NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
Formally Approved:	☒

Report to:	**Governing Body**
Meeting Date:	

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 12 January 2021	Time:	2.30pm
Venue:	MS Teams Call		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Dr Fiona Lemmens (FLE)	Chair
Jan Ledward (JLE)	Chief Officer
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Dr Janet Bliss (JBL)	GP/Clinical Vice Chair
Helen Dearden (HDE)	Lay Member for Governance/Non-Clinical Vice Chair
Dr Paula Finnerty (PFI)	GP Director
Gerry Gray (GGR)	Lay Member for Financial Management
Carole Hill (CHI)	Director of Strategy, Communications & Integration
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Sally Houghton (SHO)	Lay Member for Audit
Peter Kirkbride (PKI)	Secondary Care Clinician
Dr Monica Khuraijam (MKH)	GP Director
Jane Lunt (JLU)	Director of Quality, Outcomes & Improvement/Chief Nurse
Cathy Maddaford (CMA)	Non-Executive Nurse/Lay Member
Dr Fiona Ogden-Forde (FOF)	GP Director
Dr David O'Hagan (DOH)	GP Director
Carol Rogers (CRO)	Lay Member for Public & Patient Involvement
Dr Shamim Rose (SRO)	GP Director
Dr Maurice Smith (MSM)	GP Director
In Attendance:	
Matt Ashton (MAS)	Public Health Liverpool
Dr Rob Barnett (RBA)	Liverpool Local Medical Committee
Richard Houghton (RHO)	Corporate Services and Governance Manager
Rachael Kelly (RKE)	Transformation Accountant
Joanne Twist (JTW)	Director of Organisational and People Development
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Stephen Hendry (SHE)	Head of Corporate Services and Governance
Sarah Thwaites (STH)	Health Watch

ISSUES CONSIDERED

2021

A1 WELCOME

1. FLE welcomed all those present noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.
2. FLE informed members that due to the ongoing coronavirus (COVID-19) pandemic, the Governing Body was meeting virtually and an audio recording of the meeting would be available on the web page within three working days of it taking place.

3. Members of the public were able to submit questions to be raised at the meeting for discussion and a response would be emailed to them in due course.
4. Both the question and the response would be circulated to all members and included in the minutes of the meeting.
5. Members were also asked to raise questions by email in advance of the meeting and any questions raised would be discussed as the meeting progressed.
6. FLE took a moment to remember Professor Donal O'Donoghue who was a secondary care clinician on LCCG Governing Body since its formation who sadly passed away the previous week due to Covid19.
7. Professor O'Donoghue was an eminent Renal Specialist both locally and internationally and he was a Consultant Renal Physician at Salford Royal NHS Hospital Trust. He was also a member of the Cheshire and Merseyside Clinical Senate, and held a number of national roles including Inaugural President of the British Renal Society and Director of Kidney Care at the Department of Health between 2006 and 2013. Most recently he was Registrar of the Royal College of Physicians.
8. FLE reported that this really was sad news. Donal had served as the CCG's Governing Body Secondary Care Doctor from the beginning of the CCG in 2013 to 2018, making an invaluable contribution to the NHS in Liverpool, through his wise counsel as a member of the Governing Body and as a powerful advocate for patient involvement, innovation and quality improvement.
9. More than anything Donal would be remembered for his kindness and compassion. His CCG colleagues and friends were immensely grateful that they had the chance to know him and to learn from him. The CCG sent its sincere condolences to his family.
10. On a personal note FLE commented that she had learnt a considerable amount from Donal as both a GB colleague and from the Healthy Liverpool programme working closely with him on the hospital reconfiguration team. As well as being a well-connected, knowledgeable and eminent clinician he was also the loveliest person to work alongside and he would be very sadly missed.
11. Members held a minutes silence to mark Professor O'Donoghue's passing.
12. FLE would be sending a card to Professor O'Donoghue's family to offer condolences and members could forward messages if they wished to be added to the card.

A2 APOLOGIES FOR ABSENCE

13. The apologies for absence received for this meeting are detailed above.

A3 DECLARATIONS OF INTEREST

14. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register.

A4 MINUTES OF THE MEETING HELD ON 10 NOVEMBER 2020

15. The minutes of the meeting held on 10 November 2020 were accepted as an accurate record with the following exceptions:
    a. Page 10 point 88 be amended to read: '…in numbers of referrals and the…'
    b. Page 14 point 123 be amended to read: '…and oxygen monitors were…'

MATTERS ARISING

16. SHO asked about the CCGs representation on the Starting Well Board and how it linked to the response to the SEND examination. JLU responded that regarding SEND the expectation would be that the primary link would be around early identification of young children in the early years who may need additional support, aligning the work of health visitors to different settings such as private, voluntary and independent nurseries as well as those aligned to schools and children's centres. The earlier children who need additional help and support can be identified the better the outcome. The CCG did not play a major role here as there were only a small number of complex children who would need additional input from CCG services and the CCG had links directly or indirectly here.
17. JLE reported that the Starting Well Board was recommended but was still being considered by the Integrated Care Partnership Board (ICPB) as it was a recommendation in a report that had

been to the Health and Wellbeing board but it had not been agreed. A task and finish group was preferred to look at early years in line with planning and this was being reviewed by ICPB. MAS confirmed that the Starting Well Board was not being progressed at this point and it was still under discussion. The TOR suggested a CCG Children's Commissioning Manager may be the representative and more details on the committee would follow once they became available.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the minutes of the previous meeting			
Further actions required: • Amend minutes in line with comments received.	D Richardson	ASAP	Completed

A5 ACTION LOG

18. The action log was discussed with the following points made:

a) Item 1 regarding Health Checks. MAS reported that work was ongoing revising the model although progress had been curtailed considerably by the ongoing pandemic. Pressures on the system meant the April deadline may not be met however it would be monitored and continued. Item ongoing.

b) Item 2 regarding Roche supply issue and disruption to services. JLE raised query with NHSE who reported that there was no expectation for compensation to the NHS however a learning exercise would be undertaken for the disruption caused. Item closed.

c) Item 3, Details of NWAS issues for assurance. JLU stated that a report was going to the next Performance and Quality Committee revisiting links to NWAS quality structure. Work had commenced but had been constrained due to Christmas and the ongoing pandemic. Item remained ongoing.

d) Item 4, completed.

e) Item 5 regarding session for members to explain ratings and GBAF as required. Members commented that the GBAF felt clearer for this meeting and it was suggested this be assessed if the session was still required. Action updated and ongoing.

f) Item 6 clarify status of care homes with regard to COVID19 virtual ward and telehealth hub. MSM reported that work remained ongoing to build care home involvement; care homes had been given oximeters and it was hoped that by the end of the week there would be an agreement in place for a Liverpool specific care home pathway. NHSE was providing pillar 1 and 2 data to CCGs and had agreed this would go to the telehealth digital hub service to identify those patients at risk so hubs could proactively contact them. MSM noted that it was Important to make GP colleagues aware of the provision ~~t~~ so more people could benefit from the service and spot risks in advance for better outcomes. It was important that the service was used. Liverpool was using it but nowhere near the capacity it could cope with. RBA agreed to send a reminder in the daily bulletin. Item ongoing.

g) JBL commented that the guidance suggested remote oximetry testing for over 65s and refer as routine and was this correct. MSM reported that Covid patients should be referred to the oximetry at home service provided through the MerseyCare telehealth hub and they will be contacted the next day by the service. Patients can be triaged into high, medium and low risk although any Covid patient can be referred if there is clinical concern. If a clinician feels a patient cannot wait until the next day to be contacted by the hub they can be supplied with a pulse oximeter by the GP Practice to self-monitor aided by a paper dairy and information sheet. JBL asked how could GPs best utilize the capacity it had and encourage more remote monitoring to have a lower threshold. MSM responded that colleagues shouldn't worry about exceeding capacity; there is still a lack of awareness at this time and GPs should focus on referring all appropriate patients. RBA said he would circulate the referral criteria in relation to telehealth to GPs. This detailed various levels of monitoring and should be straightforward for

people to follow.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Governing Body Action Log			
Further actions required: • Update the action log in line with discussions	D Richardson	ASAP	Completed

A6 COMMITTEE REPORTS

19. FLE brought members attention to the revised agenda format in line with the revised committee structure which aimed to improve the effectiveness and efficiency of Governing Body (GB). Members were asked to direct feedback on the presentation of the committee reports to the Chair. The reports were presented with the committee appendices pack as supporting documentation.
20. CMA delivered the Performance and Quality Committee (PQC) Chairs report from the November meeting noting that the committee alternated with a full formal committee meeting one month and a shorter key business session looking at financial performance and key risks followed by a developmental session which included a deep dive examination of a previously agreed item the following month. The November meeting was the latter version and included a deep dive of Liverpool University Foundation Hospital Trust (LUFHT), Spire Liverpool Hospital (SLH). The meeting covered key business items with financial performance and key risks as detailed in the report. The committee also approved the revised Terms of Reference (TOR). The updated Scheme of Reservation and Delegation (SORD) was also agreed. The deep dive of LUFHT and SLH gave members the opportunity to discuss issues in detail and to triangulate work to date. It was noted that a lot of work had taken place and the committee would continue to monitor performance.
21. MBA commented in respect of the new approach between the GB Agenda and PQC report being noted with a supporting appendix, that he was also conscious there was no structured agenda item to necessarily discuss the detail of the CCGs financial position, particularly given the current deficit position. MBA was happy to take questions and suggested members considered the sequencing of information for future meetings.
22. FLE asked what would happen at the end of the financial year in respect of the deficit, had any guidance been provided regarding what arrangements would be in place? JLE reported that the current arrangements had been extended to the end of March with planning guidance due at the end of January/early February. It was too early to say either way as it would depend how wave 3 of the pandemic evolved with any recovery. The expectation was that the system would return to something similar to what colleagues were used to and some changes made during COVID19 would be kept. It had been a year of transition and some things operated through block contracts with providers which they may want to retain.
23. MBA reported that a national call taking place concurrently which the Deputy Chief Financial Officer was attending and it was hoped more information would be forthcoming from this.
24. FLE asked how difficult the current arrangements had made it to plan for the CCG. MBA replied that the CCG had been working on 3 different scenarios for NHS England; (best, worst, likely models) but it was anticipated that the CCG would have had a challenging year before the impact of COVID19 and that the CCG needed further information from NHSE for next year but would continue to work on a range of requested scenarios in the interim.
25. SHO asked what were the consequences of the CCG holding a deficit at year end

and would there be an impact on the next years funding? MBA replied that there would be a number of consequences both from a reputational perspective which was not what the CCG wanted and would ultimately result in an audit referral even in exceptional circumstances of different financial framework. The CCG was not on its own as the majority of C&M CCGs were in the same position. A deficit would also have a knock on effect for the next financial year and work was underway to understand from NHSE how the gap at a North West level could be managed.

26. SHO delivered the Audit and Risk Committee (ARC) Chairs report for the December 2020 meeting noting that the main thing to highlight was that despite all vicissitudes controls had been maintained. The team had done a really good job enabling the committee to be in the position to give assurance regarding controls.
27. When considering the committee risk register there were several concerns. These were around discharge to assess and discharge planning and were linked to the roles of the local authority, the CCG and the hospitals with reference to the suspension and subsequent reinstatement of CHC and the costs involved and the committee would like assurance there was clarity about the roles.
28. JLU thanked SHO for the opportunity to comment here stating that the area had the potential to be confusing. There is local governance in place for local discharge which is regularly reviewed to ensure the clarity of the flow of information around roles and responsibilities. In addition the capacity and flow groups were linked to the Cheshire and Mersey structure and supported common principles and common ways of working across Cheshire and Mersey which had been helpful. Each local system had varying degrees of difference depending on how they had been set up initially. In March when the first wave was happening a local group was set up in Liverpool which met several times weekly which had since settled to weekly meetings. The group had representation from Mersey Care Foundation Trust (MCFT), the local authority, the commissioning support unit (CSU) and the CCG amongst others. The group agreed standard operating procedures (SOP) for the different functions to enable a common approach to the management of a range of different functions across the whole system. A small number of very complex cases went to the weekly meetings and there was a SOP for this too. The meeting was led by the CCG who maintained oversight ensuring clarity regarding who was responsible for what and where accountability lay. This had worked successfully through the first wave of the pandemic and was continued through capacity and flow meetings since as a good basis to build for the future. There had been ups and downs regarding volumes of patients waiting for discharge as there was always movement within numbers however the system had not been substantially challenged and with the help of the mutual aid offered flow had been maintained.
29. SHO thanked colleagues for attending the External Audit training session delivered that day commenting that it was a sign of how far the Governing Body had come that so many had attended the session.
30. CRO delivered the People and Community Voice Committee (PCVC) Chairs report for the December 2020 meeting reporting that there was nothing specific to escalate.
31. The committee had endorsed the engagement approach for the blood cancer proposal noting the role and responsibilities of the North Mersey CCGs in taking forward and approving this proposal through their governing body's.
32. The Cheshire and Merseyside BAME research programme was noted and it was agreed that the CCG should support this research by sharing local insight and access to community engagement partners. The findings would come back to a future meeting for consideration
33. The committee noted the update on the CCG's Covid engagement and had requested that the full report be brought to the next meeting.
34. FLE commented that she had attended the meeting and found it enjoyable having 'real' stakeholders and public advisors as members which generated a good

discussion.

35. HDE delivered the Remuneration and HR Committee (RemHR) Chairs report for the December 2020 meeting commenting that the report was self-explanatory. HDE liked the new reporting style as it was more informative and helpful and she thanked colleagues for their reports.
36. The structure of RemHR was driven by the work programme with items added on an ad hoc basis should the need arise. There were a number of normal standing items and the last meeting had reviewed its own performance looking at the work plan against the TOR to set plans for the following year.
37. HDE informed members that the approval of a backdated payment referenced in the report was in regard to a calculating error that had been noticed. The amount was very small.
38. GGR delivered the Primary Care Commissioning Committee (PCCC) Chairs report for the December 2020 meeting commenting that the report was self-explanatory and he had nothing further to add and he was in agreement with the previous comments made by Chairs.
39. FLE informed members that the last meeting of PCCC had been struck by COVID19 with Cheryl Mould (Executive Lead for PCCC) involved with vaccination programme across the city at the time.
40. SHO reported that Mersey Internal Audit Agency (MIAA) gave substantial assurance of Primary Care Commissioning finance which was a good result for that committee.
41. PKI reported that there had not been a meeting of Clinical Effectiveness Committee (CEC) since the introduction of the report with the last meeting being held in November 2020 which agreed the revised TOR. A report would be submitted following the next meeting however as there was significant clinical input to CEC it may struggle to be quorate given the situation with the ongoing pandemic.

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

42. JLE presented the Chief Officers Report outlining the following:
    a) The offer of testing services continued and this was now rolled out across the Liverpool city region with significant demand for it. The service was going to be reoriented towards key workers to ensure the economy and the system could continue operating during the pandemic.
    b) Since the last meeting the vaccination programme had commenced with Primary Care Networks (PCN) organized into 11 sites across the city. Some were operational already with all of them expected to be fully operational by the end of the week. Vaccines were being delivered in accordance with the national guidance. Hospitals and MCFT were supporting the programme offering vaccines to staff and over 80s too.
    c) There had been a change in the national policy regarding the timing of the second dose of the Pfizer vaccine to a specific 3 months window between doses. The AstraZeneca vaccine was also available and would continue to be offered to cohorts identified for vaccines in line with the guidance.
    d) A potential mass vaccination site for the City had been identified and was under consideration. There was significant capacity to offer the vaccine once a regular supply was established. As supplies became available a better service could be offered going forward.
    e) JLE reported on the Employee of the Month programme which recognized those staff who had gone over and above normal duties saying all staff do go over and above normal duties particularly this last year and it was nice to recognise this. The scheme had been warmly received across the organisation; colleagues were nominated by their peers and received a certificate and voucher for their efforts.
    f) Current system pressures were COVID19 and winter. The CCG was working closely with providers to increase patient flow, manage pressures and working together to offer support to give the best care it could. Pressures were significant and JLE thanked staff for

their effort and dedication in trying to cope under the extreme circumstances.

g) NHS England published a paper just before Christmas outlining their next steps and what they expected to change regarding Integrated Care Systems (ICS). The ICS Partnership Board had considered the paper as had the system within Liverpool and responded.

h) RBA referred to the mention of the workload with particular attention to those working in Primary Care and General Practice who were now expected to be involved in the delivery of the vaccines stating that assurance was required regarding what the CCG would be expecting from Primary Care and General Practice and they could only do one thing at a time with regard to Local Enhanced Quality Improvement Schemes (LEQIS) and some reassurance for practices would be helpful. JLE stated that the CCG recognized this and a letter was to go out later that week thanking Primary Care colleagues for the work they were doing; the CCG understood the pressures especially with the addition of staff going off with COVID19 either with symptoms or isolating and the CCG was very sympathetic. The situation was about working as a system not expecting people to work harder.

i) JBL queried if there was any data available regarding the volume of patients attending A&E following referral from 111First. DHO responded that the data was not available. The data received regarding referrals from PC24 was broken down into three categories with a 3rd of patient enquiries closed at PC24; a 3rd of enquires sent to EDs and the remaining 3rd sent to other destinations. It was not possible to assess the impact of 111First as EDs could not provide data due to COVID19 pressures. Furthermore, it was unclear if 100% of patients would have gone directly to EDs and there were also patients being taken to EDs directly from NWAS.

j) DHO discussed the differences between 111 and 111First with 111First being ED avoidance and call handlers refer callers to PC24 for assessment and 111 being for primary care.

k) PKI asked if GB would be responding to the quasi consultation referred to in the Chief Officers report to which JLE replied that it was under discussion in the GB development sessions and an update would be included in the report next time for completeness. A collective response would be circulated ahead of the next development session.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Chief Officer report;			
Further actions required: • None identified.			

B2 CHIEF NURSES REPORT

43. JLU presented the Chief Nurses Report drawing attention to the following issues:

a) The report tried to focus on exception reporting and changes since the previous report in line with the revised GB reporting format. In terms of the context for the COVID19 update, since writing and submitting the report things had already changed and moved on. Most relevant were the sickness rates and the impact this was having on primary care with smaller practices taking a proportionally bigger hit. This was a limiting factor in how trusts were responding and informed how trusts had worked in recent days.

b) JLU had been monitoring LUFHT closely over recent weeks and months and the picture was improving. The trust was engaging well with an increased depth to discussion and sharing information so more assurance was gained regarding the concerns. A desktop review of never events had been held the previous week which went well, looking at the organisations safety systems, themes and contributory factors. Work would continue here.

c) The publication of the Ockendon report in December was a key issue for Liverpool Women's Hospital (LWH). The report detailed the outcomes of around 250 reviews from Shrewsbury and Telford but which were pertinent to the whole of the NHS. Work had been undertaken rapidly to implement those recommendations that could be implemented relatively easily to make direct improvements and more was to be done for local maternity services.

d) The management of waiting lists at Alder Hey Hospital (AHH) had been highlighted as a

problem with some patients waiting over 104 weeks for treatment. The trust had employed external expert support to help with this. A key meeting had been held in December to discuss the issues and the CCG had informed the trust of the assurance the CCG required. The Trust had kept the CCG informed of the progress it had made and a follow up meeting was scheduled shortly. A harm review process associated to this was also planned.

e) The CCG were made aware that the Care Quality Commission (CQC) had issued a Section 31 notice to AHH in light of concerns regarding the care of two young people with learning disabilities who were waiting for a tier 4 CAMHS (specialist) placement in the regional unit run by Cheshire Wirral partnership on behalf of the Cheshire Mersey system. The CCG had engaged in the work here and had a panel in place to review the incident reports related to that.

f) There was little to say about MCFT when the report was written however sickness levels had increased here since writing and MCFT had invoked its business continuity plans. Daily sitrep calls took place with all trusts to manage this through mutual aid. NWAS were in a similar situation and experiencing very high sickness levels.

g) It was reported earlier in the year that improvement work was required for Vancouver House and this had been underway in conjunction with the Local Authority however at the end of December a resident had passed away in difficult circumstances and the death was being investigated by the police and had been referred to the coroner. Further details were not available to be shared as there was media interest however the CCG was involved and participating fully with the review.

h) A deep dive exercise of Special Educational Needs and Disabilities (SEND) was underway to assess where the CCG was in relation to this. Work seemed to have stalled on the improvement work around Children in Care which had been challenging so work was underway with AHH and MC to progress this.

i) RBA referred to LWH saying it had come to his attention that there was a plan to move practice based ante-natal care service away from practices asking were the CCG aware of this intention as practices felt this would be a retrograde step and they had concerns regarding the affect this would have on the care that was given.

j) JLU responded that she was not aware of this just that this would link to changes in guidance and policy and LWH had targets to meet and had been looking at models of delivery to achieve this. JLU would pursue this and report to CQPG commenting that the trust should be working with partners and primary care was an important aspect of this, partners should be engaged throughout the process not presented with a finished article. JLU would feedback to the next meeting.

k) CMA stated that the CCG was a corporate parent of children in care and should GB be considering contributing to the ongoing review here? JLU responded that there had been a change recently within the local authority which leads the corporate parenting board with a newly elected member leading the board. The board had been refreshed and reviewed and the CCG was now more engaged with the board. The plan was to take the health performance work that the CCG was accountable for through that board for challenge.

l) The CCG did have a responsibility for the health assessments for looked after children which it wanted to make more visible to take the CCGs role as a corporate parent more seriously. A report was underway to be fed into this board to demonstrate this.

m) JLE suggested the work be linked into GB.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents of the report			
Further actions required: • Pursue LWH delivery model for antenatal care changes via CQPG and report back to next meeting; • Add work for LA Corporate Parenting Board to GB work plan.	J Lunt J Lunt	March 21 March 21	On GB Agenda March 21; On GB Agenda March 21.

B3 PUBLIC HEALTH UPDATE 1.18

44. MAS presented the Public Health Update report stating the following:

a) The detail in the report was slightly outdated and the latest COVID19 infection rates were shared. There had been a really high increase in the number of cases; in October the figure was just under 800 per 100000. The current figure was 1042.3 per 100000.

b) The doubling rate was every 4 days and this had reduced to every 7-8 days so rates may start to plateau. 30% of cases were asymptomatic.

c) If rates did plateau the hospital admissions would plateau in the next 2-3 weeks with death figures 2-3 weeks after that.

d) The virus appeared to be repeating its behavior as in the first wave in that it began in younger people travelling to older people. Rates were very high and would result in hospital admissions, severe illness and deaths.

e) The geographical spread was right across the city with all wards having very high rates. There were more females recorded but this may be due to females being more proactive regarding testing.

f) There was a lot of learning from the smart testing around its roll out; to maximize uptake; and focus the effort along with the learning which could be applied to the roll out of the vaccine programme. It was important to take the lessons learnt from the smart testing pilot and use them to take the city forward from this point; it was an enormous challenge to get the right people vaccinated.

g) MSM commented that a lot of data was available from Combined Intelligence for Population Health Action (CIPHA) which was a Cheshire & Merseyside programme that was launched in response to COVID19. MAS agreed reporting that data was used from CIPHA on a daily basis, reconfigured to a public facing page of information.

h) JBL asked if rates could be compared with the rest of the country given the additional numbers identified despite being asymptomatic due to the lateral flow testing opportunity in the city. MAS responded that rates were 20-25% higher than in the rest of the country and the lateral flow tests were picking up around 1000 cases per week that would have potentially been walking around the city with no symptoms. The cost of the testing was that rates would increase however it was reasonable to assume Liverpool would have a lower admission to hospital which was linked to PCR testing levels.

i) JBL drew attention to 20% of hospitalisations being amongst the under 50 year olds commenting that the rationale for the vaccination programme was to reduce hospital admissions and would this be the case given those figures. MAS stated that conversations were ongoing regarding ability to flex the delivery of vaccines within the overarching guidance as there were conversations in general about younger age groups in hospital. Colleagues were looking clinically at those most likely to spread the virus, those more at risk of death who needed to be vaccinated sooner and more conversations were needed.

j) The population data was from the Office for National Statistics (ONS) adjusted for mid-year.

k) HDE asked if GPs were being asked to identify additional patients who should shield as they were during the previous wave. FLE reported that shielding letters had gone out from the central national system. Colleagues were monitoring patients and would add to the list any patients who became vulnerable but it was being dealt with by the central NHS system.

l) In response to DOH querying who had access to CIPHA along with Graphnet MSM responded that good data governance is essential. Graphnet is a third-party independent software supplier who onboard pseudonymised data. Data sharing agreements are important in setting out the parameters regarding how data sharing is carried out. A process has been established whereby requests for access to CIPHA data go to a Data Access and Asset Group (DAAG). MSM reported that another GP representative on the DAAG commented that they were reassured that data access requests were being handled appropriately.

m) MAS reported that he had submitted a request regarding how the dashboard should look which could then be used as a tool to help to target the vaccination roll out more effectively giving users what they wanted.

n) DOH referred to postal testing asking if anything could be learned from this as it was

referred to in the evaluation lessons learnt slides. MAS reported that the slides were the lessons learned from the roll out of testing which took the approach of taking everything that was being offered and making it fit. An example quoted was that 35 mobile testing units were provided however there was not enough room and only 15-20 units were used. The city was given a supply of postal kits however these were not used so they were removed from the offer.

o) PFI asked if any figures were available on the variant of COVID19 versions in circulation to which MAS responded that according to the data he had seen which was provisional, the Kent variation had been circulating in the city since before Christmas with a 3%, to around 15%, and was now following a rapid escalation at 46% and this was data from sample sequencing of PCR tests so figures were with this caveat. The Kent strain was known to be between 50 and 70% more transmissible. There was no awareness of the South Africa strain as yet.

p) PFI expressed concern regarding the roll out of the vaccine in regard to the difference in health outcomes according to age and deprivation. Those who lived in more affluent areas were healthier than others who were around 20 years younger and lived in less affluent areas. These people and may benefit from what could be learnt from the mass testing experience. It was important for those in deprived areas to get access to healthcare. MAS commented that the COVID19 support line had experienced around 85% of calls from people under 65 who were looking for help and who lived in the most deprived areas of the city. People were being assessed when they called; the difficulty was getting people to call in. There was also the issue of digital exclusion and the city's faith and voluntary sector partners were supporting here.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: That Liverpool CCG: • Works with public health and other LCC and NHS partners to ensure uptake of the testing offer as well as a rapid response to future outbreaks expected in the city as incidence of new infections in the city starts to increase. • Works with LCC to support the needs of our residents affected by the pandemic in Liverpool. • Supports new initiatives and public health programmes around health checks, smoking cessation and mental health support. • Supports the promotion of all public health related communication across the city. • Participates in the development and implementation of the recommendations of the sexual health JSNA for the city of Liverpool.			
Further actions required: • None identified.			

B4 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

45. JTW provided an update on the organisation's Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR), and Issues Log stating that:

a. Although the risk scores had remained static, this did not mean that control measures were ineffective; by their nature, strategic actions to correct course or mitigate risks were achieved over a longer-term period.

b. The corporate risk register remained static too, mostly due to the situation with

the ongoing pandemic.

c. CHI reported that CO56 was to be removed from the corporate risk register and transferred to the PCVC risk register as this was the natural fit for the risk given the detail would be discussed there.

d. SHO sought clarity on the rationale behind the PCVC taking over the One Liverpool risk and CHI responded that it was in regard to the process of change and statutory duties regarding involvement which the committee had oversight of. In the context of PCVC it was about the context of change. Issues would be escalated to GB if the need arose.

e. FLE queried the risk description which stated that the risk would be if the system failed providers and system partners as opposed to patients and the public. CHI stated the risk had been conflated with a number of risks and the component was about processes and statutory responsibilities.

f. FLE asked where the other parts sat, those that were not within PCVC. CHI responded that it may sit with ICS and needed to be considered.

g. SHO commented that her initial question had been was PCVC the right place for the risk to sit but after looking at the committee TOR which included wider engagement it was exactly the place it should sit. PCVC were happy to accept the risk.

h. Discussion took place regarding EU and the risk of no deal with some members suggesting that this risk could be removed since the UK had now exited the EU. JBL suggested perhaps a reduction in the risk score would be better than removal as it was too early to know the outcome of exiting. HDE suggested reducing the risk may not be correct as it was not clear yet how things would evolve. The content of the deal was unknown in some areas as yet.

i. FLE commented that she was hearing nervousness from GB members around reducing the Brexit risk and suggested this was monitored with additional feedback at the next meeting.

j. SHO referred to GBAF02 '*Lack of clarity as to remit of Hospital and Out of Hospital Cells*' responsibility for managing clinical risk of long waits for elective care' noting that the description didn't give the solution to address the risk. JLU reported that work was ongoing with NHSE/I and C&MP to clarify what was required and once this was known the risk would be rewritten.

k. MSM suggested that GBAF04 '*Ensure maximum value from available resources*' was not well articulated and needed to be better put. JLE commented that it was helpful to hear how people read statements the team made and colleagues were learning how to write responses to risks with the knowledge that if financial balance was not achieved then controls could be removed. MBA commented that this had originally been two strategic risks and in an attempt to condense and be specific while still considering the financial risk the resulting statement had probably suffered as a result.

l. HDE suggested that CRR083 regarding phlebotomy capacity should be revisited in light of the vaccine roll out to which DHO responded that the risk position had reduced as the service had been designed to be COVID19 safe. The impact was not known yet however if it became concerning in the future it would be followed up.

m. Some dates on the report were out of date; CRR036 remained static regarding system capacity with DHO advising that there was a balance in the system resilience; entering lockdown improved system resilience as it reduces pressure on hospitals as it is intended to. JLE commented that there was an assurance meeting with NHSE the previous day and it was reported that some risks had to retain their capacity. If they became exhausted they would be reconsidered. FLE had circulated copies of the slides from the meeting to members.

Action	Lead	Timescale	Status

Recommendations approved by the committee, namely: The Governing Body is asked to: • Agree that the risks proposed within the refreshed GBAF for the remainder of the financial year 2020/21 align with the CCG's strategic objectives; • Agrees that the 2020/21 GBAF continues to align appropriate risks, key controls and assurances alongside each strategic objective (noting the change of risk description for GBAF01); • Satisfy itself that current control measures and the progress of associated action plans provide reasonable / significant internal assurances of mitigation, and; • Note the recommendation for Risk CO56 to be removed from the Corporate Risk Register.			
Further actions required: • Transfer CO56 from CRR to PCVC Risk Reg; • Monitor the impact of exiting the EU and feedback to next meeting; • Update GBAF and CRR in line with discussions;	S Hendry; S Hendry; S Hendry;	March 21; March 21; March 21;	On Agenda March 21; On Agenda March 21; On Agenda March 21.

C FOR DECISION

46. There were no items for decision.

D FOR NOTING

D1 COMPLAINTS AND FOI REPORT APRIL – SEPTEMBER 2020

47. JTW presented the Complaints and FoI Report noting the following:
    a) The report covered the period from April 2020 to September 2020. There had been a slight reduction in MP enquiries with no parliamentary questions asked in the period.
    b) There had been a reduction in FOIs but their complexity had increased. The themes were listed within the report; 89 complaints in total; 24 regarding primary care and pharmacy which were redirected. 13 were still open. 2 safeguarding issues were reported.
    c) There was one breach which went over the 20 day time limit to 26 days and this had since been responded to.
    d) Examples of lessons learnt were included in the report and a significant number of complaints were COVID19 related.
    e) HDE remarked that it was well done to the team for managing to keep on top of the enquiries and to respond in a timely fashion.
    f) JLE noted that it was worth the time invested to meet with MPs to reduce the requests for FoI's. Meetings continued regularly with those involved engaging and it was useful to learn from this.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Receive and note the contents of the six monthly summary report.			
Further actions required:			

• None identified.			

D2 OPERATIONAL PLAN UPDATE

48. JLE informed members that DHO would be presenting the Operational Plan since his recent appointment as Director of Transformation Planning & Performance. Members congratulated DHO on his new role.

49. DHO presented the operational plan update highlighting the following:

a) The paper served 2 purposes; one was to give colleagues an insight of the process that had been followed to create the operation plan and the other was for planning for the next year's operational plan.

b) The second part of the report was regarding its impact. There were diagrams covering project stages and governance and final approval would be sought from GB following the full process.

c) The report goes through a prioritisation process with schemes that had previously been funded none recurrently that had not gone ahead being prioritized for next year looking at who will be involved in the process and which groups are affected.

d) The reminder of the report goes through programmes that did not happen due to COVID19.

e) Any group that required providers to make changes which were then prevented due to COVID19 were stopped and would not be taken forward.

f) The report included risks related to those not gone ahead and those that did go ahead as well as listing those which benefited.

g) A stock take review occurred in August and an overview of this was included with the risks of those not going ahead listed too. Safe steps had been incorporated.

h) Prescribing schemes were unable to progress as these would have a financial impact.

i) Some schemes progressed despite COVID19 and some had dates booked for review while others did not. The final page listed mental health schemes with items such as crisis beds which were absolutely necessary.

j) CHI informed members that the operational plan would form a substantive part of the integrated business plan that would come to GB in March 2021. This would be linked with the council and include much more information regarding financial plans, engagement and the refreshed communications plan and these would be framed within a bigger plan for the city. Work was underway to pull this together.

k) CMA asked if there was an appeals process providers could use if their application for funding was not successful to which JLE replied that there was not a bidding process when applying for funding. The CCG worked with providers through the year assessing where investment was required and where better value could be achieved so the CCG was rarely presented with a proposal it didn't know about. DHO added that colleagues did engage with providers to ensure everything was captured and any additional funding requests were looked at on a case by case basis.

l) MBA reported that he tried to move funding around the system in an effective way and the CCG had been fortunate in that it had previously had the resource to invest from delivering investment programmes however this year had been very unusual and it was important to get the message right to providers. There had been no savings made this year and the amount available going forward was not as he would have liked.

m) MSM referred to the language used in some of the risks listed within the document mentioning one in particular which needed clarity. DHO reported that the item referred to a scheme which had started but due to COVID19 the improved outcomes anticipated had not happened.

n) JLE commented that the report was specifically asked for at the last GB meeting noting that the content would usually be within the performance report at least quarterly. The performance will be within the committee appendices for future meetings. The PQC would take assurance that plans were being delivered and the report will include an appendix to show what was or was not being delivered.

Action	Lead	Timescale	Status

Recommendations approved by the committee, namely: The Committee is asked to: • Note current progress of the schemes in the operational plan, including those schemes not progressed. • Note the planning process being enacted for 2021-22			
Further actions required: • None identified.			

E QUESTIONS FROM THE PUBLIC

50. The following question was received from the public in advance of the meeting via email on 4th January 2021.

51. Under the financial planning for the remainder of the financial year Liverpool CCG and the Pan Mersey CCGs will have to break even which will put different financial pressures on individual CCGs as they make their contribution to the balanced budgets at ICS levels. QIPP is how CCG deliver savings including CCG Medicines management prescribing optimisation programs. To what extent will we see an increase in Pan Mersey wide prescribing optimisations programs with individual CCGs contributing differing levels of savings to achieve ICS scale savings for Liverpool CCGs and Pan Mersey?

Liverpool CCG responded:

52. Liverpool CCG continues to work closely with NHS England and Cheshire & Merseyside Health and Care Partnership regarding forecast financial positions in respect of both current future and financial years.

53. With regards to the 20/21 financial year, medicines management initiatives that would normally have formed a significant part of CCG savings plans have understandably not progressed with key staff being redeployed to support front line services and other requirements including vaccination programmes etc. Many of the CCG level and wider system medicines optimisation schemes have subsequently been affected with the exception of some schemes that were already in progress prior to the pandemic to support quality and outcome improvements for patients.

54. The CCG continues to work with relevant partners to review potential initiatives either at a local level, or indeed at a wider system level but will inevitably depend on relative levels of opportunity in each part of the system and what makes sense to work together on in a collaborative basis. We are part of several C&M and regional medicines optimisation groups, working together to share best practice and improvement and apply that where it benefits our local population.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

55. The following items and committee minutes were noted:
    a) Finance report – agreed at Performance and Quality Committee Dec 20;
    b) Performance report –agreed at Performance and Quality Committee Dec 20.
    c) Ratified minutes from the following committees:
        a. Audit and Risk Committee 07/07/2020
        b. Primary Care Commissioning Committee 18/08/2020
        c. Remuneration and HR Committee 15/09/2020
        d. Primary Care Commissioning Committee 20/10/2020

G1 ANY OTHER BUSINESS

56. SHO mentioned GBAF for 2021-22 which needed to be developed. The plan was to progress this within the GBAF development sessions however the some development sessions had been postponed due to COVID19 pressures. FLE noted that the GBAF was important and work on this would continue as soon as possible and hopefully once the immediate pressures were eased.

57. No other items of business were discussed. The meeting closed.