NHS LIVERPOOL CLINICAL COMMISSIONING GROUP

GOVERNING BODY

Minutes of meeting held on TUESDAY 11TH APRIL 2017
2.30pm
BOARDROOM, LIVERPOOL CCG, THE DEPARTMENT

PRESENT:

VOTING MEMBERS:

Dr Nadim Fazlani	Chair/GP
Katherine Sheerin	Chief Officer
Prof Maureen Williams	Lay Member – Governance/Deputy Chair
Dr Fiona Ogden-Forde	GP
Tom Jackson	Chief Finance Officer
Dave Antrobus	Lay Member – Patient Engagement
Dr Monica Khuraijam	GP
Dr Maurice Smith	GP
Dr Shamim Rose	GP
Jane Lunt	Head of Quality/Chief Nurse
Dr Janet Bliss	GP
Dr Donal O'Donoghue	Secondary Care Doctor

NON VOTING MEMBERS:

Paul Brant	Cabinet Member for Health & Adult Social Care, Liverpool City Council
Sandra Davies	Director of Public Health
Dr Paula Finnerty	GP – North Locality Chair

IN ATTENDANCE:

Ian Davies	Chief Operating Officer
Cheryl Mould	Primary Care Programme Director
Samih Kalakeche	Director of Adult Services & Health, Liverpool City Council

Dyanne Aspinall	Programme Director Integrated Commissioning – Health & Social Care
Tony Woods	Healthy Liverpool Programme Director - Community Services & Digital Care
Carole Hill	Healthy Liverpool Integrated Programme Director
Mark Bakewell	Deputy Chief Finance Officer
Lynn Collins	Chair of Healthwatch
Paula Jones	Committee Secretary/Minutes

OBSERVING :

Sally Houghton	Lay Member for Audit/Financial Management

APOLOGIES:

Dr Fiona Lemmens	GP
Dr Rosie Kaur	GP
Moira Cain	Practice Nurse
Dr Simon Bowers	GP/Clinical Vice Chair
Dr Jamie Hampson	GP Matchworks Locality
Dr Rob Barnett	LMC Secretary
Tina Atkins	Practice Manager
Derek Rothwell	Head of Contracting, Performance & Business Intelligence

Public: 17

PART 1: INTRODUCTIONS & APOLOGIES

Introductions were made for the benefit of the members of the public present and the Governing Body members/attendees present introduced themselves. The Chair emphasised that this was a private meeting held in public with the opportunity for questions at the end of the agenda. Questions could be submitted by the public in advance of the meeting for a response to be prepared. There was an opportunity at the end of the agenda for succinct questions from the floor which would be answered as far

as was possible in the time available. As a small number of the public members present refused to wait until the section on the agenda for questions from the public, the Chair suspended the meeting until the members of the public present agreed to behave in accordance the protocols published on the website for a private meeting held in public.

When the meeting reconvened the Chair publically thanked the Director for Adult Health & social Care for Liverpool City Council for his contribution to the Governing Body and the health economy of Liverpool over the past ten years as he was now moving out of the post and moving on to other challenges. In the interim the post would be filled by the current Programme Director for Integrated Commissioning – Health & social Care.

The Chair also welcomed the newly appointed third Lay Member for Audit/Financial Management who would take up her post formally from 9th May 2017 and was observing the meeting.

The Lay Member for Governance/Deputy Chair noted that this was the first meeting since the ratification of the changes to the Constitution by NHS England which had changed the quorum requirement to nine voting members of which the majority needed to be clinicians rather than GPs and confirmed that the meeting was quorate.

1.1 DECLARATIONS OF INTEREST

There were no declarations of interest made specific to the agenda.

1.2 MINUTES & ACTION POINTS FROM THE LAST MEETING

The minutes of the previous meeting on 14th March 2017 were agreed as an accurate record of the discussions that had taken place subject to the following amendment:

- Item 2.1 Feedback from Committees, feedback from the Audit Risk & Scrutiny Committee, second bullet, the second sentence should end after Looked After Children followed by a new sentence reading “Improvements are required in a number of areas”.

1.3 MATTERS ARISING from 14th March 2017 not already on the agenda:

1.3.1 Action Point One – it was noted that the Equality Objectives for 2017/18 were to be brought to a future Governing Body meeting.

1.3.2 Action Point Two – it was noted that the Better Care Fund guidance being incorporated into an addendum to the Operational Plan for 2017/18 was in hand.

1.3.3 Action Point Three – it was noted that monitoring information on the Armed Forces Covenant was to be brought to the August 2017 Governing Body meeting.

PART 2: UPDATES

2.1 Feedback from committees – Report No GB 25-17:

- Primary Care Commissioning Committee 21st March 2017 – the Lay Member for Patient Engagement/Committee Chair fed back to the Governing Body:

  - ✓ Primary Care Support Services: there had been some improvement and a letter had been sent to the Chair of the NHS England Audit Committee who had agreed to meet with representatives from the CCG and senior management from Capita, hopefully this would take place around the end of May.

  - ✓ Transformation of Primary Care and Prescribing Budgets: these areas were closely monitored.

- Finance Procurement & Contracting Committee 28th March 2017 – the Chief Finance Officer fed back to the Governing Body:

- ✓ The updated Interim Provider Policy was discussed and approved.

- ✓ Delivery of the financial position for 2016/17 was discussed and would be discussed later on the Governing Body agenda.

- ✓ Operational Financial Plan update for 2017/18 and 2018/19 was discussed and was also on the Governing Body agenda for later.

- Quality Safety & Outcomes Committee 4th April 2017 – the Lay Member for Patient Engagement/Committee Chair fed back to the Governing Body:

  - ✓ Safeguarding quarterly report was presented by the Safeguarding Service – it was disappointing to note that the performance of two trusts in meeting safeguarding requirements had deteriorated and a contract performance notice was to be issued to Mersey Care.

  - ✓ Mersey Internal Audit Agency report on Patient Experience was presented – the CCG was judged as providing "limited assurance" re the visibility of its commitment to patient experience and an action plan was in place.

  - ✓ Continuing Healthcare: the CCG was working with the Commissioning Support Unit to achieve quality and Quality, Innovation, Productivity and Prevention ('QIPP') savings.

The NHS Liverpool CCG Governing Body:

- **Considered the reports and recommendations from the Committees.**

2.2 Feedback from Liverpool Safeguarding Children Board – 29th March 2017 - Report No GB 26-17

The Chief Nurse/Head of Quality updated the Governing Body on the Liverpool Safeguarding Children's Board on 29th March 2017:

- Alternative Education Provision now involved over 500 young people. An action plan was in place to work with Liverpool Community Health and Public Health to identify a clear pathway for this cohort.

- Liverpool Suicide Review – the review had been undertaken due to the number of deaths from suicide in young people, this was fully consistent with the national picture and half day stakeholder event had focussed on the challenges with provision of Tier 3 and 4 Children and Adolescents Mental Health Services. Work was ongoing with the Children's Team to investigate and was on the agenda for the Health Sub-Group of the Safeguarding Children Board.

- Safeguarding Children with Disabilities: a national working group report was tabled which identified an inconsistent picture across the Local Safeguarding Boards related to SEND Ofsted requirements. Work was underway to ensure compliance in Liverpool with SEND Ofsted requirements.

The NHS Liverpool CCG Governing Body:

- **Considered the reports and recommendations from Liverpool Safeguarding Children's Board.**

2.3 Chief Officer's Update

The Chief Officer updated the Governing Body:

- Liverpool Community Health Transaction Process – NHS Improvement had stopped the transaction of all services to Bridgewater NHS Trust. The Chief Executive and the Chair of Alder Hey NHS Trust had been appointed to caretake 'Liverpool Community Health' whilst a longer term solution was found. The CCG would work closely with NHS Improvement and other commissioners on the existing community model. Aintree and the Royal Liverpool Hospital would be part of the interim arrangements.

- CCG Joint Working – a paper had been discussed at the March 2017 Governing Body meeting on the proposed merger for Liverpool, South Sefton and Southport & Formby CCGs and approved at all the relevant Governing Bodies. During April we would be working together on the process for merger including confirming the level of support from NHS England and Local Authorities.

- As mentioned at the beginning of the meeting the Director of Adult Services & Health, Liverpool City Council was moving on to pastures new and the Programme Director Integrated Commissioning – Health & Social Care had been appointed to his role on an interim basis. The CCG and the Local Authority had always had an extremely good relationship and the work of the Director of Adult Services and Health had been instrumental in this.

- The CCG had been awarded the Health & Wellbeing Charter recognising its commitment to the health and wellbeing of its workforce and was very proud to be one of only three CCGs in the country to achieve this.

The NHS Liverpool CCG Governing Body:

- **Noted the Chief Officer's update**

2.4 Public Health Update - Verbal

The Director of Public Health updated the Governing Body:

.

- ✓ Public Health England had launched a pilot Alerting System regarding the new psychoactive substances (e.g**.** Spice). The situation in Liverpool was not as severe as that of Manchester but health professionals needed to be aware of how to deal with patients who used these substances.

- ✓ Data was being gathered on the return on investment for prevention.

- ✓ Public Health England Exercise Nurse Champion role – to promote physical activity in all clinical pathways.

- ✓ Memorandum of Understanding for Public Health support to the CCG – the action plan for 2016/17 was being evaluated and would be brought back to the Governing Body.

- ✓ Next phase of the Sugar Cube Campaign planned for May 2017 – a pre-launch was planned with a school poster competition in the Liverpool Echo, more information would be given to the Governing Body when available.

The NHS Liverpool CCG Governing Body:

- **Noted the Verbal Update.**

2.5 Feedback from Health & Wellbeing Board - Verbal

The Chair fed back to the Governing Body on the recent Health & Wellbeing Board on 23rd March 2017:

- There had been a presentation on the Local Delivery System from the Liverpool CCG Healthy Liverpool Integrated Programme Director.

- There had been a presentation on how the three Local Authorities could work together from the Director of Adult Services & Health Liverpool City Council. The Clinical Lead for Physical Activity continued that Liverpool had the ambition to be the most active city in the country by 2021. Physical activity was to be embedded into health and social care and a computer code to be found for EMIS. The Fit For Me campaign had reached over 100,000 people. The city had had over £22m of capital investment in the area of physical activity and was actually a European leader in engaging with multiple partners for physical activity and sport. Liverpool was now 6th in the core cities (previously last) for people doing 30 minutes of exercise per week which was a great credit to the work of the Liverpool CCG Living Well – Physical Activity Programme Lead and the Liverpool City Council Senior Project Manager. It was noted that Fit For Me was an exemplar project.

- The tri-partite arrangements for social care across the three Local Authorities of Liverpool, Knowsley and Sefton were discussed. It was highlighted that this mirrored the Local Delivery System.

The NHS Liverpool CCG Governing Body:

- **Noted the Verbal Update.**

PART 3: PERFORMANCE

3.1 Finance Update February 2017 – Month 11 – Report No GB 27-17

The Deputy Chief Finance Officer presented the summary of the CCG's financial performance for February 2017 (Month 11) to the Governing Body.

He highlighted:

- The CCG was on track to deliver NHS England Business Rules of 2% surplus (1% surplus plus 1% held in reserves as non-recurrent headroom) equating to £16.4m.

- 2016/17 Financial Recovery Plans Phase two savings were planned at £7.4m but only £1.5m reported by month 11.

- Cash target for February 2017 had not been achieved due to large sum of money being received on the last day of the month with no corresponding invoice information.

- Better Payment Practice Code target was achieved for payment of 95% of all creditors within 30 days of receipt of invoices.

The Chief Officer asked how confident we could about the month 11 performance not changing significantly for month 12. The Deputy Chief Finance Officer confirmed that the Finance Team were currently working on month 12 and all was on track. The Chair thanked the Finance Team for their hard work.

The NHS Liverpool CCG Governing Body:

- **Noted the current financial position and risks associated with delivery of the forecast outturn position.**

- **Noted the stated assumptions regarding proposed recovery solutions to deliver the required business rules based on current forecast outturn assumptions.**

3.2 CCG Corporate Performance Report April 2017 – Report No GB 28-17

The Chief Operating Officer presented the Corporate Performance Report to the Governing Body on the areas of the CCG's performance in terms of its delivery of key NHS Constitutional measures, quality standards/performance and financial targets for January 2017 and February 2017.

He highlighted:

- Diagnostic waiting times had improved with the 1% target of patients waiting six weeks or more for a diagnostic test being exceeded with performance at 0.75% for February 2017 compared with 2.67% in January 2017. There was steady improvement at the Royal Liverpool Hospital and Aintree Hospital although they were still individually failing the target.

- Referral to Treatment: 18 week 92% of patients on non-emergency pathways not waiting in excess of 18 weeks from referral to treatment had been missed narrowly at 90.1%. Trauma & Orthopaedics, General Surgery and Ophthtalmolgy were problem areas. A number of control measures were in place for the Royal Liverpool Hospital who were looking at adding private capacity for Trauma & Orthopaedics. Work was ongoing with the Business Intelligence Team to look at the data from the Royal and Aintree for signs of deterioration. The shift of focus in NHS England to A&E and Cancer waits meant that there was reduced

pressure the CCG could apply to providers re Referral to Treatment targets.

- Cancer Wait Times: the CCG had achieved six out of the nine cancer standards in January 2017. However a very small number of patients with complex scenarios had affected achievement of the remaining nine standards which were narrowly failed (% of patients receiving subsequent treatment within 31 days for drugs and radiotherapy and % of patients receiving first definitive treatment within two months).

- Ambulance Response Times: year to date Red 1 target was being met but in February 2017 all the Red targets were narrowly missed but were above the North West performance. The trend was Green.

- A&E Wait Times: the target for four hour waits was missed with a downward trajectory. The control measures in place were around improving patient flow through the hospital system:

  - Putting in place a comprehensive front-door primary care streaming within A&E departments by October 2017, in line with the nationally mandated model;
  - Ensuring implementation of the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary;
  - Increasing the number of 111 calls receiving clinical assessment, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this;
  - Strengthening support to Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment to avoid inappropriate hospital attendance or admission.

- Good performance around Early Intervention in Psychosis but with a slight dip in performance for

February 2017 as a small number of patients have had a significant impact.

- Improving Access to Psychological Therapies performance continued to be challenged. There had been some progress on reducing patient waiting lists for assessment.

- Mixed Sex Accommodation – there had been a further breach reported during February 2017 at Liverpool Heart & Chest Hospital due to the usual problems of critical care necessity.

The Head of Quality/Chief Nurse continued:

- Year to date there had eleven reported incidences of MRSA assigned to Liverpool CCG against a zero tolerance target. There was a relationship between outbreaks of healthcare acquired infections and periods of intense activity in the hospital sector such as the winter period. The Post Infection Review process provided feedback into the system to support the work on a pro active approach to patient flow.

- There were nine new cases of C Difficile reported in February 2017 against a monthly plan of eleven. Work was continuing with Public Health England and Local Authority Public Health re reducing incidences. MRSA and C Difficile were reported to the Quality Safety & Outcomes Committee along with other types of healthcare acquired infections which were becoming more prevalent.

The Chief Operating Officer continued:

- The Care Quality Commission had re-inspected Dr P L Gupta's practice with an overall rating of "Good" awarded.

The Governing Body members commented as follows:

- A GP member referred to the reference on page of 273 patients being removed from the general surgery case lists. It was confirmed that this was achieved by good

housekeeping/wait list management. The same GP Member asked about A&E wait times, the Chief Operating Officer responded that Liverpool was performing on a par with other parts of the country even though not achieving the targets due no doubt to the work of GP practices and community providers which was bearing fruit.

- The Lay Member for Patient Engagement asked about the Care Quality Commission inspections of General Practice and how all practices had fared. The Primary Care Programme Director responded that two practices remained to be inspected. Of those inspected two were awarded "Outstanding" and the rest were awarded "Good" which was a very positive reflection of primary care in the city.

- The Healthwatch Chair referred to a Listening Event to be held for A&E Departments and would feedback any patient views expressed as part of this.

The NHS Liverpool CCG Governing Body:

- **Noted the performance of the CCG in the delivery of key national performance indicators and the recovery actions taken to improve performance;**
- **Determined the level of assurances given in terms of mitigating actions where risks to CCG strategic objectives are highlighted.**

PART 4: STRATEGY & COMMISSIONING

4.1 Operational Financial Plan Update 2017/18 and 2018/19 Financial Years – Report No GB 29-17

The Chief Finance Officer presented a paper to the Governing Body providing an update on the operational financial plans in respect of delivering the required CCG financial position for the 2017/18 and 2018/19 financial years in line with NHS England Planning Rules. It included the relevant resource, expenditure and Cash Releasing Efficiency Savings ('CRES') required to achieve these Rules.

It followed on from the paper presented to the March 2017 Governing Body meeting. He highlighted:

- CCGs were required to deliver a minimum cumulative 1% underspend in 2017/18 and 2018/19.

- All CCGs were required to aim for an 'in-year' breakeven position, with expectations set for the minimum level of improvement in deficit CCGs;

- As in previous years, CCGs should plan for 1% non-recurrent spend with an amendment to the commitments within these expenditure plans as per below:

  - 0.5% to be uncommitted and held as risk reserve (see above).

  - 0.5% immediately available for CCGs to spend non recurrently, to support transformation and change implied by Sustainability and Transformation Plans ('STPs').

- As was the case for 2016/17 and previous years, CCGs should also plan for 0.5% contingency to manage their in-year pressures and risks.

- In 2016/17 Liverpool CCG had achieved a cumulative surplus of 2% which provided the start point for 2017/18. The surplus would then increase from £16.4m to £20.6m should the same treatment be applied in 2017/18 as in 2016/17. The cumulative surplus using the same methodology for 2018/19 would be £25m.

- Expenditure for 2017/18 for programmes was estimated at £869.5k and when Business Rules requirements of non recurrent headroom, running costs and contingency resulted in a deficit of £25m before CRES assumptions were applied. Efficiency savings had been identified in 2016/17 which would impact on 2017/18 but there remained an £8m financial gap to be filled. Additional savings had been identified for 2017/18 following a review of discretionary spend by

the Governing Body which still left a gap of £1.5m of as yet unidentified savings. However this was felt to be manageable. Spending was segmented into Pot A (Business Rules/Acting as One), Pot B (demand led activity) and Pot C (Discretionary Spend).

- Better Care Fund – this was not a budget in itself rather contained a number of budget areas. The minimum contribution was £39m but the CCG baseline would be in excess of this.

- Running Cost Allowance: for Liverpool CCG this was £10.5m.

The Head of Quality/Chief Nurse thanked the Chief Finance Officer for the presentation of complex issues in a clear and understandable format.

The NHS Liverpool CCG Governing Body:

- **Noted the Resource & Expenditure Assumptions in respective financial years.**
- **Noted the implications of the delivery of 'Business Rules' in 2017/18 & 2018/19 financial years and subsequent Cash Releasing Savings requirements that will require detailed monitoring on a monthly basis.**
- **Approved Delegation of Budgets to Senior Management Leads (with subsequent delegation to next level of hierarchy as appropriate) with sign off achieved before the start of financial year.**
- **Approved submission of final financial planning returns on this basis to NHS England with identified risks and mitigations as identified within this paper.**

PART 5: GOVERNANCE

5.1 Emergency Preparedness Resilience & Response Annual Report 2016/17 – Report no GB 30-17

The Chief Operating Officer presented a paper to the Governing Body on Emergency Preparedness, Resilience & Response ('EPRR') Annual Report 2016/17. The CCG needed to plan for a wide range of eventualities and the Governing Body was asked to acknowledge the work completed to ensure compliance with the Civil Contingencies Act.

The Chief Operating Officer was the Accountable Emergency Officer. The role of the CCG re EPRR was to:

- Ensure contracts with provider organisations contain relevant EPRR (including business continuity) elements.
- Support NHS England in discharging its EPRR functions and duties locally through membership of the Local Health and Resilience Partnership ('LHRP'), both at strategic level and on the Health Response Group.
- Provide a route of escalation for the LHRP should a provider fail to maintain necessary EPRR capacity and capability. Provider self-assessment issues will be escalated through the LHRP to ensure a collaborative solution with our health partners.
- Fulfil the responsibilities as a Category 2 Responder under the Civil Contingencies Act 2004 and the appropriate NHS EPRR guidance such as the NHS Core Standards for EPRR. This includes maintaining business continuity plans and an incident response plan for the CCG. Being represented on the LHRP (either on our own behalf or through representation by the CSU Business Continuity and EPRR Manager). The Chief Operating Officer represents the CCG on the LHRP. The Corporate Services Manager (Governance & EPRR) represents the CCG on the Health Response Group.
- Seek assurance that provider organisations are delivering their contractual obligation by monitoring through a process of self-assessment with provider EPRR colleagues.

The LHRP was primarily a strategic 'executive' forum for organisations in the local health sector (providers,

commissioners and public health) that facilitates health sector preparedness and planning for emergencies at Local Resilience Forum ('LRF') level, in our case Merseyside and was led by NHS England. The LHRP also supported the NHS, Public Health England ('PHE') and local authority ('LA') representatives on the LRF in their role to represent health sector EPRR matters. The LHRP strategic meetings were supplemented by an operational group that was made up of EPRR practitioners / leads. During the last twelve months the LHRP had focussed upon a variety of issues including: pre-hospital trauma care, power loss, including lessons learnt from several significant incidents; the junior doctors industrial action; planning for body storage in the event of excess deaths; a post Ebola debrief led by PHE; and accommodation plans for secure mental health services. The LHRP strategic meetings were attended by the CCG Chief Operating Officer and the operational group by officers from the governance team. These meetings were:

- Local Health & Resilience Partnership Practitioners Group
- Merseyside Local Resilience Forum
- Liverpool Resilience Forum
- Safety Advisory Group & Non-Licensable Safety Advisory Group.
- Quarterly Liverpool EPRR Leads Meeting.

Liverpool CCG had undertaken a self-assessment against the NHS England Core Standards for EPRR and had declared itself as demonstrating substantial compliance.

NHS England had an annual process of auditing core standards for EPRR with all trust providers, as part of this process they would conduct a review of the Liverpool Women's Hospital EPRR Improvement Plan due to their partial compliance prior to the EPRR assurance process for 2017/18. Progress had already been made against a number of actions and the trust did not have an A&E level of risk management to undertake.

Various guidance had been released during the course of 2016/17 such as the Cold Weather Plan, Heatwave Plan, Pandemic Influenza and EPRR Core Standards.

The Lay Member for Patient Engagement asked if the election of a Liverpool City Region Mayor would affect the Merseyside Local Resilience Forum. The Chief Operating Officer replied that this was unlikely as it was based around the Police structure.

The Chief Officer noted that Liverpool had excellent working relationships with its local partners such as the Police and the Local Authority.

The NHS Liverpool CCG Governing Body:

- **Acknowledged the CCG's internal and multi-agency work to ensure compliance with The Civil Contingencies Act and NHS England requirements.**

5.2 MIAA Review of Liverpool, South Sefton and Southport & Formby CCGs' Quality Assurance Processes for Liverpool Community Health ('LCH') – Report no GB 31-17

The Head of Quality/Chief Nurse presented a paper which updated the Governing Body on the outcome of the joint review with South Sefton and Southport & Formby CCGs undertaken by Mersey Internal Audit Agency regarding the assurance on quality of services, specifically focusing on Liverpool Community Health. She highlighted:

- Liverpool Community Health had been on a quality improvement journey. It had been rated as "Requires Improvement" by the Care Quality Commission in February 2014 with a Parliamentary Adjournment in July 2016 where a request for public inquiry or at least independent clinical review was made. This led to the current Clinical Review starting with the trust itself and then moving on to include the role of commissioners. In preparation for this the Mersey Internal Audit Report was commissioned, the outcome of which was that there was "significant assurance", albeit with there being some weaknesses in design and operation of controls. An action plan was in place to undertake the five recommended actions by the end of the month.

- Objective One of the findings of the report was around the quality related control mechanisms in place re the interfaces that the CCGs had with Liverpool Community Health, NHS England, Care Quality Commission and patients.

- Objective Two was around Internal CCG Quality Activities and how the Quality Safety & Outcomes Committee of Liverpool CCG and the Quality Team managed information and communicated it to the Governing Body. The Serious Incident Reporting process was looked at and its feedback mechanisms.

- Objective Three was around the control position in April 2013.

- The report contained recommendations on the three areas of oversight which were firstly the providers themselves, secondly the CCGs and thirdly the regulatory bodies.

The Head of Quality/Chief Nurse stressed that whilst the main focus was our commissioning role with Liverpool Community Health, the report covered the processes we had in place to ensure the quality of services delivered by all off our providers.

The North Locality Chair commented that she had been closely involved with issues at Liverpool Community Health as well as Aintree Hospital. She commented that South Sefton CCG had seven people in the Quality Team and Liverpool CCG had nine, but given that Liverpool was responsible for seven trusts it seemed the Liverpool had a much larger task to deal with and fewer staff in real terms. The Head of Quality/Chief Nurse added that as co-ordinating commissioner for seven trusts the Quality Team had all their Serious Incidents to deal with as well.

The NHS Liverpool CCG Governing Body:

- **Noted the contents of this paper outlining the outcome of the review**

- **Noted the actions to be undertaken.**

6. QUESTIONS FROM THE PUBLIC

6.1 A question had been submitted by Mr Sam Semoff in advance of the meeting and a response prepared and distributed to the public on arrival as follows:

Following on from the March 2017 meeting of Liverpool CCG, where Dr. Nadim Fazlani stated all four options on the future of the Liverpool Women's Hospital would be part of the public consultation, I would wish to ask the following:

1) When does the CCG envision the public consultation process will begin?

   Response: We are not yet in a position to confirm the timescale for public consultation.

   The four options in the Pre-consultation Business Case require significant capital investment and NHS England and NHS Improvement, the regulators for the NHS, have asked that further work is done to develop detailed funding plans. This work needs to show how capital funding could be secured and to demonstrate value for money. It is recognised that this presents a challenge in the current environment of constrained NHS resources.

   Once this additional work is completed, which we anticipate will be done by the end of the summer; a final version of the business case will be submitted to NHS England for approval. If NHS regulators are assured there is a sound case to invest, the options will go out to formal public consultation, giving the public an opportunity to share their views on detailed proposals for the future of women's and neonatal services.

2) What will be the format of the public consultation?

Response: We anticipate that local Overview and Scrutiny Committees will judge that the proposals represent a 'substantial variation' to these services. If this were the case, commissioners would lead a formal public consultation. This would put the four proposals, including the stated preferred option, to the public for their views. The consultation would invite people to give their views in a variety of ways, including a survey (printed and online), via public meetings, roadshows and we would conduct qualitative engagement, including with seldom heard groups. The consultation would be supported by a range of consultation materials to inform people about the context, the proposals and the process. For a proposed service change of this nature the minimum timescale for consultation would be 12 weeks.

3) If this information is not yet in the public domain, when do you expect it to become available?

Response: The pre-consultation Business Case is already in the public domain and we have been open about the need for further work on the financial case prior to being able to proceed to the next stage, which would be to conduct formal public consultation.

We will continue to communicate progress, through CCG Governing Body and Health and Wellbeing Board updates.

6.2 A member of the public present asked how, as the CCG was in debt by £4m, could it justify huge page rises for Governing Body members. The Chief Officer replied that the CCG was not in debt as had been explained very clearly earlier on in the meeting and in fact was delivering a £16m surplus as per NHS England Business Rules.

A statement had been prepared which could be shared with the public. The Healthy Liverpool Integrated Programme Director read out the statement which had been prepared:

"The salaries of Liverpool CCG Governing Body members are published annually in the CCG Annual Report, which is publicly available on the CCG website.

Remuneration for Governing Body members is set by a Remuneration Committee of the CCG, in accordance with the organisation's constitution and NHS England guidance.

In 2013/14, the first year of operation, salaries reflected the fact that the CCG was a newly-established organisation establishing its strategic role. The increase in governing body salaries in 2014/15 were in recognition of the significant system leadership roles assumed by the senior leaders of one of the largest CCGs in the country, responsible for the most complex health system outside of London.

Governing body members received no uplift in salaries in 2015/16. In 2016/17 the Chief Officer, Director of Finance, Chief Nurse received a 1% increase; all other Governing Body remuneration remained the same.

The increase in salary of the CCG's GP Chair in 2014/15 was also in part due to an increase in his CCG commitments and a corresponding reduction in his clinical practice. "

6.3 A member of the public asked why the CCG was granting contracts to private companies rather than NHS organisations, they mentioned in particular the subcontracting of part of the new Royal to a private organisation. The Chief Officer responded that Liverpool CCG had not allocated any further healthcare contracts to the private sector in the last year. With regards to the Royal Liverpool Hospital, the CCG's contract was with the Royal Liverpool Hospital NHS Trust, however they chose to sub-contract was at their discretion.

6.4 A member of the public gave a personal example of the situation of a close family member who had been adversely affected by benefit cuts.

6.5 A member of the public asked for an update on the proposals for cataract surgery follow up appointments to

be carried out by community opticians, a matter about which she was not completely comfortable given that these were profit-making business. The Chief Operating Officer noted that this referred solely to the follow up/aftercare which would free up St Paul's Eye Hospital to deal with more complex patients. The actual surgery would be carried out at St Paul's.

7. ANY OTHER BUSINESS

None.

8. DATE AND TIME OF NEXT MEETING

Tuesday 9th May 2017 2.30pm in the Boardroom at Liverpool CCG, The Department, Renshaw Street, Liverpool L1 2SA