Cheshire and Merseyside
Health and Care Partnership

Partnership Board
Tuesday 9th November 2021
15:00pm to 17:00pm
Agenda

AGENDA NO.	ITEM	LEAD	ACTION / PURPOSE
PB/21/69 15:00 - 15:05	Welcome, Introductions and Apologies	Chair	Oral
PB/21/70 15:05 - 15:10	Declarations of Interest	All	Oral
PB/21/71 15:10 - 15:15	• Minutes of the Last Meeting 14th September 2021 • Minutes of Partnership Development Advisory Group	Chair	Paper For Approval Paper For Noting
PB/21/72 15:15 - 15:20	Interim Chief Officer's Update	Sheena Cumiskey	Oral
PB/21/73 15:20 – 15:40	ICS Governance Update	Ben Vinter Sarah O'Brien	Presentation Discussion
PB/21/74 15:40 – 16:50	Children and Young People • Enacting our Strategic Priorities	Dani Jones Liz Crabtree	Presentation Discussion
PB/21/75 16:50 – 16:55	Any Other Business	Chair	Oral
PB/21/76 16:55 – 17:00	Review of the Meeting and Communications from It	Chair	Oral For Agreement
Date and time of next meeting: Tuesday 11th January 2022, 15:00pm to 17:00pm			

MEMBERSHIP – PARTNERSHIP BOARD

Chair
David Flory (DF) – Interim Chair, Cheshire & Merseyside Health & Care Partnership

Local Authorities
- Councillor Sam Corcoran (SC), Cheshire East Council
- Councillor Louise Gittens (LG), Cheshire West and Chester Council
- Councillor Marie Wright (MW), Halton Borough Council
- Councillor Christine Bannon (CB), Knowsley Metropolitan Borough Council
- Councillor Frazer Lake (FL), Liverpool City Council
- Councillor Ian Moncur (IM), Sefton Metropolitan Borough Council
- Councillor David Baines (DB), St. Helens Metropolitan Borough Council
- Councillor Paul Warburton (PW), Warrington Borough Council
- Councillor Yvonne Nolan (YN), Wirral Metropolitan Borough Council

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

NHS Providers
- Ann Marr (AM) – Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust
- Lyn McGill (LMG) – Chair, East Cheshire NHS Trust
- Dame Jo Williams (LS) – Chair, Alder Hey Children's NHS FT
- Jan Ross (JS) – Chief Executive, The Walton Centre NHS FT
- Mike Maier (MM) – Chair, Cheshire and Wirral Partnership NHS FT
- Joe Rafferty (JR) – Chief Executive, Mersey Care NHS FT

Public Health
- Ian Ashworth (IA) - C&M Population Health Lead/Director of Public Health Cheshire West and Chester

CCG Chairs
- Dr Andrew Wilson (AW), Cheshire,
- David Merrill (DM), Halton
- Dr Andrew Pryce (AP), Knowsley
- Dr Fiona Lemmens (FL), Liverpool,
- Geoffrey Appleton (GA), St Helens
- Dr Rob Caudwell (RC), Southport and Formby
- Dr Pete Chamberlain (PCh), South Sefton
- Dr Ian Watson (IW), Warrington
- Dr Paula Cowen (PC), Wirral

CCG AO representative
- Clare Watson (CW)

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

Executive Team

- Sheena Cumiskey (ShC) – Interim Chief Officer
- Keith Griffiths (KG) – Director of Finance
- Sarah O'Brien (SOB) – Director of Strategy & System Development
- Anthony Middleton (AMi) – Director of Performance and Improvement

NHSE North West

- Clare Duggan (CD) – NHSE North West Regional Director of Strategy and Transformation

In attendance:

- Local Authority Chief Executives
- NHS Commissioners
- NW Ambulance Service - Daren Mochrie (DMo) – Chief Executive Officer
- Chris Samosa (CS) – Director of Workforce
- Christine Hughes (CH) – Director of Communications & Engagement
- Dave Sweeney (DS) – Director of Partnerships
- Marie Boles (MB) – Director of Nursing
- Gerald Meehan (GM) – C&M Health and Care Partnership Advisor
- Ben Vinter (BV) – ICS Planning

Cheshire and Merseyside
Health and Care Partnership

Cheshire and Merseyside Partnership Board
14th September 2021, 15:00-17:00
MS teams – Virtual

DRAFT MINUTES

Present:

David Flory (DFL)	Interim Chair	Cheshire and Merseyside Health and Care Partnership
Geoffrey Appleton (GAP)	Chair	St Helens CCG
Dr Ian Ashworth (IAS)	Director of Public Health	Cheshire West and Chester Council
Christine Bannon (CBA)	Councillor	Knowsley Metropolitan Borough Council
Linda Buckley (LBU)	Director of Strategic Transformation and Locality Lead	NHSE
Dr Paula Cowan (PCO)	Chair	Wirral CCG
Warren Escadale (WES)	Chief Executive	Voluntary Sector North West
Louise Gittens (LGI)	Councillor	Cheshire West and Chester Council
Keith Griffiths (KGR)	Finance Director	Cheshire and Merseyside Health and Care Partnership
Dr Raj Kumar (RKU)	GP Representative & Clinical Director & Responsible Officer	Eric Moore Partnership Medical Practice & NHS Digital
Stephen McGuirk (SMC)	Chair	Warrington and Halton NHS FT for Lynn McGill
Mike Maier (MMA)	Chair	Cheshire and Wirral Partnership NHS FT
Daren Mochre (DMO)	Chief Executive	Northwest Ambulance Service
Ian Moncur (IMO)	Councillor	Sefton Metropolitan Borough Council
Yvonne Nolan (YNO)	Councillor	Wirral Metropolitan Borough Council
Sarah O'Brien (SOB)	Director of Strategy & System Development	Cheshire and Merseyside Health and Care Partnership
Marlene Quinn (MQU)	Councillor	St Helens Council
Joe Rafferty (JRA)	Chief Executive	Mersey Care NHS FT
Jill Rhodes (JRH)	Councillor	Cheshire East Council
Paul Warburton (PWA)	Councillor	Warrington Borough Council

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Cheshire and Merseyside Health and Care Partnership

Clare Watson (CWA)	Chief Executive	Cheshire CCG
Dr Ian Watson (IWA)	Chair	Warrington CCG
Dr Andrew Wilson (AWI)	Chair	Cheshire CCG

In Attendance

Dr Matt Ashton (MAS)	Director of Public Health	Public Health Liverpool
Delyth Curtis (DCU)	Deputy Chief Executive	Cheshire West and Chester Council
Rebecca Higgs (RHI)	Business Manager	Midlands and Lancashire CSU
Gerald Meehan (GME)	Local Authority Advisor to the Executive Team	Cheshire and Merseyside Health and Care Partnership
Anthony Middleton (AMI)	Director of Performance and Improvement	Cheshire and Merseyside Health and Care Partnership
David Parr (DPA)	Chief Executive	Halton Council
Steve Porter (SPO)	Assistance Director	Knowsley Borough Council
Chris Hughes (CHU)	Director of Communications	Cheshire and Merseyside Health and Care Partnership
Chris Samosa (CSA)	Director of Workforce	Cheshire and Merseyside Health and Care Partnership
Sarah Smith (SSM)	Executive Director of Adult Services	Knowsley Borough Council
Dave Sweeney (DSW)	Director of Partnerships	Cheshire and Merseyside Health and Care Partnership
Jonathan Taylor (JTA)	Assistant Director of Communications	Cheshire CCG
Ben Vinter (BVI)	ICS Planning	Cheshire and Merseyside Health and Care Partnership
Dr Adam Irvine (AIR)	GP representative	For and on behalf of Dr Jonathan Griffiths

Apologies:

Steve Broomhead	Chief Executive	Warrington Borough Council
Marie Boles	Director of Nursing	Cheshire & Mersey, NHS England and NHS Improvement

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Sheena Cumiskey	Interim Chief Officer	Cheshire and Merseyside Health and Care Partnership
Dr Jonathan Griffiths	GP Advisor	Cheshire and Merseyside Health and Care Partnership
Dr Fiona Lemmens	Chair	Liverpool CCG
Andrew Lewis	Chief Executive	Cheshire West and Chester Council
Lynn McGill	Chair	East Cheshire NHS Trust
Ann Marr	Chief Executive	St Helens and Knowsley Teaching Hospitals NHS Trust
David Merrill	Chair	Halton CCG
Graham Morgan	Councillor	Knowsley Borough Council
Kath O'Dwyer	Chief Executive	St Helens Council
Tony Reeves	Chief Executive	Liverpool City Council
Janet Rosser	Chair	The Walton Centre NHS FT
Louise Shepherd	Chief Executive	Alder Hey NHS FT

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Agenda No	Item	Action
PB/21/59	**Welcome, Introductions and Apologies**	DFL
	DFL introduced himself as the Interim Chair of the Cheshire and Merseyside Integrated Care System (ICS) and welcomed members to the meeting. Apologies received were as detailed above. DFL stated that the agenda covered a number of very significant items around the current COVID system pressures, the ambition for delivering a net zero NHS and the Memorandum of Understanding that accompanied that. There would also be a discussion on system workforce pressures and the ICS People Framework. DFL reflected on the context facing system partners referring to the legislation under discussion in Parliament. A significant part of the work up to April 2022 related to system design plans but critically also the safe and secure transition of functions from the CCGs to the new NHS ICS body (Integrated Care Board or ICB). To this end DFL welcomed CCG chairs being involved in this and other discussions. Colleagues had a collective responsibility to manage the change in a safe and secure way for populations, patients, and staff. Some of the other changes were equally significant in the way that organisations would all be able to work together alongside the ICB in partnership. It was vitally important that all sectors and all stakeholders approached the partnership feeling an equal sense of commitment and ownership. DFL reported being very encouraged by what he had encountered during his time in the system, both in the spirit and the substance of what colleagues were doing, to build effective partnerships for the future. In due course there would be a shadow ICB which would operate in tandem with this forum to support clarity by April 2022 on how decisions are made, how information is shared, and how the distinctly different roles of the two key structures in the ICS would work: an ICP and an ICB. Processes were in place to appoint a substantive Chair to the ICB and the process to start the recruitment of a Chief Executive Officer had also started. Once a Chair and Chief Executive were in post the work to build an effective and operational ICB could follow and accelerate. The ICB will be a unitary board with executives from local authorities as well as other stakeholders. The proposals set out by the government envisage that the Partnership Board will set strategy and priorities across the whole of the Cheshire and Merseyside health and care system and will be made up of partners from health, local government and from other sectors including the voluntary, community and charitable sectors. The ICB is proposed to have much more of an NHS focus but would still secure wider participation.	

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	Two other key parts of the new system were referenced that colleagues were asked to consider during the discussions: Borough place based governance and leadership arrangements: For the system to work optimally, success depended upon effective arrangements being in place in each of the nine borough places to support the delegation of decision-making and responsibility for financial resources from the ICB to local areas. Ideally delegations will be in place for 1st April 2022 but it is also important to be careful, cautious, and safe with the overriding aim being to establish borough place arrangements in a way that all parties were satisfied with. Within such a process it is important to acknowledge, if and when. things may not be quite right and that in developing joint arrangements there is enough trust between all parties to review and adjust arrangements where necessary. Decisions that support patients and their care get made best at a Borough place level, meaning, the relationship between Borough Place arrangements and both the ICB and the Partnership, as a whole, will be vitally important in the alignment of what the Partnership is trying to achieve. The second item for consideration relates to: provider collaboratives. Discussions during the meeting would cover some of the workforce challenges and the incredible pressures the combined heath and care workforce has been under. There are not enough staff, people were working too hard, too stretched and too tired after the experiences of the pandemic. Workforce needs represented a huge challenge and an important discussion area. Looking into the medium term it appeared inevitable that the resource environment would get tighter. There was a need to have better health outcomes for the population, better well-being for populations and staff, addressing the inequalities that existed, addressing the variations in outcomes in people's experience of care. The provider collaborative had done fantastic things in response to the pressures of the pandemic: embedding mutual aid; supporting elective recovery; and supporting new models of care are all initiatives that needs to continue and expand as collaboratives become an established part of the way business gets done. DFL commented that he felt very positive about the potential for the C&M Partnership and ICS overall, not only to do everything it needed to do very well over the next few months, but to be one of the leading integrated care systems in the country. Reviewing the services that are provided in all of the organisations, the region has some of the best people, providing some of the best care in the world. Colleagues had the collective job to bring the best out of their combined resources and to spread the best practice.	
PB/21/60	**Declarations of Interest**	**DFL**
	There were no declarations of interest.	
PB/21/61	**Minutes of the Last meeting – 6th July 2021**	**DFL**
	The minutes of the Cheshire and Merseyside Partnership Board held on 6th July 2021 were accepted as a true and accurate record of the meeting.	

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	The minutes of ICS Development Advisory Group of 8th July 2021, 22nd July 2021, 5th August 2021, and 19th August 2021 contained within the meeting pack, were noted for information purposes.	
PB/21/62	**C&M Covid status and implications**	**SOB**
	SOB delivered a presentation on the COVID rates and prevalence across Cheshire and Merseyside, on behalf of the Interim ICS Chief Officer, using data available on the 4th of September. The data indicated an increase in infection rates over the previous seven days and colleagues were reminded that coronavirus had not gone away and would remain a real system challenge over the next few months with the anticipation that flu might also represent a significant problem this winter. Within this context continuing with elective recovery would remain a challenge. Excellent work had gone into the vaccination programme with some vaccination rates in the high 90%. There was, however, concern regarding the number of people on the learning disabilities register who remained unvaccinated as this was a high-risk group and there was also some targeted work to be carried out with younger age groups. A national area of concern was pregnant women, who appeared to have been influenced in a not insignificant way by a lot of misinformation targeting this cohort regarding potential risks to unborn babies. This had resulted in increased hesitancy regarding the vaccine. A school-based programme for 12- to 15-year-olds was being prepared and there was likely to be some logistical challenges to deliver this with a workforce that needed to be accessed already being overstretched in many boroughs. There remained pockets of inequalities in vaccine uptake and colleagues were aware of this which was being targeted through outreach work continued in some communities. Despite measures there had been some breakthrough infections which were believed to be linked to reduced social distancing and a lack of compliance with mask wearing. Since producing the presentation it had been announced that a booster programme would be offered for the over 50s which would again stretch the workforce. Primary care was also significantly overstretched and this would further add to those workforce pressures. Immunisation programmes for children had become slightly behind during the pandemic and consideration also had to be given to how to manage this as well as the vaccination programme. It had been announced that if parents did not consent to 12 to 15-year-olds receiving the vaccine then the young people may be able to make that choice themselves. This was likely to cause some challenges and a strong communications programme was needed to help and support parents' engagement in those decisions. MAS referred to the inequalities element within the vaccination uptake and the significant challenge this represented despite the overall success of the vaccination programme and the hard work of all involved noting that the reality was that within local communities the vaccine uptake varied from 90% at the top end to 40% at the bottom end LGI thanked those involved for the fantastic work undertaken since the beginning of the pandemic voicing concern about rising infection rates. LGI suggested collective messaging focused on mask wearing in crowded spaces may help.	

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SOB supported any collective effort and consistency of messaging particularly via elected members in local communities would help to get positive messages to communities.

MQU asked if there was a plan for those that did not engage with the booster programme and would the vaccination offered as a booster be the same vaccination people had received previously; and was there a plan to deliver the booster programme in care homes. SOB responded that not all the detail was available regarding the booster programme as it had only been announced the previous day. It may be offered alongside the flu vaccination which it was hoped would encourage uptake and primary care would be targeting registered patients. It was not clear at that point which vaccine would be offered, and care homes would be managed locally in the same manner as the original roll out of vaccines.

IAS confirmed that plans were underway within local resilience forums, working with care homes to roll out the booster programme to care homes.

CBA suggested training care home staff to deliver booster vaccinations.

AIR reported that some places had flu groups which involved their care homes. The care homes were covered by the general practice contract and the community pharmacy service, and each borough would determine how people in their care were covered and would approach this differently according to what was right for the need and capacity of each place. Furthermore, the timing of the second dose of the covid vaccine determined when people could have the booster as there had to be a minimum of six months between a booster and completion of their initial vaccination cycle.

CBA stated that if different things happened in different places there was a need to look collectively to ensure we could deliver what was needed. In response SOB commented that the vaccine silver and gold meetings had the right structure and capacity to take an overview across Cheshire and Merseyside to see how it was working and this would be fed back to the groups.

DFL asked if the current level of pressure in this NHS could be contextualised compared to how previous waves had impacted the system.

JRA responded that there was not, currently, the intensity through the number of admissions and deaths at this point of the year compared to the previous year so there was more headroom but the issue was building back up and maintaining business as usual treatment levels. The risk of nosocomial infection meant providers were considerably constrained by the IPC considerations due to the high level of community transition. Elective activity could be built back up under constraints, but needed to be considered alongside staff resilience, sickness and fatigue pre any winter impact. Wider, important services, such as community services needed to come, fully, back on line and it was difficult to do this when dealing with approximately 15% sickness and the impact of Covid on staff. The significant rise in mental health demands being experienced meant we had three or four overlapping waves of dealing with covid and we needed to start to take a longer view of how to deal with this.

DMO reported a national issue across England and all devolved administrations of extremely long waits for the ambulance sector with unprecedented call volumes which had been manifesting since mid-July. Significant additional numbers of 999 call

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	handlers and additional emergency ambulances had been put on, but across the whole of the UK the struggle continued. In the North West there was a really good working relationship with acute providers around handover delays. But delays were starting to rise again because of the pressures within acute services. The Secretary of State had been briefed on some of these wider challenges. PCO gave a primary care perspective commenting that the demand was also felt in primary care and staff morale here were also at a very low ebb. Residents had more concern about health that had been delayed over the last 18 months. Primary care was open for business in a different way and getting the message across that just because things are delivered differently doesn't mean it's wrong was proving a challenge. The pressure on phone systems and services was immense. There were significant numbers of mental health issues. Plus, the issues around long COVID on top of trying to manage and prevent other long-term conditions including the promotion of self-management. AMI recognised that one of the biggest pressures being faced was the volume of patients in critical care units. Primarily, the admissions were in the unvaccinated 30- to 40-year-olds for COVID. These patients had a greater resistance naturally to any disease due to their age, however when they required critical care support because they had COVID and were unvaccinated this meant they were in for many weeks and months. And now the occupancy was very similar to some of the waves of the pandemic. Consideration was being given to how the units could be expanded. CBA declared an interest as a family member worked in the NHS and because of previously working in the NHS for 45 years commenting that there were issues and perhaps the online consultations with GPs exacerbated these as patients became frustrated so went to the A&E department where there were long waits and it was a vicious circle. People needed to understand the issues the system was facing but consideration of more face-to-face consultations becoming available was also needed. RKU referred to PCOs points regarding the pressures GP practices were facing stating that in his 21 years of experience he had never witnessed such demand. Waiting lists had never been so long which impacted primary care and included heightened presentation of patients with cancer or mental health concerns. Reports in national media were unacceptable and were fuelling patients becoming violent and showing aggression towards staff. Collectively across all ICSs, in the absence of a central message, there was a need for leadership to put the right messages out to the public advising that there were constraints resulting in limitations as to what the system could successfully support. SMC discussed the situation in hospitals agreeing with everything that had been said. Each issue alone was not huge but linked together resulted in a silting up process. The workforce was the main issue with sickness levels creeping back up. The general feeling was that winter was yet to arrive and staff were very anxious about it. The government wanted to send out an upbeat message meaning as far as much of the public was concerned the pandemic was over. The pandemic was not over and not likely to be for many months, possibly years.	

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	DFL stated that all comments were welcome and that there were no easy answers. this was uncharted territory to have these sorts of pressures on the system at this point in the year.	
PB/21/63	**System Workforce Pressures** • **Social Care**	**DCU**
	Due to the flow of the discussions it was agreed to revise the order of the agenda to discuss workforce pressures across the system next. DCU delivered a presentation, included within the meeting papers, on the adult social care staffing position which was a significant concern in terms of the pressure it created for the system and the impact it had on both patient flow quality, safeguarding admissions and readmissions in hospital. Looking ahead there is more that can be done as a Health and Care Partnership around the messaging, branding promotion and recruitment to support a more attractive offer to entice people into the sector. Could we build on the NHS and Care brand to create a local brand that was known to all that was attractive, underpinned by a Cheshire and Merseyside focussed campaign ahead of winter, ahead of and supplementing any national campaign. CBA thanked DCU for the presentation commenting that care workers needed to feel valued and respected and should have a career structure similar to roles in the NHS. YNO commented that all the potential ideas put forward were good and there was a need to combine them into a comprehensive package. In Wirral a decision was made two years previously to pay the real living wage. Feedback from providers was that this had contributed to improved recruitment and retention as staff were getting paid more than they would in other roles. It had impacted the budget and it was a difficult decision to make but it did bear fruit. Centres of excellence, career academies and blended roles were all suggestions that had been around for some time and bringing them together into a complete and comprehensive package would enable people to see the care sector as a career route. Care workers needed parity of esteem and recognition of qualifications to feel valued in the role. The quickest solution Wirral found was the most expensive however it did work. CSA commented the NHS national pay rate had an impact in social care and a whole partnership approach was needed to careers in health and social care. There was a need to invest in training and career pathways to make a longer-term impact, and a need to find ways as a system of addressing some of the short term needs of social care. LGI supported the comments made suggesting a charter for adult social care across Cheshire and Merseyside could be developed with all involved signed up. This would enhance the profile of social care for young people making career decisions. The charter would set certain standards and make an impact in terms of the Cheshire Merseyside commitment. While there may be financial challenges around this it was worth considering. DFL recognised this as a proposal with widespread support suggesting LGI worked with Delyth, colleagues and CSA to ensure the ICS played its	

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	role in supporting care sector colleagues to develop these proposals including any work to build a charter describing the common campaign. PWA reported that what had happened over the last 18 months was that people had revised the role of an essential worker. There was a need to educate not just the workforce but also the population so that they valued carers and understood the essential nature of care and that as residents of the boroughs they had to be willing to pay for that care. DCU thanked colleagues for the helpful and supportive contributions noting that collective messaging was key and it needed to be powerful. The system had coped with enormous challenges and the parity issue was a point well-made and one that was struggled with. The presentation had omitted to mention the local living wage and consideration was being given to contractual levers and fair costs to care. A workshop had been held at northwest level and there were some actions from that looking at a joint recruitment campaign. DCU would work on drawing up a potential charter with members of the group. **ACTION: Form working group to develop charter for social care career development. DCU**	**DCU**
PB/21/64	**NHSE Guidance** • **ICS People Framework** • **Update on documentation released and pending**	**CSA** **BVI**
	CSA discussed the ICS People Framework and creating an ICS People Function highlighting that the HR framework was long awaited. It was very much an internal NHS document which described the process of transferring staff. How to take them from where they were and to create the new organisation. The key element of that was to treat people with respect. Processes had to be people centred and inclusive. A commitment was made in Cheshire and Merseyside that when staff look back at the process, they must be able to say that it was done with respect and that they felt they could trust their managers, that they had consistent communication and that they felt that all the processes were very fair. All of the documentation had an employment commitment for those staff that were below board level. Such a commitment did not exist for board level staff or Board members and the HR guidance was split into two. ICS leaders would endeavour to make sure that people are lifted and shifted into the new organisation in a very supportive way, and we must not forget that at the end of everything we do there was a person. The document of more interest to this group was about how to create an ICS People Function which described how we work across the system to look at the workforce building on the conversation that had just taken place. We must look at how and where specific workforce functions are carried out, looking at what happens at a place level. What happens in provider collaboratives, what we can do once across the system. It represented an opportunity to do things differently. We also have to review and refresh our people board, which was in hand. It is also necessary to assess the system's readiness, in terms of capacity and capability, to deliver that one workforce at people function across Cheshire and Merseyside.	

A first session has been held with local authority, HR colleagues and OD colleagues, the previous week, to develop and support a common understanding and would continue to work through the required issues. An important part of any programme is continuing to work in partnership with, for example, sporting clubs such as rugby league to progress innovative work looking at careers and promoting health and well-being of staff. As we develop the one workforce approach, we should see a shift in terms of how we look at what offer we can give to staff, how we make sure it's sustainable, how we look at different and new pathways and supply routes. There was the potential to make massive changes here and hopefully get to a point where staff, no matter where they are working, health or care, are proud to work in Cheshire Merseyside.

BVI reported that following the release of numerous pieces of guidance this had been disseminated through DAG which the group had the minutes of. There had been two significant tranches of guidance. The first regarding assurance and audit areas of work around how the ICB was described at the beginning of the meeting and how it should be established. What functions it should perform, and how to manage and govern that safe transfer. And how partners, CCG's and NHS England could be assured that we were progressing on that journey with four pieces of guidance that cover that.

For this forum the second tranche was slightly more interesting in that it begins to sketch out not just from an NHS England perspective but also from partners like the LGA and others about how places and place working should be developed and how ICBs and partners need to engage with their communities. How ICBs, places and partnerships in the widest sense embed professional leadership within that clinical and care setting. Bringing to the fore the fact that this wasn't about silos but is about developing genuinely integrated ways of working and how any action in one area would necessarily have an impact on another and finally the area around voluntary community and social enterprise sector.

BVI referred to NHSX who had released guidance around what good looked like from a data perspective for treating patients with more guidance to follow (which would again be shared through DAG) regarding finance and how an ICP may be constructed.

DFL suggested members picked up any issues with CSA or BVI outside the meeting commenting that the one workforce concept was right to do. With many different statutory employers and circumstances this would be difficult however it was important to do the best that could be done to develop the concept.

SMC commented that while agreeing with the principles of treating the workforce with dignity and respect as a process of transition while hearing about the crisis in social care and people not being paid the living wage; there were also advertisements for chief executives with salaries up to £270,000. Financial realities were required asking was this the beginning of a journey or rationalisation over time with an ultimately shrinking workforce. Local government had recently shrunk and there needed to be a collective fairness with all change to be taken forward together.

CSA responded that going forward the organisation would look very different working in partnership with local authorities. A very different model was to be created and the initial agreement was we lift and shift staff, this was the term being used. As the

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	organisation progressed, we would start to see a very different shaped system as we go forward.	
PB/21/65	**C&M sustainability ambition** **Delivering a Net Zero NHS - MoU**	**DSW**
	DSW presented the sustainability ambition arising from the NHS plan. The report for the Cheshire and Merseyside Health Care Partnership emphasised the need for collaboration and partnership. In this environment, both from a transport and an environmental perspective, there was a need to work in collaboration with the local authority to ensure no duplication or reinventing of the wheel. The NHS must achieve consistency across the system and it had been working towards this with the establishment in 2020 of the Greener NHS programme. The programme had set two targets to achieve net zero by 2040 with an ambition for an interim 80% reduction by 2028 – 2032, for emissions under NHS direct control; and for net zero by 2045 with an interim 80% reduction by 2036 - 2039 which included the wider supply chain. Since the emergence of the greener NHS plan in Cheshire and Merseyside compliance had been 100%. There was a huge amount of work ahead. The NHS had played its part in damaging the climate and now had specific targets to work on. A Sustainability Board had been developed. The memorandum of understanding set out the principles of what was to be done as part of the greener NHS plan and some trusts were doing good work independently which needed bringing together for consistency. There were subgroups under the Sustainability Board which included primary care colleagues following negotiations with NHS England to get some backfill money to engage with clinical leads. A specific piece of work was being carried out on single use plastics, waste water, and general energy which included the use of inhalers and this would be discussed at Sustainability Board. Colleagues were being asked to support the memorandum of understanding which would be making the way through trust boards, local authority boards and other relevant boards in order to be fully signed off with all partners in agreement. There was a plan to hold a conference either later in the year or early next year to get into the heart of communities to discuss becoming an anchor institute. This meant giving back in terms of social value, corporate responsibility, and sustainability modelling. A sustainability team was being built across the partnership, making use of and connecting existing resources, which would feed into the Sustainability Board. From a governance perspective there was a need to deliver the ICS green plan which was under construction and would incorporate all of the trust's plans into one coherent green plan that basically spoke back to the memorandum of understanding. There were several opportunities to bring in experts which would help to define the anchor institution's criteria. We would be working with all places to ensure that those places contributed to the plan and any valuable ideas would be pushed forward.	

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	LGI commented that this was really great work, and it was good to see this all coming on board noting that quite a lot of work had taken place in Cheshire West and Chester as well as other places around sustainability. KGR supported what had been said making the link to health inequalities and particularly on air quality noting that there was enough evidence being circulated. It indicated how poor air quality actually affected the development of children and young people, both physically, mentally and their academically ability which were ingredients for some of the health equalities and differences and social experiences that were across the patch. This was an immediate problem and health and well-being started here with us now. IAS supported the work reporting that he had been closely linked to the northwest group and they were really good examples. the inequality agenda was absolutely important. RKU thanked DSW for the presentation which he would share with the Primary Care Forum. Discussion took place around primary care pharmacists and the use of inhalers. PCO reported that she led on inequalities for Wirral and the issue around inhalers with the overuse of salbutamol inhalers being phenomenal. The impact of COVID on that and long-term condition reviews has had an impact and more people had been requesting inhalers rather than having their review, so it all tied in, but the behavioural need for an inhaler in every bag was having an impact. AIR reported on two schemes that were announced the previous week for all pharmacies where they can help people get the best use out of their inhalers. Also, safe disposal so that gases and contaminants can be properly incinerated or properly dealt with. SMC commented that he felt the role at this level was to act as direct agents for changemakers with the change been done through trusts. Externally the NHS could appear as an incredibly wasteful organisation with face masks, rubber gloves, gowns and so on being single use and while there were good reasons for this there were also world class universities on the doorstep and were we being ambitious enough. We needed to engage in proper partnerships with the universities; involve colleagues from a regional level between local government and the NHS to consider traffic movement, procurements and get more ambitious about how we integrate from a net zero perspective. CBA reported that she welcomed the ambition suggesting looking at contracts going forward. **The Board acknowledged, received and supported the Plan and Green Plan MoU as submitted**	**DSW**
PB/21/66	**Chief Officers Update**	**SCU**
	SCU could not attend the meeting due to unforeseen circumstances. DFL agreed to request that SCU write to members outlining the points she would have raised if and as necessary.	

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	ACTION: SCU to write to members with update.	SCU
	Any Other Business	
	There were no items of any other business.	
	Review of the Meeting and Communications from It	
	DFL summarised the points made highlighting the following: • Important external messaging around COVID • Messages to patients about how to access the services • Messages to our populations about how to protect themselves and others going about their lives • Messages about infection prevention and control and population health safety CSA confirmed that Chris Hughes and the team would prepare a briefing after the meeting which would be included in the CONNECT newsletter. DFL thanks attendees for their contribution to the discussion and closed the meeting.	
	Date and time of next meeting: Tuesday 9th November 2021 15.00 – 17.00 pm	

DRAFT

Cheshire and Merseyside
Health and Care Partnership

ICS Development Advisory Group
Thursday 16th September 2021

Attendance

Name	Title
Sheena Cumiskey (SC)	Interim 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
Simon Banks (SBa)	Accountable Officer, NHS Wirral CCG
Fiona Taylor (FT)	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG
Clare Watson (CW)	Accountable Officer, NHS Cheshire CCG
Mark Bakewell (MB)	Chief Finance Officer, NHS Knowsley CCG
Leigh Thompson (LT)	Chief Commissioner, NHS Halton CCG
Paul Satoor (PS)	Chief Executive, Wirral Council
David McCullough (DM)	Principal Democratic and Member Services Officer, Wirral Council
Vicki Shaw (VS)	Head of Legal Services and Deputy Monitoring Officer, Wirral Council
Graham Hodkinson (GH)	Director for Adults' Care and Health, Wirral Council
Daniel Sharples (DS)	Principal Democratic and Member Services Officer, Wirral Council
Jennifer McGovern (JM)	Director of Integrated Commissioning, Cheshire West and Chester Council
Karen McIlwane (KM)	Head of Legal Services and Council Companies, Cheshire West and Chester Council
Nicola Thompson (NT)	Director of Commissioning, Cheshire East Council
Sarah McNulty (SM)	Director of Public Health, Knowsley Council
Steve Porter (SP)	Assistant Executive Director of Health and Social Care Integration, Knowsley Council
Deborah Butcher (DB)	Executive Director for Adult Health and Social Care, Sefton Council
David Cooper (DC)	Chief Finance Officer, NHS Warrington CCG and NHS Halton CCG
Maxine Power (MP)	Director of Quality, Innovation and Improvement, North West Ambulance Service
Linsey Hall (LH)	Partnerships and Integration Manager, Cheshire and Mersey Area, North West Ambulance NHS Trust
Ben Vinter (BV)	ICS Planning – Cheshire and Merseyside

Jonathan Griffiths (JG)	Primary Care Advisor, Cheshire & Merseyside Partnership
Gerald Meehan (GM)	C&M Health and Care Advisor, Cheshire & Merseyside Partnership
Natalia Armes (NA)	Programme Delivery Office Director, Cheshire and Merseyside Partnership
Katie Bromley (KB)	Deputy Lead, Programme Delivery Office, Cheshire and Merseyside Partnership
Jonathan Taylor (JT)	Deputy Director of Communications & Engagement, Cheshire and Merseyside Partnership
Jonathan McShane (JM)	Integrated Care Convener, City & Hackney
Rebecca Gale (RG)	Programme Advisor, Local Government Association
Louise Mort (LM)	Senior Advisor, NHS England and NHS Improvement – North West
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Delyth Curtis	Deputy Chief Executive – Health and Wellbeing, Cheshire West and Chester Council
Ann Marr	Chief Executive, St Helens and Knowsley Teaching Hospitals NHS Trust
Joe Rafferty	Chief Executive, Mersey Care NHS FT
David Parr	Chief Executive, Halton Borough Council
Dianne Johnson	Executive Director of Transition, Cheshire and Merseyside Partnership
Kath O'Dwyer	Chief Executive, St. Helen's Council
Ian Ashworth	Director of Public Health, Cheshire West & Chester Council
Charlotte Walton	Director of Adult Social Care & Commissioning, Cheshire West and Chester Council
Lucy Davies	Deputy Director, NHS Transformation Unit

Minutes

1.	Welcome and introductions
Sarah O'Brien (SO) opened the meeting and thanked colleagues for attending today's DAG and the Whole System Workshop. This builds upon the previous workshop where Health and Wellbeing Boards were highlighted as a topic for further discussion.	

2.	Health and Wellbeing Boards: strengthening their role in the new landscape

The LGA facilitated a workshop on Health and Wellbeing Boards and their role in the new landscape. Presentations were delivered by Jonathan McShane and Jennifer McGovern, followed by a panel discussion with Jonathan, Jennifer and Sarah O'Brien.

3.	Place-based Partnerships

- SO highlighted this agenda item is intended to help all 9 Places in their thinking as we move towards becoming a statutory ICS by April 2022. SO discussed the following points:
    - The core features of Place-based Partnerships have been reviewed considering the White Paper.
    - There have been recent changes in the language used, more specifically around ICP.
    - There is a working group examining a Place assessment framework.
    - Key definitions of ICS, ICP, ICB, Place-based Partnerships and Provider Collaboratives were outlined.
- GH discussed the variety in Place-based arrangements which bring together several elements. GH emphasised the need to acknowledge and consider this in any collaborative work. GH expressed support for the proposed definitions.
- SB expressed support for the proposed definitions and the previous point around collaboration. SB highlighted the different accountabilities at Place level and the importance of considering population health management.
- CW expressed support for the proposed definitions. CW highlighted the need to clarify the relationship between Place-based Provider Collaboratives and Place-based Partnerships.
- LT discussed the "One Halton" branding which has been used for over 4 years. LT emphasised that the interchangeability of language is dependent on the locality. LT highlighted that Provider Collaboratives are being examined in further detail in Halton.
- SC confirmed the conversation around Provider Collaboratives will be continued as part of the design work.
- DB highlighted that work will be required locally around the use of language. In Sefton, Integrated Care Partnerships currently reflect arrangements at Place.
- PS emphasised the need to focus on the residents and what the language means to them.
- FT highlighted the importance of having clear definitions when interacting with the public. FT highlighted the continued uncertainty around Provider Collaboratives and how they interact with Place.
- SC summarised the importance of using language which makes sense to local populations. There was agreement that the term Integrated Care Partnership should be used when discussing the board at an ICS level. Within localities the preferred language is Borough or Place based Partnerships. SC emphasised the importance of having a consistent language.
- SC confirmed that Provider Collaboratives will be discussed at the next DAG on Thursday 30th September. This will be an important part of our system design as we progress in Cheshire and Merseyside.
- SO summarised the guidance on Place governance and identified what is required at a Place level. SO highlighted the stages for Place delegation and Joint Commissioning. The commissioning function review has already defined what will be core functions for Place-based Partnerships. SO highlighted an ICB approach to services for Place depending on the stage of development.
- SO provided an update on the Place assessment framework. This builds upon the work undertaken by Hill Dickinson with all 9 Places. A final proposed framework will be brought back to the DAG on 14th October.
- SO discussed the suggested way forward in terms of integrated and delegated leadership at Place.

- SO summarised that Place is a key component of the emerging ICS and stressed the primacy of Place in improving population outcomes. SO acknowledged the likely variance in development stage between all 9 Places.
- SP questioned whether the ICS Chief Officer would be involved in the appointment of all Place lead roles. SP highlighted the importance of continually developing the relationship between Places and the ICS.
- SO highlighted given that CCGs are being dissolved someone will be required to oversee the health functions which remain at Place.
- The ICS Chief Officer will appoint a Place Director but seek agreement (joint appointment process) from local authority and involve key stakeholders.
- DB discussed the process of taking proposals through the cabinet and questioned whether these would have to be signed off at Place prior to socialising with the cabinet.
- SO suggested all Partners would be required to view proposals simultaneously.
- SC highlighted the ongoing conversations with each Place to understand their current thinking and ensure all Partners are aligned.
- MB questioned how financing, contracting and Place budgets will operate after April 2022. MB emphasised the need to consider any potential challenges and how a structure will be maintained.
- SO highlighted there will be limited change immediately after 1st April 2022. The key focus will be on a safe transition. SO emphasised the focus should be on the population and aligning resources to achieve better outcomes as a system.
- SC highlighted that a cultural change will be required to identify how resources can be deployed for the population to secure better outcomes.
- SB suggested further clarity is required around the role and responsibilities of Place leads.
- SC supported the point that the anticipated accountabilities and delegation of Place leads should be clearly communicated to all parts of the system.
- SO thanked colleagues for their contributions and encouraged individuals to get in touch with any further questions following the session.
- SC highlighted the significant opportunity to make a positive difference as we develop our Place-based arrangements. SC emphasised the great work that is being undertaken and thanked colleagues.

ICS Development Advisory Group
Thursday 30th September 2021

Attendance

Name	Title
Sheena Cumiskey (SC) - Chair	Interim Chief Officer, Cheshire and Merseyside Partnership
Sarah O'Brien (SO)	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Louise Patten (LP)	Director lead – ICS Network & NHS Clinical Commissioners, NHS Confederation
Joe Rafferty (JR)	Chief Executive, Mersey Care NHS FT
Ann Marr (AM)	Chief Executive, St Helens and Knowsley Teaching Hospitals NHS Trust
Clare Duggan (CD)	NW Regional Director of Transformation, NHS E/I
Linda Buckley (LB)	Director of Strategic Transformation, NHSE/I
Kate Abendstern (KA)	Programme Consultant, MHLDC Provider Collaborative
Clare Watson (CW)	Accountable Officer, NHS Cheshire 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
Mark Bakewell (MB)	Chief Finance Officer, NHS Knowsley CCG
Mark Chidgey (MC)	Chief Finance Officer, NHS Wirral CCG
Jennifer McGovern (JM)	Director of Integrated Commissioning, Cheshire West and Chester Council
Lorraine O'Donnell (LDo)	Chief Executive, Cheshire East Council
David Parr (DP)	Chief Executive, Halton Borough Council
Paul Satoor (PS)	Chief Executive, Wirral Council
Graham Hodkinson (GH)	Director for Adults' Care and Health, Wirral Council
Ian Ashworth (IA)	Director of Public Health, Cheshire West & Chester Council
Rachel Cleal (RC)	Director Adult Social Services, St Helens Council
Steve Porter (SP)	Assistant Executive Director of Health and Social Care Integration, Knowsley Council
Mil Vasic (MV)	Strategic Director, People, Halton Borough Council
Linsey Hall (LH)	Partnership and Integration Manager, Cheshire and Mersey Area, North West Ambulance Service NHS Trust
Angela Johnson (AJ)	Programme Manager, Liverpool City Region

Warren Escadale (WE)	Chief Executive, Voluntary Sector North West
Ben Vinter (BV)	ICS Planning – Cheshire and Merseyside
Christine Hughes (CH)	Executive Director of Communications and Engagement, C&M HCP
Katie Bromley (KB)	Deputy Lead, Programme Delivery Office, C&M HCP
Rebecca Gale (RG)	Programme Advisor, Local Government Association
Hannah Hayes (HH)	Policy Officer, NHS Providers
Georgia Butterworth (GB)	Senior Policy Manager, NHS Providers
Lucy Davies (LDa)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Maxine Power	Director of Quality, Innovation and Improvement, North West Ambulance Service
Delyth Curtis	Deputy Chief Executive – Health and Wellbeing, Cheshire West and Chester Council
Charlotte Walton	Director of Adult Social Care & Commissioning, Cheshire West and Chester Council
Kath O'Dwyer	Chief Executive, St. Helen's Council
Steven Broomhead	Chief Executive, Warrington Borough Council
Mark Palethorpe	Accountable Officer, NHS St. Helens CCG
Jonathan Griffiths	Primary Care Advisor, Cheshire & Merseyside Partnership
Simon Banks	Accountable Officer, NHS Wirral CCG
Deborah Butcher	Executive Director for Adult Health and Social Care, Sefton Council

Minutes

1. Welcome and introductions

The chair, Sheena Cumiskey, opened the meeting. SC thanked colleagues for attending the DAG.

No changes required to the minutes of the previous meeting.

2. Minutes & action log

Action 082: ***Linda Charles-Ozuzu to be invited to present on the delegation of commissioning functions.***

To be presented at a future DAG meeting. Action ongoing.

Action 083: ***SO to present the Place Target Operating Model at a future DAG meeting.***

To be presented at a future DAG meeting. Action ongoing.

Action 091: ***CH to feedback on discussions with Healthwatch and present the draft communications strategy.***

Presented during agenda item 6. Action closed.

Action 092: ***DiJ to confirm whether a Local Authority representative can sit on the Joint Committee as an observer.***

David Parr has been confirmed as the Local Authority representative on the Joint Committee. Action closed.

Action 093: ***WE to share learning from Greater Manchester with JL on potential contractual arrangements with the Voluntary Sector.***

WE has shared learning from Greater Manchester with JL. Action closed.

Action 094: ***The Partnership to review the position of CCGs in relation to the 3% salary increase for staff.***

Christine Samosa has confirmed that if people are on agenda for change the increase will have been automatically applied. VSM are not eligible for an increase this year. Action closed.

3.	Current issues

- SC discussed the significant work ongoing to develop the Integrated Care System. This includes preparing for the safe close of CCGs and transfer of functions into the ICS. SC emphasised the importance of remembering the Triple Aim and engaging widely with partners to ensure co-production. SC highlighted the statutory requirements to establish an ICB and ICP. SC acknowledged the significant pressures health and care are currently facing and the need for a collaborative system response.

4.	Provider Collaboratives

- LP presented an overview of Provider Collaboratives and discussed the following additional points:
  - A single organisation is unlikely to solve all system issues. Solutions will be found in Providers working together with a range of partners.
  - COVID-19 has emphasised the benefits of Providers working together.
  - Many types of collaboratives are likely to operate locally, at a system level and regionally.
  - Collaboration will be required between organisations to address specific issues. These could include centralising procurement, forming joint executive committees and forming a group structure to address quality and finance issues, amongst other things.
  - Trusts involved in Provider Collaboratives in other regions have seen significant improvements in quality and finance.
  - In Primary Care, the South West London Alliance have become a consortium of Providers. There is representation at all levels from neighbourhood, to place, to ICS level.
  - There are several ways that responsibilities can be delegated depending on the specific arrangement.
  - There is a strong need for system stewardship and a collective approach to tackling population health issues.
  - A public consultation would still be required if Provider Collaboratives plan to alter their services.
  - The NHS Confederation, LGA and NHS Providers can help to publicise Cheshire and Merseyside achievements.

- AM presented an overview of Provider Collaboratives and made the following additional points:
    - There is a significant opportunity to work together as a system.
    - We need to consider how Primary Care can link into both Provider Collaboratives.
    - Place-based Partnerships are critical to system working.
    - There are significant workforce challenges in recruiting staff across the system. We need to identify more innovative solutions.
    - Services can often be fragmented which makes it challenging for people to navigate the system.

- AM summarised the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST), its key progress to date and vision. AM made the following additional points:
    - The Hospital Cell managed mutual aid during the COVID-19 pandemic. PPE was shared amongst trusts and critical care and elective capacity was identified across the system.
    - Existing networks across trusts are working to improve productivity and quality.

- JR summarised the background, core purpose, progress to date and approach of the Mental Health, Learning Disability and Community (MHLDC) Provider Collaborative. JR made the following additional points:
    - Strong working relationships were developed through the Out of Hospital Cell and COVID-19 pandemic response.
    - Organisations in the MHLDC Provider Collaborative are unique but complement CMAST.
    - Better outcomes were achieved when the physical and behavioural needs of individuals were considered synergistically. This presents a significant opportunity.
    - We need to identify what can be done consistently across the Provider Collaborative to add value in every Place. This could include analytical support or the reduction of unwarranted variation.
    - The MOU will be a live document.
    - Further work is needed to understand how the ICS will lead key programmes with the MHLDC Provider Collaborative providing operational delivery support.
    - Population Health Management will enable a structured approach to ensuring equity.
    - This approach is in addition to Place-based approaches and work.

- IA highlighted the opportunity to tackle health inequalities together through Provider Collaboratives and a Population Health Management approach.
- DP thanked colleagues for the information shared. DP emphasised the importance of having a common understanding across the system. DP highlighted the desire of Local Authorities to be engaged in the development of Provider Collaboratives. DP emphasised the importance of working collaboratively together at Place and adopting a whole system approach. DP discussed the opportunities to address system challenges through joint working. DP questioned whether a Place Provider Collaborative is being considered as an option.
- LP highlighted the significant delay in the publication of guidance on Provider Collaboratives. LP discussed the historic split between Providers and Commissioners and cultural shift required. LP emphasised the opportunity for Places to work with Provider Collaboratives to address the health needs of their local population.
- AM emphasised that both Provider Collaboratives in Cheshire and Merseyside are in the initial stages of their development. AM highlighted that preparation was required in advance of the guidance being published. AM discussed the support required from Places to develop CMAST's long-term priorities. A key focus should be addressing deprivation and health inequalities.
- JR emphasised the majority of work completed to date has been preparatory. There is some work that Provider Collaboratives will have to complete as regulated organisations. JR highlighted the desire to engage with Places and identify solutions at a local level.
- DP emphasised that Places want to co-produce and be involved in this work.

- FT highlighted that Sefton have requested leadership support to understand how relevant parties at Place can work together. FT emphasised the common agenda and opportunity to maximise the benefits of Provider Collaboratives.
- GH thanked colleagues for the information shared. GH highlighted the value of collaboration and opportunity for system working. GH discussed the different priorities of Places and potential challenges that could be created by this variation. GH emphasised the opportunity to develop an approach from the bottom up and ensure this aligns with all 9 Places.
- AD suggested that organisations could be brought together around a common theme. This could cover a regional, borough or neighbourhood level issue.
- PS highlighted the ongoing work in Wirral to establish local connections with the Provider Collaboratives. PC questioned how we can engage the voluntary and third sector who are key to delivering many services.
- LP emphasised that collaboration will still be vital in solving system issues. LP highlighted the importance of involving clinicians and professionals throughout the development of Provider Collaboratives. This will enable better co-ordination of the patient or service user experience. LP emphasised there will always be a need for collaboration with Place.
- AM highlighted the need to bring together best practice and address unwarranted variation.
- JR emphasised that the Cheshire and Merseyside Provider Collaboratives will continue to communicate and work with Places. JR highlighted the significant opportunity to work differently between Places. JR highlighted the need to address significant issues consistently and utilise additional scope available in Places.
- SC highlighted the Triple Aim and collective desire to tackle health inequalities. SC discussed the need to reduce unwarranted variation and address the health needs of our population. SC emphasised the importance of partnership working to achieve better population health outcomes. SC thanked Louise Patten, Ann Marr and Joe Rafferty for their contributions at today's meeting.

5. Update on NW ICS Development Workforce Steering Group

- CW highlighted the current focus of the Group on assurance plans and readiness to operate. The Cheshire and Merseyside action plan has been submitted to the North West Regional office. CW highlighted the main challenge is the contractual elements, particularly for CCG staff.
- CW discussed the local CCG group which has been established to ensure a consistent approach and message across all 9 CCGs. Key communications have been shared amongst all CCG staff.
- CW questioned which time the plans being developed will cover.
- CW confirmed the plans cover the transition of staff from CCGs into the ICS. Different arrangements are being reviewed for Board level staff. CW emphasised the need to ensure continuity of care within the transition plans.
- AD questioned whether future communications and information could be simplified before sharing with staff. AD highlighted the need to ensure structural commitments from the receiving organisation.
- CW confirmed communications will be simplified.
- SO emphasised the ICS have a clear focus on the critical timelines and information required they need to provide as a receiving organisation.

6. Communications Strategy

- CH presented the ICS Communications and Engagement Strategy for 2021/22. CH highlighted the context behind the strategy, discussed the aims and principles of the strategy, explained the stakeholder mapping, and identified key engagement activities. CH emphasised the importance of working with Places and Provider Collaboratives and ensuring all stakeholders are informed.

- SC requested that any feedback or further questions regarding the communications strategy are shared with CH.
- WE questioned who the third sector representative is and offered his support.
- CH welcomed the opportunity to work with WE on the communications strategy.
- SC emphasised the importance of involving the third sector and ensuring all parts of the system are connected.
- WE highlighted that further clarity is needed on the future of the Partnership Assembly. WE emphasised the importance of communicating this with individuals previously invited to the Assembly.
- CH confirmed that further communication is required from the Partnership.

Action 095: *CH to clarify the future of the Partnership Assembly and issue communications regarding this event.*

7.	AOB

No other business was raised.

Summary of actions

Action 095: *CH to clarify the future of the Partnership Assembly and issue communications regarding this event.*

ICS Development Advisory Group
Thursday 14th October 2021

Attendance

Name	Title
Sheena Cumiskey (SC) - Chair	Interim Chief Officer, Cheshire and Merseyside Partnership
Sarah O'Brien (SO)	Executive Director of Strategy & System Development, Cheshire and Merseyside Partnership
Clare Duggan (CD)	NW Regional Director of Transformation, NHS E/I
Linda Buckley (LB)	Managing Director, Cheshire & Merseyside Acute and Specialist Trusts
Jan Ross (JRo)	Chief Executive, The Walton Centre NHS FT
Dianne Johnson (DiJ)	Executive Director of Transition, Cheshire and Merseyside Partnership
Andrew Davies (AD)	Accountable Officer, NHS Warrington CCG and NHS Halton CCG
Jan Ledward (JL)	Accountable Officer, NHS Liverpool CCG
Mark Palethorpe (MP)	Accountable Officer, NHS St. Helens CCG
Simon Banks (SB)	Accountable Officer, NHS Wirral CCG
Amanda Ridge (AR)	Associate Director New Models of Care, NHS Cheshire CCG
Lorraine O'Donnell (LDo)	Chief Executive, Cheshire East Council
Nicola Thompson (NT)	Director of Commissioning, Cheshire East Council
Deborah Butcher (DB)	Executive Director for Adult Health and Social Care, Sefton Council
Graham Hodkinson (GH)	Director for Adults' Care and Health, Wirral Council
Delyth Curtis (DC)	Deputy Chief Executive – Health and Wellbeing, Cheshire West and Chester Council
Steve Porter (SP)	Assistant Executive Director of Health and Social Care Integration, Knowsley Council
Linsey Hall (LH)	Partnership and Integration Manager, Cheshire and Mersey Area, North West Ambulance Service NHS Trust
Angela Johnson (AJ)	Programme Manager, Liverpool City Region
Warren Escadale (WE)	Chief Executive, Voluntary Sector North West
Ben Vinter (BV)	ICS Planning – Cheshire and Merseyside
Christine Hughes (CH)	Executive Director of Communications and Engagement, C&M HCP
Katie Bromley (KB)	Deputy Lead, Programme Delivery Office, C&M HCP

Lucy Davies (LDa)	Deputy Director, NHS Transformation Unit
Sophie Whitham (SW)	Associate Consultant, NHS Transformation Unit

Apologies

Name	Title
Steven Broomhead	Chief Executive, Warrington Borough Council
Kath O'Dwyer	Chief Executive, St. Helen's Council
Charlotte Walton	Director of Adult Social Care & Commissioning, Cheshire West and Chester Council
Joe Rafferty	Chief Executive, Mersey Care NHS FT
David Parr	Chief Executive, Halton Borough Council
Helen Charlesworth-May	Executive Director Adults, Health and Integration, Cheshire East Council
Jennifer McGovern	Director of Integrated Commissioning, Cheshire West and Chester Council
Clare Watson	Accountable Officer, NHS Cheshire CCG
Fiona Taylor	Accountable Officer, NHS South Sefton CCG and NHS Southport & Formby CCG
Jonathan Griffiths	Primary Care Advisor, Cheshire & Merseyside Partnership

Minutes

1. Welcome and introductions

The chair, Sheena Cumiskey, opened the meeting. SC thanked colleagues for attending the DAG.

No changes required to the minutes of the previous meeting.

2. Minutes & action log

Action 082: ***Linda Charles-Ozuzu to be invited to present on the delegation of commissioning functions.***

To be presented at a future DAG meeting. Action ongoing.

Action 083: ***SO to present the Place Target Operating Model at a future DAG meeting.***

Presented during agenda item 4. Action closed.

Action 095: ***CH to clarify the future of the Partnership Assembly and issue communications regarding this event.***

Action ongoing.

3.	Current issues

- SC provided an update on the ICS Development and great progress achieved thus far. SC highlighted the key aims of reducing health inequalities, improving people's care and ensuring the best use of system resources. SC emphasised the importance of remembering wider ambitions when undertaking this work and considering the potential impact on the population.
- SC confirmed the Readiness to Operate has been submitted to the region as an assurance that Cheshire and Merseyside are on track. SC thanked colleagues for their hard work and ongoing contributions. SC discussed the 4 statutory ICS roles guidance which has been released. Further guidance on ICB constitutions will be published shortly. SC acknowledged the importance of safely closing CCGs and transferring the relevant functions into the ICS.
- SC emphasised the importance of individuals and their colleagues prioritising well-being throughout the change process.
- SC confirmed the process of appointing a permanent Chief Officer is underway. SC confirmed that David Flory will continue as Interim Chair through to March 2022.
- CD emphasised the importance of supporting individuals to prioritise their well-being, express their emotions and seek support where necessary.
- SB discussed the various resources and support available for staff. SB emphasised the importance of ensuring compassionate leadership whilst continuing to deliver key system priorities.

4.	Place Development Framework

- SO thanked colleagues for their contributions to this work. SO presented the Place Development Framework and highlighted examples which were previously shared with DAG members.
- SC emphasised the intention for this to be a supportive development framework.
- MP questioned where the emerging Provider Collaboratives will fit into the self-assessment.
- SO highlighted the importance of including Provider Collaborative members in the completion of the framework through Place-based Partnerships.
- SC emphasised the need to consider how Provider Collaboratives can work together at a Place-level to benefit local populations.
- LB confirmed a national Provider Collaborative System Development Framework has been developed. This is currently being completed for Cheshire and Merseyside. LB offered to share this framework with DAG members to ensure alignment between the two assessments.

Action 096: ***LB to share the Provider Collaborative System Development Framework with DAG members once complete.***

- LB highlighted the ongoing Provider Collaborative work with Hill Dickinson where their relationships with Places will be considered. LB emphasised the importance of involving Places throughout any design work.
- DB expressed support for the proposed Place Development Framework.
- SB expressed support for the proposed Place Development Framework.
- DC highlighted ongoing work in Cheshire West and Chester to gather views from Place executive members and ensure a collective response. DC offered to share this approach with DAG members.

Action 097***: DC to share engagement approach with DAG members regarding Place Development Framework.***

- SB emphasised the importance of co-ordination between Provider Collaboratives and Places.
- AR questioned whether specific funding would be delegated based upon this self-assessment.
- SO emphasised this is an assurance tool and specific delegation has not yet been confirmed.
- WE questioned what work is ongoing across the system with Hill Dickinson.

- SO confirmed some Places have chosen to continue working with Hill Dickinson on their governance arrangements.
- AD highlighted positive feedback on the document in supporting the Place development journey.
- SC confirmed the framework was endorsed by DAG members.
- SO confirmed the Place Development Framework and associated excel spreadsheet will be emailed to CCG Accountable Officers and Local Authority Chief Executives following today's DAG for completion. SO agreed to share the framework with the Provider Collaboratives.
- SC highlighted the opportunity to gather the views of system partners and understand what is working well. SC discussed the system development journey required over the next few years. SC thanked LDa for her efforts in developing the framework and those who participated in the Task and Finish Group.

5. Update on NW ICS Development Workforce Steering Group

- SC confirmed there is no specific update on the workforce item from the NW meeting. The next meeting of the C&M Workforce and OD Steering Group will be held on 20/10/2021.

6. AOB

- AD questioned whether further communications will be sent to system partners clarifying the future of the ICS Chair position.
- SC confirmed the recruitment for a permanent ICS Chair will begin again in 2022. David Flory will continue in the post until March 2022 and provide stability for Cheshire and Merseyside. This will enable the continued development of positive working relationships.
- CH emphasised the opportunity for DAG members to communicate these key messages to system partners.
- SB highlighted the significant positive contributions of both the ICS Interim Chair and Chief Executive.

- SO discussed the H2 planning round and thanked colleagues for their contributions. Cheshire and Merseyside were able to submit their plans on time. SO highlighted the need for a continued co-ordinated system effort in the Primary Care response. SO acknowledged the significant task required and emphasised the importance of considering colleagues well-being throughout this period.
- SC confirmed the next DAG meeting will take place on 11th November.

Summary of actions

Action 096: *LB to share the Provider Collaborative System Development Framework with DAG members once complete.*

Action 097*: DC to share engagement approach with DAG members regarding Place Development Framework.*