NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
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Report to:	**Governing Body**
Meeting Date:	**14 September 2021**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 13 July 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
Dr Stephanie Gallard (SGA)	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
Peter Kirkbride (PKI)	Secondary Care Clinician
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
Dr Shamim Rose (SRO)	GP Director
In Attendance:	
Matt Ashton (MAS)	Public Health Liverpool
Dr Rob Barnett (RBA)	Liverpool Local Medical Committee
Dr Ed Gaynor (EGA) for item A7	GP
Stephen Hendry (SHE)	Head of Corporate Services and Governance
Richard Houghton (RHO)	Corporate Service Manager
Sallyanne Hunter (SHU)	Deputy Head of Corporate Services & Governance
Sarah Thwaites (STH)	Health Watch
Michelle Timoney (MTI) for item A7	Transformational Change Manager, LCCG
Amanda Williams (AWI)	Deputy Director of Quality Outcomes & Improvement
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Jan Ledward (JLE)	Chief Officer
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Dr Monica Khuraijam (MKH)	GP Director
Carol Rogers (CRO)	Lay Member for Public & Patient Involvement
Joanne Twist (JTW)	Director of Organisational and People Development

ISSUES CONSIDERED
2021

A1 WELCOME

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

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

2. FLE reminded members that the Governing Body was meeting virtually, and an audio recording of the meeting would be available on the web page shortly after the meeting.
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 to obtain the Chairs attention when they wished to make a comment.
5. Chair welcomed new Governing Body member Dr Stephanie Gallard who was representing South Liverpool.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

7. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register. However, all members noted conflict regarding discussions around the Integrated Care System (ICS) as their roles may not exist in the new organisation or could be very different.

A4 MINUTES OF THE MEETINGS HELD ON 28 MAY and 11 JUNE 2021

8. The minutes of the meetings held on 28 May and 11 June 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 committee reports and the request to add an update from the minority group to each REMHR agenda. Item completed.
   b) Item 2 from the chief officer report which asked CHI to raise a question regarding communications to the public and who was responsible for these. CHI reported that the issue had been raised however there was no clarity of response yet. Guidance was issued to trusts for one-to-one communications with patients regarding waiting lists, but the CCG was not aware of any other overarching campaign. Item closed.
   c) Items 3, 4, 5, and 6 from the public health update were ongoing.
   d) Item 7 requested that JBL share information on the national weight management programme with James Woolgar. This was completed, item closed.
   e) Item 8 revisit CRR for a root and branch review in line with discussions. The revised risk register format was presented with the papers for discussion later on the meeting agenda. Item closed.
   f) Item 9 suggest LMC's be included on joint committee memberships. This item was still under discussion, item ongoing.
   g) Item 10 update the terms of reference for governing body and revisit the work plan considering this. This was underway and would be brought to the next meeting. Item closed.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Governing Body Action Log			
Further actions required:	D Richardson	ASAP	Completed

• Update the action log in line with discussions			

A6 COMMITTEE REPORTS

10. HDE delivered the Remuneration and HR Committee (REMHR) Chairs report from the June committee meeting noting that the committee did appreciate it had a limited life as a committee and for the organisation so it may be queried why the committee continued with the rolling review and update of policies. The committee was focussing on standardising policies and procedures across the region to ease the forthcoming transition and viewed it as a legacy project.
11. Conscious of the Governing Body's decision to go for gold accreditation of the Defence Employer Recognition Scheme the committee approved an amendment to the special leave policy to give clarity over the entitlement to two weeks paid leave for mandatory training for reservists. This supported the silver application which was in progress.
12. An area of concern was the potential impact on staff of a move to the ICS and the ability to deliver business objectives despite the ICS framework and employment principles that had been published. This was felt to be a significant risk and was noted in the committee risk register and would be closely monitored
13. FLE commented that it was pleasing to see the Defence Employer Recognition Scheme come through and that she agreed with the decision to continue with business as usual.
14. SHO delivered the Audit and Risk Committee (ARC) Chairs report from the June committee meeting noting that the meeting was specifically arranged to review the annual report and accounts which were reported at the extraordinary Governing Body meeting held in June. There was nothing further to add.
15. In the absence of CRO, CHI delivered the People and Community Voice Committee (PCVC) Chairs report from the June committee meeting reporting that the engagement team had conducted work around the impact of COVID-19 on access to NHS services and patient experiences and the committee had received the full report of this at the June meeting. The committee discussed where the findings needed to go to ensure they informed service improvement and patient experience going forward. The committee also considered the city's vaccine inequalities improvement plan, seeking advice from lay advisors which was felt to be valuable. The committee also agreed the workplan for 2021-22.
16. CMA delivered the Performance and Quality Committee (PQC) Chairs reports from the May and June committee meetings which demonstrated the considerable amount of work underway to ensure performance, quality and finance were being managed to meet the CCGs duties to achieve a smooth transition to the new organisation.
17. At the May meeting assurance was received that the CCGs statutory duties relating to adult safeguarding would be discharged effectively by the new Liverpool Safeguarding Adults Board. A deep dive report was presented for Alder Hey Children's Hospital (AHCH) which provided assurance that the trust was aware of areas where improvement was required, and an action plan was in place to address this. The serious incident annual report for 2020-21 was presented and the committee noted Mersey Internal Audit Agency's substantial assurance rating of the CCGs systems and processes in place for the management of serious incidents.
18. A deep dive review was also undertaken for NWAS at the request of Governing Body. The review highlighted a need for a more comprehensive picture to understand the challenges faced by NWAS and this would be brought to the next Governing Body meeting. The committee also received a verbal report on procurement decisions; the committee approved the re procurement of translation services; members received an overview of the operational plan and the integrated business plan with Liverpool City Council. The financial assumptions were also approved at the meeting and the

corporate performance report represented a stable position.

19. The June meeting received the quality overview report (previously called Chief Nurse Report) which highlighted areas including work being undertaken at Liverpool University Hospital Foundation Trust to address the gastroenterology waiting list issue; a planned change in the IT system which had been postponed due to unforeseen issues with an interim measure in place; an action being taken on the acknowledgement and actioning of outstanding test results which was now being managed and poor performing areas were being supported.
20. Mersey Care Foundation Trust (MCFT) acquired North West Boroughs Healthcare (NWB) on 1st June and work was on going to align systems and processes with the intention of having one clinical quality performance group (CQPG) in place by 1st September.
21. MCFT missed the deadline for continuing healthcare assessment and reviews in May and were likely to miss the June deadline too despite the high level of support offered. The committee approved a request for contractual action and a more formal approach to be taken regarding the missed deadlines. The committee approved the issue of a contract performance notice.
22. MCFT was also working with the CCG and other partners to improve performance around children in care service; eating disorders service; autism spectrum disorder service; and the waiting time between IAPTs steps. A meeting was to be held to decide the next steps.
23. Liverpool Women's Hospital (LWH) had been subject to several whistleblowing's from staff which were being reviewed by the national guardian office. The trust was due to provide an overview shortly. A shortage of midwifery staff caused a closure to admissions and diversion to other trusts. The trust had taken steps to remedy this with an action plan in place that the committee would monitor.
24. The committee also received the regular finance and performance reports which highlighted pressures being observed in trusts following the relaxation of measures; it was noted that the COVID-19 pressures were likely to increase as restrictions were increasingly relaxed. The committee approved the safeguarding policy; the SORD updates; and the revised equality impact analysis report for the targeted lung health check programme.
25. MBA commented that it was an extremely busy committee reporting that the financial side was operating on the revised regime for months one to six. The forecast currently was a break even position however there were several risks to the delivery of that. The guidance for H2 was not yet available, it was a challenging time as it prevented planning with no building blocks to plan from. There would be an increased efficiency ask around waste (waste management, waste efficiency) figures of around 3% which would be a real challenge.
26. FLE sought clarification on the term waste management and was informed it was regarding duplication of tasks and processes and streamlining for efficiency.
27. SHO referred to the listing on the Corporate Risk Register for Liverpool Women's Hospital for the stand-alone issue commenting that with the ongoing staffing and maternity issues added to the publication of the Ockenden report and complying with the recommendations it contained asking if Governing Body should be discussing the trust further.
28. JLU responded that it was a good point and went on to state that staffing of maternity units was an issue across Cheshire and Merseyside which was under discussion and a recruitment programme for nursing and midwifery was in place. Mutual aid options were also being explored along with varying the skill mix to free up midwives and healthcare assistants. The stand-alone issue of Liverpool Women's Hospital would not be resolved for some time and mitigations were in place in the interim. However, the conversation would be useful particularly with the move towards the new organisation to ensure the correct information was handed over when the time came.

29. A quality risk profile for each trust was being considered as a handover document to the new organisation which would include details on risks and mitigations in place. As the risk was not owned by the CCG this risk profile would include the relevant information and give the new organisation all pertinent details. This would contextualise the potential risks for further discussion around what should or should not be included on a risk register depending on the direction the new organisation wished to take.
30. DOH suggested that the risks for Liverpool Women's Hospital were being managed from a trust perspective regarding the stand-alone status and there may be another perspective to consider, noting that there was a maternity system in place led by Liverpool Women's Hospital and frequently Liverpool Women's Hospital did not seem to understand that processes were in place to give assurance, and this needed to be expressed within the risk.
31. SHE agreed commenting that the matter of assurance included the levels of assurance, and a meeting was scheduled to discuss the performance and quality committee risk register.
32. FLE stated that the committee was well sighted on risks and was considering the ways to manage the risks. SHO advised that she had been reassured from the discussion noting that the committee did not want to lose oversight adding that including it on the risk register indicated to staff that additional resource was required.
33. RBA commented that regarding Liverpool Women's Hospital and risks he had raised concerns about changes to the way the workforce was being deployed several months ago. The concerns were not addressed or resolved, and he had little confidence in what he was hearing as there was no workforce planning taking place not just for Liverpool Women's Hospital but across the healthcare system. RBA went on to state that he was not happy with the comments about waste management, he would be happy to discuss waste management but not cost efficiency savings. Cost efficiency savings had taken place year on year and there was 'no fat left, there is no meat never mind the fat left on the bone. We were in the dire straits we find ourselves in because the system is running on fumes'. Heading into the summer the workforce was completely worn out and demoralised, GPs in their 50s were leaving the NHS workforce which was disgraceful.
34. FLE noted the support for RBAs view. FLE went on to highlight a declaration of interest as her spouse was an employee of NWAS which was listed on the LCCG list of declarations however FLE went onto state that there were complex commissioning arrangements in place for NWAS and they were under immense pressure asking did the committee feel adequately cited on the risks and how did it plan to gain assurance that mitigations were in place to manage those risks.
35. JLU responded that this had been discussed at committee and a deep dive report had created more questions than it had answered. CCG colleagues had ensured that they were represented on performance and quality meetings, challenging and scrutinising data. Experience from across the patch had been brought in and colleagues had been clear how this linked to serious incident work. Blackpool CCG was the coordinating commissioner which meant it was sometimes easy for serious incidents that affected Liverpool to be lost and so it had been made clear that Liverpool CCG wanted to have oversight of what was happening locally and had asked the committee for more time to understand how it looked in Liverpool, looking at what had an impact on performance, how NWAS could address areas with support from the rest of the system and work around urgent care to have a positive impact on patient flow. By getting the understanding right this would enable NWAS to feed the message into partner CCGs for the connected wider work.
36. GGR delivered the Primary Care Commissioning Committee (PCCC) Chairs report from the June committee meeting discussing the updated workplan, risk register, performance quality and contract report noting good improvements on annual health

checks for people with learning disabilities and mental health although there were still some concerns regarding gaps. The finance report was also presented with nothing of note to raise.

37. Three papers were brought for approval which were agreed.
38. Regarding items for positive assurance, the committee confirmed services required for patients from an orphan practice were being provided. The committee also noted a potential risk for the cost of supply of flu vaccine.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Committee Chairs reports			
Further actions required: • None identified			

A7 HEALTHY LUNG PROGRAMME UPDATE (This item was taken at the beginning of the meeting).

39. Ed Gaynor (EGA) presented an update regarding progress with the Healthy Lung Programme thanking Governing Body for the opportunity to share the excellent work that was on going. EGA was a GP partner and previously Clinical Lead for cancer services at the CCG until April 2021. He was Chair of the steering group for Targeted Lung Health.
40. In 2016 Liverpool CCG invested in the Liverpool healthy lung project as lung cancer was the leading cause of cancer death in Liverpool at that time; it accounted for a 12% gap in life expectancy with 37% of those diagnosed only as emergency presentations. Liverpool was further behind than the rest of England and needed to do more to reduce the gaps.
41. The project ran from April 2016 to March 2020 with the first round almost complete at the beginning of COVID-19. To be eligible participants had to be aged 58 to 75 and to have smoked or been diagnosed with COPD. A lung check was offered followed by a CT scan if 5% or more risk was found. This would be followed up clinically if required. Three external evaluation reports were written in 2016/7; 2017/8; and 2020.
42. Of those invited 39% attended, 6822 underwent CT scans and of these 1271 (18.6%) underwent further investigation. 126 Cancers were diagnosed which equated to 1.8% of those scanned and 1090 new cases of COPD.
43. Findings included an estimated absolute reduction in five-year (*lung cancer*) deaths, a relative reduction of 30%. This translated to one life saved per 227 scans, and one life saved per 42 subjects recalled for further investigation.
44. Of those surveyed, 328 (89.4%) were very satisfied with printed information, 349 (95.1%) were very satisfied with staff communication, and 349 (95.1%) were very satisfied with the health check overall.
45. Lung cancer usually presented late with not a good outcome, and this had been turned around. Lung cancer was also more common with increased levels of deprivation.
46. Two years ago a national programme was introduced and the local project was not invited to be involved, however in 2021 the national programme changed its direction and invited Liverpool CCG to join the national programme in collaboration with Halton and Knowsley CCGs and the Cheshire and Merseyside Cancer Alliance.
47. The national programme brought significant funding and joined CCGs, the Cancer Alliance and Research groups giving local access to CT scanners, identifying sites to deliver at scale over 7 days spread across 4 teams locally. This enabled the targeting of higher risk populations earlier. The risk score was lowered enabling more people to have scans and it was agreed to deliver the programme from one trust,

Liverpool Heart and Chest Hospital (LHCH).

48. Strong governance had been associated with the programme across the three CCGs involved with genuine shared decision making between these CCGs and the Cancer Alliance. A lot of progress had been made over the last 6 months with lung clinics commencing the day prior to the meeting. A media day was planned and mobile scanning would commence from 26th July.
49. This was a moment to reflect on the NHS working at its best; patients first, team working, delivering quality care and rigorous governance.
50. MTI added that it was an ambitious programme and the three external reports demonstrated that a difference was being made to mortality with early detection and survival. Lung cancer was by far the biggest cancer killer locally and this project has evidenced success in making a difference by deliberately taking action. It had been a for a team effort with primary care, secondary care, all partners and providers, the public, and volunteers; reiterating that it was a model of how programmes should be run and how the NHS worked at its very best thanking all involved for their hard work.
51. DOH pointed out that work on lung cancer had gone on a lot longer noting that EGA had been involved as early as 2012 and was quoted in the NHS 5 year forward plan.
52. RBA commented that he was pleased to hear of the success noting that there were some criticisms of the Liverpool programme one of which was the interface with general practice and how patients were followed up particularly with incidental findings, asking if this had been streamlined in the new process as colleagues were critical of the workload that had appeared. EGA responded that the criticism was fair and it reflected the funding situation at that time, secondary care colleagues were also asked to take on extra work for no extra resource and a huge effort was made with a debt of gratitude owed to colleagues in both primary and secondary care.
53. With the revised process incidental findings would be managed much more sophisticatedly and largely by the programme. There was likely to be some additional support required from primary care but it was not anticipated that this would be in large volumes and comprehensive guidance was available to support the process which could be shared with LMC if welcomed.
54. GGR reported that he was very impressed with the parallel approach of preventative medicine asking how it planned to link together. EGA responded that it was an important part of the programme with lifestyle advice, smoking advice and all aspects of care were central to the Liverpool healthy lung clinics. The programme had identified a lot of undiagnosed COPD. The programme was not just about lung cancer but was about educating noting that lung health for all patients was a priority. The group was disappointed in the smoking cessation success rate and had learnt from it and changed the system in the hope it would do better in future. The group was also disappointed in the recruitment to the programme which was set at 40% and had achieved 39% and it was hoping it would achieve higher engagement in future.
55. FLE thanked EGA and MTI on behalf of Governing Body commenting that she knew it had been a passion for them both and Governing Body was delighted it had been a success noting that it was an excellent legacy from the CCG.

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

56. MBA presented the Chief Officers Report on behalf of JLE noting that some areas mentioned in the report had already been discussed within the meeting and highlighting the following:
    a) The annual assurance letter noted a positive outcome for the CCG given the difficult circumstances it had been operating within.
    b) The draft ICS legislation bill was included with several pieces of information regarding the ICS development notably the ICS framework, the employment commitment, and an early draft of the performance framework for the new

organisation, all of which were included for reference.

c) MBA went on to thank all colleagues involved with the pandemic response and the vaccine programme as well as day to day activity commenting that the work involved had been incredible in the really challenging circumstances, noting JLE's thanks also.

d) DOH noted that the CCG was being asked to acknowledge the information and not act around it commenting that perhaps some discussion should take place regarding it. FLE responded that when NHS England initially sent the information out comments were fed back as a system and a Governing Body development session was planned in August which would give the opportunity to get into the detail of the information for a response.

e) STH noted that a detailed look at the papers would be useful. Understanding the detail and its implications was going to be vital. They were a hard slog to read to make sense of what lay behind it.

f) JBL had sent in comments in advance of the meeting highlighting positive behaviour changes around mutual aid which seemed to be continuing. JBL had also highlighted a comment from the appendices framework which stated 'equal access for equal need' which could be interpreted several ways, asking did colleagues think Liverpool's allocation would remain the same or would it increase or decrease in the future?

g) MBA responded that there was no level of detail known yet regarding system allocation and what would be managed at a local place level. The guidance suggested some areas would be managed at a place level but there really was no further information at that point to enable a response. His personal view was that a status quo was likely initially, and things would move towards a system-based direction in the longer term. It would be really challenging to make the changes ahead of the April deadline and that was notwithstanding the cost savings required.

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

B2 PUBLIC HEALTH UPDATE

57. MAS presented the Public Health Update report highlighting the following:

a) At that point in time the weekly case rate was 485 per 100,000 which was a slight improvement as it had been 510 recently although still not low. It was predominantly affecting the younger age population particularly 18–24-year-olds. As schools finished for summer holidays it was expected that this would impact too along with 'Freedom Day'.

b) There was some pressure in hospitals which was manageable. The infection rate in over 60's ages groups was over 100 per 100,000 which was concerning and probably representative of those unvaccinated.

c) Other areas around Merseyside were in a similar position with the North West leading in the third/fourth wave although rates in the North East had increased rapidly with 800 and 1000 cases per 100,000 population which showed the virus had not gone away.

d) The Health Protection Board delivered a statement which could be found at this link: https://liverpoolexpress.co.uk/advice-for-residents-and-visitors-to-liverpool-post-lockdown/ which included advice for residents and visitors to Liverpool post 'lockdown' urging caution and the continuation of COVID-19 control measures

where possible. The message was shared across the region with the aim of encouraging caution as much as possible.

e) Moving on to the vaccination programme MAS expressed thanks to the fantastic colleagues involved in the amazing programme stating that it was very complicated and lots of people had been working incredibly hard. Recognising how well the programme was operating while being aware of the significant challenge around uptake, a vaccine inequalities plan was in place and the focus needed to move towards getting as many people who were vaccine hesitant to be vaccinated where possible.

f) The healthy weight grant had been received and it was being commissioned into a Tier 2 service; there was a particular issue around the supply of champix for the smoking cessation programme and health checks were agreed at LMC and should be rolled out from September. Work around behavioural insights remained ongoing. Actions from the last meeting would continue and be brought to the next meeting.

g) The Public Health report on the COVID-19 journey was shortlisted for an award with the Municipal Journal. The outcome had not been revealed at this point.

h) PKI asked if there was anything further that could be done to encourage caution when things opened up again on 19th July noting that Scotland intended to keep mask wearing as mandatory and enquiring about any byelaws that might be permissible.

i) MAS responded that the roadmap had implied that the Director of Public Health would have additional power in certain situations, but it was not clear what this would be and it was anticipated that it would be difficult to enact and would be relevant to specific situations. Locally, leaders were encouraging the transport authority to enforce the mandatory wearing of face coverings; guidance around large scale events was not clear and it was difficult to tell people what they must do in this situation.

j) PKI asked if it was possible to see data on vaccination by age, ethnicity, etc. asking if there were any concerns regarding supply of the vaccine. MAS replied that there were no concerns with supply although demand had plateaued and there was a need to create a requirement for more. The data was available and was constantly updated with FLE reporting that twice weekly meetings looked at length at the data looking at practice level to see which practices had the lowest uptake to see where specific action plans may be required. Funding was available to support PCNs to deliver where uptake was lower than average, and all sites were reporting significant drops in uptake. All sites were registered on the national booking system however it was becoming increasingly unviable to continue to run all the clinics. The focus was being moved towards drop in and mobile clinics where possible.

k) RBA cited a recent survey from the BMA which found that the majority of doctors felt face masks should continue to be mandatory particularly in healthcare settings, asking was it possible that public health could write a letter recommending face masks continued to be worn in healthcare settings. MAS agreed to pick this up with RBA outside the meeting commenting that he had heard NHS England were planning to ask everyone to continue to wear face masks although this had not been confirmed.

l) FOF asked for feedback from the mass pilot event which had taken place in the city when rates were at low prevalence. MAS responded that there were two outcomes from the pilot events which were the evaluation of community testing and the actual community testing which resulted in an 18% detection in community cases that would have gone unfound and a 21% reduction in cases. Links to the reports are: https://news.liverpool.ac.uk/2021/06/28/university-research-contributes-to-governments-events-research-programme-findings/ and

https://liverpoolexpress.co.uk/liverpool-pilot-events-have-no-impact-on-covid-spread-in-the-region/

m) The events proved it was possible to hold COVID-19 safe events by working hard and working together. The findings were fed into the national events research programme with the intention of informing national policy and strategy which did not appear to have happened yet. Members were reminded of the different context of the situation at the time of the events.

n) DOH asked about the removal of sexual health services which MCFT had announced to patients via their website commenting that it was hoped access to services was not going to be reduced and that people needed to be informed of the proposed changes. MAS asked DOH to email any specific issues through to him noting that details on proposals in this area would be brought to the next meeting.

o) PFI pointed out that the Health Service Journal (HSJ) had informed readers that the public were being asked to continue to wear face masks after 19th July and she hoped primary care would do the same. PFI went on to ask about numbers attending vaccination events and was informed by FLE that 2727 people attended the vaccination tent in Sefton Park the previous weekend, approximately 900 of those received their first COVID-19 vaccine, 303 were over 50 years old and a diverse population attended. Translators coordinated by the community engagement team at Liverpool City Council (LCC) had spoken 21 different languages over the course of the weekend which was viewed as successful. MAS commented that it was important to celebrate the wins, it took a lot to resource and was an important intervention, asking colleagues to promote the pop-up clinics where possible.

p) SGA reported that over the last three months the numbers of people receiving the vaccine over the age of 80 had stopped at 94.8% which meant that 1 in 20 were not vaccinated, MAS informed members that there was an additional 5% drop of from dose 1 to dose 2 in that age group. RBA referred to the disparity between wards noting the 40% difference between the least and most deprived areas in the city with those in the more deprived areas being most likely to end up in hospital stating that the divide was very disturbing.

q) STH commented that she shared the concerns about the disparities across wards and this would be crucial moving forward. Healthwatch had commenced a survey of 18–25-year-olds and their attitudes to the vaccine which was online with the intention of face-to-face focus groups in future with the aim of understanding any hesitation and perhaps allaying fears to increase uptake.

r) FLE reported that the CCG was trying to think of ideas regarding what more could be done to encourage uptake while informing members that there were anti-vaccination protestors at Sefton Park during the vaccination event the previous weekend and this had been challenging.

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 delivering 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.			
Further actions required: • None identified.			

B3 GBAF, AND CORPORATE RISK REGISTER UPDATE

58. SHE provided an update on the organisation's Governing Body Assurance Framework (GBAF), and Corporate Risk Register (CRR) thanking members for their input to the GBAF and outlining the following:
    a. The framework for 2021-22 required formal sign off by members. The framework reflected themes the CCG was facing in delivering its statutory requirements reflecting the key themes identified in development sessions in the context of this being the final year of the CCGs existence before it transitioned to the ICS.
    b. At the end of the financial year consideration would need to be given to how residual risks would be moved to the new organisation.
    c. GBAF04 was a financial risk that needed monitoring over the next months, it was a risk the CCG had the least influence over. Risk GBAF06 was regarding the CCGs reputation; this has been changed recently to safeguard the CCG as a system leader and it was important to monitor this risk too.
    d. The CRR had changed format to become easier to read with a focus on the gaps in control in an attempt to eliminate these gaps. The format was similar to the GBAF and committee risk registers with the intention of creating a thread through the documents.
    e. CO36 and CO84 had been removed, the system resilience risk and the mental health system resilience risk. Both were removed in favour of a new risk CO87 which captured both the previous risks.
    f. CO85 was the EU exit risk which remained on as NHS England and Improvement (NHSEI) had asked all NHS organisations to have a single operating model and the recommendation was that the risk stayed until organisations were told to stand it down.
    g. FLE commented that the aligned presentation enabled practice at reading in the same format which was better.
    h. SHO concurred noting that the new format was good. SHO agreed that CO85 should be left on as it incorporated risks in place due to the command-and-control situation and suggested it be revised to remove the reference to 'no deal' Brexit while the risks to staffing remained. SHO then referred to risk CO54 regarding Liverpool Women's Hospital (LWH) and the inability to secure capital investment to promote relocation, commenting that it was a risk but perhaps not necessarily a risk for the CCG asking what the value of it remaining on the register was and would it be counterproductive to keep it there in the longer term.
    i. FLE suggested keeping it on the list would enable it to be transferred to the new organisation when the time came noting that LWH were

reenergizing their future generation strategy so it may be updated although a solution was not likely for some time.

j. DOH pointed out a reference which stated that FLE chaired the CQRM at LWH which was out of date.

k. FLE commented that the summary tables at the beginning of the document were very useful, they helped members get into the detail of the document.

l. Subject to the updates discussed members agreed to the 'close down' of the GBAF for the financial year 2020/21 and the transfer of any relevant residual risks / mitigating actions to the 2021/2022 GBAF.

m. Members were satisfied that the 2020/21 GBAF had aligned appropriate risks, key controls, and assurances alongside each strategic objective and that the control measures and the progress of associated action plans provided reasonable / significant internal assurances of mitigation.

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: • Update GBAF and CRR in line with discussions.	S Hendry	Sept 21	On Sept 21 GB agenda.

C FOR DECISION

59. No items.

D FOR NOTING

D1 GOVERNING BODY WORK PLAN

60. FLE presented the Governing Body work plan for noting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the work plan.			
Further actions required: • None identified			

E QUESTIONS FROM THE PUBLIC

61. FLE notified members that the following questions were received from the

public in advance of the May meeting and responded to shortly afterwards as indicated.

62. Email received 27/05/2021
NICE published new guidance on Atrial Fibrillation NG196 on 27 April 2021 which includes the following recommendation:

"For people already established and stable on a vitamin K antagonist, the committee agreed that the benefits of changing to a direct-acting anticoagulant need to be discussed. Therefore, the risks and benefits of changing medication, the person's time in therapeutic range and the person's preferences should be explored at their next routine appointment."

Does the CCG have a general process to ensure that applicable NICE guidance is implemented?
Can you give an assurance that the above recommendation will be carried out?

63. Liverpool CCG Response:

Liverpool CCG has a Clinical Effectiveness Committee, which provides assurance to the Governing Body that the CCG is developing and implementing clinical policies in line with the organisation's strategic direction and in accordance with national clinical guidance and local priorities.
Individual service providers are also responsible for ensuring they are responding to relevant clinical guidance.

A full review and consideration of the most appropriate medication for a patient form part of a routine anti-coagulant clinic appointment and the risks and benefits would be considered and discussed with a patient when attending for their review. Where a vitamin K antagonist is not appropriate, the service would support GPs to manage the change in a patient's treatment to a DOAC.

64. Email received 25/05/2021

I have received a number of concerned letters as below. Can you clarify the situation that supported living Services face and provide information that may alleviate the concerns felt by the many people that have written to me?

I am writing to you to request your support to save a vital community mental health service in Merseyside.

Mersey Care NHS Foundation Trust provides Supported Living Services (SLS) for service users with a diagnosis of a learning disability who may also present with additional mental health issues and has been doing so for over twenty-five years. However, I understand that this will be scrapped later this year. I am dismayed that service users will then be expected to arrange their own care using personal care budgets. This decision is both saddening and frustrating and I am extremely concerned about the plans for the future of the service.

Clearly such a valuable service should continue to be provided by the public sector- ideally in its current form. This service is a rare example of a care service which puts people over profit and quality care over quarterly financial reports. I am sure you'll agree with me that the social care sector is fragmented, underfunded and failing. We must not let this service be transferred to a private provider that is only interested in profit. Merseycare, the CCG and Liverpool City

Council need to take responsibility and ensure that this service is protected.

Please could you write to the CCG, Liverpool Local Authority and Merseycare and ask them to urgently reconsider their decision?

65. LCCG response sent 09/06/2021

Decommissioning of Mersey Care Foundation Trust Supported Living Service

Background

1.1 Mersey Care Foundation Trust (MCFT) directly provides a 24hr supported living service (SLS) to 10 adults with learning disabilities living in their own homes. It has provided these services for approximately 20 years, having established the service originally to facilitate the closure of a long stay hospital which it operated at that time.

1.2 As a health care provider MCFT decided that it will not continue to offer supported living services in the future. It intends to withdraw from the provision as the 10 people the service currently supports move on to personal budgets

1.3 The purpose of allocating a personal budget is to ensure that people have the maximum level of choice and control over their care and support and are fully involved in making decisions about how their assessed needs are met.

1.4 In line with its obligations under the Care Act 2014, Liverpool City Council and Liverpool Clinical Commissioning Group (LCCG) are working closely together in arranging for each adult to have a Care Act assessment. In line with the Care Act, following assessment, each adult will be allocated a personal budget to fund their future care and supports.

The Process

2.1 At all stages, the adults will be fully supported in their decision making by LCC social workers and the people that are close to them. They will also have access to independent advocates and, where families and carers have expressed a wish to be part of the process, they will be fully included and informed.

2.2 The Council, LCCG and MCFT are in agreement that the wellbeing of the adults is of paramount importance and this would guide how the process is undertaken from start to end.

2.3 Whilst the social care needs of the adults will be reviewed through a Care Act assessment, social workers will also complete a Continuing Health Care (CHC) checklist and arrange for CHC assessments will be completed where the checklist identifies that any individual may be eligible for CHC funding.

2.4 Upon completion of the Care Act and CHC assessments, the Council and LCCG will allocate a personal budget to each adult and support them to develop a plan to use their budget to fund their future support to live a life which is as fulfilling and independent as possible.

2.5 Each adult will be offered options on how to take control of their personal budget. There are a number of options available and these will be explained fully along with details of what each option would entail. No-one will have to arrange their own care and support.

2.6 One option is to take some (or all) of the budget as a Direct Payment and to arrange future support directly. For adults choosing that option, they will be supported by LCC's in-house team at all stages. In addition, adults will be offered the opportunity to meet with an independent user led organisation to plan how their support. This will enable the person (or someone on their behalf) to take control of and manage their Direct Payment and future support to meet their assessed needs in the way they choose.

2.7 Adults will also be able to choose to continue to receive a care service arranged and managed by the Council and/or LCCG. Where adults choose this option, they will be offered the opportunity to be fully involved in choosing a future provider and in selecting a staff team to support them.

Ensuring Future Support is of High Quality

3.1 Liverpool has a diverse independent specialist care and support sector for people with learning disabilities. Many of our commissioned providers are from the not-for-profit sector. The sector already supporting more than 1000 people with learning disabilities and mental health conditions - including many with complex needs - across the City. We are confident that providers from the sector with a proven track records can provide high quality care and support to the adults in the future.

Transition to new arrangements

4.1 Whatever support arrangements each adult chooses, the transition to new support arrangements will be managed sensitively and carefully and will take place over time to minimise any potential impact on the people supported.

4.2 A core principle of this work is that the transition period will be personalised to each adult's needs to ensure a safe transition to future care and support provision

Support from MCFT Community Services

5.1 During the assessment period, the transition period and when new support is in place, MCFT's Community Learning Disability Team will remain on hand to provide any specialist support the adults may require.

Impact on MCFT SLS staff

6.1 There will be no redundancies for MCFT staff as MCFT have stated they are able to absorb all of the staff and offer them comparable employment.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

66. The following items and committee minutes were noted:
    a) Corporate Performance report – agreed at Performance and Quality Committee June 2021.
    b) Finance report – agreed at Performance and Quality Committee June 2021.
    c) Ratified minutes from the following committees:
        a. Audit and Risk Committee – 13/04/2021 and 11/06/2021.
        b. People and Community Voice Committee – 06/04/2021.
        c. Performance and Quality committee – 27/04/2021 and 25/05/2021.
        d. Primary Care Commissioning Committee - 20/04/2021.
        e. Remuneration and HR Committee – 16/04/2020.

G ANY OTHER BUSINESS

G1 Summary of Business/Risk Review

67. FLE reminded colleagues that the meeting covered positive success stories with the Healthy Lung Project which was a good legacy for the CCG. And the importance of the purpose of the CCG in leaving a good legacy with clear thorough ledgers to the end of the year.
68. Positive actions were reported around COVID-19 and the vaccination programme despite caveats regarding inequalities remaining; colleagues had worked extremely hard on Performance and Quality Committee and the enhancements on the GBAF were a positive development.
69. Members had identified the requirement to spend time discussing the future; the health and social care bill and transition to an ICS and the approach of governing body to the rest of the time as a CCG, the approach to the region (Cheshire and Merseyside) and the national changes.

G2 ANY OTHER BUSINESS

70. No other items of business were discussed. The meeting closed.
71. Date of next meeting Tuesday 14 September; 2.30pm.