NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	**8 September 2020**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 14 July 2020	Time:	2.30pm
Venue:	Skype Conference Call		

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

ISSUES CONSIDERED
2020

A1 WELCOME

1. Fiona Lemmens welcomed all those present noting that business would be conducted on the

assumption that members had read all papers ahead of the meeting.

2. FLE informed members that due to the coronavirus (COVID-19) pandemic, the Governing Body was meeting virtually and an audio recording of the meeting would be available on the web page within three working days of it taking place.
3. Members of the public were able to submit questions to be raised at the meeting for discussion and a response would be emailed to them in due course.
4. Both the question and the response would be circulated to all members and included in the minutes of the meeting.
5. Members were also asked to raise questions by email in advance of the meeting and any questions raised would be discussed as the meeting progressed.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

7. Along with the declarations listed on the LCCG register PKI reminded members that he had returned to practice, working in oncology at Clatterbridge albeit remotely, to help out during the pandemic.
8. MSM noted that reference would be made to a payment for substance misuse in the forthcoming Public Health PH paper which GPs had an interest in although there was no decision to be made regarding this item. This was also true for the Public Health local enhanced service agreements.

A4 MINUTES OF THE MEETING HELD ON 22 MAY 2020

9. The minutes of the meeting held on 22 May 2020 were accepted as an accurate record with the following exceptions:
    - Page 11, point ff to read: '...although it was up to 30% false negative.'
    - Page 15 point n to read: '...was recorded as decreasing by 249 from March to April on the register.'
    - Page 17 point s remained outstanding, JLE to follow this up.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approve the minutes of the previous meeting			
Further actions required: • Amend previous minutes in line with discussions; • Clarify Point 7 in GBAF – reference to attendance at M&C overview and scrutiny committee.	D Richardson J Ledward	ASAP Sept 2020	Completed On agenda for Sept 2020 GB meeting.

A5 ACTION LOG

10. The action log was discussed with the following points made:
    a) B2 Chief Nurse Report was a repeat of item B5 Performance report and would be taken to Performance and Quality Committee in August. The issue was not about monitoring the risk but was about what the actual risk was. More work was required here to clarify this and the BI team would be completing this. There was a quality dimension and a performance deterioration aspect which both needed to be considered. Action ongoing.
    b) A summary of the financial decisions would go through the audit committee due to the sensitive nature of some of the items listed on the decision log. Action completed.
    c) B6 updating action completed
    d) B6 discussion of command and control situation was on the Governing Body (GB) development session agenda for 22nd July 2020. Action completed.
    e) B6 risks added to CRR completed, action closed.

f) B6 committee structure was dealt with in the private GB meeting and is ongoing. Action moved to Private GB action log.
g) B6 CHC issues have been escalated to regional level and a Cheshire and Mersey (C&M) wide paper is being developed to support CCG. Action ongoing.
h) E Response to public completed and online on CCG webpages.

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

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

11. Jan Ledward presented the Chief Officers Report outlining the following:
a) Members are well aware of the work taking place across the system to manage Covid-19. In terms of numbers it is significantly lower than it was at its height in April. There had been a lot of support across the Liverpool system from Trusts, community services, GPs and the local authority working together along with the fire service and a contribution of face coverings from Liverpool Football Club.
b) Some populations are disproportionally affected by Covid-19 and risk assessments had been carried out from an NHS employers perspective to protect staff where possible.
c) Further information on the financial situation looking towards recovery would follow later however to return to some normality was not easy. Additional cleaning regimes were required; there was reduced capacity in terms of bed spaces which meant managing waiting lists was a challenge. Work was underway across the system and with NHS England (NHSE) to do this safely and to gain public confidence.
d) RBA commented that the report mentioned waiting times and problems within systems raising concerns that the bottlenecks would remain indefinitely causing additional problems for GPs. It was difficult to ask patients to attend primary care and then refer them to secondary care in an attempt to improve their expectations only to have them dashed. This caused a strain on practices and added anxiety. This was an additional strain on the mental health of GPs.
e) JLE stated that this was recognised however there was a need to maintain conversations about what could and could not be done while considering alternative ways of delivery and providing the service to keep the public informed. Consideration of opportunities to increase capacity would continue. There had been much reported about cancer and mental health with issues increased threefold. There was increased demand across the board for services.
f) FLE commented that it was difficult to advise patients when the advice received from above was unclear and contradictory; it made the situation challenging for all involved. A whole system approach to keeping the public informed would be helpful, there were different pressures in different parts of the system across the city. LMC was doing a very good job of keeping GP colleagues informed under the circumstances. Liverpool University Hospital Foundation Trust (LUFHT) was considering providing a telephone advice line and Mersey Care Foundation Trust (MCFT) has a telephone advice line in place for care workers.
g) JBL suggested that the only way to avoid bottle necks would be to share waiting lists.
h) SJA informed members that work had commenced on a single waiting list looking at capacity in its entirety to meet the needs of the most urgent patients with joint working and mutual aid which would change the way of working across all providers in future. JLE added that there was a single waiting list in place across Cheshire and Mersey (C&M) for cancer patients.
i) PKI asked if the CCG staff were still working from home and would the organisation

remain working virtually. JLE responded that the message nationally was to work from home if possible and so 95% of staff were continuing to do so. Capacity within the building had been reviewed and the plan was that 50% of staff only could be in the building at one time so rotas were being considered depending on staff preferences. Some staff were shielded and may not be able to return; the situation would be kept under review particularly given the potential for a second spike. It was not anticipated that any staff would be returning until schools opened up again.

j) CMA enquired about the effect of the virus on the voluntary and faith communities. JLE responded that some had been affected more than others. Some organisations had worked to help support shielded patients as had the council with the most vulnerable stating it had been a combined effort. The support had been invaluable and local communities couldn't be thanked enough.

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

B2 CHIEF NURSES REPORT

12. Jane Lunt presented the Chief Nurses Report drawing attention to two issues namely:

k) How assurance was being sought from Trusts for BAME and other vulnerable staff through CQPGs and the safety and learning culture. Covid-19 was a new virus which may be around for a long time and we were learning how to respond to it.

l) There was a need to focus locally on reviewing what has happened around Covid-19 highlighting what went well and what did not go so well, learn from the experience and promote the learning as the virus continues.

m) The impact of the increased infection prevention and control (IPC) measures in reducing the time available to treat patients who had already been waiting to be treated due to the pandemic was likely to last for some time. This was being monitored from a quality perspective for patient safety and experience. Work was underway collectively to gain assurance regarding clinical prioritisation keeping patients safe looking for clear processes and embedding these in each trust. The analysis and interpretation was being brought back to each committee to share the oversight.

n) Work was ongoing with the cancer alliance to avoid duplicating work with trusts.

o) There were increased mental health presentations occurring along the full range of mental health impacts at the acute end resulting in an increase in inpatient numbers.

p) Phlebotomy was an area of concern with the pandemic having a significant impact and work was underway to remodel the process with IPC at the forefront. Vulnerable groups required extra consideration and data needed to be interpreted effectively. Dr Foster analytics team had offered to work collaboratively on the data to ensure the understanding was there; this would benefit from being carried out across the C&M footprint to ensure it was being carried out correctly.

q) FOF asked about the discharge to assess process status and was informed that the group was now meeting weekly which was down form three times per week. The 14 – 21 day review process was in place and performed remotely. The first review takes place 24 hours after discharge to check the discharge went well. The review is documented and logged in a central place and a SharePoint system is being developed to enable sharing the information.

r) PFI asked if the CHC assessment and choice was suspended to which the response was that it was temporarily suspended and being considered centrally regarding setting it back up again. Estimates of patients for review in September had been requested. FOF reported that there were 400 bed vacancies across the care home sector as of that day.

s) JBL asked if the safeguarding policy had changed as a result of the learning. JLU responded that some referral had come via the safeguarding route and they were still being investigated so not all outcomes were known yet. The outcome for North West Ambulance Service (NWAS) to convey or not convey was the correct clinical decision at

the time and people were right to challenge.

t) FLE asked if the three occurrences were Covid-19 patients and this was not clear. JLU agreed to clarify this. It was noted that the sharing from the learning here would be shared via safeguarding through the local authority and potentially more widely depending on the route. Public Health departments and North West universities are involved in supporting this. The intention was to feed back into clinical processes putting the learning into the system and learning from the benefits the pandemic has brought.

u) JBL enquired about routine testing and tracing for staff and JLE responded that there was reasonable routine testing for care home staff weekly but there is not the capacity in the system to do this. There was a clear prioritisation process supported by NHSE. PBR noted that there was weekly testing in care homes for staff and testing every 28 days for residents since 11th June 2020. This would move on to social care staff at a time yet to be determined.

v) MKH commented that with regard to serious incidents and Never Events in various settings; members would have a copy of the plan for external review, and will they have sight of any learning outcomes that were identified. JLU responded that this was the intention to avoid the events happening again. This was the purpose of the national framework.

w) HDE referred to the safety and learning culture and the support given by the Freedom to Speak Up Guardian (FTSUG) asking if organisations had been asked to give support to the role and does it report regularly into the various Boards stating that this would give a feel for how "open" culture was and if it was assurance rather than just reassurance.

x) JLU responded that this was mentioned in a recent CQPG cycle where it was reported as a positive aspect where Trusts had increased FTSUG roles or created other channels for staff to communicate or highlight other issues or concerns. LUFHT had created spaces for staff to sit with psychologically trained people for support and a lot of mental health support had been put into place with risk assessed support for staff physically and mentally.

y) DOH asked if Dr Foster Analytics were a non-commercial partner to which MSM responded that they were a commercial entity commissioned to provide reports. They extracted anonymised data from health bodies to provide independent analysis. The data was extracted by NHS Digitals data access service.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents of the report			
Further actions required: • Clarify if 3 NWAS patients not conveyed were Covid-19 patients;	J Lunt	Sept 2020	On Sept 202 GB agenda

B3 PUBLIC HEALTH UPDATE

13. Matt Ashton presented the Public Health Update outlining the following:

a) A plan to control local outbreaks had been produced and was live and on the website for consultation which was due to close that day. The plan outlined how services anticipated they would respond to any complex local outbreaks should they need to. The plan listed seven priority areas: care homes, schools, local testing capacity, high risk places, contract tracing in complex settings, vulnerable people, data integration and local boards. The local governance process was a weekly test and trace meeting which reported into a health protection board monthly which included CCG representation and then reported to a health and wellbeing board on a quarterly basis. This was alongside monthly political engagement.

b) There were three main LES's in place; sexual health, substance misuse and NHS health checks. Details were in the report. More work was to be carried out regarding health checks; this had been delayed due to Covid-19 and would be returned to.

c) Work continued on health and social care recovery looking at themes which were listed in the report. A rapid evidence review had been commissioned through Liverpool John Moores University (LJMU) reviewing the impact of Covid-19 on the population. The report

will go some way to answering some of the questions around health inequalities along with the work being carried out by the North West mortality cell who were looking wider at mortality. The LJMU report should be signed off shortly and will be circulated once it is agreed.

d) A partnership group had completed a needs assessment which fed into the next steps and future intentions across the whole mental health and well-being pathway not just mental health. Specific smoking cessation support has been provided with the help of GPs to vulnerable groups. Work continued around physical activity campaigns with "this girl can and we are undefeatable. Also people are being encouraged to engage with the test and trace programme.

e) RBA asked what direction Liverpool City Council was going to take regarding health checks in light of the letter that came out the previous week from Public Health England regarding the health checks. MAS stated that work remained outstanding in this area and there was no capacity to return to it at that point, members would be informed when things changed. RBA stated that the letter stated that health checks should be recommenced at the end of July and was this likely to happen. MAS reported that the conversation had not commenced yet. More clarity was required regarding the process. Agreed that MAS and FLE discuss the issue further offline.

f) DOH commented that the effectiveness of the outbreak plan was reliant upon having the right data to which MAS responded that the data was improving and since mid-June they were now receiving pillar 2 level data which included postcode, gender, age and ethnicity information although the ethnicity completeness was poor. If there was a complex outbreak it had been agreed that local areas would receive full data sets and the previous week the authority had been able to identify a small spike which led to interventions being put into place and sharing the message across the city.

g) An outbreak in south Liverpool had 31 positive case focused on the 15-24 age group so enhanced testing was carried out to avoid a large scale outbreak.

h) SHO asked if obesity has been shown to be a factor in contracting Covid-19 and its severity and if so what were public health plans for a campaign regarding this.

i) MAS reported that this was linked to the 'This Girl Can' and 'We Are Undefeatable' campaigns.

j) CMA commented that voluntary and community services play a vital part in supporting the mental health and learning disability services and what had been the impact in terms of funding on those services and can they continue to provide a public service.

k) MAS reported that from a public health perspective a review of services was underway, there were lots of services that were not necessarily joined up and clarity was needed to see what the offer was. Work had been carried out on the communications element to make things clearer.

l) PBR commented that there was a web of infrastructure which had been under huge stress with the pandemic and some had fallen. There was an acknowledgement in the cabinet of the stresses in the voluntary and community services but they were not necessarily limited to mental health; the cabinet was having a conversation to prioritise what opens as a priority the difficulty was funding with a £51m gap pre Covid-19.

m) JLE commented that the CCG had committed to investing in mental health services over recent years, crisis services had been put in place 24/7 and we were working with service providers to manage and cope with demand. It must be recognised that we were struggling to recruit to MH services prior to Covid-19 and so staff are stretched.

n) CRO asked if cold spots could be tracked across the city to help target efforts in Covid-19 public health communications around engagement and understanding. MAS replied that there were 4 pillars to the communications strategy but it was in its early stages. As it evolved it would have that level of insight. FLE was involved with the Health and Social Care group and could update members after its next meeting.

o) PBR stated that the public health team had been working at enormous pace, providing real time advice for the care sector, the reopening of the city centre, setting up a test track and trace scheme and doing the day jobs too. The demand on the team was overwhelming and they were working heroically to manage to respond to requests, they were working all the hours available at the moment.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • review the content of the Liverpool Outbreak Control Plan and their role in the implementation of the plan • work with public health and GP partners to develop a new NHS Health checks model for Liverpool • support the implementation of any new models to improve engagement with smokers in the city • reflect the increased needs of children and young people as a result of COVID-19 in the future implementation plans of the One Liverpool strategy • support the development of Liverpool's first, city-wide all-age Wellbeing and Mental Health Strategy • support the promotion of all public health related communication across the city •			
Further actions required: • Circulate findings from rapid evidence review; • MAS and FLE to discuss reinstating health checks;	M Ashton F Lemmens	ASAP Sept 20	On Sept 20 GB agenda On Sept 20 GB agenda

B4 FINANCE REPORT

14. Mark Bakewell presented the Finance Report outlining the following:

a) This report contains the financial performance update within the 2020/21 financial year and is based upon the revised financial framework for months 1-4 as determined by NHSE England. The position reflects the impact of revised in-year allocations, payment guidance to NHS / non-NHS providers and elements of Covid-19 related expenditure up to Month 2 (May).

b) The main aspects of the CCG's financial reporting position in relation to the current are included on the executive summary on big page 61
- As at M02 reported position 31st May 2020, the CCG is reporting a £3.9m overspend against revised allocations as set by NHSE, with a forecast overspend of £7.1m for the first four months of 2020/21.
- Additional resources limits totalling £7.1m (Year to date £3.9m) are anticipated to be received from NHSE as part of a CCG 'True-Up' exercise that would result in a revised break-even performance for the CCG.

c) By way of comparison the CCG had £5.0m adjusted from its total allocation for the same period based on the methodology within the paper
- Notified Block contract payments totalling £55.4m per month of being made to named NHS Trusts & FTs in line with nationally notified figures. These costs are fully funded within the revised allocations and there are no variances are reported in the year-to-date position in respect of these payments.
- The CCG has incurred year-to-date COVID-19 specific costs totalling £2.4m and is forecasting costs of £4.0m by the end of July. It is expected that these costs will be fully funded through the NHSE 'True-Up' exercise.

d) I can confirm that an adjustment was made in m3 relating to Covid-19 related expenditure incurred for m1&2
- Other costs exceed notified allocations by £1.5m year to date (forecast overspend of £3.1m at the end of July), based on NHSE budget setting methodology compared to actual 2020/21 costs. Further details are provided in the Operating Costs section of

this report. Again the CCG is expecting that these costs will be fully funded through NHSE's 'True-Up' exercise but this has not yet been received

e) Further information is included on pages 63 to 66 regarding the month 1 &2 reporting position and also within the planning update later on todays agenda
f) No further guidance has been received as yet regarding arrangements for rest of the financial year but there is an expectation that revised financial management arrangements approach will continue in some form.
g) The governing body is asked to note the contents of this report
h) MSM asked if historic provider debts were permanently written off and the response was that this was not the case; the presentation of historic provider debts had partially been described as a write off but now appeared in the balance sheet and the organisation had to pay off the debt over a longer period depending on the organisation. The cumulative position was converted to a bearing position with interest repayment and this doesn't appear on the balance sheet in the same way.
i) PBR commented that this sounded like capitalisation in local authorities and it was not the impression formed when the health minister spoke some weeks ago. PBR asked what clarity there was about the revised financial arrangements that government would return to the status quo in next financial year.
j) MBA provided a useful link to kings fund article on provider debt here: https://www.kingsfund.org.uk/publications/financial-debts-and-loans-nhs#debt-write-off
k) The response was that expenditure related to Covid-19 had been non recurrent and colleagues were working on the assumption they would return to the previous situation but this was not certain at all given the command and control situation. The benefit of taking this approach enabled access to national sustainability fund which meant Trusts had been able to submit break even plans and access funding.
l) HDE asked about the risk of not reconciling the figures for Covid-19 expenditure to which MBA responded that months 1-2 had been reimbursed. The Senior Leadership Team (SLT) had looked at additional expenditure very carefully with the intention of making sure they weren't putting the CCG at risk for further validation. They had been successful in large expenses quoting telehealth as one example.
m) Regarding the remainder it was noted that if the CCG had its original allocation it would broadly be in balance and the challenge was in entering into the year with an underlying deficit position. It was known that if the situation became difficult at some point in the year the challenge would be more difficult later with funding set at STP or partnership level.
n) The mental health investment standard was important on a local basis; there was a need to give clarity but there wasn't the ability to at this point. Although there is no certainty, there was confidence the CCG would not be left with a residual risk but it was not clear what this would mean later in the year.
o) MBA and SHE would work on how this was presented in the risk register.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the current financial position, nationally determined block contract payments to NHS Trusts / FTS, additional COVID-19 expenditure and anticipated 'true up' allocations that would deliver financial break-even.			
Further actions required: • Record the potential risk of non-recovery of Covid-19 expenditure within the risk register	M Bakewell / S Hendry	Sept 20	On Sept 20 GB agenda

B5 PERFORMANCE REPORT

15. Sam James provided an overview of the Performance Report, informing members that:
a) Some of the information had been reported in previous reports although the report

showed the impact of Covid-19 and the challenges facing the CCG and wider system.

b) Improvements were listed on page 72 and 73. There was a new performance indicator for a faster cancer diagnostic of 28 days for which the minimum standard was 70%.

c) The report was difficult to compile with all indicators remaining below the national standards and showing a significant deterioration. One example listed was an increase from 14% of patients waiting over 6 weeks for a diagnostic test to 70% of patients now waiting over 6 weeks. We are starting to see breaches on a more regular basis both in primary and secondary care.

d) Work was underway with providers to coordinate the system to address the issues, this was the first time providers had come together to support individual provider issues potentially hitting their own performance. Providers were operating at around 60% capacity which was likely to continue until the end of the financial year. Work continued to attempt to understand system capacity.

e) The command and control situation remained in place so there was a limit to what providers could be asked to do in the structure and focus needed to be on quality and performance.

f) RBA asked what had been put in place regarding access to IAPT services stating there was likely to be a need for more of these. A common sense approach was required to enable patients to access the right services easily which would improve the patient experience.

g) SJA responded that there had been significant investment in the IAPT services and the psychological support line was up and running this year instead of next year as a result of this investment. Calls were increasing into the service and work was ongoing with MCFT looking at issues around performance and gaining assurance for quality. Going forward work would be carried out looking at what would be required and how it could be delivered across the wider teams working with public health and local authority.

h) PKI asked how the data was put into context and how reliable the data was. SJA responded that providers were well versed in putting the data into context and looking for any reductions or improvements in performance. The difficulty was how to benchmark the information; it was considered on a month to month basis looking at best and least performance to consider. Appendix 2 showed nationally prescribed peers grouped for comparison based on various indicators. It gave a starting point for comparison. It gave an opportunity to learn for other CCGs, if others performed better in similar circumstances it was an opportunity to learn from them.

i) STH commented that the data was supported by anecdotal evidence from enquiries and surveys; patients were waiting for treatments or in some instances closure following treatments for cancer and they had not received it. Initially people were patient and understanding regarding the delays but now they are asking if pubs are opening why weren't they being treated, there had been an increase in requests for complaints advocacy work.

j) RBA commented that there were a large number of patients who were booking in for treatment and then not turning up. STH told members that there was a divide and some people wanted to attend while others didn't and communications to the public on both aspects would be helpful.

k) DHO reported that alder hey could possibly help with scanning but the difference in adults and children was an issue. Alder Hey did take some adults from a treatment perspective during Covid-19; DHO will discuss the possibility of using the scanning facilities as a shared resource.

l) SJA reported that Chief Operating Officer conversations had included Alder Hey and they were willing to offer up capacity when the conversation took place.

m) HDE enquired about capacity levels prior to Covid-19 to which JLE responded that between sickness, annual leave, routine maintenance, staff training day etc. it was not possible to answer in a perfect way. On average demand fluctuated month by month and although colleagues had a good understanding of what would be expected to be delivered the reduced number of beds due to spacing, cleaning between treatments, staff isolating and a range of factors had to be considered now. It was felt that the system was running at around 60% of what it would 'normally' be running at.

n) Noted the level of concern and frustration from members around the performance of the system along with a level of frustration regarding the lack of ability to influence

performance in the current situation.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the performance of the CCG in the delivery of key national performance indicators for the period highlighted and of the recovery actions taken to improve performance and quality. • Determine if the levels of assurance given are adequate in terms of mitigating actions, particularly where risks to the CCG's strategic objectives are highlighted.			
Further actions required: • Investigate potential for using Alder Hey facilities for adults	D Horsfield	Sept 20	On Sept 20 GB agenda

B6 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

- **Corporate Risk Register**
- **Governing Body Assurance Framework**

16. Stephen Hendry provided an update on the organisation's Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR), and Issues Log stating that:
    a) In terms of corporate functions the GBAF had suffered most as the 2020-21 GBAF was not fully up and running. It was a priority and was an agenda item for a GB development session before autumn. Conversations were underway with SJA and MBA.
    b) SHO reported that the GBAF was discussed at the Audit and Risk Committee the previous week and as the system moves from crisis to recovery the need to pick this up again was recognised. The GB development session would consider how to proceed with the GBAF and whether to keep Covid-19 separately or within the corporate risks.
    c) FLE stated that the September session was earmarked for this as some members were unable to attend in August and the whole membership involvement was required.
    d) Item CO81 regarding Liverpool Womens Hospital was to be updated regarding progress.
    e) Item GBAF06 was to be put back on the SLT agenda.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents of the report • Note the issues relating to the COVID-19 response and NHSE/I Command and Control Arrangements; • Satisfy itself that current control measures and the progress of action plans provide reasonable / significant internal assurances of mitigation.			
Further actions required: • Scheduled GB development session to consider GBAF 2020-21; • Update item CO81 regarding LWH and progress to date; • Add Item GBAF06 to SLT agenda	F Lemmens S Hendry J Ledward	ASAP Sept 2020 ASAP	On Sept 20 GB agenda, On Sept 20 GB agenda, On Sept 20 GB agenda

B7 BETTER CARE FUND 2020-21.

17. Deferred to next meeting.

B8 COVID-19 EQUALITY BRIEF

18. CHI updated members on the equality brief report noting the following:
    a) Despite being under command and control the CCG still had duties both as an employer and as a CCG.
    b) The brief was to inform the governing body of the need to take into account equalities issues and their impact on the population health with particular reference to Covid-19. It pointed to further sources of information and good practice. The report was a live document which had been updated with additions since it was circulated to members. Resources would be available to support the CCG in its duties and the report was to make GB aware of issues to consider and the responsibilities it had.
    c) FLE commented that the report was a good reminder that although funding and responsibilities had been taken from the CCG some statutory responsibilities still sat with the CCG.
    d) CHI stated that work continued with local providers using the example of working with the deaf community to consider patient experience and quality issues to ensure any adjustments that needed to be made were made and peoples circumstances were taken into account.
    e) RBA declared an interest sharing that his sister worked with people with a visual impairment and as the public were moving toward a situation where they were expected to wear masks this created difficulties for people who would lip read and people with visual impairments stating it was almost impossible to seek guidance regarding what was being done to ensure these people were being supported.
    f) CHI reported that the NHS was ordering PPE stock with clear sections in to enable those hard of hearing to see the face of the person they were interacting with. CHI was not aware of specific work taking place nationally or locally to support visually impaired, she would check and feedback to RBA directly.
    g) DOH asked about the level of assurance required for understanding health inequalities to which CHI responded that this would be discussed at the GB development session the following week. The intention was to look at the learning gathered in regard to the impact of Covid-19 to date. Data and evidence was available which had to be understood to establish what the baseline was to move forward from for the One Liverpool plan focusing priorities on three areas including health inequalities as health and care systems would directly feed into the revised Liverpool city plan in terms of health behaviours.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note and pay 'due regard' to the COVID-19 Equality Brief			
Further actions required: • Research support for visually impaired	C Hill	Sept 2020	On Sept 20 GB agenda,

C FOR DECISION

19. No items.

D FOR NOTING

D1 CONSTITUTION

20. Stephen Hendry delivered a verbal update noting that the Constitution was now available online with the Governance Handbook.
21. RBA commented that the number of GP members of GB does not reflect the constitution

and there may be a potential vacancy, what was the CCG planning regarding this.

22. JLE responded that conversations were underway regarding potential mergers which may alter things and this along with the funding situation meant there was a requirement to hold vacancies pending decision making. The membership would be kept informed however the CCG would hold the vacancy in the interim to enable them to meet running cost totals.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the verbal update.			
Further actions required: • None identified.			

D2 CCG RESPONSE TO COVID-19

23. SJA presented a report outlining the following:

a) The comprehensive report highlighted the work undertaken by the CCG in response to Covid-19 and included contributions from all SLT members with much of it being covered in the discussions thus far.

b) FLE commented that it was a wide ranging, and informative report showing how far and wide the impact of Covid-19 was showing.

c) CMA asked if the working from home risk assessments included display screen equipment assessments to which JLE responded that this had been facilitated as much as possible with staff being given monitors and chairs where they were needed.

d) The mental health investment standard had been released and this had been met, FLE would circulate the letter confirming this to members.

e) JLE reported that Seacole beds were included in the work of the out of hospital cell to meet the need for sub-acute beds as requested by NHSE. There was an opportunity to bid for national capital for the beds with no outcomes reported as yet. The beds are not residential nursing beds and would require a higher level of AHP and medical intervention support and could not easily be taken up by additional existing capacity.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the report			
Further actions required: • Circulate letter regarding meeting requirements of mental health investment standard to members;	F Lemmens	ASAP	On Sept 20 GB agenda,

E QUESTIONS FROM THE PUBLIC

24. One question was submitted by email 3 July 2020.

a) My question relates to those people who, despite not being hospitalised, have or continue to show symptoms of Covid-19 19 and how we as a society can support their quality of life including their mental health.

b) What is being done to support the many people who:-

- have long term symptoms and are being told by 111, clinics and GPs they may be infectious still and are therefore long term isolating as well as unable to try returning to their normal lives
- are also being told they are anxious, their symptoms doubted as they cannot be measured and are being prescribed antidepressants
- have GPs who seem to be unaware of long term Covid-19 19 and that tests are not being carried out on people who are more than 48 hours from onset. A test for this situation could offer reassurance one way or another.

25. A response will follow in due course

26. The questions below were submitted to the previous meeting:

Questions to Liverpool CCG Board Meeting 22 May 2020

Care Homes

Background

On 19 May the Liverpool Echo reported 20 deaths from Covid-19 at Paisley Court Care Home, and also mentioned earlier care home deaths at Oak Springs (16), Beechwood Specialist Services (9), and Grace Lodge (6). On 7 May, Mayor Anderson's research assistant Emily Fletcher wrote to Dr Alex Scott-Samuel, mentioning Covid-19 outbreaks in 39 care homes in Liverpool. Office for National Statistics data this week records 128 care home deaths in Liverpool by 8 May, the 7th highest figure amongst 346 local authorities and Health Boards in England and Wales.

In the papers for this Board Meeting, Chief Nurse Jane Lunt states:

"Collaborative work has been undertaken with Liverpool City Council Public Health and Public Health England (PHE) and the Infection Prevention and Control (IPC) team in Mersey Care to support Care Homes with training re IPC and with supplies of PPE."

"Initially 270 hospital patients were deemed 'ready for discharge' (RFD) and were discharged over the days prior to Easter weekend to prepare for the surge anticipated at that time. The current recording system is being refined as some patients have tested positive for Covid-19 and LUHFT have retained them for 2 weeks before discharge."

"A small number of Care Homes in Liverpool have experienced outbreaks and a number of deaths of residents, reflecting the national picture."

"IPC Training has been provided to staff and work has been undertaken to ensure in so far possible that PPE is supplied."

Director of Public Health Matthew Ashton states:

"From a very early stage LCC Public Health team identified care homes as a key priority area for intervention. In partnership with Adult Social Care, Liverpool CCG, Mersey Care NHS Trust, The Royal Liverpool University Hospital Infectious Disease Unit, Cheshire and Merseyside Health Protection Team and care home providers the public health team have led the delivery of an intensive infection prevention and control strategy for care homes in the city. The work has involved a range of interventions including the early closure of care homes, the issuing of infection prevention control guidance prior to national guidance being issued and intensive support from the infection prevention control team during outbreaks."

"The testing of all asymptomatic residents in care homes without outbreaks is also another important prevention strategy. The early identification and isolation of asymptomatic cases ensures the spread of the virus to other residents is prevented. Liverpool was the first local authority to pilot this strategy across all care homes without an outbreak."

Questions

27. **Q1**: Why did the intensive infection prevention and control strategy fail to prevent outbreaks in 39 care homes and the deaths of 128 residents in Liverpool by 8 May?
28. **Q2**: How many of the 270 patients discharged from Liverpool University Hospitals before Easter were tested for coronavirus before being placed in care homes?
29. **Q3**: Why is PPE not supplied to all staff in Care Homes, rather than "in so far possible"?

Contact Tracing

Background

The Director of Public Health states:

"In Liverpool this work is in the early stages of planning and will be overseen by a partnership group led by the Director of Public Health. Key priorities for this strategy are logistical approaches to the distribution of swab kits, the availability of laboratory capacity, prioritisation of testing and capacity to contact trace the contacts of positive cases. The health and social care system in Liverpool is working alongside a range of partners to identify innovative approaches to delivering this priority."

30. **Q4**: Will Liverpool CCG exercise its influence to ensure that contact tracing in Liverpool is led by local public health teams and public sector partners without the involvement of Serco, Capita, or G4S, bearing in mind their track record of failure?

31. Response sent by email 14 July 2020:

Please find responses to the questions set to Liverpool Clinical Commissioning Group Governing Body below:

Q1: Why did the intensive infection prevention and control strategy fail to prevent outbreaks in 39 care homes and the deaths of 128 residents in Liverpool by 8 May?

It has been recognised, both nationally and locally, that the impact and outcomes for those who develop COVID19 is felt most severely on those with increased frailty and other underlying health conditions. The reasons for the number of cases, and sadly the number of deaths in care homes, are multi-factorial. Reviews of what happened during the early stages of the pandemic suggest that there were some common themes that may have contributed to outbreaks:

- Supply and training in use of PPE
- The challenge in isolating residents who may have cognitive difficulties
- Implementation of visitor restrictions
- Training and educational support for care homes in infection prevention and control
- The impact of sudden increases in staff sickness and absence

All of these themes have been used to support in quality improvement and form part of the social care action plan for care homes. Further information regarding support for care homes can be viewed here:

https://liverpool.gov.uk/communities-and-safety/emergency-planning/coronavirus/community-support-carers-and-care-homes/support-for-care-homes/

Q2: How many of the 270 patients discharged from Liverpool University Hospitals before Easter were tested for coronavirus before being placed in care homes?

Only a small number of the 270 patients will have been care home residents. The CCG has requested further information from Liverpool University Hospitals.

Q3: Why is PPE not supplied to all staff in Care Homes, rather than "in so far possible"?

Adequate and appropriate supply of PPE is the responsibility of the employing organisations, however it was recognised both nationally and locally that there were challenges for homes in accessing PPE. Liverpool City Council responded in setting up a mutual aid scheme with local system partners to support homes in accessing PPE supplies in line with national guidance.

Q4: Will Liverpool CCG exercise its influence to ensure that contact tracing in Liverpool is led by local public health teams and public sector partners without the involvement of Serco, Capita, or G4S, bearing in mind their track record of failure?

Liverpool has recently developed a local outbreak plan, which sets out our approach to managing the next stage of the pandemic in Liverpool, working alongside the NHS Test and Trace programme.

https://liverpool.gov.uk/communities-and-safety/emergency-planning/coronavirus/liverpools-covid-19-outbreak-control-plan/

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the questions raised			
Further actions required: • Respond to the questions raised (point 24)	C Hill / F Lemmens	ASAP	On Sept 20 GB agenda

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

32. The following items and committee minutes were noted:
    a) Chairs report from Audit and Risk Committee 23rd June 2020
    b) Ratified minutes from Audit, risk and Scrutiny Committee 25 February 2020

G1 ANY OTHER BUSINESS

33. FLE asked members for their feedback on holding the committee virtually stating that chairing meetings via Skype was difficult, MSM commented that it was difficult to concentrate effectively throughout it. HDE stated that in her experience chairing the meeting while reading and responding to comments in the chat screen was difficult to manage but that he chats helped the meeting with people contributing to the chat more than in person sometimes so it was helpful.

34. Microsoft Teams was suggested to be better with the option to 'raise a hand' and private message and it was noted that it was difficult to keep track of the points raised in the chat screen.

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