to the May Board where SO will summarise to the outputs of the workshops. The Board noted that CCG's have also had their first workshop of the Joint Committee of the CCG's, a paper will be prepared for the May Board that will summarise the progress made on the joint committee of CCG's. Provider Collaborative development was also referenced. The Board was advised that they have been working with Louise Robson who has been put in place to support development in this areas in the North. There is a workshop on Friday for Provider Chief Executives.	
PB/21/38	**Review of the Meeting and the Communications from It**	AY
	AY thanked all attendees for a good meeting, and reviewed the meeting: • Commitments have been made to the programme governance approach and to the development advisory group. • Discussed how we will induct the future board. • We were all taken by the health needs assessment. • Looked at the strategy and taken on board helpful comments. • MoU is going well and that will give us the authority for the new arrangements to operate. • A Board forward plan is starting to develop. • KG's reassured that issues are starting to become more transparent between organisations. KO asked for an AOB advise colleagues that there is a piece of work ongoing across Liverpool City Region with businesses around mental health, as pressure on mental health services prior to covid was significant, and the anticipated pressure post covid is likely to be crippling. The project is going well and there may be some potential funding for smaller business. Will have a slot at the Good Business Festival in July.	
	Date and Time of Next Meeting – Wednesday 25th May 2021at 3:00pm.	

C&M Partnership Co-ordination Group
Thursday 29th April 2021

Attendance

Name	Title
Jackie Bene (JB) - Chair	Chief Officer, Cheshire and Merseyside Partnership
Sarah O'Brien (SO)	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Clare Watson (CW)	Accountable Officer, NHS Cheshire CCG
Simon Banks (SB)	Accountable Officer, NHS Wirral CCG
Mark Palethorpe (MP)	Accountable Officer, NHS St. Helens CCG
Dianne Johnson (DJ)	Accountable Officer, NHS Knowsley CCG
Andrew Davies (AD)	Accountable Officer, NHS Warrington CCG and NHS Halton CCG
Jan Ledward (JL)	Accountable Officer, NHS Liverpool CCG
Tracy Jeffes (TJ)	Director of Place (South), NHS South Sefton CCG and NHS Southport & Formby CCG
Deborah Butcher (DB)	Executive Director for Adult Health and Social Care, Sefton Council
Kath O'Dwyer (KO)	Chief Executive, St. Helen's Council
Christine Hughes (CH)	Executive Director of Communications and Engagement, Cheshire and Merseyside Partnership
Jonathan Griffiths (JG)	Primary Care Advisor, Cheshire & Merseyside Partnership
Lucy Davies (LD)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Linda Buckley	Director of Strategic Transformation, NHSE/I
Eileen O'Meara	Director of Public Health and Public Protection for Halton and Warrington
Maxine Power	Director of Quality, Innovation and Improvement, North West Ambulance Service
Steven Broomhead	Chief Executive, Warrington Borough Council
Fiona Taylor	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG

Minutes

1.	Welcome and introductions

The chair, Jackie Bene, opened the meeting.

No changes required to the minutes of the previous meeting.

2.	Minutes & action log

Action 037: ***SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.***

Action ongoing.

AD agreed to share a report with group members highlighting learning from NHS 111 First at a Cheshire and Merseyside level.

New action 076: ***AD to circulate report detailing NHS 111 Learning with PCG group members.***

Action 073: ***KO to speak with DCS's and confirm whether a representative from this group is needed on the ICS Development Advisory Group.***

KO confirmed that DCS would like a representative to join the ICS DAG. Representative to be confirmed. Action ongoing.

Action 074: ***Bring revised TOR for ratification to the next Partnership Co-ordination Group meeting.***

Discussed during agenda item 4. Action closed.

Action 075: ***SO to confirm with Christine Samosa what workforce information is still required from the Places.***

SO commented that workforce information was still outstanding from the CSU. SO awaiting further update from Christine Samosa. CW agreed to follow up with the CSU.

New action 077: ***CW to follow up with the CSU regarding outstanding workforce information.***

3.	Current issues

- No current issues were raised.

4.	**Responses to ICS Development Advisory Group TOR**

- JB anticipates the DAG membership will continue to evolve. There were no objections to the TOR at the Partnership Board on 28th April 2021.
- KO commented that where a CCG representative is also a Place lead this should be made clear.
- JL requested clarity around point 3 of the functions list and questioned how ICS allocation functions will be decided.
- JB confirmed that the DAG would provide advice on this issue. JB confirmed that the Task and Finish group have worked through and identified proposed functions of the ICS.
- SO confirmed these proposed ICS functions will go to the May Partnership Board. SO emphasised the importance of understanding how the ICS functions will work at a system and

Place level. SO highlighted that the ICS form and operating model are still under discussion and will be tested out through the DAG.

- JB emphasised the developmental nature of this work. JB highlighted that further information is expected following the second reading of the bill. This will need to be applied to a Cheshire and Merseyside context once received.
- SB questioned whether information around ICS allocation functions could be shared ahead of the JCCG on 18/05/2021.

Action 078: *SO to bring update (paper if possible) regarding ICS allocation functions work to DAG on 13th May.*

- JB emphasised the importance of aligning this with the ongoing delegated commissioning work.
- AD highlighted that several functions lie between system and Place and should be captured.
- JB gained consensus that this group will transition to become the ICS Development Advisory Group. JB emphasised the importance of including Primary Care in the development of the ICS and questioned whether there was appropriate representation on the DAG. Following discussion it was agreed that there was appropriate representation.

Action 079: *SO to confirm with JG there is sufficient Primary Care representation on the DAG.*

- JL questioned whether Specialised Commissioning representation is required.
- CW highlighted that Specialised Commissioning sits within NHSE/I which will be represented on the DAG.
- SO commented that a regional group is in the early stages of being established. It may be appropriate to use the NHSE/I representative to connect with Specialised Commissioning.

5.	Feedback from JCCCG

- DJ provided the following feedback from the workshop held on 22/04/2021.
  - All 9 CCGs approved the establishment of the Joint Committee following the due governance processes within each of the statutory bodies.
  - The workshop focused on the membership of the Joint Committee and refining the TOR.
  - A consensus was reached to have a committee which reflect the Governing Body requirements as set out in statute.
  - The importance of having sufficient clinical representation was emphasised. Additional clinical leads will be included in the membership.
  - There will be a statutory post holder from each CCG (either the Accountable Officer or Chief Financial Officer).
  - The incumbent Governing Body Chair's will be selecting a Chair and Vice-Chair for the Joint Committee.
  - Additional roles to attend were discussed including an ICS representative (Sarah O'Brien), Healthwatch representative and CHAMPS representative.
  - The workplan was discussed and refined further.
  - The Joint Committee will be held in public and use the existing Collaborative Commissioning Forum time slot.
  - The first meeting will be held on Tuesday 18th May.
- DJ commented that the White Paper requires the Joint Committee to rapidly develop in order to be the function through which several duties are discharged.
- JB thanked DJ for leading this work. JB commented that future guidance may dictate the remit of the Joint Committee.
- AD highlighted that the Joint Committee is NHS focussed as its function to discharge CCG duties.
- DJ emphasised that the Joint Committee are reviewing areas of NHS commissioning that is done at scale. DJ agreed to share the output of this workshop once finalised.

6.	Update on NW ICS Development Workforce Steering Group

- CW confirmed that the following documents are anticipated to be released: HR Technical Guidance, Making Senior Appointments During Transition and Core Transition Principles. There is no release date for these papers. The current position is for no permanent appointments to be made at a senior level. Revised guidance regarding secondments and fixed term appointments is being sent out to all AO's.
- KO highlighted the continued uncertainty amongst Local Authorities and the appointment of Place leads. Place leads will be a statutory role and must be signed off by the Secretary of State. KO suggested that further guidance clarifying this would be helpful.
- JB confirmed there are ongoing conversations with Local Authority Chief Executives to discuss this issue. Place leads are not statutory posts until April 2022 but must be agreed by all partners.
- SO highlighted the variety of options for the Place lead. SO discussed the accountability of this role to both the ICS and Place.
- JB is attending the Joint Chief Executives meeting and offered to re-visit this issue if required.
- DB confirmed clarity around this process and expressed an understanding that further guidance is to be issued on the appointment of Place leads.
- MP supported the HCP's engagement with Local Authority Chief Executives and suggested a follow up written note could be valuable to reinforce the message.
- JL suggested it would be helpful to include CCG AO's or Chair's in these conversations.
- JB emphasised that all the information in discussed those conversations are already shared in this forum. These discussions focussed on the need for agreement from all parties in the Place and the lines of accountability. JB agreed to attend a joint meeting between CCG AO's and LA CEO"s if invited by the Place.
- SO emphasised the importance of clarifying when the Bill will be read in Parliament.
- CW commented that HR guidance could be released at the end of July.

7.	AOB

- No other business raised.

Summary of actions

Action 076: *AD to circulate report detailing NHS 111 Learning with PCG group members.*

Action 077: *CW to follow up with the CSU regarding outstanding workforce information.*

Action 078: *SO to bring update (paper if possible) regarding ICS allocation functions work to DAG on 13th May.*

Action 079: *SO to confirm with JG there is sufficient Primary Care representation on the DAG.*

ICS Development Advisory Group
Thursday 13th May 2021

Attendance

Name	Title
Jackie Bene (JB) - Chair	Chief Officer, Cheshire and Merseyside Partnership
Sarah O'Brien (SO)	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Linda Buckley (LB)	Director of Strategic Transformation, NHSE/I
Clare Watson (CW)	Accountable Officer, NHS Cheshire CCG
Simon Banks (SBa)	Accountable Officer, NHS Wirral CCG
Mark Palethorpe (MP)	Accountable Officer, NHS St. Helens CCG
Dianne Johnson (DJ)	Accountable Officer, NHS Knowsley CCG
Andrew Davies (AD)	Accountable Officer, NHS Warrington CCG and NHS Halton CCG
Jan Ledward (JL)	Accountable Officer, NHS Liverpool CCG
Fiona Taylor (FT)	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG
Deborah Butcher (DB)	Executive Director for Adult Health and Social Care, Sefton Council
Steven Broomhead (SBr)	Chief Executive, Warrington Borough Council
Kath O'Dwyer (KO)	Chief Executive, St. Helen's Council
David Parr (DP)	Chief Executive, Halton Borough Council
Paul Satoor (PS)	Chief Executive, Wirral Council
Sarah Smith (SS)	Executive Director (Health & Social Care), Knowsley Council
Graham Hodkinson (GH)	Director for Adults' Care and Health, Wirral Council
Mil Vasic (MV)	Strategic Director, People, Halton Borough Council
Ian Ashworth (IA)	DPH Cheshire West & Chester Council
Jonathan Griffiths (JG)	Primary Care Advisor, Cheshire & Merseyside Partnership
Warren Escadale (WE)	Chief Executive, Voluntary Sector North West
Lucy Davies (LD)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Christine Hughes	Executive Director of Communications and Engagement, Cheshire and Merseyside Partnership
Maxine Power	Director of Quality, Innovation and Improvement, North West Ambulance Service

Minutes

1.	Welcome and introductions

The chair, Jackie Bene, opened the meeting and welcomed colleagues joining the ICS DAG.

No changes required to the minutes of the previous meeting.

2.	Minutes & action log

Action 037: ***SBr to determine how the learning from Warrington (as an early adopter of 111 First) can be shared across C&M.***

Action ongoing. Steven to bring a report to the ICS Development Advisory Group.

Action 075: ***SO to confirm with Christine Samosa what workforce information is still required from the Places.***

SO confirmed that CSU workforce information is outstanding.

FT contacted the CSU to follow-up for Sefton on 13/05/2021.

JB highlighted further work is required collectively to understand the delivery of functions.

CW highlighted that the information is anonymous and agreed to confirm the outstanding information with the CSU. Action closed.

Action 076: ***AD to circulate report detailing NHS 111 Learning with PCG group members.***

AD confirmed the paper was circulated to ICS DAG members on 13/05/2021. Action closed.

Action 077: ***CW to follow up with the CSU regarding outstanding workforce information.***

Discussed above - see action 075. Action closed.

Action 078: ***SO to bring update (paper if possible) regarding ICS allocation functions work to DAG on 13th May.***

SO commented that the ICS allocation functions work is still ongoing and a paper will be circulated once complete. Action closed.

Action 079: ***SO to confirm with JG there is sufficient Primary Care representation on the DAG.***

JG agreed to discuss this issue with the Primary Care Forum. Action closed.

3.	Current issues

- SO highlighted the ICS framework is expected to be published next week. SO commented that the second reading of the bill could be later than expected which would delay the publishing of the HR guidance.
- JB highlighted the ICS framework will further detail the requirements of the ICS NHS Body.
- LB confirmed the framework includes details on the purpose of the Partnership Board and NHS Board. LB commented this will be taken to the NHSE board next week and published then.
- SBr emphasised the need to remain focused on Social Care. SBr confirmed there will be no major changes in the membership of the 9 Places following the recent elections. There will be changes in some Local Authorities to the Health and Social Care portfolio holders.

- KO highlighted the leadership changes in Halton and Liverpool and suggested the Partnership connects with those individuals prior to the Political Assembly.

4.	Developing the ICS and Place-based commissioning

- SO discussed the developing ICS and place-based commissioning options. The content has been collated from the White Paper, national seminars and information shared with SO. SO made the following points with regards to the ISC and Place-based commissioning:
    - There are key deadlines the ICS and system must work towards. SO highlighted that by Q2 an MoU must be agreed with each Place.
    - Once CCGs are dissolved there will be a focus on place-based partnerships through which the ICS can discharge its statutory functions. This will require an agreed Place lead in all 9 Places.
    - The four fundamental purposes of ICSs aligned to the White Paper were discussed.
    - Various options for possible approaches to commissioning services at a Place level were discussed. This would depend on the maturity of each Place and result in varying levels of autonomy. SO acknowledged that all 9 Places are at different stages of development.
    - There needs to be consideration around how finance can be collectively managed. The ICS would hold any contracts and link in with the Place based partnership. Further work is required to determine the possible financial flows.
    - Places should consider how decisions will be made once the ICS becomes a statutory body.
- SO emphasised the need for a clear plan from Places which evidences integrated partnership working, evidence of jointly delivering plans and resolving issues.
- DP thanked SO for the information shared. DP questioned the role of CCG Boards in this process given their current legal powers. DP highlighted the Local Authority democratic decision-making process and questioned how the two connect. DP acknowledged the need to operate differently in each Place. DP questioned how we can ensure consistency across the system given the different operating models. DP highlighted the different funding regimes for Local Authorities and questioned how this will be resolved to ensure system working.
- JB emphasised that this build one existing joint arrangements and Local Authorities and CCGs should continue working together. JB commented that many elements of the future arrangements are still to be determined. JB supported the point around ensuring consistency given the different operating models. JB highlighted that the ICS will need to hold some budgets in a joint arrangement with Place.
- SBr expressed appreciation for the information shared. SBr emphasised the need to clarify the criteria which determines the level of maturity and delegation. SBr commented further clarity and criteria around the role of Place lead would also be valuable.
- JB emphasised the importance of co-production and supported the sharing of criteria. JB highlighted the decisions regarding maturity will ultimately sit with the ICS with a degree of oversight from regional colleagues.
- JG questioned whether Primary Care commissioning is expected to be delegated from NHS England and General Practice to the ICS.
- SO commented that some elements of NHS commissioning are expected to be delegated to the ICS which could include elements of Primary Care.
- AD emphasised the need to ensure thorough planning and preparation to prevent health inequalities widening between Places depending on their level of maturity.
- SO commented it will be a challenge to ensure any staff employed by the ICS across the system are working collaboratively.
- SO highlighted the next stage of the commissioning work is to develop the target operating model. SO emphasised the need to work together and accept that current CCG resource in Place may be a system resource.

- JL highlighted the importance of building relationships and considering specialist commissioning. JL emphasised the focus should be to reduce health inequalities. JL commented that the ICS will hold the contracts as the statutory body from April 2022.
- SO requested that group members share the slides with their colleagues. A maturity assessment framework now needs to be developed by the ICS. The Hill Dickinson report will help all 9 Places to identify their strengths and areas for improvement. SO highlighted a group may need to be convened with one representative from each CCG and Local Authority representation to further discuss how to deliver the target operating model and functions at a system and Place level. SO commented that a session with CCG AOs and CFOs is also required to discuss and hypothesise how the costs budgets could be run.
- JB emphasised that as further guidance is released this will provide clarity.

5.	Update on NW ICS Development Workforce Steering Group

- CW highlighted discussions regarding the different approaches to governance across the NW region. A delay in publishing of the HR guidance remains the biggest risk. CW emphasised there will be further information to feedback once the guidance has been published.
- SBa questioned whether there will be considerations made given the delay in publishing of the guidance and in the context of ongoing COVID-19 requirements and BAU.
- JB highlighted ongoing conversations with CCGs about managing the workforce and finance transition elements. Further conversations are required.

6.	AOB

- No other business raised.

Summary of actions

No new actions.

NHS 2021/22 H1 Planning Round

Cheshire & Merseyside HCP submission overview

Report To:	**C&M HCP Exec**
Date of Report:	18/05/2021
Report Author(s):	C&M HCP Planning Team
Purpose:	**To provide an overview of the NHS 2021/22 planning context and the initial C&M HCP submission, including a summary of risks to delivery, and to outline the process for final submission**
Recommendation(s):	The C&M HCP Exec is asked to note the report and agree approach to sign off of final submission. Due to the timing of these deadlines and HCP Executive meetings, agreement is sought for the plans to be signed off by management in advance of a June Board briefing on the final submission which will highlight any material variation from the initial submission.

Cheshire & Merseyside HCP Context

1. Cheshire and Merseyside is one of the largest ICSs with a population of 2.6 million people living across a large and diverse geographical footprint. The ICS brings together nine 'Places' coterminous with individual local authority boundaries, 19 NHS Provider Trusts and 51 Primary Care Networks.
2. There are many underlying population health challenges in the region; for example in Liverpool City Region 44% of the population live in the top 20% most deprived areas in England, 26% children (0-15 years) live in poverty and compared to England average, the region performs significantly worse for premature cancer, Cardiovascular disease (CVD) and respiratory deaths.
3. Whilst the levels of deprivation are not as high in Cheshire, there are stark pockets of deprivation and health outcomes for some long-term conditions, and alcohol and self-harm are worse than the England average.
4. Demand for health and care services in the region is very high and growing (exacerbated by the impact of the Coronavirus pandemic). Our services are not sustainable without a different approach in how we work together, and a shift in focus away from the treatment of illness to one of prevention and wellbeing.
5. Equality, diversity and inclusion is part of everything we do and we have made a series of pledges to address race equality. After an extensive project to gain insight into our ethnic communities we now have a deeper understanding of them and their needs. This will inform our decisions and developments.

NHS Planning Context

6. On 29 January 2020 we started to treat this country's first patients with COVID-19 and began to see the impact of the pandemic on the NHS, social care, and the wider public sector. Since then the NHS has treated over 390,000 people with COVID-19 in hospitals, and many more in primary, community and mental health care. At the same time the NHS has continued to deliver other essential services, treating people with cancer and dealing with increases in urgent and emergency demand, as well as delivering the vaccine. At the time of writing, the NHS in England has delivered more than 45 million COVID-19 vaccination doses.
7. Whilst the vaccination programme and public adherence to social restrictions have had a significant impact on transmission rates and hospitalisation rates have fallen, we do not yet know what the pattern of COVID-19 transmission will be over the next 12 months and it is clear that the impact of the last year will be felt throughout 2021/22 and beyond.
8. It is within this context that the NHS has set out its priorities for the year ahead:
    A. Supporting the health and wellbeing of staff and taking action on recruitment and retention
    B. Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
    C. Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
    D. Expanding primary care capacity to improve access, local health outcomes and address health inequalities
    E. Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
    F. Working collaboratively across systems to deliver on these priorities.

9. The Government has agreed an overall financial settlement for the NHS for the first half of the year (H1) which provides an additional £6.6bn + £1.5bn for COVID-19 costs above the original mandate. The financial settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS going into the second half of the year. In addition, £1.5bn funding has been allocated for elective recovery, mental health and workforce development. For Cheshire & Merseyside this equates to the following:
    - A total financial envelope of circa £2.7bn for the first six months of 2021/22, and which includes additional funding to cover inflationary growth, ongoing expenditure related to the pandemic response as well as the continuation of top-up financial support to systems as per the 2020/21 regime.
    - An additional £44m in Service Development Funding (SDF) and Spending Review monies to target priorities in areas such as mental health, primary care, cancer, Ageing Well and learning disabilities and autism.
    - In addition, the Cheshire & Merseyside health system will also benefit from 'outside of envelope' funding in critical areas of ongoing support including the Hospital Discharge Programme and the COVID vaccination programme.
10. The C&M plans will need to address these national priorities. At the same time the underlying demographic challenges that have surfaced are deep rooted and have to be our main focus.
11. In addition, Local Authority plans will have been prepared and the ICS and each place need to take both sets of plans and build up the integrated approach and collaboration mechanisms that are necessary to reduce the health inequalities identified above.

NHS Planning Requirements

12. Due to the nature of the financial settlement, the NHS has asked systems to develop fully triangulated plans reflecting activity and performance levels, workforce and finances for the first half of the year, H1 2021/22.
13. For mental health services funding is provided for the full year and these plans therefore extend to 12 months.
14. Plans are therefore required at an ICS level and comprise the following:
    - **Activity and performance:** Single ICS level plan incorporating CCG and provider level breakdowns across a range of areas
    - **Workforce:** Single system level plan across acute, community and primary care, incorporating, as appropriate, provider level breakdowns
    - Dedicated **Mental Health** plan collection at system and provider level
    - **Finance:**
        i. System financial planning template
        ii. Provider financial planning template
        iii. Mental health CCG financial planning template
    - **Supporting narrative:** A single system level template covering:
        i. the actions and assumptions that underpin the trajectories within the activity and workforce numerical submission; and
        ii. other critical actions that the ICS will take over the next 6 months to address the priorities set out above.

Planning Timeline and Sign Off

15. The C&M ICS has set up a dedicated time-limited PMO to coordinate the development of the plan content and ensure that the deadlines are met
16. The first submission, through assigned executive leadership, was made on Thursday 6 May 2021 and included the system finance plan, the Mental Health finance submission, draft activity, workforce (primary and secondary care) and MH workforce numerical submissions and a draft narrative plan submission
17. A provider organisational finance plan submission is due w/c 24 May 2021
18. The final narrative, activity, workforce and MH workforce numerical submission is due on Thursday 3 June 2021
19. It is assumed that by submitting the return the ICS confirms that the plan is a reflection of the collective intentions of the system for the rest of the year, that activity and workforce plans align and that the plan is agreed by all ICS partners.

C&M ICS Submission – Headlines

ICS Vision, Mission & Aims

20. Together, the Partnership has agreed and is working jointly to achieve:
    - The ICS Vision: We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer.
    - The ICS Mission: We will tackle health inequalities and improve the lives of our poorest fastest. We believe we can do this best by working in partnership.
    - The ICS Aims:
        i. Improve the health and wellbeing of local people,
        ii. Shift from an illness focus to a health and wellbeing model,
        iii. Provide better joined up care, closer to home.
21. The ICS has a key role to play in delivery through:
    - Providing system stewardship to ensure the 9 Places and the whole partnership work together to achieve our vision & goals.
    - Ensuring our arrangements as an ICS are inclusive with parity between public/professional, commissioners/providers, statutory and non-statutory partners.
    - Engaging the public, staff, and other stakeholders at the C&M footprint level, ensuring there is a robust approach for stakeholders to hold the ICS to account.
    - Planning and establishing our approach to financial and performance management.
    - Enhancing integrated commissioning at Place/Borough and streamline it at system level.
    - Incorporating NHS providers through a Provider Collaborative using a peer leadership approach
    - Responding to and embedding the NHS Constitution and other statutory duties relevant to the partnership
    - Working closely with academic partners so programmes are underpinned with the latest evidence and evaluated rigorously.
22. Our Places will be expected to develop an integrated approach to commissioning between health, local authority and wider local partners (such as shared posts, joint teams and pooled budgets) to underpin and support the ICS. A set of minimum requirements has also been agreed for establishing Integrated Care Partnerships:

- ICP Board to include breadth of place partners not just health & social care, e.g. housing, PCNs, voluntary sector
- ICP nominated 'Place Lead' with remit for integrated working who will connect with ICS
- Shared vision and plan for reducing inequalities and improving outcomes of local people (underpinned by local population health and socio economic intelligence)
- Agreed ICP development plan
- Defined Neighbourhoods, clinically led by PCNs, working with social care, community, mental health, voluntary sector and other community groups, and linked to wider place agendas such as economic growth, community safety and education agendas
- Programme of ongoing public and wider stakeholder engagement at Place.

Finance

23. The Cheshire & Merseyside ICS has submitted a breakeven financial plan, based on a notified resource envelope of circa £2.7 billion for the first half of 2021/22 (i.e. H1 21/22). The achievement of this overall position has, however, involved the management of number of financial risks on a system-wide basis – primarily through the delivery of cost-efficiencies, the re-profiling/re-prioritisation of planned expenditure and the accrual of additional financial income through non-recurrent streams such as the Elective Recovery Fund.
24. The key assumptions/premises underpinning this half-year plan are as follows:
    - All acute providers funded to deliver activity at least equal to the staged elective recovery thresholds in the planning guidance.
    - Finance plans have been broadly triangulated with those of Workforce and Activity/Performance, particularly in relation to the elective backlog.
    - Providers have been advised not to limit the level of activity that they have the capacity to deliver and finance plans should reflect the cost of delivering the maximum levels of activity possible to facilitate backlog clearance. See below re Elective Recovery Fund.
    - Expenditure growth based on the pay and price inflation factors set out within guidance published by NHS England and Improvement in March 2021. Where local expectation is that these rates will be less than those actually experienced, the differential has been quantified as an expenditure risk.
    - Organisations are committed to working collaboratively, including as a whole-system or on a sub-system (i.e. collective of Places) basis, to identifying opportunities for risk mitigation which do not compromise the achievement of ICS objectives.
25. Principal challenges identified which require collaborative mitigation include:
    - The financial risk associated with price inflation not covered through nationally funded pay and price growth – this is particularly pertinent in relation to primary care prescribing and continuing healthcare expenditure. CCG plans have assumed 1% growth in prescribing and CHC costs which is below current trends. This assumption follows national planning assumptions which were used to determine the H1 total envelope, and has been specifically highlighted as an area of risk in the financial plans.
    - The affordability of existing unfunded pressures and necessary investment
    - Workforce-related risks.
    - Detailed implementation plans to support the delivery of the 2-hour community crisis response standard are currently being developed but at

present the costs of delivering this are not included in our plan and present affordability challenges.

- Additionally, the anticipated financial contribution from delivery of the staged elective recovery thresholds is integral to the achievement of system break-even. The health system continues to work collaboratively to ensure that the primary objective to addressing the elective backlog is not compromised by affordability challenges.
- Addressing the historical variation in service provision and outcomes across Cheshire and Merseyside presents a complex challenge which the ICS will work closely with our constituent Places to address

26. Initial feedback on the submission has highlighted some additional work to finalise commissioner and provider efficiencies required to meet breakeven.

Workforce

27. The C&M HCP approach builds on the Cheshire and Merseyside People Plan, and describes how we support our staff, volunteers, and carers to cope with the changes in demand and the pressures facing each town or place, whilst ensuring that they feel empowered, valued, developed, trusted, and motivated to move towards the future.
28. It is recognised that we need more people, working differently, in a compassionate and inclusive culture, including having more people in training and education, and subsequently recruited, to ensure that our services are appropriately staffed.
29. They will need to embrace new ways of working in teams, working across organisations and sectors, and supported by technology.
30. The C&M HCP continues to work with Higher Education Institutions to ensure the outturn of students is at expected levels and the promotion of careers and training in health and care continues to result in increased applicants for clinical programmes.
31. To support a sustainable recovery from the pandemic, staff are encouraged to take regular breaks from work, not to undertake excessive additional shifts and to access all health and wellbeing services available to them. These include the Cheshire and Merseyside Mental Health Resilience hub, employee assistance programmes and in-house psychological support services.
32. We know from WRES data that as a system, we still have considerable work to do to make our workforce representative of the communities we serve. This will, in turn, improve the patient experience.
33. The Health and Care Partnership is fully committed to equality, diversity and inclusion. We are committed to act and do things differently, to work together to make a significant and sustained change.
34. The Health and Care Partnership Board (ICS) has determined that it is no longer enough for us simply to stand up to and condemn racism but that we must, as a system, be actively anti-racist. We must work together with our communities and across all sectors to create a better future where everyone enjoys the same freedoms, rights and opportunities in Cheshire and Merseyside.
35. Key workforce risks identified in the plans include:
    - Student applications not at expected levels
    - Numbers completing clinical training choose not to enter the workforce
    - Supply not available to meet the expansion forecasted
    - Turnover increases due to staff fatigue and staff retiring
    - Age profile of Cheshire and Merseyside means that we could see significant numbers of staff retire with no future pipeline being secured.

- Social care staffing levels reduce / turnover increases which results in more pressure on NHS staffing
- Long term sickness levels increase due to Long COVID and trauma related illness.
- Bank and agency levels increase

36. Initial feedback on the draft submission has identified some technical adjustments required ahead of the final submission. The workforce plans are subject to ongoing triangulation against finance & activity, to ensure the realistic action plans are in place to mitigate the risks above & support the delivery of future planned activity.
    - **Acute, Community & Ambulance Workforce submissions:** substantive staff shows an overall increase over the 6 months of +806 WTE (+1.3%) by September 2021, with a 30% reduction in Bank staff and 28.6% reduction in agency staff. Individual meetings with NHS Trust Directors of Nursing & finance leads have been conducted to review the workforce plans and confirm the submissions reflect assumptions to mitigate the risks as described above for the period of the plan. Medium to long-term mitigations were also reviewed in the context of this submission.
    - **Primary Care Workforce submissions:** are underpinned by local workforce modelling and support from the Primary Care Training Hubs to strengthen PCN workforce planning approaches & expansion of new roles in General Practice. Specific attention is given in the C&M Primary Care Workforce Steering Group to the recruitment/expansion of Community Paramedics in collaboration with NWAS, and collaborative recruitment, rotational working and appropriate support/supervision models are currently in progress.
    - **Mental Health Workforce Submissions:** the initial submission for Mental Health Workforce against the 7 Long Term Plan (LTP) Area is showing an overall 6.2% (371.7 WTE) vacancy rate, with a 5.2% (313 WTE) planned growth in workforce by Mar-2022, across NHS and non-NHS Providers.
    - **Cross-cutting workforce modelling planned for 2021/22:** subject to confirmation of funding for some workstreams, there are detailed projects being developed to understand the workforce need for maternity services, theatre pathways, critical care, community diagnostic hubs and wider workforce demand from each of our 9 Places using a population centric workforce planning approach – beyond the timeframe of this plan submission.

Activity & Performance

37. Activity and performance plans have been submitted on the basis of the following high-level assumptions:
    - **COVID:** Overall assumption is that there is not a 4th wave and therefore no requirement for significant critical care surge capacity. Some degree of IPC and social distancing requirements will continue to be in place, which will reduce productivity by between 10 and 15% in elective care.
    - **Capacity:**
        i. Independent sector activity will be at 2019/20 CCG activity outturn levels, with a place-based alignment and balance between new referrals and existing NHS waiting list patient activity.
        ii. All community and social services will be able to return in broad terms to pre-covid structures and activity levels approximately at 2019/20

actual levels.

iii. Assuming between a 10 and 15% impact on elective care productivity due to observing IPC measures.

- **Diagnostics:** Diagnostics to return to 100% of pre-COVID activity levels, and to incorporate development of Community Diagnostic Hubs
- **52 Week Waits for elective treatment:** Significant reduction across 2021/22 with eradication of 52-week waiters as follows:
  i. Admitted recovery by Nov-22
  ii. Non-admitted recovery by Mar-23
- **Priority 2 (P2) Backlog:** For Priority 2 patients (those requiring surgery/treatment within 4 weeks), the majority of Trusts treating all P2 backlog patients within 4 weeks by end of Q1 2021/22.
- **Elective Activity:** Majority of Trusts returning to 100% of pre-COVID activity by October 2021.
- **Outpatient referrals/new appointments:** Within plans there is consideration to an additional 20% referral "bounce back", in reflection of patients having not sought NHS assistance during the pandemic and with a possible implication for change of case mix as a result of this delay in accessing care
- **Urgent & Emergency Care:**
  i. A&E Attendances at 100% of pre-Covid levels.
  ii. Non-elective admissions at 100% of pre-Covid levels.
- It should be noted that at mid-April 2021 non-elective demand is already higher than that in the previous year.
- Levels of Primary Care appointments are projected to exceed 2019-20 levels
- The plans confirm the ICS will meet the national objectives in relation to Learning Disability Health Checks, Personalised Care, Social Prescribing, General Practice Access, and reducing levels of inpatient care for people with a learning disability or autism

38. **Elective Recovery Fund:** Systems have been asked to plan for the highest possible level of activity. The Government has made additional funding available to allow systems to step activity back up and so systems that achieve activity levels above set thresholds, i.e. the levels funded from core system envelopes, will be able to draw down from the additional £1bn Elective Recovery Fund (ERF) for 2021/22. The threshold level is set against a baseline value of all elective activity delivered in 2019/20, allowing for available funding, workforce recovery and negative productivity impacts of the pandemic through 2021/22. For April 2021 it will be set at 70%, rising by 5 percentage points in subsequent months to 85% from July. C&M HCP plans meet this trajectory.
39. Initial feedback on the draft submission from NHSE/I NW region has identified a number of minor technical adjustments that are required ahead of the final submission. In addition, in response to KLOEs we are reviewing the profile of plans given that Month 1 actual data is now available, and this may lead to some revisions in terms of the level of ambition for some organisations and points of delivery

Next Steps

40. The C&M HCP has held a feedback meeting with NHSE/I NW region on 19 May 2021. This, along with detailed feedback from the various directorate leads within NHSE/I will be used to inform the final version of the workforce and activity and performance plans as well as the overarching narrative.
41. The C&M HCP Planning PMO will continue to coordinate and ensure that the final

submission is made in line with national deadlines on 03 June 2021. Due to the timing of these deadlines and HCP Executive meetings, agreement is sought for the plans to be signed off by management in advance of a June Board briefing on the final submission which will highlight any material variation from the initial submission.

42. It is critical that, as we move forward, all partners understand and own the path that is being described within the plans.

Cheshire and Merseyside
Health and Care Partnership

Joint Committee of Cheshire and Merseyside CCGs

Overview of the establishment the Joint Committee of the nine Cheshire and Merseyside CCGs

May 2021

Title	**Establishment of the Joint Committee of the nine Cheshire and Merseyside CCGs**
Author(s)	Dianne Johnson, Lucy Davies
Version	V0.3
Target Audience	Cheshire & Merseyside Health Care Partnership Board
Date of Issue	18/05/2021
Document Status (Draft/Final)	Final
Description	This document sets out the background, purpose, principles, responsibilities and representation of the Joint Committee of the nine Cheshire and Merseyside CCGs. It also outlines the key next steps over 2021/22 to support the ICS statutory establishment.

Document History:

Date	Version	Author	Notes
29/04/2021	0.1	Dianne Johnson/ Lucy Davies	Initial draft
14/05/2021	0.2	Dianne Johnson/ Lucy Davies	Final for HCP Board
18/05/2021	0.3	Dianne Johnson/ Lucy Davies	Final amends from AO's
Reviewed by:			Dianne Johnson

Distribution

Version	Group or Individual	Date	Comments
0.2	Cheshire & Merseyside Health and Care Partnership	14/05/2021	For update

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1. Introduction

The Cheshire and Merseyside Health and Care Partnership (C&M HCP) is on a journey to be designated as an Integrated Care System (ICS) by April 2021. Key to this is developing the system architecture to support consistent operating arrangements for the future ICS.

In response to this, the nine Cheshire and Merseyside CCGs have established a Joint Committee of CCGs to make commissioning decisions 'at scale' across Cheshire and Merseyside.

This document sets out the background, purpose, principles, responsibilities and representation of the Joint Committee of the nine Cheshire and Merseyside CCGs. It also outlines the key next steps over 2021/22 to support the ICS statutory establishment.

The purpose of this document is to provide C&M HCP with an update on the establishment of the Joint Committee of the nine CCGs across Cheshire & Merseyside.

2. Background & process

2.1 Background

Discussions on the Joint Committee of Cheshire and Merseyside CCGs have been undertaken with Governing Bodies, system leaders, and on a one-to-one basis, which included CCG Accountable Officers, CCG Chairs, Local Authority Chief Executives and Place leads, and Health and Care Partnership leads.

There was consensus on the need for the majority of commissioning to remain local at Place. There was general agreement that Primary Care services, Community Care services and Voluntary Care services should continue to be commissioned at Place. There was also consensus that there was merit in exploring services that could be commissioned at scale and that CCGs should consider establishing a Joint Committee of Cheshire and Merseyside CCGs.

Proposals for the purpose, principles, responsibilities, outline workplan, representation and terms of reference were taken to each of the 9 Governing Bodies for discussion and approval between December 2020 and March 2021. Included within this were 3 recommendations:

I. It is recommended that the CCG Governing Body approves the proposed purpose and principles of the Joint Committee of Cheshire and Merseyside CCGs.
II. It is recommended that the CCG Governing Body approves the proposed responsibilities, focus and outline initial workplan of the Joint Committee of Cheshire and Merseyside CCGs.
III. It is recommended that the CCG Governing Body approves Option 3 for the representation of the Joint Committee of Cheshire and Merseyside CCGs and identifies the individuals it wishes to put forward.

The proposal and recommendations received a high-level of engagement and great feedback which has been utilised to refine the Joint Committee. All Governing Bodies supported the recommendation with caveats for further work required on the workplan and more detail needed around the representation. The inaugural Joint Committee was held on the 22nd April where the thematic responses were discussed and concluded (thematic responses can be found in Appendix A).

2.2 Process

In order to establish the Joint Committee of Cheshire and Merseyside CCGs, a process of engagement and discussion has been undertaken. This has included:

- 28 one-to-one discussions with system leaders were undertaken in October and November 2020. This included: CCG Accountable Officers, CCG Chairs, Local Authority Chief Executives and Place Leads and Health and Care Partnership leads.
- Participants were asked the following key questions:
    - What are your thoughts on the commissioning function(s) that should happen locally at Place?
    - What are your thoughts on the commissioning function(s) needed at a C&M level?
    - What are your thoughts on establishing a robust joint decision-making forum at a Cheshire and Merseyside level by April 2021?
    - What support would you need to help your membership or elective members consider and hopefully approve new arrangements by March 2021?
- Collective discussions were held at a workshop on the 4th November attended by 23 of these leaders.
- Follow-on discussions have taken place at the CCG Accountable Officer regular meeting on the 16th, 23rd, 30th November and 7th December 2020.

Using this engagement and a review of the Collaborative Commissioning Forum minutes, a list of potential services[1], which could be commissioned 'at scale' on a Cheshire and Merseyside footprint was developed, which was refined by the CCG Accountable Officers.

The list of services, outline workplan, proposed membership and Terms of reference for the Joint Committee were then shared for approval in each Governing Body between January 2021 and March 2021.

[1] Focus of discussions has been on the CCG function of *'commissioning healthcare services to meet the reasonable needs of the persons for whom they are responsible'* .

3. Joint Committee of Cheshire and Merseyside CCGs

3.1 Purpose

The Joint Committee of Cheshire and Merseyside CCGs has been established with the primary purpose of enabling Cheshire and Merseyside CCGs to work effectively together and make binding decisions on agreed service areas, for the Cheshire and Merseyside population. Members will represent the whole Cheshire and Merseyside population and make decisions in the interests of all patients.

In addition, the Joint Committee will also provide a forum for the nine CCGs to consider national initiatives and/or new policy implementation. Working collaboratively, the CCGs will review, determine at which level commissioning should take place i.e. C&M scale or at 'Place' and, where appropriate, agree common standards.

Joint Committees require an annual workplan to be agreed by each constituent CCG however in a changing NHS landscape there is a need to be flexible and be able to respond to change in year. It should be noted that any addition to the agreed annual workplan will be approved by each constituent CCG.

The nine CCGs in Cheshire and Merseyside are:

- NHS Cheshire CCG
- NHS Halton CCG
- NHS Knowsley CCG
- NHS Liverpool CCG
- NHS South Sefton CCG
- NHS Southport and Formby CCG
- NHS St Helens CCG
- NHS Warrington CCG
- NHS Wirral CCG

3.2 Principles

The commissioning of health and care services in the Cheshire and Merseyside system, whether undertaken at a Place or 'at scale', should align with the strategic priorities of the C&M HCP and contribute towards the achievement of these in order to improve outcomes for our population.

The C&M HCP strategic aims are aligned to the NHS Long Term Plan (2019) which focuses on improving and modernising our health and care services by:

- delivering safe and sustainable high-quality services;
- improving the health and wellbeing of local communities and tackling health inequalities; and
- delivering better joined up care closer to home.

Therefore, in identifying service areas which could be managed 'at scale', the following principles, aligned to these strategic priorities have been agreed.

Figure 1: Principles

HCP strategic aims	Principles for identifying service areas which could be managed 'at scale'
a) Delivering safe and sustainable high-quality services	**The service requires a critical mass beyond a local Place level to deliver safe, high quality and sustainable services;** ▪ *A level of activity required to ensure optimal patient outcomes* ▪ *Clinical evidence base* ▪ *A scarcity in the workforce required to deliver a safe and sustainable service* ▪ *Working at scale will result in efficiencies and greater value for money than would be achieved otherwise* ▪ *Reduce inequalities and improve all aspects of quality* ▪ *To undertake activities in such a way as to support provider collaboratives to develop and mature*
b) Improving the health and wellbeing of local communities and tackling health inequalities	**Working together collaboratively to tackle collective health inequalities across Cheshire and Merseyside** • *Must require a C&M approach* • *Levelling up approach – prioritising one area must not lead to increased inequalities in another area*
c) Deliver better joined up care closer to home	**Working together will achieve greater effectiveness in improving health and care outcomes** • *Low volume/high cost* • *Activities must complement local arrangements and support integration at place* • *Brings together a team of talents to look at more complex issues*

3.3 Responsibilities

For these agreed service areas, to be jointly commissioned 'at scale', the responsibilities of the Joint Committee of CCG would include:

- Ensuring the Joint Committee of Cheshire and Merseyside CCGs conducts its activities cognisant of the statutory duties and responsibilities of CCGs;
- Population analysis of needs which should be addressed at a Cheshire and Merseyside level;
- Setting common standards across the agreed commissioned service areas, to be adhered to across Cheshire and Merseyside and aligned to where services are commissioned outside of Cheshire and Merseyside;
- Monitoring standards and providing assurance;
- Overseeing and co-ordinating any public consultation or engagement required in relation to these agreed service areas (individual CCGs would undertake the public consultation and engagement and remain accountable); and
- Allocating spend related to the decisions made on the agreed service areas.
- Influencing services which are provided at scale such as ambulance services, specialist services etc

3.4 Membership

The membership of the Joint Committee of Cheshire and Merseyside CCGs has been developed based upon constraints developed through discussion and is outlined in Figure 2.

Constraints:

- Each of the nine CCGs in Cheshire and Merseyside should be represented.
- The Joint Committee will be NHS based with the decisions in the Joint Committee made by CCGs.

Figure 2: Joint Committee of Cheshire and Merseyside CCGs makeup

Roles: voting members
Per CCG, one member with statutory duties • CCG Accountable Officer (x7) • CCG Chief Finance Officer (x2)* ***When an AO is the AO of 2 CCGs**
• x1 Chair** • x1 Vice Chair** ****To be appointed from incumbent Chairs/Vice Chairs*** Each CCG to provide one of the following Governing Body roles • x4 Clinical Leads • x1 Secondary Care Doctor • x1 Registered Nurse • x1 Lay Member – audit & governance • x1 Lay member - PPI • x 1 Quality Lead

In attendance
Healthwatch representative
Cheshire & Merseyside ICS representative
Public Health representative

The Joint Committee of Cheshire and Merseyside CCGs will co-opt representatives from other partners as required to deliver the workplan.

3.5 Support to the Joint Committee of Cheshire and Merseyside CCGs

To enact the business of the Joint Committee of Cheshire and Merseyside CCGs and progress the workplan for agreed service areas, dedicated administrative resource will be required. This is in the process of being identified.

The Joint Committee of Cheshire and Merseyside CCGs will establish task and finish groups as well as subgroups as required to deliver the agreed workplan e.g. to ensure effective clinical commissioning expertise. The established Cheshire & Merseyside Collaborative Commissioning Forum provides a natural environment for some of development work required to continue supporting the Joint Committee over 2021/22.

3.6 Workplan

The Joint Committee of Cheshire and Merseyside CCGs outline workplan has been developed collaboratively. It is recognised that the Integration and Innovation White Paper "Working together and supporting integration proposals" is awaiting further detail and confirmation and therefore more service areas may be added to the work plan as the Joint Committee develops. Any such development will be aligned to the principles outlined in **Figure 1.** Any changes to the agreed workplan will need to be approved by the Governing Body of each CCG.

Figure 3: Outline initial workplan

Service area to be commissioned 'at scale'	Specific services to be included in the workplan of the Joint Committee of Cheshire and Merseyside CCGs
Mental Health Services	A. Children and Young People mental health services • Crisis services • Eating disorder services B. Agree common standards and develop a common workforce strategy to address widespread variation in access, provision, quality and outcomes C. Out of area placements
Acute services	A. Specialist Rehabilitation services (Neuro, Mental Health, Stroke, complex cases) B. Re-procure Bariatric services during 2021/22. C. Spinal services D. Standardise clinical policy e.g. IVF, interventions of low clinical priority E. Agree to adopt the National Specification for Stroke services across C&M

It is important to note that commissioning at scale does not mean that the result will be a one size fits all solution when delivering at Place.

4. Next steps

As outlined in this paper the Joint Committee of Cheshire and Merseyside CCGs is now a functioning group with a clear purpose, principles, responsibilities and outline workplan. The Joint Committee will meet on a bi-monthly basis as outlined in the Terms of Reference and utilise the Collaborative Commissioning Forum to support the Joint Committee and to provide a forum to continue the development of the Joint Committee.

Key next steps for the Joint Committee are to:

- Determine the required constitutional changes and CCG sign-off route, per CCG, engaging governance leads and/or legal support where required.
- Enact changes to CCG constitutions which includes:
    - Completion of variation request applications for NHS England/Improvement.
    - Receive authorisation letters from NHS England/Improvement.
    - Refinement of supporting Standard Financial Instructions and Scheme of Reservation and Delegation to allow the Joint Committee of CCGs to make binding decisions against agreed budgets.

The C&M HCP Board are asked to:

- Note the information provided

Appendices

Appendix A: Governing Body thematic responses to Joint Committee proposals

A summary of the recommendations and the thematic responses from Governing Bodies is provided below:

Recommendation	Thematic response
It is recommended that the CCG Governing Body approves the proposed purpose and principles of the Joint Committee of Cheshire and Merseyside CCGs.	▪ Approved the proposed purpose and principles outlined for the Joint Committee ▪ Request to further understand how the needs and scale of inequality will be addressed through this committee
It is recommended that the CCG Governing Body approves the proposed responsibilities, focus and outline initial workplan of the Joint Committee of Cheshire and Merseyside CCGs.	▪ Approved the proposed responsibilities ▪ Majority approval of the workplan with requests for further refinement to cover: ○ Workplan needs to be more ambitious ○ How the work will be undertaken/conducted/resourced ○ More detail required on the scale and scope of the work plan and that services suggested have been assessed against the principles ○ One strong objection to Mental Health being commissioned at this level
It is recommended that the CCG Governing Body approves Option 3 for the representation of the Joint Committee of Cheshire and Merseyside CCGs and identifies the individuals it wishes to put forward. This option allows for a broad representation of different views from across a typical governing body.	▪ Approved Option 3 for the representation of the Joint Committee with caveats detailed below: ○ Greater representation of clinical colleagues required ○ Consideration to be given to Healthwatch and Lay membership ○ How to ensure all current or future Governing Body roles are covered? ○ Independent Chair vs incumbent ○ Role of a vice-Chair ▪ It was also suggested that the JCCCG should be unitary board with equal representation of exec, non-executive and clinical and equality of representation across the existing 9 CCGs.

Other feedback themes included:

- Terms of reference require further significant development and to be brought back to Governing Bodies
- What is the engagement process pre and post JCC meetings for CCGs to consider the JCC papers so as to help provide the attendees with the considered opinion/position of their respective CCG?
- How do we agree the delegation of the budgets by each CCG against the services within the 3 themed areas or the principles or processes around then allocating the expenditure?
- Should a large CCG have the same voice of that with a much smaller population?
- If voting, does it have to be 100% unanimous and if not what is the quoracy required?

Appendix B: Examples of other Joint Committee structures

Lancashire and South Cumbria
Joint Committee of CCGs

- Joint Committee of 8 CCGs
- Focused on taking collective decisions about services provided to the L&SC population.
- Independent Chair in place
- It has 2 x reps from each CCG
- Quorate if there is one voting member from each CCG present
- Aim for consensus but if not achieved, decisions need 75% of voting members to approve.
- Meetings held in public.
- Collaborative commissioning arrangement in place with (NHS E/I for services which are directly commissioned by NHS E/I and Local Authorities as outside of the delegated authority of the Committee).

(Terms of Reference, December 2019)

Cheshire CCGs
Joint Commissioning Committee (AHEAD OF MERGER)

- Joint Committee of 4 CCGs (Ahead of Merger)
- Focused on delegated decision making for *recommendations made at a C&M level for adoption across Cheshire strategic oversight and development of a workplan for the establishment of unified commissioning of health and social care services across Cheshire on commissioning services at scale.*
- Chaired by one of GP clinical Chairs
- Each CCG had equal representation (CCG clinical chair and GP rep, CCG AO and executive director, Lay member)
- Additional standing members included: Secondary Care Doctor, Reg Nurse, Healthwatch, Public Health rep, Local Authority Chief Executive.
- Quorate if there are two voting members present from each CCG, GP Chair or Lay member, CCG AO and Chair of Joint Committee.
- Aimed for consensus but if not achieved, decisions needed 75% of voting members to approve.
- Meetings held in public.

(Terms of Reference, May 2019)

Commissioning Function Review - ICS and Place responsibilities and next steps

Report To:	Cheshire & Merseyside Health & Care Partnership Board
Date of Report:	26th May 2021
Report Author(s):	Prof Sarah O'Brien Executive Director Strategy & System Development
Purpose:	This paper presents to the HCP Board the outcomes of the Commissioning Function Review and recommended next steps.
Recommendation(s):	1. Board are asked to endorse the outcomes of the commissioning function review (Appendix 1) Board are asked to approve the next steps: 2. The Executive Director of Strategy & System Development to work with the task and finish group to develop proposals for commissioning and quality operating models at place and system. Proposals would be taken through the ICS Development Advisory Group for further comment and input and brought back to HCP Board for approval in July. 3. A set of case examples will be developed to demonstrate how the new approach to commissioning at system and place will work in practice. 4. The HCP to work with NHSEI and CCG colleagues on a 'Transition Plan' to move to new commissioning operating models ahead of April 2022. 5. Work will continue with each of the nine places to develop proposals for place governance and leadership in line with current national guidance and time frames. Places to continue to explore opportunities for integrated commissioning between the NHS and local authorities. The current national expectation is a MOU between each Place and the ICS by the end Q2 (September).

Introduction

Cheshire and Merseyside were formally designated as an Integrated Care System on 1st April 2021. As part of this process, the HCP were assessed against a formal ICS framework and one area of this framework was 'streamlined commissioning'. At the point of designation the HCP didn't have a Joint Committee of CCGs and system wide commissioning was limited, therefore this was a key element of the subsequent development plan agreed with NHSEI. Moreover, since designation, the White Paper 'Integration and Innovation: working together to improve health and social care for all' has been published and sets out plans to dissolve CCGs and move their statutory functions into ICSs from April 2022. This proposed legislation reinforces the need for the HCP to review current arrangements for commissioning and agree a Target Operating Model for the future of commissioning activities and functions once CCGs are dissolved and the ICS becomes the statutory body.

NHSEI guidance for ICS development recommends that the first stage of the process to streamline commissioning is to complete a 'Commissioning Function Review' whereby existing commissioning activity (services, duties and functions) are reviewed and a decision is made regarding each and whether it is best led and or delivered at a system level or at a 'place' level. Following this process, the required operating model for NHS commissioning in each of the 9 C&M places and at ICS level can be determined. This work is pivotal to the ongoing transition and development of the partnership under the proposed new legislation and needs to be completed urgently.

The board has previously approved the HCP System Development Plan and supported the undertaking of a commissioning function review and the aim of this paper is to present to board the outcome of the function review for endorsement and to propose for approval the next steps required to further develop commissioning and establish the required operating models at place and system.

Function Review Process & Outcomes

The HCP team led the function review with support from NHSEI by means of expert facilitators for a number of workshops, one of the facilitators had supported other ICSs with function reviews so was able to share the process, principles and outcomes. In addition, a commissioning lead from the national policy team joined a C&M initial session to outline the national context and policy direction for commissioning. Following this initial session a workshop with representatives from each CCG (including AOs and Chairs) was held and at this session a set of underlying principles were agreed to underpin the work. It was agreed to hold two task and finish groups following this initial workshop to undertake the detailed function review, each CCG was asked to nominate a representative and there were also two local authority representatives invited to participate (one Chief Executive from Cheshire & one from Liverpool City Region). In addition, a third facilitated session was held with the Directors of Quality / Chief Nurses from each CCG and the NHSEI Director of Nursing for Cheshire & Merseyside to undertake the same process in terms of current CCG quality functions.

Each participant at these sessions was also asked to discuss and explore the work in their respective CCGs/ places so that when contributing to the task and finish groups they were bringing a wider view from their organisations and some CCGs submitted extra documentation to inform the process.

The aim was to reach a consensus from the C&M system as to which commissioning functions, duties and services would be best undertaken once across the system, at place or a combination of both. This was achieved and an agreement reached on all the areas reviewed and the outcomes are summarised in Appendix 1. Board are asked to endorse this function review.

Key Points To Note:

During the process a number of key points and questions were raised that will require ongoing exploration and further work as we mature as an ICS and move towards statutory status. In addition, the White Paper has been published with emerging NHSEI guidance and a plethora of expert commentary. This section of the paper summarises for board some of the key areas that will need to be addressed and worked through as part the ongoing development of system and place commissioning and as part of the next steps recommended below. We also anticipate further NHSEI guidance for ICSs on some of these areas as the legislation passes through parliament.

1. Whilst the list in Appendix 1 outlines an agreed position on functions at system versus place it is evident that there is significant overlap and you can't and shouldn't completely separate place and system. There will need to be strong connections between place and system and between ICPs and Provider Collaboratives especially in pathway and transformation work. The operating models that emerge for both place and system need to reflect and support integrated, collaborative working vertically and horizontally at place and system. Place is fundamental in ICSs but so is system and how we work together 'as one' will be a key challenge and priority.

2. Commissioning remains an important part of the system architecture BUT needs to be different as CCGs dissolve. Under new legislation 'commissioning' will be done together at both system and place and decisions between key partners can be made together. It is important that we use commissioning skills and processes to understand population needs, bring together health and care organisations and work collaboratively across the ICS to integrate services at a place and system level and set priorities to meet these needs. Commissioning needs to evolve into a process of transformation, re-design and co-production and move away from transaction and contract management. Planning, design and review can be done together at system, within ICPs and Provider Collaboratives.

3. As CCGs dissolve and the ICS becomes the statutory accountable body for NHS finance and performance across C&M there needs to be a robust process for delegation of responsibilities to the 9 places. There was a lot of discussion during the work on accountability, this will be complex in the new emerging ICS with overall NHS Statutory responsibility and accountability sat with the ICS NHS Body but different elements of responsibility will be delegated through Place-based Partnerships and Provider Collaboratives and there will be mutual accountability in the system.

   More work is needed on the governance and leadership required in each Place in order for the ICS to delegate responsibilities and accountabilities and this work is ongoing. In addition, we expect technical guidance on the allocation of finances and delegated

budgets as the legislation passes through parliament. However, it is also important to note that we do not expect much (if any) extra funding as ICSs become statutory and C&M is already a financially challenged system, therefore the new way of working has to be about how local systems come together and use existing resource (staff and services) to meet population health needs by doing things together and doing it differently and not to expect 'additional' funding or a disaggregation of existing budgets (which are already allocated to key services) to new additional innovations. The focus at Place will need to be on pathway re-design, sharing of resources across partners / services and understanding and addressing priorities for local people within existing resources.

4. There was recognition in the discussions that the new legislation requires fundamental changes to the way NHS commissioning and provision currently works and the way in many areas health and social care work together. The need for cultural change and organisational and system development support at place and system to facilitate this was noted. Much of the national commentary on ICSs is also citing the need for a different set of leadership behaviors and skills and a focus on system, collaboration and people and less focus on organisations.

Next Steps:

The HCP needs to build on the outcome from the function review and develop an operating model for commissioning at place and system in line with emerging legislation and national thinking. To enable this, the next steps recommended to board are:

1. The Executive Director of Strategy & System Development to continue to work with the task and finish group to develop proposals for commissioning and quality operating models at place and system. Proposals would be taken through the ICS Development Advisory Group for further comment and input and brought back to HCP Board for approval in July.

2. A set of case examples will be developed to demonstrate how the new approach to commissioning at system and place will work in practice.

3. The HCP to work with NHSEI and CCG colleagues on a 'Transition Plan' to move to new commissioning operating models ahead of April 2022.

4. Work will continue with each of the nine places to develop proposals for place governance and leadership in line with current national guidance and time frames. Places to continue to explore opportunities for integrated commissioning between NHS and local authorities. The current national expectation is a MOU between each Place and the ICS by the end of Q2 (September).

APPENDIX 1

Commissioning Functions Review Fina

CCG Functions, Duties and Services (commissioning & other)

Note: Statutory accountability for ALL functions, duties & services will move to ICS in 2022. But our aim is a model of operationally shared accountability between ICS & Places (once places 'ready' for delegation), table indicates where responsibilitywill sit in practice, where services will be commissioned and where delivery of functions / services will be.

Functions & Duties	Responsibility		Delivery	Comments
	Place	System		
Quality duties including safeguarding **(designated professionals)** **Members Community safety, health protection, youth justice & safeguarding boards at place**	√	√	**System & Place**	Statutory function and accountability will move to **ICS,** but blended model required that demonstrates the desire for **Place working between health and LA**
Current duties to: **Contribute to JSNA & HWB** **Produce local commissioning plan** ***Consult & engage local population on commissioning plan & on any service changes**	√		**Place**	Accountability at **ICS** delivered locally Integrated commissioning teams & **ICPs at Place** could deliver this Places will need population health management approach as will system Statutory duty to consult will move to ICS
Financial duties –programme & running costs, duty to balance	√	√	**System & Place**	Will need place-based teams to manage budget but oversight & statutory responsibility will sit at **ICS**
Digital	√	√	**System & Place**	**ICS** accountability and drive common care record and interoperability with delivery and adoption at **Place**
Contract Management	√	√	**System & Place**	Contract management at **ICS and Place**. With the proposed changes to competition & procurement, this may lead leaner teams undertaking different tasks *Further clarity & discussion on contracting required and link to financial framework and model*
System Performance & Assurance		√	**System**	System Assurance required at **ICS** with accountability for delivery at **Place and Provider Collaboratives** ICS – will need to hold Places to account for delegated budget & commissioning of place

Place Performance & Assurance	√		**Place**	services and outcomes Resource requirements at Place to support performance work but could be integrated with LA & NHS providers to form Place performance teams. They could also undertake population health management and support commissioning and service re-design at Place
Quality Assurance	√	√	**System & Place**	**ICS** will be accountable for system surveillance, reviews and learning, while delivery will be in **Place and ICP and Provider Collaboratives** Quality assurance can sit at ICS with a small team supporting safeguarding, CHC etc at Place and some resource in providers (think about SUI management, LEDER etc)
Quality Improvement	√	√	**System & Place**	**ICS** will be accountable for a range of improvement measures, while delivery will be at **Place within ICPs and Provider Collaboratives**
Governance: ***Governing Body or equivalent, constitution, annual report, etc***		√	**System**	Likely to be at **ICS** level when NHS Board established, Place Governance (committees) will cover / oversee accountability at place and could be sub committees of NHS Board (*to be finalised post Parliamentary Process / NHSe/I guidance*)
Complaints, FOI, HR, coms & media, IG **EPRR**	 √	√ √	**System & Place** **System & Place**	**ICS** accountability and a mixture of ICS and **Place** delivery Will need local arrangements for other types of governance at Place could be linked with LA or provider at Place EPRR at Region, System and Place
Workforce	√	√	**Place & System**	**ICS** to have strategic workforce oversight & leadership, including oversight of training hubs (primary care) etc. This ICS will be the statutory employer initially for all relevant accoutnabilities. **Place teams (ICP)** will need to have a focus on planning for local workforce and what is required to meet needs local population & tackle health inequalities, etc. Also aim will be to explore & establish integrated roles at place or acroos places
Medicines Management	√	√	**System & Place**	**ICS:** development of protocols/ PDGs/ prescribing guidelines, some system wide savings **Place:** Local prescribing teams' presence and connection to PCN's – some should be system wide but a lot of activity in primary care (QIPP), needs further review after programmes submitted plans next year

Services	Commissioned		Delivery	Comments
	Place	System		
Ambulance Services		√	**System**	**ICS**: Ambulance 999 (Blue light)
Patient Transport	√	√	**Place**	**ICS: may contract some as part of ambulance services** Potential for collaboration of places to commission the service Service delivery at **place**. Possible monitoring of performance at place.
Cancer Services		√	**System & Place**	**ICS** - Cancer alliance (strategy), specialist services, holding the contract, budget, commissioning decisions and oversight **Place** - local delivery, prevention, screening **Considerations:** Need to engage with local clinicians on pathways and screening. Also links to additional roles within PCNs and the voluntary sector
Wheelchair **home oxygen**	√	√ √	**Place**	**ICS:** setting standards and specialist provision **Place:** delivery in all or acroos Places, link to LA, to inclue non specialist to re main as part of local delivery offer, assessment, commissioning and procurement **Considerations:** Wheelchairs form part of PHB's, this needs to be considered.
Abortion services		√	**System**	Policy/Standards could be set at system (**ICS**) so as to avoid variation across Place.
Infertility services		√	**System**	Single policy at **ICS**
Infectious diseases		√	**System**	**Regional / ICS:** Role of PHE re advising outbreak management Development of guidance/protocols Providing/Commissioning specialist advice. **Place:** Leading Local outbreak management. Local Health protection and surveillance (this is Public Health remit)
Acute / specialist LD		√	**Place & System *(as required)***	**ICS:** Oversight / strategy / Contract **Place:** delivery Local pathways and multi provider working on pathways Place

Acute MH (adults & children) including crisis & inpatient care & out area placements		√	**Place & System *(as required)***	**ICS** Strategy and Oversight / Contract **Place / Provider collaborative** to deliver and drive improvement in acute & crisis MH
Acute elective care (including Independent Sector)		√	**Place & System**	**ICS:** Oversight / strategy / Contract Some hospitals co-terminus with place so delivery is in place but not all are. **Provider collaborative** to drive improvement in elective care but link Place pathways
Maternity services		√	**Place & System**	**ICS:** Oversight / strategy / Contract Fits with LMS work – drive pathways but link to Place
Acute emergency care	√	√	**Place & System**	**ICS**: Contract and oversight / acute Trust contract **Place / Provider Collaboratives**: Some hospitals co-terminus with place so delivery is in place but not all are. Urgent Care Pathway / admission avoidance work is in Place
Urgent Care Treatment centres	√		**Place**	**Place**: Front door and back door of all services have to be designed and responsive to that need UTCs in places, there may be potential distinction between contracts & pathway design
Diagnostics		√	**Place & System *(as required)***	**ICS**: Contract, oversight and C&M standards & expectations **ICPs** in place (with integrated commissioning) need to deliver local pathway & services
Long Term Condition Management (diabetes, respiratory, dermatology etc)	√	√	**Place & System *(as required)***	**ICS:** Development of standards/protocols and agreement of outcomes. (LTC in acute hospitals within contract held by iCS but have to work with Place on service delivery) **Place:** integrated commissioning needs to deliver local pathways within the place and different providers within each place to support pathways such as with the third sector.
Out of Hours Care	√		**Place**	**ICS**: Standards **Place** or potential collaboration of Places for delivery
Adult Community health services	√		**Place / Neighbour hoods**	Core part of **ICP at place** and integrated working with PCNs Collaboration of Places
Older Peoples Services	√		**Place**	Similar to LTC point above some sits in acute
Rehab services	√		**Place**	**ICS:** to set standrds**, but needs further definition** **ICS:** Specialist Provision, including assessment, commissioning and procurement.

				Place: Handover to CHC Teams.
Palliative Care & EOL (including hospice)	√		**Place**	**ICS:** Development of clinical pathways/ standards **Place:** Commissioning at place maybe through place collaboration.
Community paediatrics	√		**Place**	**ICS**: Set Standards and provider oversight **Place**: Delivery through provider collaboratives
Community Mental health (adults & children)	√		**Place**	**ICS**: Strategy and standards to address large variations in offer in each Place **Place**: Collaboration of place (linked to funding) so need to address this
Community LD	√		**Place**	Some sits in primary care (e.g., health checks) & social care
CHC	√		**Place**	Real opportunity for integration at Place with LA.
Voluntary sector	√		**Place**	**ICS** commission services from the larger national orgs, **Place** local integrated approach with LA (or collaboration of places) would be best to commission more local or smaller VCFS org. Depends on size of organisation.
Primary Care	√		Place	Currently delegated by NHSE and not all functions delegated (*to be finalised post Parliamentary Process / NHSE/I guidance*)
SEND	√	√	Place	**ICS**: Strategy and standards statutory function with CCG, will move to ICS but need a Place model for delivery **Place**: Health delivery linked to community paeds & therapy BUT wide variation in funded services & issues.

NHSE: **Dentistry** **Pharmacy** **NHS eye tests** **Prisons** **Spec com**		√	**Place & System *(as required***	We need to understand what will come to ICS and then some of primary care services could go to Place – this needs further review

Services	Place	System	Delivery	Comments
LOCAL AUTHORITY: **Public health:** 0-19 Sexual health Infection control Drug & alcohol Other local wellbeing services **Social Care:** Care homes Dom care LD services Older people services S17 aftercare BCF with CCG Voluntary sector Children's placements & other support C&YP at place	√		Place	Places need to look at how integrate approach to commissioning. Public health commission some vital NHS services e.g., 0-19

20/21 Financial Out-turn

Report To:	Cheshire & Merseyside Partnership Board
Date of Report:	26 May 2021
Report Author(s):	Keith Griffiths, Director of Finance, Cheshire & Merseyside Health & Care Partnership
Purpose:	This short report confirms the final 20/21 Income and expenditure positions for each NHS organisation in the Cheshire and Merseyside system. Equally it highlights the non-recurrent changes in the NHS finance regime that were introduced nationally in response to the Covid 19 pandemic which led to the reported positions.
Recommendation(s):	The Partnership Board is requested to note 20/21 out turn positions for each NHS organisation and the underlying financial challenges that remain.

Financial Overview

It will be noticed from the table below that the Cheshire and Merseyside system ended the year with a £10m deficit, which compares to an original planned deficit (pre pandemic) of £144m. i.e. an improvement of £134m.

Table 1 - Summary of 2020/21 Financial out-turn

	Plan £m	FOT £m	Under/(Over)Spend £m
NHS Cheshire CCG	(10.1)	0.0	10.1
NHS Halton CCG	(5.3)	0.1	5.4
NHS Knowsley CCG	(6.6)	0.0	6.6
NHS Liverpool CCG	(8.3)	0.0	8.3
NHS South Sefton CCG	(4.1)	0.0	4.1
NHS Southport and Formby CCG	(3.1)	0.0	3.1
NHS St Helens CCG	(6.8)	0.0	6.8
NHS Warrington CCG	(2.3)	0.0	2.3
NHS Wirral CCG	(2.5)	0.6	3.0
CCG Total	**(48.9)**	**0.7**	**49.6**
Alder Hey Children's NHS Foundation Trust	(5.2)	0.0	5.3
Bridgewater Community Healthcare NHS Foundation Trust	(3.2)	(2.2)	1.0
Cheshire and Wirral Partnership NHS	1.3	1.1	(0.1)

Foundation Trust			
Countess of Chester Hospital NHS Foundation Trust	(5.2)	(1.4)	3.8
East Cheshire NHS Trust	(0.1)	3.2	3.3
Liverpool Heart and Chest Hospital NHS Foundation Trust	(1.4)	0.4	1.9
Liverpool University Hospitals NHS Foundation Trust	(27.0)	1.8	28.8
Liverpool Women's NHS Foundation Trust	(4.6)	(4.2)	0.4
Mersey Care NHS Foundation Trust	(6.6)	1.4	7.9
Mid Cheshire Hospitals NHS Foundation Trust	(10.2)	(4.4)	5.8
North West Boroughs Healthcare NHS Foundation Trust	(4.1)	(0.2)	3.9
Southport And Ormskirk Hospital NHS Trust	(1.7)	0.3	2.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(15.9)	(2.6)	13.2
The Clatterbridge Cancer Centre NHS Foundation Trust	(0.3)	1.2	1.5
The Walton Centre NHS Foundation Trust	(1.3)	1.5	2.8
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(10.2)	(6.8)	3.5
Wirral Community Health and Care NHS Foundation Trust	(0.0)	0.1	0.1
Wirral University Teaching Hospital NHS Foundation Trust	0.3	(0.1)	(0.4)
Provider Total	**(95.5)**	**(10.8)**	**84.7**
Total	**(144.4)**	**(10.0)**	**134.4**

During the first half of 20/21 (due to the pandemic) all original planning and contractual arrangements were paused and all NHS organisations could recover from the treasury the actual costs they were occurring each month. In the second half of the year a fixed financial envelope was given to each ICS system which could not be exceeded, but which was also set at a level deemed to be sufficient to cover the predicted costs – this prediction was clearly non-the-less volatile given the 2nd and 3rd waves of Covid that hit Cheshire and Merseyside. Allocation of this envelope was managed by the ICS and ultimately agreed by all partner organisations.

Another important point to draw from the above is that the CCG's all delivered break even, whereas prior to the pandemic they were predicting an overspend of £48m. By ensuring CCG's achieve Break even in 20/21, the Cheshire and Merseyside system has protected resources in 21/22, given that any 20/21 CCG deficits would have to be repaid in full in 21/22. Thus, it was through a commitment of collaboration by all partner organisations that above position was achieved.

As regards the Provider positions, it will equally be noted that there is a mixture of small surpluses and deficits across the system. It is important to note here that this set of results were the consequence of a professional and managed set of actions that were predominantly driven by late amendments to national policy – particularly regarding annual leave being carried over from 20/21 and support for lost non-NHS income in 20/21.

Thus, in overall terms, the reporting of a £10m deficit for the whole of Cheshire and Merseyside is a successful result, particularly given the fixed financial envelope in the second half of the year when operational and hence financial uncertainties where very significant and financial collaboration across sectors was a key requirement.

The current financial Landscape

Clearly the impact of the Covid pandemic is still with us and the operational / workforce / financial challenges remain, be it that their nature is shifting as we move into a sustained period of elective recovery, see a different demand for acute physical and mental health services and deal with the out of hospital impact of long Covid. Thus, the financial arrangements set nationally remain exceptional, be it with another six-month fixed financial settlement. Suffice to say that the underlying deficit in the Cheshire and Merseyside health system, as originally predicted in the original plans our constituent organisations prepared late 19/20 and pre pandemic, is still being artificially covered by significant additional, non-recurrent resources and a centralised 'block' payment regime. Thus, as the NHS emerges from the Pandemic the underlying financial challenges will re surface – the level of which cannot be assessed at this time – but which will still need to resolve by the ICS leadership across health and Social Care. Alongside this NHS deficit, Local Authority organisations have underlying and new economic challenges which need to be aggregated to the NHS position and the totality collectively addressed over future years.

Cheshire and Merseyside
Health and Care Partnership

Population Health Management Next Steps

Sarah O'Brien
Executive Director Strategy &
System Development

ICS Vision & Priorities

VISION:

We want everyone in Cheshire & Merseyside to have a great start in life, and get the support they need to live healthy & longer

MISSION:

We will tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership.

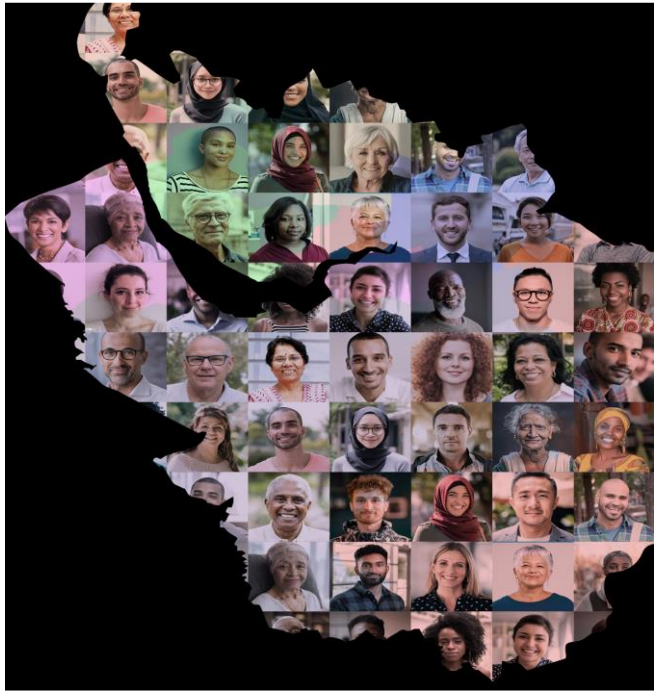
ICS Strategic Priorities:

1. **Improve population health & healthcare**
2. **Tackling health inequality, improving outcomes and access to services**
3. **Enhancing quality, productivity and value for money**
4. **Helping the NHS to support broader social and economic development.**

Improving Health and Wellbeing in Cheshire and Merseyside

Strategy 2021-2025:

- Vision & mission
- Strategic objectives
- 7 enablers



Population Health Work to Date:

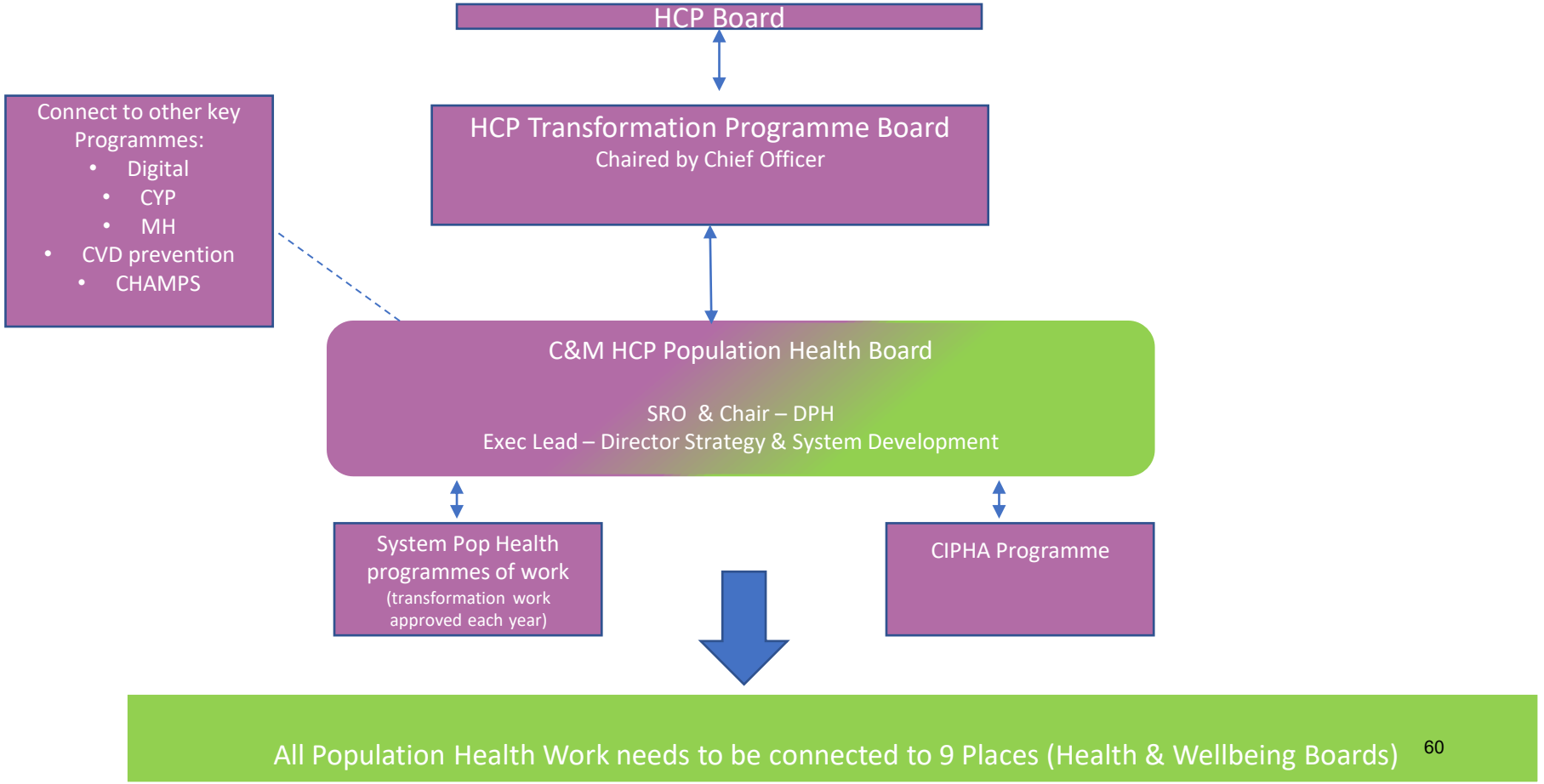
- Pre-Covid – Marmot & Place Plans
- Prevention Work through Programme Board
- Assembly Inequalities
- COVID – CIPHA, lessons learned & evidence review of impact
- Work on social value, anchor institutions
- Rapid Needs assessment (last board)

Next Steps – Taking Action:

- Refresh Population Health Board – system leadership, oversight, connect to place & yearly priorities
- All programmes – focus on inequalities & connect to Place
- System P
- C&M Strategy – implementation
- Places / ICPs: focus inequalities & pop health management
- System: further Marmot work, develop system dashboard, digital review (pop health), CIPHA another year, NHSEI population health programme

CULTURE – Whole system priority needs to be pop health & reducing inequalities TOGETHER!

C&M Population Health Management – Governance



Summary

- Pop health & reducing inequalities = Top HCP Priority
- Know issues + impact & learning from COVID
- Now about taking action together & doing this differently – Places & Programmes are key

Cheshire and Merseyside
Health and Care Partnership

Thank You