NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	**13 July 2021**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Friday 28 May 2021	Time:	2.30pm
Venue:	MS Teams		

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

ISSUES CONSIDERED
2021

A1 WELCOME

1. FLE welcomed all those present noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.
2. FLE reminded members that the Governing Body was meeting virtually and a recording of the meeting would be available on the web page within three working days of the meeting taking place.
3. The meeting was also being broadcast live enabling members of the public to join online.
4. Members were reminded to keep microphones on mute unless they were speaking and to use the 'hands up' facility or chat function to obtain the Chairs attention when they wished to make a comment.
5. FLE referred to the new Mayor of Liverpool and the new cabinet noting that Frazer Lake would replace Paul Brant as the Cabinet Member for Adult and Children's Health and Social Care formally thanking Paul for his input over the years which had been knowledgeable, stimulating, interesting, amusing and helpful in equal measure. Paul would be missed and Frazer would be made very welcome.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

7. HDE declared a connection with Mersey Care Foundation Trust (MCFT) which had been long declared and for which members agreed no action was necessary. FOF also declared that she was an employee of MCFT and again no action was necessary. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register.

A4 MINUTES OF THE MEETING HELD ON 9 MARCH 2021

8. The minutes of the meeting held on 9 March 2021 were accepted as an accurate record.

A5 ACTION LOG

9. The action log was discussed with the following points made:
   a) Item 1 regarding assurance of NWAS issues within the corporate performance report: JLU informed members that a report had been to Performance and Quality Committee in May and the findings from this would come to the next Governing Body meeting. Steps had been taken to ensure the CCG had access and strengthened the reporting around NWAS quality governance. Regular updates would go to Performance and Quality Committee to fully understand the quality of services on the population. Item closed.
   b) Item 2 Session for GB members regarding Ratings for Risk and GBAF: the session had been held; item closed.
   c) Item 3 Add entry regarding life expectancy considering the impact of COVID-19 particularly on vulnerable groups to GBAF for 2020-21 and 2021-22. This item had been added to the following year's GBAF. Item closed.
   d) Item 4 Feedback comments regarding proposals to JLE and FLE. This item had been completed and was on the meeting agenda. Item closed.
   e) Item 5 Feedback comments regarding joint committee to working group as discussed. This had been completed and was on the meeting agenda. Item closed.
   f) Item 6 Ensure OOH cell discussed all recovery activity not just surgery. This had been completed, item 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

A6 COMMITTEE REPORTS

10. HDE delivered the Remuneration and HR Committee (REMHR) Chairs report from the March committee meeting noting that the committee had welcomed Andrea Hutchinson (AHU) as BAME representative and Heidi Minnaar (HMI) as the Staff Engagement Group representative. It was helpful to have diverse attendance, and it was AHU who had suggested recommending unconscious bias training be mandatory training for all staff.
11. Risk was reviewed regularly as a standing item, with time spent giving the appropriate level of scrutiny and challenge. Time was spent discussing the Governing Body appraisal process and whilst acknowledging the process was light touch and therefore had some shortcomings, Governing Body members could be reassured that it was a reasonably robust process of one-to-one conversations which members reported as being productive. Further developments areas had been identified as a result.
12. The committee was pleased with the results of the staff survey particularly when viewed through the lens of change and uncertainty and recognizing that the CCG could not be complacent, an action plan was in place to capture actions and monitor progress. There was nothing to draw members attention to.
13. FLE commented that it was good to hear about AHU joining particularly as FLE herself had attended a national webinar the previous day and it was reassuring to see the CCG was taking the actions that were being recommended. FLE asked if the committee would consider an update from the minority network as a standing agenda item to which HDE responded that this could certainly be added to the work plan.
14. SHO delivered the Audit and Risk Committee (ARC) Chairs report from the April committee meeting noting that the committee had met twice in April with a standard committee meeting on 13th April which discussed the expected items and good progress was reported from Internal Audit reports with substantial assurance from three reviews and further progress in clearing outstanding recommendations.
15. The committee carried out its annual self-assessment review which led to a focus on the coordination and inter relationships between committees and how they considered risk to ensure nothing was missed. A meeting was held on 18th May with all committee chairs in attendance; the meeting was held to discuss ways forward for the risk register; it had been a very positive meeting which agreed the method of the review of risk which would be brought forward by the Corporate Services Team to ensure all business was properly packaged and completed.
16. The committee met again on 21st April 2021 to review the Annual Governance Statement (AGS) and Annual Reports and Accounts (ARA) and to make comments in advance of the 11th June meeting when the audit would be complete. SHO on behalf of Audit and Risk Committee sent congratulations to all involved in putting the documentation together which was a mammoth task under normal circumstances and given the difficulties faced over the last year the achievement was remarkable.
17. FLE echoed the comments made thanking all involved in the task.
18. CRO delivered the People and Community Voice Committee (PCVC) Chairs report from the April committee meeting reporting that there was nothing to escalate. A summary of items discussed included the excellent report regarding COVID-19 engagement and accessing or attempting to access NHS services in Liverpool. With over 1400 people responding, it enabled the building of awareness upon the findings

and would be shared with Primary Care Commissioning Committee and other committees as well as Senior Leadership Team (SLT).

19. The committee also looked at how to move forward with the vaccine inequalities plan; there were several updates on service changes which were also discussed with agreements made to take these forward.
20. CRO reported that the committee had settled into its rhythm and it would like to move towards hosting the meetings in a community setting when permitted to show its commitment to the community.
21. HDE commented that it was pleasing to see how engagement was used and incorporated into plans and planning. CRO responded that it was credit to the team and thanked them for the work involved. FLE echoed the sentiment commenting that she had listened to the conversation regarding eConsult and used it to inform conversations since noting that the committee had really taken off under the guidance and leadership of CRO.
22. CMA delivered the Performance and Quality Committee (PQC) Chairs reports from the March and April committee meetings thanking DHO, JLU and MBA for the comprehensive reports provided monthly to the committee which were extremely useful in supporting the committee discussions while recognising the systems were under great pressure.
23. In March the committee received a deep dive review into Mersey Care Foundation Trust (MCFT) which demonstrated the ability to integrate issues relating to quality performance and finance. The report highlighted several areas requiring ongoing monitoring and improvement to give assurance to the CCG. These included continuing healthcare, children in care services, eating disorders, and the autism spectrum service.
24. MCFT would merge with North West Boroughs (NWB) in June and enhanced surveillance may be put into place to recognise the additional risk brought about by the merge.
25. The committee received the performance report which noted dips in performance; the LeDeR report; and noted that the contracts team had developed a database which had involved undertaking due diligence on 120 providers. Improvements were also noted on SEND primary care performance. The committee approved the continuing healthcare specification at the March meeting and several services at MCFT required further assurance which were brought to the Governing Body's attention.
26. At the April meeting the bimonthly Chief Nurse Report highlighted waiting list issues in gastroenterology at Liverpool University Hospital Foundation Trust (LUHFT); regular reviews would continue here. An update on MCFT demonstrated that progress was being made. Liverpool Womens Hospital (LWH) was making progress on the Ockendon report; the draft financial planning process was received along with regular finance and performance reports and a summary of digital procurement for quarter 4. The digital procurement was approved under a national framework approach.
27. The committee also looked at the committee risk register and there were no items to escalate from the April meeting.
28. SHO mentioned the April meeting asking if there were lessons to be learned regarding the Merseyside and Regional Stoma service which had appeared to encounter issues once it went 'live'. The issues were not discovered despite undergoing due diligence previously. MBA responded that the service was not technically live as it had been delayed due to the points raised noting that with procurement greater emphasis was put on specifications and some aspects needed more emphasis to prevent it from reaching this position. When trying to Commission services on a wider scale it did bring more challenges with the different perspectives involved and there was learning for the wider footprint. Those aspects had been noted and recognised and the team was considering how to adjust going forward. The service would not go live until key aspects had been answered by the provider

and regular communication was ongoing to move this forward.

29. FLE congratulated the team on addressing the LeDeR review backlog which was at 111 and had reduced to 2 asking that the committee take and report back on the learning from this review. JLU responded that the LeDeR annual report would be presented at the next Performance and Quality Committee (PQC) and the report would do this, commenting that it was about getting the learning into the service to not make the same mistakes again.
30. FLE referred to the April PQC notes where Liverpool CCG was identified as the lead CCG for finance for the Cheshire and Merseyside system asking if there was capacity. MBA responded that this was a continuation of what was already happening; it brought an extra burden but also brought the advantage of knowing what was happening and the opportunity to challenge early in the process. Mitigations were in place and joint working gave marginally more capacity. Working in different environments allowed more flexibility, for example block contracts; also the CCG was receiving contributions towards the team which were not all absorbed internally. The situation was comfortable now with a healthy balance and it was preferable to be in rather than out.
31. FLE noted that it was good to see the committee coming together so well. Initially there were anxieties with the large remit of the committee and it was good to see the learning of the Kirkup report being applied.
32. GGR delivered the Primary Care Commissioning Committee (PCCC) Chairs report from the April committee meeting adding thanks to SHO for organising the committee chairs meeting in May which was very positive and achieved a lot, making sure that committees over did things rather than miss anything. As lay member for financial oversight GGR sent thanks to the finance team for their work in preparing the accounts.
33. GGR went on to state that the Primary Care Commissioning Committee (PCCC) Chairs report from the April committee meeting report was self-explanatory; the committee received a good presentation from the Liverpool Networks Alliance (LNA) and the committee then put the LNA under scrutiny regarding what it had achieved against the objectives set. The committee had also looked at the committee work plan with several things agreed for approval; the committee had also considered the committee risk register. There was a need to monitor contract renewals given the short termism in place and one or two areas needed deep dive reviews. There were no items to be escalated to Governing Body.
34. PKI delivered the Clinical Effectiveness Committee (CEC) Chairs report from the March committee meeting noting the committee had been in existence since 2019 but had not operated properly until recently due to the pandemic. The committee had been considering its relationships with other committees namely the Clinical Forum, Medicines Optimisation Committee and the Research and Development Group. There were no items for escalation.
35. HDE commented that she found the committee reports very informative thanking colleagues for their reports noting that from a governance perspective they worked very well. FLE agreed commenting that it felt like a team approach.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Committee Chairs reports			
Further actions required: • Add update from minority group to each REMHR agenda	J Twist	July 21	On July 21 GB agenda.

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

36. MBA presented the Chief Officers Report on behalf of JLE noting the following:
    a) The report highlighted issues and risks which had reached the attention of the Chief Officer over recent weeks and largely referred to actions and activities regarding the COVID-19 pandemic and the vaccination programme with recent large scale event pilots. Notwithstanding the challenges remaining particularly around the inequalities programme and resistance to the vaccine remarkable progress had been made on the vaccination programme.
    b) The report noted the system response and challenge to return to pre Covid-19 performance levels and more operational details regarding the CCGs planning approach for 2021-22 were included on the agenda for the meeting.
    c) The CCG had considered the communications out to GP practices in recent weeks regarding the restoration of face-to-face activity which was an important factor and work continued on this.
    d) On a more local basis the Cheshire and Merseyside team had applied for Integrated Care System (ICS) formation work to continue to progress. Subject to legislation it was anticipated that the ICS would become a statutory body by April 2022. The Memorandum of Understanding (MOU) had been agreed and was shared with the meeting papers for information.
    e) FLE noted that the Chief Officers report was written around two weeks prior to the meeting taking place and the CCG was acutely aware of the pressure in primary care and practices knowing they had remained open throughout the pandemic, working exceptionally hard to keep staff and patients safe. The SLT had met the previous week and written to all member practices; the CCG trusted their GPs and providers and wanted to understand the best approach for them.
    f) RBA commented that he found the wording on the Chief Officers report interesting as guidance cannot instruct it guided; NHS England and Improvement (NHSEI) clearly became confused believing they could instruct what they wanted noting that if it was not in the contract then it could not be enforced. RBA was grateful to the CCG for the support to general practices commenting that primary care had been under strain far outweighing that prior to the pandemic. The system was working in really difficult times; the work mirrored what was happening in secondary care and it was going to take a long time to get back to any semblance of normality. Pre pandemic the number of people waiting for treatment over 15 weeks was 165, in March across Cheshire and Merseyside that number was over 15000 and the figures were increasing by around 4000 per month. The system was under a lot of pressure and patients being seen were undoubtedly becoming more complex and more ill as time went by. The overall system needed to acknowledge that fact.
    g) DOH referred to the development of the ICS and the MOU that was in place noting that the architects of the structures and approach had since declared that they were unclear about the purpose and intention of the ICS, asking how would the MOU be reflecting this change. MBA responded saying that the question was timely and new appointments may bring slightly different perspectives and there would be a need to take stock. While waiting for the legislation to be agreed the CCG had to maintain the direction of travel noting that regular meetings with the local authority, local CCGs and the Health and Care Partnership (HCP) team which brought togetherness and enabled the identification of issues with the ability to work through some of these. It allowed members to be clear on roles and responsibilities of the system identifying what the work programme should look like and give the opportunity for reflection. Members were trying to make sure it represented local needs and issues from the ICS development plan to get

the health balance from both aspects.

h) JBL added to RBAs comments regarding frustration with the system noting that primary care staff were getting an increasingly negative experience in trying to be more open with patients telling them how long treatment might take but were frustrated with not knowing what was happening.

i) STH echoed the comments stating that more transparency would be useful. Shops and bars and other places were opening up but not the NHS and people did not understand why this was. A frank conversation would help the understanding around this.

j) CHI commented that providers were expected to have regular conversations and updates with patients on waiting lists so they were not left unaware of when they would have treatments. These patients should be prioritized and the expectation was that they would have one to one communications with providers. There was also a requirement in a more global sense to be more transparent about challenges around the recovery work nationally and to provide a framework for this. Failure to have this conversation meant that frustration and dissatisfaction would only grow.

k) RBA stated that there was a need to try and ensure secondary care did its share of the workload and did not refer patients back to GPs as often when answers were with secondary care it caused more delays for patients.

l) DOH asked who had control of communications being shared, could they be arranged locally or were they being managed centrally to which CHI responded that it was about what could be done at the various system levels which were interconnected and a conversation needed to happen regarding this. There was a meeting the following week where she would raise the question on behalf of Governing Body for a transparent and honest conversation to support front line practitioners.

m) HDE commented on the increase in A&E attendances asking about plans for joint messaging about the use of A&E noting that people had stayed away during COVID-19, either dealing with matters themselves or seeking advice elsewhere asking if they could be encouraged to continue to do this.

n) CHI responded that conversations were continuing across the wider system for a campaign approach noting that there was a role for that here and it was also important to look at complex issues as sometimes it was regarding access and sometimes it was about whether people were aware of the choices available to them. A known issue was regarding students locally with a lower level of GP registrations this year which was hoped not to be repeated when freshers arrived again. There was a need to look at why there was the demand with pressures increasing in order not to raise expectations.

o) DHO reported that the matter of communications had been escalated to regional level and the intention was for a national large-scale communications programme to encourage the public to use NHS111 although there had been no evidence the programme had been delivered yet.

p) From a local perspective a survey had been delivered and the results were to follow. The survey asked why people were at the emergency department and what services had they tried prior to attending the emergency department to help understand what communications needed to happen locally to target population groups. Once the results were available they would be shared with the region with the intention of being shared for a larger communications exercise.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Chief Officer report;			

Further actions required: • Raise question regarding communications to public and who was responsible.	C Hill	ASAP	On July 21 GB agenda.

B2 PUBLIC HEALTH UPDATE

37. SBA presented the Public Health Update report on behalf of Matt Ashton highlighting the following:
    a) At that point in time the weekly case rate was under 10 per 100 thousand which was a drop of 25% on the previous week, and highest in the 20-29 age group. Vaccine coverage was looking good and was the lowest in the Liverpool City Region while Liverpool had the highest uptake of all cities. A third of the population had received the second dose of vaccine. The report included demographic information and accumulative mortality information.
    b) JBL commented that it was interesting to see in the epidemiology report how close COVID-19 deaths were to CVD and cancer deaths noting that CVD deaths appeared to have increased during the pandemic and asking did cancer deaths increase also. SBA responded that with COVID-19 being an associated cause it had particularly affected people with underlying causes and she would take the question away for a response.
    c) DOH thanked SBA for the report commenting that page 8 was disturbing in how the mortality rate was used to skew the message. Putting Sefton as having the highest mortality rate effectively hid the significantly higher deaths in Liverpool noting that the populations differed significantly, citing the number of people over 80 years old as a proportion of the population as one example. The case fatality rate was a random number reflecting the number of cases found and which referred to the success of testing in Liverpool and not one that can be compared with real use. Regarding the underlying cause of deaths it would be useful to look at the number of deaths and the number of people dying with COVID-19 in each group which can be found on CIPHA and blood pressure seemed to have the highest increased rate with cancer the lowest although all were fairly similar with the biggest risk seeming to be the over 80 age group and deprivation which would explain why so many younger people had died in Liverpool in comparison with other cities. SBA responded that age specific figures were available if of interest to members and she would check if these could be shared. With ethnicity figures deaths were predominantly amongst older white British people as the older age groups were predominantly white British. There was a lot of nuance behind the figures and the comments made would be fed back.
    d) FLE clarified that in comparison to core cities regarding vaccinating the population Sheffield and Leeds had been more successful and colleagues were seeking comments from Sheffield and Leeds to see what they were doing that LCCG could learn from. SBA commented that also the vaccination bus was out a lot which increased the rates too.
    e) PKI commented that the vaccination programme had been a great success generally and consideration should be given to how the CCG could take the success of the programme and build on it in the future with other public health initiatives. PKI asked if the vaccine bus could be utilized for other vaccine programmes for populations that were harder to reach. SBA responded that this had been discussed as it was a great idea and it would be useful to combine it with the flu vaccine.
    f) FLE commented that the vaccine programme was still deep in operational day to day running and it would need to capture the learning from the experience. One major item was joint working and how successful it had been.
    g) MSM stated that the vaccine had been successful because it was delivered in the middle of a pandemic and people were terrified. The bigger risk was how to prevent that falling away as people become confident. There was a need to think

about mitigating the negative effects of misinformation in social media arenas with low uptake and to consider how to get to those groups noting that there may be a need for an annual vaccine and booster ahead.

h) MKH reported that when Swine Flu was around an increase in flu vaccinations was noticed. MKH asked if there was any data from the testing of major events in the city recently to which FLE responded that there had been a publication which could be circulated to members. No increases had been found as a result of the events.

i) FOF expressed positivity to see the planned work regarding eScooters and risky behaviour. Given they could travel at 15mph on roads and that there had been a spate of admissions to trusts with severe injuries it was pleasing to see the work being undertaken.

j) JBL asked if the funding available for adder process support which had been made available for people with substance misuse problems was available for people in the criminal justice system only or was it also available to those in the community for support. SBA responded that it was available to the community and to work with the police noting that it was not confirmed yet if the funding would be granted and work needed to take place with the police regarding what was required to deliver as the funding would be a one-off amount for the next year. JBL went on to ask if the work the insight team were carrying out for the next year would include plans to work with mental health issues noting that it was important to use the resource to address the needs of the population. SBA was unaware and would check and feedback a response to this.

k) Commenting on the level 2 funding for a weight management programme JBL asked if the team were aware of the digital weight management programme being rolled out nationally stating that she would forward the information to James Woolgar.

l) Noting that the vaccine bus had identified 30 patients not registered with a GP JBL asked if a process had been identified for this to which FLE responded that where possible support with registering with a GP was being given noting that IT issues often made this difficult, FLE and JBL would continue this discussion outside the meeting.

m) DOH suggested using the data to look at inequalities in relation to responses particularly digital inequalities and those around mental health and how they perhaps affected services where an email address was required.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • That Liverpool CCG Governing Body note the information contained in the report. • That the Liverpool Public Health Epidemiology team to continue to monitor the epidemiologic situation in a timely manner and alert the Liverpool system on any changes. • That Liverpool CCG Governing Body and Liverpool City Council work proactively to reduce inequalities in COVID-19 vaccination by appropriately resourcing the COVID-19 vaccination inequalities plan. • That Liverpool CCG GB works with LCC to support the needs of our residents affected by the pandemic in Liverpool.			

Preventative and recovery measures need to be targeted to address the health needs of those who are disadvantaged by deprivation and by the direct and indirect impact of the pandemic. • That Liverpool CCG GB supports new initiatives and public health programmes around healthy weight, sexual health, smoking cessation, mental health and children and families support.			
Further actions required: • Ascertain if cancer deaths had increased during the pandemic; • Share age specific data if available and permissible; • Circulate report of findings from major events testing; • Clarify remit of insight team regarding mental health for the next year; • Share information on national weight management programme with James Woolgar.	S Baird S Baird S Baird / F Lemmens S Baird J Bliss	July 21 July 21 July 21 July 21 July 21	On July 21 GB agenda. On July 21 GB agenda. On July 21 GB agenda. On July 21 GB agenda. On July 21 GB agenda.

B3 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

38. SHE provided an update on the organisation's Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR), and Issues Log stating that:
    a. Members were being asked to approve the closure of the GBAF for 2020-21 transferring residual risks and actions to the 2021-22 GBAF. The number of red risks should be pared down subject to written confirmation following a recent meeting with NHS England (NHSE).
    b. The annual governance statement (AGS) and the draft head of internal audit opinion (HOIAO) had been used to weigh some assurance ratings.
    c. The Governing Body development session earlier that week had been very positive and had agreed all principal risks for the next financial year and the new GBAF would be presented at the next Governing Body meeting.
    d. Items CO36 and CO84 on the Corporate Risk Register (CRR) referred to resilience risks, work was underway revisiting these as the descriptions and context of the risks had changed over time along with the system pressures.
    e. DHO commented that time had been set aside to consider these risks, looking to reframe system pressures and looking at mental health bringing risks up to date to be more accurate.
    f. Work was ongoing to make the CRR less cumbersome using the format of the GBAF giving a clearer line of sight regarding who was responsible for actions. The risk management strategy would be considered at the next SLT and then the next Audit and Risk Committee, the strategy would be in place until March 2022.
    g. SHO thanked SHE and RHO for their input and support on this welcoming the root and branch analysis of the risks mentioned noting that because a lot of the risks had been on the register for a long time a root and branch review would benefit all those listed as they had morphed over time; looking at the framing of each risk would be a useful rigour to all the risks on the CRR. The timing was good also

when closing one years register while commencing the next years one.

h. FLE echoed SHOs comments thanking the team for the work involved.

i. Members agreed to close the GBAF for 2020-21.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Governing Body is asked to: • Agree the 'close down' of the GBAF for the financial year 2020/21 and transfer of any relevant residual risks / mitigating actions to the 2021/2022 GBAF; • Satisfy itself that the 2020/21 GBAF has aligned appropriate risks, key controls and assurances alongside each strategic objective; • Satisfy itself that the control measures and the progress of associated action plans provide reasonable / significant internal assurances of mitigation.			
Further actions required: • Revisit CRR for root and branch review in line with discussions.	S Hendry	July 21	On July 21 GB agenda.

B4 COMPLAINTS, SUBJECT ACCESS REQUESTS, FREEDOM OF INFORMATION REQUESTS AND MP ENQUIRIES REPORT 2020/2021

39. SHE delivered the Complaints, Subject Access Requests, Freedom of Information Requests and MP Enquiries Report 2020/2021 highlighting the following:

a. There had been a slight increase in MP complaints and enquiries and no parliamentary questions and a sharp drop in subject access requests.

b. Freedom of Information (FOI) lines of enquiry requests had increased sharply. There were two breaches to report which were due to the electronic system not functioning as well as it should, and a formal process had been put into place to remedy this.

c. There had been a significant increase in complaints, with complaints about providers generally being more serious and about clinical issues. There had been an increase in complaints regarding Alder Hey Childrens Hospital about a perceived gap in services left by one consultant retiring; Alder Hey had acknowledged that the circumstances were not ideal and lessons had been learnt.

d. Regarding CHC complaints, retrospective reviews were being managed by the quality team and it was important to separate the retrospective reviews from the genuine complaints about the process. It was anticipated that there would be an influx of complaints regarding CHC when the system returned to more normal levels, this was a risk with the resources available within the CCG.

e. STH commented that people raising complaints through the NHS complaints process would be more stressed than normal due to the frustration with how long responses were taking and a complaint that could have been dealt with relatively easily became magnified as it was affected by the delays caused by the pandemic and the difficult communication process.

f. HDE stated that to answer all but two FOIs was to be applauded under

the circumstances; the Information Commissioners Office (ICO) had extended time scales and so technically there was not an issue from a compliance perspective; the process was operating well and within time scales. SHE thanked HDE for the comment which he would pass on to the team.

g. PKI suggested that looking at the number of complaints received they appeared to fit with COVID-19 and asked if they were predominantly regarding access related to COVID-19. Clarification was sought regarding page 166 where the provider was referred to as NHSE. SHE responded that it was fair to assume COVID-19 complaints were around access to GPs, however medical complaints were dealt with by NHS England and the CCG could only do so much before referring them on so this was an assumption. The CCG kept an audit trail of complaints which were sent on to NHS England. Where NHSE was listed as provider on the report, this indicated where the complaint was forwarded to NHS England for a response as the 'owner' of the complaint process in that instance. This was differentiated between GP practices and other primary care services within the report.

h. MSM commented that general practices nationwide felt inundated since having moved to the total triage model. The unforeseen event was that practices had struggled to cope with the number of online consultations this had generated with more and more appointments being dealt with than prior to the pandemic. This would be a challenge for practices as the system returned to the new normal. The CCG had commissioned extended access to support patients however patients were not always happy as they appeared to feel they were receiving a worse service here. There was a need to understand the workload implication moving forward.

i. RBA stated that there was a need to make sure patients were informed regarding what was available and how they could access services so they understood what was available and so that their expectations were managed.

j. FLE thanked colleagues for the report noting that what was being complained about was something for the Performance and Quality Committee to consider at another time.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Governing Body is asked to: • Acknowledge the CCG's internal and multi-agency work to ensure compliance with the Freedom of Information Act, Data Protection Act, Health and Social Care Act and NHS Complaints Regulations; • Receive and note the contents of the annual summary report			
Further actions required: • None identified			

C FOR DECISION

C1 JOINT COMMITTEE FOR THE PROPOSAL FOR A COMPREHENSIVE STROKE CENTRE

40. CHI discussed the joint committee for the proposal for a Comprehensive Stroke Centre which was seeking approval to delegate decision's as set out in the proposal provided. The joint committee allowed a more streamlined decision-making process which was in line with the principles first established in the Healthy Liverpool programme to ensure that services that could be delivered locally were delivered locally.
41. The proposal was at the pre consultation business case stage; it had been given approval by the medical Senate to move forward and decisions were now to be made regarding the pre consultation business case.
42. The joint committee needed to consider the pre consultation business case and report its findings regarding assurance and communicate back to the Governing Body of each CCG involved. Assurance would be reported via the minutes which would be shared with the Governing Body of each CCG involved.
43. Section 6 of the proposal outlined the next steps and a conversation needed to happen with NHS England regarding this. The aim was to have the process completed before the end of March 2022 prior to forming the ICS. Members were being asked to approve the delegation of decision making regarding the proposal and membership of the joint committee for the stroke centre, the proposal would be going to the five other CCGs over subsequent weeks.
44. FOF asked how the proposal fitted with the planned work areas of Cheshire and Merseyside who were also looking at strokes to which CHI responded that this proposal was specifically for the acute part of the pathway while other elements would be looking at different areas; this proposal was limited to the 5 CCG populations and not linked to the Cheshire and Merseyside services.
45. SHO enquired about Knowsley and was informed that Knowsley was included within the proposal.
46. MBA pointed out that there was further work to be carried out regarding finances for the proposal which would form part of future discussions. FLE clarified that if decisions were delegated to the joint committee as requested this would not mean losing the ability to discuss finances. MBA concurred noting that the proposal was asking for approval to proceed with the joint committee and financial autonomy was the role of the CCG. It would be a joint piece of work to progress the proposal with joint CCGs involved and the financial impact was to be addressed. FLE noted that this point would be reached quickly if decisions were delegated; CHI commented that some decisions around governance and operational structures would need to be made soon.
47. JBL asked if delegating the decision making would implement the decision to re-site the hyper acute stroke unit at Aintree to which CHI replied that it could not be predetermined what any decision would be as it was a proposal. The proposal would give independent clinical assurance and the CCG felt it was the right thing to do in streamlining the process.
48. STH commented that Healthwatch as an organisation would have limited influence on the different demographics involved due to the membership constraints.
49. Members agreed to support the delegation of decision-making regarding the proposal for a Comprehensive Stroke Centre to the joint committee and to approve the extension of membership of the North Mersey joint committee to include West Lancashire CCG, limited to the proposal for a Comprehensive Stroke Centre.

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

• Approve the delegation of decision-making regarding the proposal for a Comprehensive Stroke Centre to the joint committee; • Approve the extension of membership of the North Mersey joint committee to include West Lancashire CCG, limited to the proposal for a Comprehensive Stroke Centre.			
Further actions required: • None identified.			

C2 NHS OPERATIONAL PLAN 21/22 AND INTEGRATED BUSINESS PLAN

50. DHO delivered the NHS Operational Plan 21/22 and Integrated Business Plan noting that the plan was an integrated business plan between the CCG and the local authority. Appended to the business plan was the operational plan and the financial assumptions.
51. It was intended to be a live document to be amended as the year progressed. There was uncertainty around due to the proposed formation of the ICS and lack of information regarding finances which was another reason for updating the document constantly; the document would be versioned and monitored and sent to Performance and Quality Committee regularly; it aimed to deliver the plan for Liverpool and the process would be continued and reiterated as it moved forward. The plan was detailed and members were asked to absorb the content and any comments would be welcomed following the meeting.
52. RBA referred to the information on page 183/184 regarding the components of the plan which suggested increasing general practice appointments by 50 million. RBA felt Liverpool had reached its capacity here. There were targets listed relating to mental health however some things were missing i.e., eating disorders and eating disorder services; ADHD and there were a lot of services not being provided in Liverpool possibly not provided across Cheshire and Merseyside either, however primary care were seeing more and more patients with these conditions without having the ability to care for them.
53. DHO informed members that the chart related to national priorities that had been directed to the CCG and would be amended. Members should find more details later in the document and the key priority was to know what needed to be addressed noting that the chart listed the national priorities.
54. MBA reported that part of the Mental Health Investment Standard (MHIS) would cover what RBA had mentioned with eating disorders being a clear national priority with funding available to support this and details would become available as more planning information became available.
55. DHO went on to highlight that there were 3 key parts to the plan and although approval was being sought from members it was with the understanding that the plan would change. This year was different as it had a view toward the future and working with the local authority while looking at Liverpool as a whole trying to work closely with the ICS looking at how information passed through which was new and was moving quickly. As this was a new way of working it was anticipated that changes would be made along the way as obstacles were found and the plan would be reiterated accordingly. There were national timetables which the ICS must respond to, and the operational plan informed the ICS of what was happening within the Cheshire and Merseyside region and the ICS needed the operational plan to progress its own plans.
56. The plan had 7 objectives and 4 enabling functions which were split across the integrated business plan and the operational plan, this was due to the CCG being a statutory body. The plans linked together and work continued with the local authority to build on them. There were challenges ahead with recovery

from the pandemic on the horizon and variants to be concerned about which could impact on the ability to deliver what was outlined in the plans however the CCG must still aim to achieve what it needed to achieve in the year.

57. There were a lot of financial uncertainties in the system and to achieve some of these objectives required investment into the system and to make any savings required investment. Moving the CCG into an ICS also destabilised the plans and the impact of this and how the plan could be delivered was not clear yet.
58. The plan included the national priorities which reflected everything in the local health system which the government required to see improvement on and which meant that the CCG had quite a task ahead.
59. MBA reported that all systems had been given a 6-month funding envelope for April through to September to work with and the expectation was to break even at the end of the six months. All CCGs and providers had been working through the assumptions and what that meant for them. It was further complicated by additional funding envelopes for specific areas which were changing and it was not yet clear how the changes would manifest.
60. The CCG had a potential deficit of £6.5M for the first six-month period which was broadly in line with the 2020-21 financial year, that was without system allocation of resources and without having to achieve cost savings and/or efficiency programmes. The view for H2 (October to March) was that planning guidance on financial regimes would return to more normal processes although it was not yet clear how that would happen, discussions with the treasury were ongoing.
61. Details regarding inflationary pressures were included in section 4.4 to section 5 of the paper. The £6.6 million excluded risks around prescribing and continuing healthcare, and there was a real risk that pressure could increase in these areas. The CCG would need to try to generate its own savings to bridge some of the gap.
62. RBA noted that p193 referred to the impact of the pandemic on local health and care services being a real challenge which was an understatement and the concern was there was an actual need to work hard to try to resolve the backlog and there was no capacity to do much more than this. There was concern that the challenges set would take people away from services due to political imperatives which would destabilise services further.
63. FLE agreed with the comment stating that the CCG was aware of that. DHO concurred saying that the CCG was committed to ensuring services remained stable where possible.
64. Members noted the NHS Planning Guidance and priorities for 2021/22; approved the CCG Operational Plan submission for inclusion into the Integrated Care System (ICS) Operational Plan; approved the financial planning assumptions and noted the financial regime for 2021/22 and its impact on the Operational Plan; and members also approved the Integrated Business Plan for delivery in 2021/22.
65. MBA pointed out that an appendix was missing from the report the contents of which had been discussed within the update and which was subsequently circulated to members.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the NHS Planning Guidance and priorities for 21/22;			

• Approve the CCG Operational Plan submission for inclusion into the Integrated Care System (ICS) Operational Plan; • Approve the financial planning assumptions, and note the financial regime for 21/22 and its impact on the Operational Plan; • Approve the Integrated Business Plan for delivery in 21/22.			
Further actions required: • None identified.			

C3 CHESHIRE AND MERSEY JOINT COMMITTEE WORK PLAN

66. FLE presented the Cheshire and Mersey Joint Committee Work Plan on behalf of JLE noting the plan covered the 9 CCGs which formed the Cheshire and Merseyside ICS footprint. The terms of reference and work plan for the committee had been discussed at a Private Governing Body meeting previously and feedback had been incorporated into the documents presented.
67. Page 253 listed the principles for identifying service areas to be managed at scale which members were broadly comfortable with; page 254 detailed the revised membership with the workplan on page 255 which had been cut down significantly.
68. RBA commented that concerns raised previously on behalf of LMC's were not within on the document presented and asked if these could be represented as it was disappointing not to see LMCs included on the membership. FLE agreed to escalate the concerns.
69. FOF pointed out that the document stated that it was a final document while members were being asked to approve an outline and the document should be draft. Page 256 said it was a functioning group with an outline work plan which indicated that an agreement had been reached. FLE responded that this had been pointed out in Accountable Officer meetings and colleagues were informed that this was a final draft. The plan could not happen unless colleagues agreed to it suggesting members did not get too hung up as there were some obvious missing details regarding for example how decisions would be taken and resources and functions to support the committee in making decisions, it was also worth remembering that the joint committee would only be in place until March 2022.
70. DOH pointed out that the people who coordinated the report were now leaving the organisation stating that they did not understand what the organisations purpose was when they joined and perhaps the framework would be revisited. FLE pointed out that the Accountable Officers of the 9 CCGs involved put most of the work into the document albeit under the guidance and direction of the Health and Care Partnership Leadership Team; all Terms of Reference should be reviewed on a regular basis and perhaps these should be reviewed on a more frequent basis.
71. Members approved the outline initial workplan of the Joint Committee of Cheshire and Merseyside CCGs.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Approves the outline initial workplan of the Joint Committee of Cheshire & Merseyside CCGs.			
Further actions required:			

• Suggest LMCs be included on joint committee memberships.	F Lemmens	July 21	On July 21 GB agenda.

D FOR NOTING

D1 GOVERNING BODY WORK PLAN

72. FLE presented the Governing Body work plan for noting.
73. SHO reminded members that the work plan would move and could be added to, and this was the first iteration. SHO went on to suggest the Terms of Reference be revisited regarding the work plan with both documents being updated.
74. SHE to update the terms of reference for Governing Body and revisit the work plan considering this.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the work plan.			
Further actions required: • Update the terms of reference for Governing Body and revisit the work plan considering this.	S Hendry	July 21	On July 21 GB agenda.

D2 UPDATE TO AUDIT AND RISK COMMITTEE ANNUAL REPORT

75. SHO delivered an update to the Audit and Risk Committee annual report noting that the update referred to the counter fraud self-assessment return which had been submitted.
76. There were 12 components to the review, one of which was split into two. The CCG was assessed as green on 10 items and amber on 3 with a work plan in place to address these which was a good result.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the update to 2020/21 Audit and Risk Committee Annual Report.			
Further actions required: • None identified.			

E QUESTIONS FROM THE PUBLIC

77. FLE notified members that the following question was received from the public in advance of the meeting on 4th April via email.
78. "What provisions have been made to outsource and liaise with private providers to help reduce cataract waiting lists following the introduction of the Increase capability framework which is being funded by NHS England?"
79. On 14th April 2021 LCCG responded:
80. A contract has been placed by Liverpool CCG with an Independent Sector provider, SpaMedica, utilising the Increasing Capacity Framework (ICF) to treat long waiting cataract patients at Liverpool University Hospitals FT (LUHFT).
81. NHS Providers are also able to use the ICF to sub-contract and this option could be explored by local providers.

82. Liverpool CCG is party to other independent sector contracts being placed by other local CCGs, which include cataract surgery. One local private provider of Ophthalmology, Spire Liverpool, has under the ICF ceased provision of ophthalmological procedures.
83. Under the terms of the ICF, initial contracts were for a maximum of 6 months. During the next few months Liverpool CCG, along with the other local CCGs, will be reviewing what services and volumes are required before undertaking any further actions using the ICF.
84. Further questions had since been received and would be included in the next meeting, the enquirers had been responded to in the interim.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

85. The following items and committee minutes were noted:
    a) Corporate Performance report – agreed at Performance and Quality Committee May 2021.
    b) Finance report – agreed at Performance and Quality Committee April 2021.
    c) Ratified minutes from the following committees:
        a. Audit and Risk Committee – 16/02/2021.
        b. Clinical Effectiveness Committee – 17/11/2020 and 19/03/2021.
        c. People and Community Voice Committee – 02/02/2021.
        d. Performance and Quality committee – 26/01/2021; 23/02/2021; and 23/03/2021.
        e. Primary Care Commissioning Committee - 16/02/2021.
        f. Remuneration and HR Committee – 15/12/2020.

G ANY OTHER BUSINESS

G1 Summary of Business/Risk Review

86. SHO suggested there was a need to revisit continuing healthcare which had been suspended and not picked up again.
87. GGR suggested looking at elective care to ensure an effective response was formulated.
88. FLE mentioned changes to the risk register, the Governing Body Terms of Reference, and possibly a deep dive into specific practices concerns within primary care.
89. MSM noted the huge risk of the COVID-19 pandemic continuing and its impact on system recovery.
90. JBL mentioned having an honest conversation to manage the expectations of the public.

G2 ANY OTHER BUSINESS

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