NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	**12 January 2021**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 10 November 2020	Time:	2.30pm
Venue:	MS Teams Call		

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

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.
6. At the commencement of the meeting a minutes silence was held to honour the memory of Councillor Richard McLinden (Chair of the Health and Social Care Select Committee) and Mayor Anderson's brother who had sadly died of coronavirus recently.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

8. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register. Both FLE and MSM were mentioned in the Chief Officer Report for noting.

A4 MINUTES OF THE MEETING HELD ON 8 SEPTEMBER 2020

9. The minutes of the meeting held on 8 September 2020 were accepted as an accurate record with typos and amendments forwarded outside the meeting.

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

A5 ACTION LOG

10. The action log was discussed with the following points made:
    a) Item 1 was ongoing, it had been delayed by the second wave of the pandemic and would be progressed as soon as the opportunity allowed.
    b) Item 2 linked to ongoing work on language services which was underway. A report would be going to People and Community Voice Committee and then Performance and Quality Committee in due course. Item closed.
    c) Item 3 had been progressed to the Cheshire and Merseyside Quality Surveillance Group as the issue was not specific to Liverpool. A response would come back via the Performance and Quality Committee and the Chief Nurse report. Item closed.
    d) Item 4 was recorded on the PCCC Risk Register and the item could be closed.

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 highlighting that it was written prior to the current situation regarding COVID19 which had seen a significant rise in admissions to over 480 cases admitted to Liverpool University Foundation Hospital Trust (LUFHT) at one point.
12. The CCG was heavily involved in supporting the army and city in dealing with the mass testing arrangements following the recent announcement to get testing centres up and running. It was too early to have any reliable data from the testing but the data obtained would be looked at locally.
13. The report noted that the new end of life service was more responsive to patient needs which was a benefit to the local population; There would be a significant change with the introduction of 111First in mid-November giving alternate pathways for patients to utilize instead of using A&E; The impact of COVID19 on Mental Health was well documented and the report mentioned the requirement to use out of area places which continued albeit in very small numbers. Work was ongoing to try to contain this.
14. In line with Black History month the Black Lives Matter movement was discussed at a recent staff briefing with a talk given by Sam James which was inspirational.
15. JLE also reported that MSM and FLE had their contracts extended to July 2021.
16. PFI asked if any feedback was available regarding how successful 111first had been elsewhere with JLE responding that it had been positively received in Warrington and the figures reflected that 20% of calls that would have gone directly to A&E had been redirected to alternative services or given advice rather than treatment. There had been concerns raised about the impact on primary care as a result of 111first redirecting patients but there hadn't been a noticeable impact on primary care to date. This would be monitored in the city to see how it evolved; Liverpool had more alternatives to offer such as walk in centres and urgent treatment centres and there was confidence that the demand could be managed appropriately.
17. PBR asked if there was sufficient data or indication as to who would be the priority groups for the vaccine following the recent announcement of the successful trial of the COVID19 vaccine. The assumption was that it would be rolled out via primary care and would be limited; would the cold chain infrastructure be ready on time? RBA responded that this wasn't known yet, early indications were that healthcare workers in primary and secondary care and care homes along with those over 80 years old would be vaccinated initially possibly with those who were housebound and over 50 years old living in secure units. It was likely to be rolled out through age groups but this was not yet known for certain.
18. Regarding the cold chain logistics, information had only been released within the previous 18 hours which suggested 15000 designated sites to maintain the cold chain. The vaccine needed to be stored at -80 degrees and it was not clear what would happen in practices as they had to be used within 5 days or 2 hours if diluted. Every effort would be made to not waste any of the vaccine and it was hoped clear answers would be ready by 17th November.
19. JLE reported that the CCG was required to have a roll out plan and was working with NHSE to put the plan together. There remained a lot of questions and work was underway to make it work and make sense for the population.
20. FOF referred to the comment in the report regarding a well-functioning test and trace system asking how Liverpool's test and trace function was operating. JLE responded that work continued to try to make it as accessible as possible; there had been challenges with the national booking arrangements. The CCG was taking peoples experiences and adjusting and changing the local system accordingly. The tracing and tracking system was developed nationally and feedback had been that people preferred to remain anonymous which had to be respected although there was some reliance on people being open and sharing information; everyone had a responsibility here to look after each other.
21. MAS commented that testing and tracing were the two fundamental elements but it was also about what people did as a result. Testing was limited previously along with turnaround time challenges but there was plenty of capacity at this time. Contact tracing was more challenging, it was a nationally run model and there was a local contact tracing model in operation also. There had been more success locally but this was only when accurate contact details were provided. There was a team of 16 people in Liverpool carrying out contact

tracing, chasing around 300 people daily.

22. DOH thanked members for the work they were doing mentioning the academic attacks in particular saying it was not ideal given where the city was with what it had been given (mass testing pilot) and colleagues needed to keep clean minds and dirty hands making the most of the opportunity to learn and teach the country how better to respond.

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

B2 CHIEF NURSES REPORT

23. Jane Lunt presented the Chief Nurses Report stating that Trust updates were outlined within the report along with some context in regard to COVID19 to enable colleagues to understand the increased pressures Trusts were under.
24. LUFHT remained under enhanced surveillance and there had been a CQC visit in September as expected and the report from this visit had not yet been received. The Trust was under increased pressure regarding the number of COVID19 positive patients which meant it had to reduce its elective activity to respond to the increased number of COVID19 patients.
25. The Single Item Quality Surveillance Group (SIQSG) took place in October and the resolution from the outcome from that meeting and the further support that would be given to the Trust was still being worked through.
26. The report went on to mention how Liverpool Womens Hospital (LWH) was dealing with RTT as well as the response from Alder Hey Childrens Hospital (AHCH) regarding the recently discovered absence of a local pathway related to a service for children with ticks and tourettes. A pathway was being defined which reflected practice in other areas and used evidence based practice.
27. Mersey Care Foundation Trust (MCFT) continued to be challenged in community services and mental health services and had continued to utilize out of area beds and this was being closely monitored.
28. North West Ambulance Service (NWAS) had been challenged due to staffing numbers and increased demand and this would continue to be monitored. The Roche supply issue was a national issue and discussions were taking place regarding whether the incident met the criteria for a serious incident and which organisation would manage this if it was.
29. The CCG continued to work with partners to support care homes with outbreaks.
30. Nationally elective activity had stopped or reduced due to the pandemic and a harm review was underway to ensure trusts were treating patients in order of clinical priority.
31. With regard to SEND, Liverpool was subject to a Written Statement of Action (WSoA) and work continued on the action plan which outlined the progress being made locally with support from NHSE and the Department of Education to implement the SEND Code of Practice locally.
32. The report also included some updates regarding safeguarding in particular around the Liverpool Safeguarding Children Partnership (LSCP) and the independent scrutiny the CCG had commissioned which was in three phases with phase one completed, and phase two in progress.
33. Work continued to address the Children in Care pathway issue and there was an update on the medicines management national issue of Essential Pharma and brands of lithium. Work continued looking retrospectively at charges for continuing healthcare to support discharges during the first wave of COVID19.
34. RBA referred to the Roche supply issue and the disruption it had caused asking if the CCG was going to seek compensation given the extra workload it had caused to practices and MCFT saying the NHS had not taken the issue seriously. JLU commented that she did not disagree with the comments regarding the impact the issue had on the system and from a serious incident perspective the CCG was trying to process the learning from around the

incident to see if there were any areas where it could have taken control to respond more swiftly and effectively to minimize the impact on patients out with local control. JLE stated that she would make enquiries to see if the issue had been taken up nationally.

35. JBL asked when the findings from the harm review would be ready for sharing with Governing Body members. JLU responded that a plan was in place to complete the reviews however the challenge was that NHSE had recently released new guidance and the role the CCG would have usually carried out in the process was now being asked of by the Trust. As a result Cheshire and Merseyside as a region was considering one standard approach as potentially there may be a move towards having one combined waiting list across the region for efficiencies.

36. DOH commented on the granularity of the reviews expected to happen saying there had been a few different descriptions of it so far; the Cancer Alliance (CA) had a lot of detail but this would involve a lot of work for Trusts. There was some agreement about reducing numbers overall on whom full reports would be received which had the potential to increase the information received for the cases seen but may reduce the detail. There was still a lot of work to be put in place.

37. JBL mention the impact of COVID19 on SEND asking what assurance there was that the action plan was being managed appropriately. JLU responded that new ways to address some of the issues had been found. AHCH had been undertaking assessments for AHH; ADHD; and ADD pathways virtually. The recovery plan had only been delayed by the first wave of COVID19 and they were now trying to offer as many assessments as they could virtually working with the forum to refine the process and this was working well. There had been challenges regarding Speech and Language Therapy (SALT) which was getting back to pre COVID19 levels although it was anticipated the second COVID19 wave would impact this. Other therapies were managing well with virtual input, work with parents and carers had moved online. COVID19 had not had such a catastrophic impact here. There was an issue with annual health checks and work continued with Primary Care Networks (PCN) and MCFT to use learning disability health facilitators to enable a system response.

38. CMA commented that the report noted the number of outbreaks in care homes during the second wave was higher than during the first wave of COVID19 asking with the systems and support now in place why were numbers higher this time? JLU replied that this was being looked at and a learning event had been held. During the first wave the CCG offered infection prevention and control support from the basis of more techniques were needed however this time round one of the major issues had been asymptomatic staff carriers which was not anticipated as well as it may have been. The issue of testing care home staff and patients was gaining more attention but it was believed the causes would be multifactorial with the main challenge being asymptomatic carrying of the virus.

39. PBR commented that during the first wave it was assumed that people from care homes were COVID19 positive if they were symptomatic regardless of whether they were tested or not. People were being tested more now so the numbers may have increased due to this. Some homes were compartmentalized and it was not possible to compare like for like. There was a declining number of infections and more intensive testing with a better quality of care being delivered in care homes.

40. DOH referred to the update on LUFHT asking if there was anything the CCG needed to do to be assured that it was not at risk of not supporting the trust and other providers enough. JLU replied that for LUFHT in particular there was a monthly commissioning forum due to the size of the geographical area it served and the wide range of services it delivered. The forum challenged the trust in a supportive manner about the services it delivered seeking assurances and offering best practice and guidance. The issues highlighted were not new to the CCG; they had been raised prior to the CQC visit. Assurances were met through the usual governance processes.

41. PFI asked if CHC choice had been suspended for the second wave as it had been for the first wave of COVID19. JLU responded that this was not the case to date. Patients had an opportunity to request to move to another place if they were not happy with where they were placed; patients did not always go to their first choice on discharge from hospital.

42. FLE mentioned the NWAS action from the last meeting and the recent major incident that was declared asking for more detail from NWAS colleagues for assurance at the next meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the content of the report			
Further actions required: • Make enquiries nationally regarding Roche supply issue and disruption to services; • Details of NWAS issues for assurance.	J Ledward J Lunt	Jan 2021; Jan 2021	On GB Agenda Jan 2021; On GB Agenda Jan 2021.

B3 PUBLIC HEALTH UPDATE

43. Matt Ashton discussed the Public Health situation stating the following:

44. The health and social care recovery work continued on winter plans for what was known to be a challenging winter ahead; work continued on the rapid mental health needs assessment identifying wellbeing and putting more community mental health and wellbeing services in place, more details would follow regarding this in due course.

45. Targeted communications continued to be circulated with guidance regarding isolating, social distancing and lockdown measures and work continued with national colleagues towards improving test and trace.

46. The Liverpool City plan had been updated and circulated; work continued on the action plan to address inequalities. Health checks were paused and the paper outlining the new model was due at the January 2021 Governing Body meeting. Work continued with the Cancer Alliance on targeted awareness around cancer screening to encourage people to attend screening appointments during lockdown.

47. With regard to COVID19, MAS reported that the rate was down to 244 per 100,000 which although was a good reduction showed there was still some way to go and it would be a while before the city was out of the woods.

48. Mass testing had gone live the previous week and was up to 20 sites with more sites to follow, concentrating on a focused delivery i.e. in schools and universities. Of around 30,000 people tested over 150 had tested positive while being asymptomatic. Testing would be repeated weekly to understand the frequency.

49. There were also mobile testing units available with more mobile units to follow. Lateral flow tests gave results within the hour and others gave results within two to three days. The pilot was running for ten days initially and it was hoped it could be extended to the end of November to get as many people as possible tested. By breaking the chain of transmission the population would be in a stronger position when the national lockdown ended.

50. RBA enquired about the length of time proposed for the mass testing pilot saying if it did not run for long enough the opportunity would be missed. MAS responded that he had held positive discussions and although nothing was confirmed yet it was anticipated that the testing would operate for the foreseeable future and at least until the end of November at which point how it would operate would be discussed again.

51. JBL asked how many people needed to be tested in order for the pilot to be considered a success, was it 50% of the population or higher? MAS replied that he was not putting a percentage on it; the aim of the pilot was to understand who was coming forward to be tested and to understand the reasons behind it.

52. DOH asked how people could be encouraged to attend for testing to which MAS replied that any push colleagues could give would be appreciated; trusted figures such ad GPs suggesting people went for tests to protect the city was a strong message and it would be helpful if colleagues did this. Testing was not mandatory, there was no payment for being tested and the test was not pleasant but it was also not the most invasive test either.

53. HDE asked if there was any information available on the data collected so far however MAS reported that no information was available yet as the data was still being collected.

54. FLE thanked MAS and his colleagues for the work they were doing noting how very much it was appreciated.

55. Following the meeting MAS circulated the following statement:

January 2021 will see the inaugural meeting of the Starting Well Board, established after Liverpool City's revised governance structures for children and young people (C&YP). The strengthening of existing C&YP governance structures was recommended within the Liverpool Public Health COVID19 Impact report for C&YP and was endorsed by the Health and Well Being Board in September 2020. The Starting Well Board will replace the Children's Transformation Board, with fewer delivery groups simplifying the system including LCC Better Start group and the Children and Families MDT Steering Group.

The bi-monthly meeting, will be Chaired by the Liverpool City Council (LCC) Director of Public Health (Matthew Ashton) and co-vice chairs will be Liverpool City Council Director of Children's Services (Steve Reddy) and C&M SRO for Paediatrics, CEO Alder Hey (AH) Children's NHS FT (Louise Shepherd).

The Starting Well Board will deliver the One Liverpool Children and Families priorities; coordinating innovation and service development and delivery to offer the best possible outcomes for C&YP and their families, and will seek to maximise the opportunity of partnership working across Liverpool. The Starting Well Board will have a reporting line into the Liverpool Provider Alliance for these delivery priorities.

The Board will bring together all partners and strategic developments, into a single, shared C&YP group which encompasses all ages and stages in the 'Starting Well' life course phase – from pre-birth to 18-25's (dependent on service/cohorts). The Starting Well board will be accountable for delivery of the 'Better Start' objectives to;

- Address known modifiable risk factors for infant and child mortality in families and communities.
- Ensure parental mental health and parent infant attachment are priorities across the commissioning and provider systems.
- Improve children's readiness to learn with a specific focus on communication, speech and language skills from birth.
- Reduce the number of care entrants aged 0-4.
- Address and reduce the impact of known modifiable risk factors for child poverty.
- Drive system responses and recovery from COVID19 impacts on C&YP

The Starting Well Board terms of reference will clearly indicate the connection with other One Liverpool delivery groups, ensuring a system focus across the whole life course and effective management of interdependencies.

The revision of the governance structures was completed as part of a whole system review of existing structures toward the end of 2019 and further discussions have been ongoing to align processes with partners including the CCG, CVS, LCC and NHS stakeholders. The full Terms of Reference and proposed reporting structures will be taken to the next Health and Well Being Board in December 2020.

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

B4 FINANCE REPORT

56. Mark Bakewell presented the Finance Report reporting on:

57. Financial Performance which continued under the existing temporary finance regime which

covered the period April to September 2020 which was built on a combination of revised allocations, block payments and other nuances;

58. The level of 'True-Up' funding expected from NHS England during October 2020 that would support a Month 06 year-to-date financial break-even position.
59. The forecast outturn for the Mental Health Investment Standard.
60. The financial framework beyond Month 06.
61. The CCG anticipated that the excess of costs above the notified allocation would be fully funded through the NHSE 'True-Up' allocation process. Planning guidance for the final 6 months of 2020/21 required NHS Commissioners and Providers to contain costs within a C&M HCP system resource envelope. Indicative organisational plans continued to be assessed by the Health & Care Partnership.
62. FLE commented that she could only imagine how difficult it was to be a Director of Finance of a CCG that was performing very strongly until the beginning of COVID19 and then found itself in a position it had not been in before. FLE went on to ask if there was a recognition that CCGs were being asked to support requests without additional resources.
63. MBA responded that the assurance gained from regularly examining the figures showed the expenditure was not out of control; the CCG had good systems and processes in place under the normal financial regime; variances were driven by the allocation methodology which doesn't give the CCG what it normally had. The national model assumed a 1% increase in costs for the year when in reality the actual increase would be 4-6% and without the opportunity to have cost saving measures there was no ability to claw costs back.
64. The team would query additional funding at national level. The lack of clarity made it difficult.
65. RBA noted his concern regarding the comment that some things were not defendable when it was his opinion that the allocation formula was not defendable. The area had high health inequalities and life expectancy had decreased over recent months; balancing the books did not show the value of a life.
66. MBA replied that this was a valuable point; he had been lobbying about the allocation methodology for some time however it was difficult to get a tangible response at a national level. The CCG was fortunate to break even previously and it was known that there would be problems ahead; the tension had always been that by spending more money the tradeoff was a loss of control and autonomy; it was hoped there would be a settlement to bridge the gap.
67. MSM asked what the £5.3M discharge monies had been spent on to which MBA responded that it was predominantly discharges out of hospital into beds which could be care homes, care packages etc. The vast majority of the costs were in relation to discharges with a small proportion being related to avoidance. The discharge programme replaced normal CHC type costs the CCG would normally have incurred. MSM asked who was in receipt of the funds, was it local authority, local providers, where had the payments gone? MBA responded that it would have gone largely through the local authority to care homes. MSM sought clarity on the increased costs given the number of beds hadn't increased and JLE informed members that this was to fund continuing healthcare of these patients that would have previously been assessed as either free nursing care or local authority funded. They were discharged without that need for assessment and funded until requirements were put back in place and the CCG now had to go through a process of assessing a significant number of people. JLU added that when the CHC framework was suspended along with choice and the care act assessment the NHS paid for care that would normally be paid for by an individual or a local authority as part of the specific measures put in place.
68. MSM proceeded saying that after consideration of the figures presented was he correct that the CCG no longer had a contingency? MBA commented that technically he was right and the CCG did not carry out any normal planning under normal business rules at the commencement of the financial year and so the CCG had not operated in the normal manner in having to hold a contingency.
69. MSM noted that to date the CCG had largely received what it had claimed with a £400000 deficit; it forecast £11.3M expenditure for the remaining six months of the year with the expectation that this would largely be reimbursed and there were further areas to be identified for mitigation. MBA commented that it was not yet clear what the CCG would be able to mitigate against; there was a lot of variance in the deficit which was driven by budget allocation type issues rather than just expenditure. The CCG was being asked to explore from the regional team if there were any other areas it could look at, any things it could do at a

system level. The CCG was trying to be realistic in dealing with the year on an exceptional basis. A common set of principles operated across all organisations within the system and the CCG would have to take its share of the deficit; there was a lot of uncertainty sitting behind the nuts and bolts which were in place to help manage the moving forward.

70. DOH thanked the team for the detailed report mentioning the MHIS in particular which gave the detail he had been seeking. The report indicated that money was not being spent on mental health services which were needed and what could be done about this? MBA responded that there was a need to take stock in the new year. The lines in the report related to points in time within various contracts and agreements and they needed to be considered as a whole. The CCG had tried to put in place longer term investments to avoid annual fluctuations which might have worked better under normal circumstances however given the climate we were in, more needed to be done to reflect this. From a commissioning point of view the CCG did not want to give funding without projected trajectories being met; it was important to use resources in the right place.

71. JLE commented that recruitment to mental health posts was poor nationally and MCFT was a good provider. Consideration needed to be given to an IAPTS plus type module while understanding the tight measures needed to be applied to change the model to meet the needs of users. There was frustration with the allocation this year and it had been raised with Cheshire and Merseyside partnership asking for more granular detail but this had not been forthcoming.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • The existing temporary finance regime that covers the period April to September 2020. • The level of anticipated 'true-up' funding expected to be received from NHS England during October 2020 that will deliver a break-even position for the reporting period. • The update on the financial framework beyond Month 06 and the further work is required to identify areas to mitigate the deficit position across the system.			
Further actions required: • None identified			

B5 PERFORMANCE REPORT

72. SJA provided an overview of the Performance Report, informing members that:

73. The CCG met its target against 15 out of 30 reported indicators.

74. 28 Day Faster Diagnosis Standard continued to be maintained above target.

75. The 62 Day Cancer Standard from Consultant Upgrade was met in both July and August which was the first time it had been achieved since December 18.

76. Cancer 31 Day Standard to subsequent treatment for both Anti-Cancer Drugs not only met the target, but Liverpool CCG was also benchmarked as best in its peer group.

77. The CCG met the target for the proportion of SMI Physical Health Checks to be delivered in Q1 20/21.

78. The CCG did not meet its targets for the remaining 15 of the 30 reported indicators.

79. Some areas continued to show a deteriorating trend. These included the A&E 4-hour standard; the Dementia diagnosis rate; and NWAS performance against national standards.

80. The RTT Incomplete pathways within 18 weeks improved in August, the first month-on-month improvement since July 2019.

81. Performance against the 6-week Diagnostic Waiting Time standard had improved for the fourth consecutive month.

82. It was noted that, despite not meeting the standard, achievement against the 62 Day Cancer Standard from urgent GP referral to treatment was the highest it had been since March 2018.

83. IAPT access improved upon the previous reporting period, having previously declined for four reporting periods, and IAPT Recovery had again improved upon the previous reporting period.

84. There were pressures across the system and targets due to the COVID19-19 pandemic.

85. RBA referred to the recent deaths in Cambridgeshire due to eating disorders stating that England needed urgent changes asking what the CCG was doing to ensure it took eating disorders seriously enough to ensure there were adequate services. SJA responded that the waiting list was not achieving its target and breaches were dealt with via the root cause analysis (RCA) process with reasons behind this and mitigations from the provider included in the RCA report. It was on the CCG agenda for consideration and also formed part of the CQM conversation monthly. The report focused on Alder Hey and colleagues were aware that this was relevant for MCFT also.

86. PKI referred to the 31 day cancer targets being met whilst radiotherapy was rated red in August asking what had happened. SJA replied that the radiotherapy targets had not been achieved and this would be picked up in the day to day management conversations as routine monitoring with the trust.

87. MSM reported that in regard to the dementia diagnoses, GPs were not referring patients unless it was urgent, did all GPs know that referrals were back to normal in theory? FLE stated that this could be put in the bulletin although GPs should have been informed.

88. DOH commented that although the numbers had improved slightly this was mainly due to the drop in numbers of referrals and the pressures remained. Colleagues still needed to work hard to deal with different issues.

89. FLE formally noted her thanks to SJA along with Governing Body members for his work on the GB and its committees, mentioning in particular the progress made with reports, and in planning and performance; he would be greatly missed.

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: • Remind GPs that referrals were back to normal via bulletin;	F Lemmens	ASAP	On GB Agenda Jan 2021.

B6 GBAF, AND CORPORATE RISK REGISTER UPDATE

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

90. SHE presented the Governing Body Assurance Framework (GBAF), and Corporate Risk Register (CRR), noting that:

91. Approval was being sought for the GBAF which would usually be launched at the beginning of the financial year however this had been delayed by COVID19. The new format was based on practice at other CCGs and included nuances and risks previously mentioned with the challenges of being under command and control which impacted the GBAF too. The challenge for GB members was to look differently at evidence and assurance. Whilst in the command and control situation the CCG was looking to NHSE for assurance. Members were asked to note the content, agree the risks listed within it and satisfy itself that current controls and mitigations satisfied members of the right level of assurance.

92. DOH and FLE both commented that the new format was cleaner and easier to read, with the content being cleaner and easier to follow.
93. JBL commented that GBAF01 may not be true as aligning with NHSE/I objectives / priorities may still fail to improve health outcomes while agreeing that it was difficult to word pending future changes and given the increased health inequalities caused by COVID19.
94. SHE replied that this was a difficult risk to phrase and as it was not known what would happen in 2021-22; the aim was to look at the evidence and assurance in a different way and to see how the GBAF evolved over the remainder of the year and the following year. This document was an important part of the annual governance statement along with the corporate risk register and had to serve that purpose also.
95. SHO commented that there was work still to do but progress had been made. SLT were taking on more ownership of actions and there was a lot more for GB to act on. It was a tribute to staff in other areas of work that with everything that had gone on this year colleagues had managed to put improvements in along with everything else they had to complete.
96. DOH commented that it was clearer to see where issues were and where there were gaps in control and where there was assurance or not. The issues the CCG had during the year were evident and it enabled the ability to highlight things such as the legal basis of the STP and the annual work plan around GB controls.
97. FLE echoed DOH comments thanking SHO for her guidance and leadership on the process.
98. SRO commented on the residual risk rating suggesting percentages be included. The document followed a standard format using statements. Discussion took place around how the ratings were applied and their direction of travel as the year progressed. SHE suggested holding a session for members who wished to have a fuller explanation of the ratings used on the GBAF.
99. CMA commented that she was pleased with the presentation of the GBAF noting the risk appetite would help to focus the debate on priorities.
100. Discussion moved to the Corporate Risk Register (CRR) with SHE reporting that there were three extreme risks, namely EU exit; system pressures; and demand on mental health services.
101. NHSE had begun preparations for the transition period in regard to the EU exit.
102. For all three risks using a COVID19 lens the risk scores remained the same and red.
103. FLE commented that it was hard to keep up with the pace of change in the risk register.
104. SHE commented that there was a further conversation to be had around risk appetite noting that some items the CCG had no control over and some were in response to NHSE requirements. The register had increased and more may be added over the coming months with the pace of change being a risk in itself.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • 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; • Satisfy itself that current control measures and the progress of associated action plans provide reasonable / significant internal assurances of mitigation			
Further actions required: • Arrange session for members to explain ratings and GBAF as required;	S Hendry	ASAP	On GB Agenda Jan 2021.

B7 BETTER CARE FUND 2020-21.

105. MBA reported that the CCG had been waiting for planning guidance since the start of the year, however due to COVID19 this had not happened and so colleagues had taken the decision to try to reflect the current position.
106. The report contained some errors; p119 'total' column contained a formula error however the totals were correct; also under section 2.1.1 on the same page had rounding errors.
107. The combined value for the BCF excluding the discharge programme was £123.8m with contributions from 2 different partners. Appendix 1 was a deed of variation to the section 75 agreement and appendix 2 included more detailed information.
108. The proposal would be presented at LCC cabinet meeting in December and the Health and Wellbeing board in January 2021 in line with national guidance.
109. HDE asked if the CCG had contributed more than it needed to historically and was this recognized; should it continued to do so. MBA replied that as part of the measures to be considered the CCG was above the level. As part of future arrangements it would need to be revisited to ensure objectives were met for all parties.
110. JBL clarified that this was an update and refresh.
111. SHO asked if the figures would be affected by the issues discussed earlier regarding CHC within the finance report. MBA responded that they would be affected to a degree but a figure could not be listed for the discharge stream as it fluctuated monthly as it was updated. The pathway described within appendix 2 would however be updated and it would be monitored here.
112. Members approved the proposal.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Support and approve the 2020/21 Deed of Variation to the Section 75 Partnership Agreement between NHS Liverpool Clinical Commissioning Group and Liverpool City Council to incorporate the BCF changes. • Support and approve the Better Care Fund expenditure plan for 2020/21 between NHS Liverpool Clinical Commissioning Group and Liverpool City Council. • Support and approve the approach of implementing an additional Deed of Variation, based on the national template document, to incorporate the 'Enhanced Discharge Service Requirements' and the 'Discharge to Assess' model as set out in the Deed of variation of the Section 75 Partnership Agreement. • Note the requirement and plan for approval by the Liverpool Health and Wellbeing Board following approval by Cabinet and Liverpool Clinical Commissioning Group Governing Body.			
Further actions required: • None identified			

B8 EPRR ASSURANCE REPORT 2020-21

113. SHE delivered the report noting that:

114. This was the annual assurance report and was subject to a light touch from NHSE with the granular detail lifted this year.
115. The CCG was declaring standard compliance and had improved on the previous year. One standard remained outstanding which was partially complete, the delay was due to losing a member of the team over the summer.
116. The section on learning from COVID19 was a review of the last eight months and the learning taken from it.
117. Members were asked to note the contents of the report and the self-assessment as substantial compliance.
118. FLE commented that it was impressive how the incident management team had pulled together over the last months to cope and deal with everything that had happened and not let things slip.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Notes the contents of the report; and • Notes that the CCG has achieved 'substantial compliance' against the 'light touch' National Core EPRR Standards for 2020/21.			
Further actions required: • None identified			

C FOR DECISION

119. No Items.

D FOR NOTING

120. No Items.

E QUESTIONS FROM THE PUBLIC

121. The following is a copy of questions received from the public in advance of the meeting along with the response which was emailed:

- Why can't patients have 1 person chaperone with them?

a. You say it's because you need to minimise the spread of the virus but people may already have had it.

b. Vulnerable people need their family member.

c. People who are sick can miss giving vital information to hospital which has an impact on their care.

Visitors accompanying patients to appointments are currently restricted, to minimise the risk of infection.

Where a carer or a chaperone is supporting someone with a mental health issue such as dementia, a learning disability, autism or other similar complex conditions, patients can be accompanied where not being present would cause the patient to be distressed.

The majority of outpatient appointments are now being undertaken remotely, but if it is necessary to attend a face to face appointment, patients are asked to attend alone. Where this is not possible, either due to potential psychological distress or physical support, one person may accompany the patient, by agreement.

- Why are some doctors refusing to speak to patients next of kin?

A medical next of kin is someone a patient nominates to receive information about their medical care. If a patient has not chosen a next of kin, it will usually be assumed to be a close blood relative, spouse or civil partner. Most NHS Trusts ask a patient to nominate their next of kin when admitted to hospital.

Medical teams cannot automatically speak to or share information with a patient's next of kin. The patient must give permission for medical teams to share information with their next of kin.

Next of kin may act on a patient's behalf if the patient is unable to do make decisions themselves, for example if they are unable to communicate due to illness or being unconscious, only if their next of kin has Power of Attorney (POA). In situations where relatives do not have Power of Attorney it is good practice that they should be consulted by medical staff regarding decisions about care.

Specific issues or complaints about a doctor refusing to speak to a patient's next of kin should be directed to the relevant NHS organisation.

- Why is this inconsistent within the same hospital?

Every patient and their circumstances are different, but all medical teams should act within the principles stated above.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

122. The following items and committee minutes were noted:

a) Remuneration & HR Committee Chairs report September and October 2020
   I. HDE reported that there had been two meetings in the period with nothing to be escalated, noting the performance framework which was a new approach and the remuneration framework, both of which held potential conflicts for members who discussed it and had agreed to act in the best interests of the CCG.

b) Audit and Risk Committee Chairs report September 2020;
   I. SHO commented that it was important to change in line with the style of the committee structure and committees would be doing more work as delegated to them from GB. There was uncertainty around the operational plan for the following year and the report would be received at the next GB meeting.

c) Performance and Quality Committee Chairs report October 2020
   I. CMA reported that a paper had been received from finance around contractual documentation and review of the central register of healthcare contracts which was approved to be undertaken, however due to COVID19, a rapid review had taken place and further work was due to take place to produce an action plan for agreement by SLT and then agreement at Performance and Quality Committee. There may be financial issues which would need to be raised for escalation once more information was known when the work was complete. The EDS2 Contract plan and procurement contract recommendations were approved.

d) MBA commented that the contract team were doing a lot of work to understand the priority areas and trying to keep up as things changed under capacity constraints.

e) PKI queried the level of detail required in the reports with members agreeing that different levels of detail would be required relevant to the committee and timing.

f) Ratified minutes were received from the following committees:
   I. Committees in Common – February 2020

G1 ANY OTHER BUSINESS

123. MSM reported that the COVID19 virtual ward via the telehealth hub was live. This was a benefit for Liverpool and would be rolled out across the region. The ward could monitor up to 500 patients weekly on a risk stratified basis and oxygen monitors were being delivered as necessary. A lot of work had been done in advance of the roll out of this by MCFT.

124. PFI commented that she had spoken to two patients who were grateful for the telehealth care and service.

125. FOF asked if care homes were on the pathway to which MSM replied that he would take the question away as an action as he was unclear where this was up to.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely:			

• Notes the items of business.			
Further actions required: • Clarify status of care homes with regard to COVID19 virtual ward and telehealth hub.	M Smith	Jan 2021	On GB Agenda Jan 2021.

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