NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	**28 May 2021**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 9 March 2021	Time:	2.30pm
Venue:	MS Teams		

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
In Attendance:	
Matt Ashton (MAS)	Public Health Liverpool
Dr Rob Barnett (RBA)	Liverpool Local Medical Committee
Paul Brant (PBR)	Cabinet Member for Health & Social Care – LCC
Peter Evans (PEV)	Estates Implementation Manager
Stephen Hendry (SHE)	Head of Corporate Services and Governance
Trish Hogan (THO)	Estates and Facilities Manager
Sallyanne Hunter (SHU)	Deputy Head of Corporate Services & Governance
Sarah Thwaites (STH)	Health Watch
Joanne Twist (JTW)	Director of Organisational and People Development
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Dr Maurice Smith (MSM)	GP Director

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 reminded members that 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. The meeting was also being broadcast live enabling members of the public to join online.
4. With this in mind, members were reminded to keep microphones on mute unless they were speaking and to use the 'hands up' facility or chat function to obtain the Chairs attention when they wished to make a comment. The chat was only to be used for business and cameras were permitted if members wished to leave theirs on or they could switch them off if they preferred.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

6. 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 12 JANUARY 2021

7. The minutes of the meeting held on 12 January 2021 were accepted as an accurate record with the following exceptions:
    a. Although not in attendance MSM had provided the following amendments in advance of the meeting: Item 44 points l and m to be amended to: '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'.

A5 ACTION LOG

8. The action log was discussed with the following points made:
    a) Item 1 regarding a Public Health Update: FLE reported that discussions had taken place and colleagues were aware of the need to reinstate the health checks however the pandemic response had overtaken the issue and it had been difficult to progress. Members agreed to close the item aware that LMC had become involved and once progress was made it would return to the meeting for an update.
    b) Item 2 regarding assurance of NWAS issues within the corporate performance report: This item was to be discussed at the April 2021 meeting of Performance and Quality Committee (PQC) and would then come to the May meeting of Governing Body (GB). Item ongoing.
    c) Item 3 Session for GB members regarding Ratings for Risk and GBAF: The item was placed on hold following the NHSE letter advising that all activity be concentrated on the covid19 response and the vaccination programme. As this restriction was being lifted it was agreed that the session be rearranged.
    d) Item 4 regarding the status of care homes and virtual ward and telehealth: The Covid19 telehealth pathway was live in care homes with oximetry at home also available. All actions completed, item to close.
    e) Item 5 regarding changes to the antenatal delivery model in Liverpool Womens Hospital (LWH): This item was complete, LWH have changed the model of delivery and two GB clinicians were involved in the change process. RBA noted that the changes were delayed but not in time for midwives to be moved and it had been carried out without putting patients at the centre of the changes. It would continue to be monitored at CQPG.
    f) Item 6 regarding the Corporate Parenting Board being added to the GB work plan. FLE reported that a draft version of the GB work plan would be circulated shortly and the Corporate Parenting Board was included on the work plan. Item closed.

g) Item 7 regarding transferring CO56 from the Corporate Risk Register (CRR) to the People and Community Voice Committee (PCVC) risk register. Complete, item closed.
h) Item 8 was on the meeting agenda and could be closed as it would be monitored within the CRR.
i) Item 9 update the GBAF and CRR was complete.

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

9. CMA delivered the Performance and Quality Committee (PQC) Chairs report from the January and February meetings noting that there had been one item to be escalated from the January meeting which was the MIAA report on community services and this was on the meeting agenda.
10. The SEND report provided an overview of progress and identified that Liverpool had agreed to take part in the national process led by Ofsted and the Care Quality Commission (CQC) to elicit learning from the response to Covid19.
11. A deep dive of Liverpool Women's Hospital was undertaken and the committee learnt that it needed to consider performance and financial aspects to enable a more rounded view. Financial issues were discussed and reporting continued to reflect the revised financial framework that was in place as a result of Covid19. An update was delivered regarding Alder Hey waiting lists which gave more assurance.
12. The CQC has now published its report on Liverpool University Hospitals Foundation Trust (LUHFT) and a report was received outlining the work Mersey Care Foundation Trust (MCFT) had undertaken to address environmental issues transferring patients in the mental health setting. This would be kept under review.
13. Care home issues and safeguarding were considered and would continue to be.
14. Further guidance regarding 2021-22 contract planning remained outstanding however the team continued to work through the contract and procurement planning issues.
15. The CRR highlighted the impact of the pandemic across the board.
16. At this point FLE invited MBA to highlight any key financial headlines in view of financial uncertainties noting that details of finance reporting were contained with the appendices of the committee papers.
17. MBA delivered key headlines noting that the framework and the financial allocations were very different for the 20- 21 year due to the Covid19 pandemic.
18. Based on the reporting period up to month 10 (January) the forecast deficit was improving with the position now down to £3M from £8M at M7. The CCG was hopeful to be able to report break even by month 11 and was similar to all CCGs in Cheshire and Merseyside.
19. This safeguarded the cumulative surplus position and helped with the year end audit and accounts processes. There had been some variances against months 7 to 12 plans and details of this were included in the report.
20. SHO asked for clarity regarding references to system level targets included within the report. MB responded that for months 7-12 each system was given an overall envelope and was required to achieve a break even position. Each organisation (CCG and provider) within Cheshire and Merseyside were given financial targets to reach which met the Cheshire and Merseyside position. The work referenced locally was to try to bring the CCG back to an even position before the end of the financial

year. SHO commented that she wasn't sure what the CCGs contribution to the overall target was but it was clear now.

21. HDE raised two queries asking how the revised approach to procurement activity and not having to put contracts out for tender moving forward would impact for the next 12 months with particular emphasis on the move towards an integrated care system (ICS); Also with the move towards finance and performance being more disciplined to enable a more rounded view from committees to facilitate learning from this, was there any general learning for other committees to apply?
22. CMA responded that a paper on quality had identified issues the Trusts were recognizing at the time and when this was discussed it highlighted performance issues linked to questions around finance and these needed to be triangulated as the information was interrelated and impacted on each aspect. In the future the committee would look at the three areas to consider the impact each had on the other. It was anticipated that moving forward with this approach would identify further learning and how to progress this along with what other information may be needed such as public and patient perception and other sources of information for a deep dive.
23. MBA informed members that more detail regarding legislation changes as the move towards an ICS was yet to be released. In the meantime the CCG was looking at its own plan to see what changes it needed to make. There were not many at that point and this would be monitored as more information became available.
24. JLE noted that language often used may not always be clear to the general public and 'system' referred to Cheshire and Merseyside 'place' referred to Liverpool and so balancing the system referred to Cheshire Merseyside and the CCG had statutory requirements to meet within its own objectives.
25. FLE noted that the PQC meeting had extended to three hours monthly due to the weighty agenda reminding the PQC Chair to escalate any matters that may be unmanageable and to consider building in a comfort break commenting that the committee operated well under her leadership.
26. SHO delivered the Audit and Risk Committee (ARC) Chairs report for the February 2021 meeting noting a strange year overall for audit with the external audit of the last years accounts carried out remotely and activity carried out remotely stating that it was a tribute to CCG staff that they had managed to keep governance at the forefront of its agenda and not just maintaining governance but moving it forward too.
27. The CCG had received a number of 'high' assurance audit reports rating in finance systems and processes and also EPRR was rated high assurance. Mersey Internal Audit Agency (MIAA) sent out briefings and checklists to which the CCG had stood up well against all criteria listed. It had been a good year for the CCG in governance although challenges remained. Key dates were noted for the submission of the annual report and accounts noting that an additional meeting of GB would be required in June with members asked to be aware of this as quoracy must be achieved.
28. FLE thanked SHO for the reminder and passed on congratulations to all teams involved noting that as Chair of audit SHO was to be commended for achieving this.
29. CRO delivered the People and Community Voice Committee (PCVC) Chairs report for the February 2021 meeting reporting that there were no items to escalate and the February meeting had been a single item meeting due to the majority of members being heavily involved in the vaccination programme.
30. The meeting was timely in being focused on the vaccination programme and the approach to reaching different BAME groups. There was good attendance and engagement from lay attendees on the committee noting that the CCGs role was to connect with key partners and providers, this included Liverpool City Council (LCC) who were delivering a campaign to encourage BAME groups to take up the vaccine offer, sharing information with PCNs ensuring the information was available in other formats. A discussion took place which resulted in a commitment, and confirmation

to work together to harness community capacity to engage with community groups which was a key action in representing those groups in the design and inclusion of more inclusive practices moving forward.

31. The committee agreed the plan for engagement and an approach to ensure a high uptake of the vaccine within BAME communities.
32. PBR expressed his thanks to primary care providers and to the CCG generally for the work carried out to date and the close partnership in dealing with vaccine hesitancy in working to resolve lower vaccine take up in some areas. It was key to overcome the effects of Covid19 which had fallen disproportionately on those communities.
33. One to one communication was overwhelmingly the key reason their fears were overcome along with speaking to key people namely the GPs. PBR stated that the local authority did not want to lose this close working relationship.
34. DOH commented that it was not just BAME groups that were under represented at different levels; there were often difficulties identifying different groups in society and colleagues needed to consider all groups who might find it difficult to access services and consider all groups as much as possible.
35. FLE reflected that it was a good meeting of a relatively new committee and the public made significant contributions some of which made the CCG squirm and challenged its thinking around its approach to BAME populations and any assumptions the CCG might have been making. The CCG used the umbrella term BAME and was aware of differences amongst the groupings and was now getting better data.
36. PKI delivered a report on the Clinical Effectiveness Committee for the first time noting the committee was established immediately prior to the pandemic, meeting once in shadow form during 2020 prior to being stood down during the first wave of the pandemic. The committee met once again in November 2020 and the January meeting was stood down following instructions from NHSE to concentrate all efforts on the Covid19 response and vaccination programme.
37. The committee was due to meet later in March 2021 to discuss the terms of reference for Clinical Forum which would impact the terms of reference for the committee.
38. GGR delivered the Primary Care Commissioning Committee (PCCC) Chairs report for the February 2021 meeting commenting that finance continued as forecasted with the Additional Roles Reimbursement Scheme (ARRS) being a key risk as the CCG could potentially lose funding if it did not have a full take up this year however another review was in place to encourage take up.
39. Performance against targets continued to be impacted by Covid19 although the vaccination programme had been praiseworthy with the committee recognizing the success of that programme.
40. One item for approval was the sale and leaseback arrangements for GP practices. It was noted that the requirement to allow this process was confusing over rules in place with questions raised over the reasoning behind the requests. One request was approved while further information was sought regarding the other.
41. RBA asked if any further information had come to light regarding the outstanding request to which DHO responded that a definitive answer had not yet been received. When a response was given DHO would report directly to RBA. RBA reported that the confusion was regarding the different lease types.
42. DOH asked was the CCG able to identify how PCNs could take up the ARRS funding to which MBA responded that the scheme was quite rigid. In previous years the funding could be allocated but this was not the case this year with unspent funding being clawed back. NHSE have been contacted for clarification and this would be fed back to colleagues once it was received.
43. MBA went on to report that correspondence had been received regarding the lease situation and the practice was now satisfied with the arrangements agreed.
44. FLE commented that it was unfortunate that clinical directors had their attention

pulled elsewhere over recent months resulting in this situation. DOH suggested preparing job descriptions for support roles which could be relatively easily amended to incorporate duties to avoid this situation in future to which FLE responded that the LNA (Liverpool Network Alliance) was looking at this moving forward.

45. SHO asked if there was a role for the CCG to disseminate good practice across PCNs considering how learning disability health checks had been heavily impacted with practice resources diverted elsewhere during the pandemic response.
46. RBA stated that colleagues needed to interpret the learning disability health check data carefully. Where practices had only one learning disability patient they could easily achieve 100% returns whereas those with 100 patients would find it more difficult to achieve 100%. Practices strive to provide the health checks but this had to be considered amongst everything else the practices were performing. Trying to get health checks completed within the particular time frame was difficult to balance.
47. DHO supported those comments noting that the CCG had contacted those with nil returns offering support.
48. FOF reported that the performance report gave evidence that there was a 3-month lag on health checks and the situation was better than was believed. There was still room for improvement but it was better than the figures showed.
49. STH noted that the health checks were a good tool providing they were used in a meaningful fashion, practices would be better taking time to obtain better results and not driven by data.

A7 COMMITTEE ANNUAL REPORTS

50. It was noted that the PQC annual report was discussed at Audit and Risk Committee and was not for discussion at this meeting. If members wished to make any comments they could do so in matters arising.
51. SHO delivered the ARC annual report noting that GB specifically delegated oversight and responsibility for the annual report and accounts and annual governance statement (AGS) to ARC. The report takes GB through the structure of the committee with work undertaken throughout the year. It was noted that it had been a strange year due to the pandemic however a full programme of work had been completed, sufficient to support the AGS.

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

52. JLE presented the Chief Officers Report noting the following:
    a) Usually at this time of year the report thanked colleagues for coping with winter pressures however this year huge thanks go to the whole system for coping not just with winter pressures but also the vaccination programme, and Covid19 response which had an unprecedented demand. Thanks go to the whole system; social care; primary care; community services; mental health and our acute colleagues too.
    b) It was pleasing to note that close to 160,000 people in the city had received the first vaccination and 7500 people had received the second vaccination last week, this was over 90% of people over 70 years old with huge thanks to all involved.
    c) Guidance had not been received from NHSE regarding confirmation of allocations to enable the development of the operational plan, it was hoped that this would be ready for the May meeting.
    d) Members were reminded of the Governments intention to subsume CCGs within the proposed ICS systems subject to government agreeing to the statutory changes proposed.
    e) The proposal strengthens the requirement for systems and providers to collaborate, it recommends the health services safety and investigatory body becomes a statutory department. There are changes to NHS procurement legislation regarding competitive tendering along with changes to the role of the competition and markets authority in

reviewing mergers of NHS Trusts. These were significant and broad changes to the health and social care act and more details had not been promoted yet.

f) The CCG was commending this to GB for reference and to reflect the likelihood of the CCG only having another 12 months left to operate as an organisation in this format.

g) Over the coming 12 months the CCG needed to work closely with the ICS to take on functions in the development of the new organisation. This would be discussed further in the GB development sessions as more information became available.

h) RBA commented that there was real concern as to the void likely to be left when the CCG went. If members did not make sure there was something effective in operation between PCNs, the ICS, and GP practices, how would the system function adequately and effectively? During the pandemic it had become apparent that the need for good effective management support was vital and where would that come from in a years time?

i) JLE responded that the expectation was that a significant proportion of the work currently being carried out would be retained; it was not known how yet and this would be worked through to assure as much as possible of what was in place is kept at place.

j) STH spoke from a patient point of view noting that if it was hard for members to understand the changes proposed how would the public perceive this; how would they have any influence? There was a real lack of clarity how this would be done; what would or wouldn't be included; and how it was based on their needs and not a national instruction.

k) JLE replied that the CCG would be happy to work together to support communities and voluntary organisations in sharing the message and was willing to have a conversation outside the meeting to discuss the matter further.

l) FLE noted the concern shared by the CCG which was particularly disappointing given the progress made with PCVC. When more is known regarding what the structure would be within place the intention was to continue with what the CCG had previously planned as much as possible.

m) DOH commented that there was a lot to read however not a lot of information within the proposal, there was nothing more than the word 'place' with no description of what that meant. There was reference to local authority and the census and local elections however very little further information and a concerning amount missing which needed to be provided before any progress could be made to have the system in place by April 2022. No extra budget had been provided to oversee the implementation of the changes whatever they might be and the changes were meant to be in place by April 2022. Routine guidance had been delayed already this year due to the pandemic so it was unlikely that the guidance for the proposals would be available on time given they had to be discussed in parliament.

n) PBR reminded colleagues that resource allocation was predicated on census numbers and it was important people completed it. PBR went on to say that it was important not to lose the very good working relationship between the local authority and the CCG whereby colleagues had the ability to pick up the phone and share information without having a blame culture. It was hoped that under the new system the ability for this was not lost. CCGs were created to be locally accountable organisations covering the health system holistically looking at trusts as well as community and primary care and there were good aspects focussing on primary interventions and this should not be lost in the new organisation given the scale involved.

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

B2 CHIEF NURSES REPORT

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

a) The CCG responded to the NHSE letter in January regarding the stopping of non-essential meetings due to Covid-19 3rd wave locally by reducing quality surveillance

activity and supporting trusts to focus on the key issues that would support the system in terms of infection prevention and control (IPC). Trusts were written to recently to be informed that the usual regular activity was about to be stepped back up again.

b) Mersey Care Foundation Trust (MCFT) had been under enhanced surveillance since the acquisition of Liverpool Community Health (LCH) in April 2018. A recommendation would go to quality and surveillance group next month to step down to routine surveillance. This was due to the service running safely as would be expected. In several months MCFT would acquire North West Boroughs (NWB) and so would return to an enhanced surveillance position. Lifting the enhanced surveillance now would enable MCFT to rebalance in readiness for the next acquisition.

c) There had been some movement of services in MCFT with the Star unit moving to Byron Ward in NWB. This was managed effectively and the transfer of patients occurred without problem, the CCG continued to have oversight of this with Halton CCG via the quality handover. There were issues regarding the Star unit which the CCG was fully aware of prior to the acquisition of NWB.

d) With regard to the CCGs governance and improvement work there was a huge overlap between what was reported in the Chief Nurse Report (CNR) at GB and what was reported to PQC and so it was noted that the CNR would no longer be presented to GB with any escalations coming via the relevant committees.

e) PFI asked how the move to Byron ward for learning disability patients which involved a relocation from Liverpool to Warrington impacted on families, asking if the distance raised concerns with families? Furthermore, with the acquisition of NWB by MCFT, once acquired would MCFT enter enhanced surveillance again and what would be the likely impact on quality issues?

f) JLU responded that the Star unit provided services to patients from both Liverpool and Sefton and these were moved to the Warrington site. No concerns were raised that the CCG had been made aware of and it was not clear yet if the move was a long-term solution or temporary as the previous environment became unfit and time was limited. Regarding the acquisition of NWB JLE reported that any acquisition was a time of risk with organisations taking on different cultures, different staff, new environments etc. and MCFT knew it needed to stop what was in place to start over again and it was working closely with NHSE to plan what the service would look like as it moved forward.

g) FOF referred to LocSSIPs (Local Safety Standards for Invasive Procedures) in relation to Liverpool Women's Hospital (LWH) and the reference to Serious Incidents (SI) and never events within the CNR asking if there was a way that trusts could share the learning across in order to learn from each other? JLU responded that this had been suggested and would continue to be as it would be easier to follow a process rather than develop a new one however some trusts struggle to adhere to the processes.

h) RBA enquired about the status of the named GP for safeguarding as the post was currently vacant and was informed that the post was to be replaced with an advert out at the time of writing. The intention was to have two individuals covering 4 sessions each.

i) STH commented that in the longer term moves such as the Star unit to Byron ward should be a planned decision considering all people affected and reflecting on the assessed decision. Priorities may differ for different families and the decision needed to be balanced.

j) SRO noted that Byron ward was in a beautiful location with a well thought out calm environment stating that she felt families would be happy to have their loved ones there. It was a good move for patients.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents of the report • Note this will be the final Chief Nurse Report in this format			
Further actions required: • None identified			

B3 PUBLIC HEALTH UPDATE

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

a) Since providing the report there was good news with the up to date infection rate at 57 per 100,000. This was much improved from the report and it was hoped this would continue as schools returned. Hospital pressures were reducing helped with lower rates in the over 60s age groups and outbreaks would need to be responded to as the city opened up further.

b) While it was good that infection rates were low this was unlikely to continue and the data had to be watched to see what the pressure would translate into.

c) The report included information regarding the impact of Covid19 on life expectancy with a fall of 2.4 years. It was unusual to see a reduction and this illustrated the challenge of being faced with over 1000 Covid19 deaths in the city alongside the increased morbidity which would manifest over time. Some areas were less or more affected than others with the Princes Park area being the worst affected. It was important to focus on vulnerable groups and that the city built on its recovery with a relentless focus needed on health and well being particularly on those communities that need the most help and support to build in equalities.

d) Testing continued via a framework of testing centres, employers, community, schools, care home etc. with community testing to be refocused to reach the populations that most need access.

e) With regard to the vaccination programme support was being given to the CCG around the inequalities strategy with the programme going very well. There was a need to encourage uptake in all groups and a campaign was being developed with C&M to encourage this.

f) The health protection board had met weekly throughout the pandemic and this had been a useful mechanism to allow key partners to come together to work on rebuilding the plan for Covid19 and reviewing the outbreak control plan. The CCG was part of the health protection board and their contribution was valued. The longevity of the board was under discussion and whether the health protection board become a subgroup of the health and wellbeing board would be useful to continue when discussing ways forward.

g) Liverpool City Council had developed 10 recovery pledges which included 'Well Liverpool'. This was an important pledge around the impact of Covid19 on communities including long-covid, mental health, inequalities, service recovery and so on. CCG membership had been requested on the Well Liverpool working group.

h) The public health annual report would tell the story of the pandemic and would be presented to GB at a future meeting.

i) STH remarked that it was encouraging to see the focus on inequalities and it should be made a top priorities particularly with the shocking death rate in the city, STH was happy to support here where possible.

j) PFI also noted the shocking reduction in life expectancy along with the increase in premature deaths and the mortality rate which was 87% higher than the rest of the country noting that colleagues needed to be mindful of these statistics when making decisions. PFI asked who collated the vaccination data as there was limited information available.

k) JLE responded that the vaccine data was heavily restricted by NHSE, more data was given to bronze level colleagues but this could not be published.

l) PKI asked for reassurance on the number of hospital admissions noting that the figure seemed high still asking as the figures were reducing in community were hospital admissions reducing too? In response MAS replied that the length of stay was longer during this wave and patients were younger and so the pressures on hospitals were coming down but were still high. This would continue to be monitored as the high uptake of vaccinations amongst older age groups may result in more younger people being hospitalised, also younger people tended to be less likely to have the vaccine and more likely to be socializing when restrictions eased.

m) JBL asked how quickly life expectancy was likely to be reversed given the excess death rate was mainly due to Covid19 to which MAS responded that it was not going to be quick as the impact of Covid19 was likely to be felt for a long time to come. There would be the impact from mental health issues, the vaccine rollout and hesitancy amongst some groups. Work was underway regarding vaccine hesitancy with issues including ability to

access the vaccine, beliefs, importance to individuals personally, myths about fertility and so on. A large scale communications campaign may not be the answer here and more progress may be made using personal relationships and family links.

n) DOH thanked MAS and the team for all they were doing asking as the Well Liverpool initiative was launched what was being done to ensure digital exclusion was not exacerbated. MAS responded that this was a great question and colleagues needed to think about how accessibility works stating that the answer was not clear yet and that digital exclusion had been an issue throughout the pandemic.

o) RBA reported that at that point there were just under 130 patients in LUFHT with Covid19 and 15 in critical care.

p) CMA remarked that it was good to see that only 17% of Covid19 deaths in Liverpool were from care homes compared to the 24% nationally asking was there any learning to be shared here. MAS responded that practice had been shared already, working with the CCG on IPC and with care home providers to put measures in place, testing residents and staff ensuring safe visiting protecting residents and staff. All learning was fed into the national care home working group and included within the guidance however there would always be good care homes and other that needed to do more. Care home settings required a relentless focus on quality and despite the best efforts sometimes infections still occurred.

q) PFI noted the reduction in deaths from respiratory disease with very little flu cases around and the difficulty to come in autumn with immunity reduced. MAS reported that there was a concern that next year the challenge may be flu and there was a need to build on the vaccine programme to ensure the roll out of the flu vaccine. It was difficult to build on the previous instance when there was none and this was to be considered for the flu vaccine next time.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: That Liverpool CCG: • That Liverpool CCG Governing Body note the information contained in the report. • That the Liverpool Public Health Epidemiology team to continue to monitor the epidemiologic situation in a timely manner and alert the Liverpool system on any changes. • That Liverpool CCG Governing Body and Liverpool City Council work proactively to reduce health inequalities by identifying and addressing barriers to access and uptake of vaccination in the operational design and implementation of the programme as well as ensuring that effective and transparent data systems are in place to monitor uptake and support the development of locally sensitive approaches. • That Liverpool CCG GB works with LCC to support the needs of our residents affected by the pandemic in Liverpool. Preventative and recovery measures need to be targeted to address the health needs of those who are disadvantaged by deprivation and by the direct and indirect impact of the pandemic.			

• That Liverpool CCG GB supports new initiatives and public health programmes around mental health support.			
Further actions required: • None identified.			

B4 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

55. SHE provided an update on the organisation's Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR), and Issues Log stating that:
    a. Although it had been an unprecedented year where it could influence there had been progression. The internal audit had progressed however closing down the GBAF this year would be difficult. Some controls were in place although there was a lack of external assurance which was affecting some assurance ratings.
    b. Setting up the GBAF within a 6-month period had been difficult.
    c. A GB development session to map the GBAF for 2021-22 had been postponed and the corporate governance team had a lot of work to complete by April to develop the new plan. Added to this the CCG was entering a year of transition with the set back of health inequalities. It was important to get the objectives right and this was difficult with a lack of description regarding what place would look like.
    d. To progress this a survey would be sent out to members for a response.
    e. FLE commented that this would be picked up in the development session in order to begin the conversation.
    f. RBA commented that changes in structure within both the CCG and the ICS had been alluded to and all of this depended on having a workforce in place in March 2022. Reorganisation created uncertainty so what was the CCG doing to engage the workforce?
    g. JLE reported that regular engagement sessions were being held and she had retained the open door sessions albeit virtually, however the best way to engage staff was to engage them in the process which the CCG was doing with a joint working agenda with the local authority describing very positively what it could do. The CCG understood the situation and would continue to support staff and keep delivering a positive message. Work continued to happen and people still wanted to work and to be part of a successful team.
    h. JTW reported that the HR framework would follow and this would support the transition in the lead up to March 2022.
    i. SHE commented that there had been no changes to the corporate risk register in terms of additions however one risk was recommended for removal regarding phlebotomy capacity. This was planned to be stepped down to committee risk register level.
    j. Discussion took place regarding EU exit and it was agreed that this would stay on the register until daily reporting was stopped. There had been no reported issues within the timeframe.
    k. Risk CO56 listed in the report cover sheet referred to CO83 not CO56.
    l. MAS suggested an entry regarding life expectancy in light of the impact of Covid19 particularly on vulnerable groups be listed on the risk register. SHE agreed to include it on the GBAF also for the following year.

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 CO83 to be removed from the Corporate Risk Register.			
Further actions required: • Add entry regarding life expectancy in light of the impact of Covid19 particularly on vulnerable groups to GBAF for 2020-21 and 2021-22.	S Hendry	May 21	On GB May 21 agenda

C FOR DECISION

C1 JOINT COMMITTEE OF CHESHIRE & MERSEYSIDE CLINICAL COMMISSIONING GROUPS

56. JLE delivered a proposal to join the committee of Cheshire and Merseyside clinical commissioning groups noting that there would be a requirement to support the ICS throughout the year from a CCG perspective in making collective decisions for the ICS as the CCG was the statutory body and the ICS was not and would not be until April 2022. In the interim a mechanism needed to be in place to enable decisions to be made collectively.
57. Members were informed that they needed to agree that they would allow the Joint Committee to be formed, then what it could make decisions on, then its membership. The paper had been to the other CCGs and had received support with caveats regarding what could and could not be done.
58. JBL asked how members could ensure local needs were being met particularly in regard to mental health services and when considering the population needs for Cheshire and Merseyside they were very different and the aim was not to widen health inequalities so how was this going to be considered?
59. FLE noted the comments reporting that they would be fed back as at that point there were more questions than answers.
60. FOF asked if members were being asked to approve something which was already mandated or was this more about how the paper was written to which JLE responded that it was not mandated but it was a requirement for the ICS to establish a joint committee in order to become an ICS. There were a number of CCGs in Cheshire and Merseyside and it was recognized that this was not an easy request.
61. FLE noted the tension in retaining statutory responsibility in the final year before the CCG was disbanded.
62. RBA commented that it was important that the meetings were held in public however there was a difference in attending as a member of the public and in attending and participating as a member of the LMC and perhaps the membership should be considered within the Terms of Reference.
63. JLE recognized the membership issue noting that it was the same for Healthwatch and other organisations noting that it would have to consider how business was conducted. The decision to delegate to the committee would reflect how business would be conducted.
64. MBA commented that the purpose of the Joint Committee was to make binding decisions on behalf of the population it served and from a finance point of view it was not clear if decisions made for Cheshire and Merseyside determined who would contribute what and this needed more work. JLE agreed that more detail had to be

worked through with finance being the first issue needing to be addressed and what resource was available to the joint committee to make this happen.

65. SRO commented that if the CCG chose not to become part of the Joint Committee and withdrew it may become a time-consuming process for the last 12 months of the CCGs operation. JLE agreed saying there needed to be some reality about the situation.
66. DOH suggested 12 months was an optimistic interpretation and it was important to build flexibility around this timeframe.
67. FLE agreed noting that members had to bear in mind that the committee may be in existence for longer than the stated 12 months. The situation was that the CCG had been given a choice that was not really a choice but more a strong direction of travel with the white paper and the expectation from NHSE was that the CCG would comply. The CCG would agree to this as it was the right thing to do for the population the CCG served and it gave the ability to influence the system. There were significant issues with the proposed work plan and no issues with the principles proposed.
68. The first principle proposed was that the service required a critical mass beyond a local place to deliver safe, high quality and sustainable services. When applied to some areas within the workplan for example mental health, crisis services and psychological services did not require a critical mass at Cheshire and Merseyside level and was critical to the local population and warranted a Liverpool specific offer. Some services fit the economies of scale while others did not and these should come out of the work plan.
69. HDE stated that she could not comment on the work plan as this needed clinical input although the principles seemed fine. More detail was required including how the funding would flow through the system and what the governance would be. Who sits on the committee was key and it could be problematic if too many people were involved which was a difficulty with so many organisations joining up quickly.
70. FLE asked members to forward any comments for inclusion.
71. JLE reported that proposed membership on the committee would include an Accountable Officer (AO) from each CCG and she was not necessarily in agreement with that. CCGs enjoyed clinical leadership and a range of skills around the table and this had been raised with the working group. Suggestions would be put forward if members wished to make any. JLE suggested that as a minimum it should include either the Chief Finance Officer (CFO) or the AO and a clinical representative.
72. FLE stated that there was an additional question regarding lay representation. There is a collaborative commissioning forum for the 9 CCGs involved and this was a topic for discussion there, colleagues can send suggestions in to JLE or FLE in the interim.
73. CRO stated that it was crucial to have clinical and lay member representation on the committee noting that the value of this had been demonstrated at place level. The difficulty was in having a diverse membership representing all involved.
74. SHO commented that it was crucial to include lay membership to consider governance and accountability issues as they were the issues that were difficult to resolve and that was the strength of lay members.
75. JLE asked members if she suggested to the working group that of the 9 CCGs involved there should be a mix of AOs and CFOs as the executive representation and approximately 5 clinicians and 4 lay members from across the 9 CCGs and this would give 2 representatives from each CCG.
76. PKI asked what would happen if the CCG did not agree to which FLE responded that in conversations with Alan Yates he had indicated that full membership was not required to progress through to an ICS. The overall direction was not up for debate so it was not in the interests of the population not to be engaged. Following this route allowed some influence in future governance arrangements.
77. Members agreed to approve the proposal that Liverpool CCG would join the Cheshire and Merseyside CCGs Joint Committee with the caveats discussed. Members did not approve the scale and scope of the delegation of decision making set out in the proposal and would like it discussed further. Members agree to the principles but did not agree to the suggestion around crisis and place-based arrangements and these were not felt to be justifiable to Cheshire and Merseyside level.
78. Members did not agree to the composition of the Joint Committee membership and CCG

representation; preferring to submit the suggestions proposed by JLE and discussed today.

79. Members were encouraged to send comments regarding the Terms of Reference, which would be approved by the newly formed Cheshire and Merseyside CCGs Joint Committee to FLE and JLE.

80. JLE reported that there was one more CCG yet to make its decision. JLE would write to CCG AOs and Jackie Bene informing them of the discussion and what was agreed at this GB meeting after discussion at the fortnightly AO meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the proposal that Liverpool CCG would join the Cheshire and Merseyside CCGs Joint Committee; • Approve the scale and scope of the delegation of decision making set out in the proposal; • Approve the composition of the Joint Committee membership and CCG representation; • Comment on the Terms of Reference, which would be approved by the newly formed Cheshire and Merseyside CCGs Joint Committee.			
Further actions required: • Feedback comments regarding proposals to JLE and FLE; • Feedback comments regarding joint committee to working group as discussed.	All JLE	ASAP May 21	On GB May 21 agenda; On GB May 21 agenda.

C2 HIGHLY COMPLEX INDIVIDUAL PLACEMENTS

81. VAT asked members to approve the intention to implement standard NHS Contracts for highly complex patient and Learning Disability (LD) placements, which would incorporate the standard NHS approach to inflationary uplifts.

82. The CCG had recently received a small number of requests for cost inflation increases to care packages for highly complex patient placements, which reflected increased overhead cost charges, such as the National Living Wage (NLW), food and utilities etc.

83. Whilst the CCG had historically aligned routine care fee uplifts with the Local Authority (LA) annual fee review approach, this had meant any provider whose fees exceeded the highest LA rates did not receive any uplift.

84. There was concern that the LA approach did not fully recognise the complexity of the more complex CCG care placements and therefore an alternative approach to fee uplifts was required.

85. Additionally, it had been recognised that there was a need to formalise contractual arrangements for highly complex patient packages of care, by moving them on to NHS Standard Contracts, which would in future mean that there was a standard NHS approach to inflationary cost uplifts.

86. In advance of the new contractual arrangements being formalised, there was a need to have an agreed approach for current uplift requests and therefore it was proposed that the same NHS standard inflation mechanism was used.

87. Implementing the new contracts and inflationary uplift approach would have financial implications for the CCG with a potential pressure of up to £64k this financial year. However, it was considered appropriate that providers received nationally calculated uplifts to fees where true additional costs were being incurred.

88. There are risks to the CCG not agreeing a fee uplift position including the potential threat to terminate the placement which would be detrimental to patients and the CCG reputation; a potential legal challenge as the CCG did not appear to have an agreed

mechanism for inflationary uplift for highly complex patients; and potential difficulty in sourcing future placements if Providers felt they would not be treated fairly.

89. Therefore, it was appropriate to seek a consistent solution to deal with fee increase requests for complex placements and treat all providers equitably.

90. FLE sought clarification on whether the uplift would be awarded only if providers requested it and the response was that this was not the case. Providers with contracts in place would be eligible automatically for the uplift and would be awarded it.

91. FOF commented that she recognised the care provided was highly complex while asking if other CCGs were taking this approach too? VAT replied that the question had not been asked however larger providers had contracts in place and would be used to this approach. Providers could request a fee change if it was in relation to a change in patient needs. JLU commented that given the size and complexity of the population there would be a number of smaller CCGs that would not experience this.

92. HDE asked was the plan for going forward only or would it include retrospective requests for the 2020-21 year to which VAT responded that a number of requested had been received prior to Christmas and there would be a part year affect for some providers.

93. Members agreed to approve the intention to implement standard NHS Contracts for highly complex patient and LD placements.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the intention to implement standard NHS Contracts for highly complex patient and LD placements, which will incorporate the standard NHS approach to inflationary uplifts.			
Further actions required: • None identified.			

D FOR NOTING

D1 COMMUNITY SERVICES REVIEW

94. JLU presented the Community Services Review for noting informing members that the action plan included actions from a review by MIAA as well as the Capsticks and Kirkup reviews.

95. Although the Kirkup and Capsticks reviews were carried out from a community trust perspective the learning from these reviews could also be applied to the CCG as an organisation. Although the findings listed within the report were comprehensive it was noted that more work had been undertaken and the evidence of this had been discussed in the business of the meeting and the impact of the changes that had been made as a result of this.

96. The Kirkup review was not yet complete and a second review was due to take place once the Covid19 situation had settled further. The work will continue to focus on harm to staff and patients. Changes had been made to the local system within MCFT however with the acquisition of NWB the CCG would be monitoring the situation to ensure the correct amount of surveillance was in place and how the system embedded as much of the learning as possible.

97. A lot of work had been undertaken internally however there was more to be done. This was difficult given the uncertainty regarding future changes.

98. FLE commented that the report pulled the changes together well with CMA noting that the report was discussed at PQC and one question raised was whether or not Governing Body was satisfied with PQC to have oversight of future actions from this review or should it be redirected to Governing Body.

99. JBL reflected that the events discussed took place during the last major reorganisation

of the NHS and it was about to embark on another reorganisation when members felt they had only just matured and learnt from the previous one. How could the learning from the last reorganisation be passed on to the next organisation?

100. FLE responded that this was a great question and one that had moved colleagues into a good discussion about governance and what the CCG had learnt and tried to pass on. JLE agreed stating that it was a reflection on colleagues ability to listen and learn which was significant, there is a danger that when people are busy they can stop listening and it was hard to continue being ambitious for improvement. JLE asked colleagues to not forget the experience of the transition since the harm continued and was exacerbated. Staff should be actively encouraged and supported to speak freely and whistle blow if necessary noting that the second review will remind colleagues how shocking this situation was. FLE echoed the comments stating that it was beholden on members to move on while sharing the experience and the learning.

101. SHO suggested in response to CMA that PQC retains oversight of the action plan following discussion at the MCFT quality committees, bringing back any concerns as part of the PQC report. FLE agreed noting that the way the committee worked gave the opportunity to discuss the detail within the action plan which was important.

102. CMA thanked colleagues for the response which provided clarity in what the expectation was for the PQC.

103. DOH clarified that this also provided clarity for auditors.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the activity to date; • Note the impact upon the CCG's internal governance; • Note the further work planned in order to further embed the work.			
Further actions required: • None identified.			

E QUESTIONS FROM THE PUBLIC

104. None received.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

105. The following items and committee minutes were noted:
   a) Corporate Performance report – agreed at Performance and Quality Committee February 2021.
   b) Finance report – agreed at Performance and Quality Committee February 2021.
   c) Ratified minutes from the following committees:
      a. Audit and Risk Committee - 22/09/2020 and 08/12/2020.
      b. Clinical Effectiveness Committee - 18/02/2020.
      c. People and Community Voice Committee – 18/08/2020; 09/10/2020 and 04/12/2020.
      d. Performance and Quality committee – 25/08/2020; 22/09/2020; 27/10/2020; 24/11/2020; and 22/12/2020.
      e. Primary Care Commissioning Committee - 15/12/2020.
      f. Remuneration and HR Committee – 16/06/2020 and 27/10/2020.

G1 ANY OTHER BUSINESS

106. RBA asked what was happening in terms of provision for eating disorders locally to which JLE responded that eating disorders did not feature on the Mental Health Investment Standard unfortunately, however it was a waiting list issue and the CCG was aware that it needed to be addressed and it could lead to serious issues for vulnerable people and it was being picked up within the mental health team.

107. FLE responded that there was a focus on elective recovery which seemed to have an emphasis on patients requiring surgery when recovery needed to include all services and this was to be raised with the out of hospital cell.

108. PFI asked if colleagues had any idea how long the mutual aid to support recovery would remain in place to which JLE responded that this was unknown although it was anticipated that it would continue at least while the command and control structure remained in place and perhaps the ICS may continue some elements of it.

109. JBL reported that eating disorder services was discussed at the monthly quality meetings and mitigating actions were in place and these were being monitored. The area was specialized and struggled to fill vacancies which had lead to delays prior to the pandemic which had increased the demand for services.

110. RBA voiced concerns that GPs within the community were trying to manage patients almost on their own with limited support available. Patients needed twice weekly tests and GPs were not able to interpret subtle changes which meant there were no adequate provisions in place. This was a serious issue as well as a worrying issue for families

111. JBL replied that the service was psychology led to which RBA responded that in his opinion a safety net was not in place and the service was not managing patients properly.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the comments raised			
Further actions required: • Ensure OOH cell discussed all recovery activity not just surgery.	F Lemmens	May 21	On GB May 21 agenda.

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