NHS
Liverpool
Clinical Commissioning Group

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

Report to:	**Governing Body**
Meeting Date:	**14 July 2020**

MINUTES OF THE MEETING OF THE

GOVERNING BODY

Date:	Friday 22 May 2020	Time:	1.00pm
Venue:	Skype Conference Call		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Dr Fiona Lemmens (FLe) Jan Ledward (JLe) Mark Bakewell (MBa) Dr Janet Bliss (JBl) Helen Dearden (HDe) Dr Paula Finnerty (PFi) Gerry Gray (GGr) Sally Houghton (SHo) Peter Kirkbride (PKi) Dr Monica Khuraijam (MKh) Jane Lunt (JLu) Cathy Maddaford (CMa) Cheryl Mould Dr Fiona Ogden-Forde (FOf) Dr David O'Hagan (DOh) Carol Rogers (CRo) Dr Shamim Rose (SRo)	Chair Chief Officer Chief Finance & Contracting Officer GP/Clinical Vice Chair Lay Member for Governance/Non-Clinical Vice Chair GP Director Lay Member for Financial Management Lay Member for Audit Secondary Care Clinician GP Director Director of Quality, Outcomes & Improvement/Chief Nurse Non-Executive Nurse/Lay Member Programme Director Provider Alliance GP Director GP Director Lay Member for Public & Patient Involvement GP Director
In Attendance:	
Matt Ashton (MAs) Dr Rob Barnett (RBa) Helen Galley Stephen Hendry Carole Hill (Chi) Dave Horsfield (DHo) Sallyanne Hunter Samson James (SJa) Barry Kushner (BKu) Sarah Thwaites Joanne Twist (JTw) Debbie Richardson	Public Health Liverpool Secretary of Local Medical Committee Executive Office Manager Head of Corporate Services and Governance Director of Strategy, Communications & Integration Head of Transformation & Programmes Deputy Head of Corporate Services and Governance Director of Planning, Performance & Delivery Councillor, Liverpool City Council HealthWatch Director of Organisational and People Development Committee Secretary, Liverpool CCG
Apologies Received:	
Dr Maurice Smith	GP Director

ISSUES CONSIDERED
2020

A1 WELCOME

1. Fiona Lemmens welcomed all those present noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.
2. FLe informed members that due to the coronavirus (COVID-19) pandemic, the Governing Body is meeting virtually and an audio recording of the meeting will be made available on the web page within three working days of it taking place.
3. Members of the public were still able to submit questions to be raised at the meeting for discussion and a response would be emailed to them in due course.
4. Both the question and the response will be circulated to all members and included in the minutes of the meeting
5. Members were also asked to raise questions by email in advance of the meeting and any questions raised would be discussed as the meeting progressed.
6. The Governing Body began with a minutes silence to pay respect to staff and the people in the city who have died from coronavirus.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

8. No declarations of interest were made although Dr Kirkbride informed members that he had returned to practice, working in oncology at Clatterbridge albeit remotely, to help out during the pandemic. Normally the CCG Governing Body Secondary Care Clinician should not be employed by a local trust due to perceived conflict of interest. However, given the current circumstances, it was agreed that this could be accepted, especially as this stipulation seems likely to change in the future. Dr Kirkbride will still fulfil all obligations as a Governing Body member, and will make sure that his conflict is recorded.

A4 MINUTES OF THE MEETING HELD ON 10 MARCH 2020

9. The minutes of the previous meeting held on 10 March 2020 were accepted as an accurate record with the following exceptions:
    - Page 2, point 2.1 second paragraph amended to read: '…positive than anticipated as the organisation had undergone reorganisation.'
    - Page 5, point 3.1 to read: '…involvement over the year. '
    - Page 8. Question from a member of the public to be amended to read: '…what was happening here; a merger was being proposed and so the guidance around dissolution was not relevant.'
    - Page 11, 1st line to read: 'CMa commented that residual risks were reviewed..'
    - Page 13, point 6.1 final response to questions from the public amended to read: '…redirect their questions. Emergency treatment will be available to anyone who needs it.'

10.

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

A5 ACTION LOG

11. The action log was discussed with the following points made:

a) Meeting held on 10/03/2020: *Matters Arising - From item 4.4 - Turning Tides - Report on NHS LCCG's Community Investment Programme updated report to be presented to the Governing Body.* – It was noted that the programme needed to be considered in the context of current financial framework and relevant local funding constraints. Agreed that the item would remain on the action log for updating in due course.

b) Meeting held on 10/03/2020: *Matters Arising - From item 5.1 d - Proposed changes to LCCGs Constitution - Chair to look at Terms of Office* – It was noted that a new constitution would be formed if the new merged CCG went ahead and so no further action was required.

12.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Note the Governing Body Action Log			
Further actions required: • Update the action log in line with discussions	D Richardson	ASAP	Completed

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

13. Jan Ledward presented the Chief Officers Report outlining the following:

a) Since the last meeting things have taken a significant change in direction and the report summarises this, some details are outlined below with more detailed reports later on the meeting agenda:

b) The CCG has delivered upon its financial requirements for the previous year, posting a surplus of £6.5m. The year-end accounts and annual report were submitted in line with national deadlines in April and we are currently working with our external auditors to review the submission in order to achieve sign off by the 25th June 2020.

c) The CCG have been developing the 'One' Liverpool strategy with the support of key system partners, however, on 17th March 2020 additional contracting guidance was published in response to the national COVID-19 crisis which superseded all previous planning guidance and changed the approach for 2020/21 for all NHS organisations. The NHS is now in a national command and control structure. In support of this, the CCG had organised itself into two teams, one to manage the COVID-19 response led by Dave Horsfield and Cheryl Mould (Primary Care Lead), and the other to manage business as usual led by Samson James. From the middle of March, all CCG staff that could work from home were asked to do so. This, along with a rapid review of business continuity plans and identification of business critical functions has helped the CCG to fulfill its statutory functions whilst responding to the incident. The CCG as part of the National Emergency Planning and response (EPRR) procedures set up our local incident room which is manned Monday to Friday 9am – 5pm and over the weekends and evenings remotely. Locally the health and care system has worked collaboratively to manage capacity and flow of patients. At the start of the pandemic the Provider Alliance Team were

realigned to support Primary Care. The team has ensured that support has been given to each individual practice and Primary Care Networks as they manage the delivery of services for both Covid19 and non Covid19 patients.

d) The CCG continue to discuss and progress the preparation of an application to NHS England to merge with our colleagues across North Merseyside. However, NHSE North West have paused all merger applications from Trusts and CCGs due to the national emergency.

e) Approximately 95% of our workforce is working from home. To support a coordinated response across the system, a number of staff had been redeployed. A number of staff had also been involved in the establishment and operationalisation of Satellite Testing Centre's and trained to undertake swab testing. A Survey Monkey has gone to all staff in May, as we start our recovery/reset planning. The survey asks staff what has gone well with our planning and response to the pandemic, what shall we keep doing and what could we have done better, to ensure we capture all refection's and learnings.

f) Dr Barnett enquired about the proposed merger which was on hold due to the pandemic. JLe informed members that both Sefton and Southport & Formby CCGs were to re ballot their members in June 2020 following their first ballot being impacted by the onset of the pandemic. Discussions and preparation of an application have progressed in the interim.

g) Dr O'Hagan enquired about the cells listed in the NHS England (NHSE) governance table with some listed as regional and how was Liverpool integrating to ensure its voice was being heard to influence decisions. JLe reported that the operational and tactical response to Covid19 was being led by NHSE with hospital and out of hospital cells. The hospital cell is heavily acute focused with the out of hospital cell incorporating mental health, primary care, community services and social care. JLe is involved with the out of hospital cell from a commissioning point of view and Liverpool's voice is heard. There is now a North West managed response.

h) SJa commented that the Liverpool recovery group is developing links, with NHSE/ NHSI providing the regulator with local insight into recovery plans and influencing decisions at Cheshire and Merseyside level.

i) HDe referred to the collaborative working to manage the system and a return to business as usual, asking if the mutual aid approach would continue in the future and how would this work in governance terms. JLe responded that command and control was likely to continue for the time, in part due to the concerns regarding a second surge of the virus and the need to manage recovery. Trusts remain dependent on each other and would work together on recovery plans to improve access to hospital services. Work is ongoing to identify why some patients were reluctant to use planned hospital services. This seemed to be happening across the North West and people needed reassurance that they would not catch the disease while they visited hospitals.

j) FLe commented that Covid19 featured heavily in each paper presented and this may be continuing for some time.

14.

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

B2 CHIEF NURSES REPORT

15. Jane Lunt presented the Chief Nurses Report outlining the following:

a) The report was difficult to write due to the profound changes that have taken place with regard to the normal way of working for the CCG. Members could get a sense from the agenda that the new way of working is quite different, and all members of staff rose to the challenge to deliver what was required and in a short timeframe.

b) The report refers to the structure of the NHS COVID-19 response and Merseyside Resilience Forum. Reference was made to the guidance to different parts of the system which were interdependent and together formed the system response. Reference had been made to changes required to community health services and in primary care, to reduce the burden and release capacity to respond to the Covid19 crisis. The impact on CCG functions is mentioned within the report including how mutual aid has become integral in all responses.

c) Early on some staff were redeployed to support teams where they were required and the safeguarding team has remained within the CCG supporting various work streams. A skills audit was undertaken to identify experience and match skills to need.

d) In consultation with NHSE/I we have moved to a focused approach to quality, focusing on exception reporting for quality assurance purposes, using skype and telephone calls for regular meetings, acknowledging that Trusts were focusing on their own Covid19 responses. This included Serious Incident (SI) reporting which were still being recorded on the STEIS system. 72hr assessments were still being carried out with more detailed Root Cause Analysis (RCA) reports being postponed until post Covid19, as advised.

e) Root Cause Analysis (RCA's) are on hold, which means there would be a significant workload when they recommence. Incidents would need to be considered by Trusts then reviewed through the full CCG SI process when it is re-established. In comparing data from March/April 2020 with the same time the previous year there is a reduction in the number of SIs reported this year but there was a significant change in activity and bed occupancy and this needs to be further understood, whether the change is due to capacity or under reporting.

f) The Mersey Care mental health action plan was highlighted; this is reviewed quarterly with the Trust. This work was in place prior to Covid19 and we have tried to conclude it. Quality visits have been stepped down due to infection prevention and control risks. CCGs were advised to retain their designated professionals; this has helped to provide a consistent North Mersey response in primary care.

g) The Adult and Children's Safeguarding Board stood down sub groups to focus on its response to Covid19. Regular contact has been maintained to enable swift action when necessary and consideration is being given to whether processes can be brought back up to a level similar to it was prior to Covid19. Within the Discharge workstream the National Framework for Continuing Healthcare (CHC) was temporarily suspended, this had significant implications for the CCG, and coupled with the suspension of means testing and the suspension of choice for individuals this means that post Covid19 CCGs and Local Authorities (LA) will have significant work to reassess and clarify that individuals needs are being met appropriately.

h) In recent weeks further guidance has become available to support the NHS and LA's to support care homes in response to the crisis.
i) During the response to Covid19 the CCG has been a key partner in the local authority care home cell, the Merseyside Resilience Forum and in the NHS response. Key pieces of work were undertaken, particularly around end of life care, and in the expansion of Tele-health support. In recent weeks there has been a further expansion of the NHS support to care homes, largely around infection prevention and control but also around primary and community services and implementation of the primary care DES. A top priority for the CCG has been the coordination of the infection prevention and control response, in terms of training for care home staff.
j) With regard to special educational needs and disability (SEND), members would be aware that a written statement of action was in place and work continues to address the specific CCG actions during Covid19 where it has been possible to maintain momentum. For example, in terms of health advice the CCG were able to maintain 100% performance however assessment in terms of autistic spectrum disorder and attention hyperactivity deficit disorder (ADHD) have been impacted somewhat.
k) As part of the recovery the CCG will be putting together an action plan from Alder Hey and Mersey Care to understand how they will revise the trajectories to get back in line with the original aims in terms of being compliant with the NICE guidelines for those pathways.
l) In conclusion a huge amount of work has been undertaken in recent weeks to respond to Covid19, much of it has been positive even despite the adverse circumstances and through the ongoing recovery work the CCG aims to capture those benefits that should be retained, such as the progress in the discharge pathway which has created a much more cohesive and coherent approach to discharging patients from our acute trusts. The CCG will be progressing that over the next few weeks and more detail around that will be covered in further reports.
m) CMa enquired about nursing homes and discharges, stating that there had been concerns that patients who were in hospital were perhaps discharged with COVID-19 before testing was in place. Did the CCG know whether that had happened in Liverpool?
n) JLu responded that Liverpool recognised the potential risk of discharging potentially Covid19 positive patients into care homes so Liverpool University Hospitals Foundation Trust (LUHFT) did test all potential patients for discharge quite early on using their own laboratory capacity and took the decision that they would not discharge any Covid19 positive patients, retaining them in hospital until they tested negative . The acute trusts developed a RAG rating that they applied to all patients so that they were very clear who was Covid19 positive who was post Covid19 and who never had Covid19 and that was how they worked internally to support patient flow so that they didn't mix cohorts of patients. This was carried through into how they discharged patients to support the care homes in the wider community.
o) FOf reported that there was a programme of swabbing in the care homes which was coordinated by Public Health
p) Following on from this CMa enquired if there had been any help to enable

colleagues within the nursing homes to have access to things like telemedicine and also to contribute to the daily and weekly sit rep positions given they were likely to have various levels of IT ability.

q) FOf responded that the telemedicine offer in older peoples care homes is a 24 hour seven day week 365 days a year clinical triage offer which will help to support them with identifying deteriorating patients. It can also help them to support carers in making decisions as to whether 999 is called or out of hours as required. This offer has been in the care homes and had been very underused until March. Since then we have noticed a massive increase in use across the care homes.

r) DHo informed members that the CCG also supported the use of Attend Anywhere remote consultation software using its computers in care homes in partnership with Mersey Care.

s) CMa proceeded to ask if within the guidance regarding trusts continuing with their quality commitments, were members able to have sight of the minutes of those meetings which also supported the exception reporting that they were submitting to the CCG.

t) JLu responded that board meetings for Trusts are all within the public domain so board papers are published and their quality reports will be part of that and the CCG has links to many of the key committees within the Trusts either as an observer or as an advisor particularly around safeguarding but also around quality. This is the next aspect of assurance for the CCG.

u) SHo commented that the recovery trajectory post Covid19 had been referenced and should this be included within the risk register along with serious incidents reporting. There was likely to be a back log of operations and this needed to be reflected on the risk register with Governing Body monitoring it.

v) JLe responded that the recovery process has commenced with the immediate peak being managed. The CCG was working with Trusts to identify the services that could be safely brought back online with the constraints that NHS England require Trusts now to operate within in terms of ensuring that there is capacity available should there be a second surge and so the switch back on services is restricted and the CCG are working with the system to look at the prioritisation to ensure safety. If we do start to see COVID-19 numbers increase, services would be stepped back down very quickly.

w) FOf enquired whether the reduction in SIs from April 2019 to April 2020 should formally record and reflect the reduced occupancy and attendances within the report. Also with regard to discharge planning and the data flow, in particular the day 14-21 data flows which need remedial work, was there any evidence of harm as a result of the data flows not being as they should have been?

x) JLu responded that there had been twice weekly system meetings to oversee the implementation of the new discharge pathway with representatives from local authorities, CCGs and all of the Trusts to support working that through. Whilst the data flow hasn't always been as good as it could be there have been safeguards in the system which means that it has been apparent when for example information hasn't been collected as expected. The patients eligible for the 14 and 21 day reviews are the more complex patients who are looked after either in a care home or at home with a package of support and are usually cared for by a group of people who know that there is a review due which acts as a

safety net to alert us if the review were not undertaken. There is a much better understanding now and clearer data flows so the chances of this happening are much rarer. There are checks and balances in place with professionals working with the individual carers and no incidents of harm have been brought to our attention to date. The CCG were very clear to build in safeguarding and safety nets for these patients.

y) DOh reported that Liverpool Womens Hospital (LWH) had conducted harm reviews where appropriate.

16.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Note the content of the report			
Further actions required: • Post COVID-19 recovery trajectory to be included within Risk Register with Serious Incident reporting.	S Hendry	ASAP	On GB Agenda July 2020

B3 PUBLIC HEALTH UPDATE

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

a) The Public Health (PH) team have been working really hard on a number of things including work with the care homes with vulnerable groups and around some things they don't normally expect to be working on including morgue capacity, the test track and trace programs and stepping into more focused conversations around recovery. Members would be aware that the area has been hit relatively badly by Covid19, with Knowsley and St Helens seeing higher rates of infection than Liverpool. There have been a significant amount of deaths and we are now slowly coming down the other side of the curve. We haven't yet plateaued off and we are not quite sure why this is the case, we are monitoring the data to understand this.

b) From an NHS capacity perspective managing the pandemic had gone well but on a broader impact the outbreak has had some bad outcomes. Work is ongoing with colleagues from the universities and other organisations to try to understand the reasons behind this, PH believe it's due to deprivation and historical levels of ill health but research will continue in this area to find out exactly why.

c) PH are now starting to work on recovery, looking at potential scenarios over the next months. PH is feeding into the recovery work right across the city including social care, the economy, communities, schools and education and so forth. PH are also looking at what messages it needs to communicate to minimise the risk of any future waves and what can be done to prevent this.

d) This is all alongside the business as usual public-health work which it has tried to maintain wherever possible although there have been some changes under the circumstances. Public Health budget savings had to be implemented and work continued on those.

e) PH has been looking at the health and well-being legacy to identify the benefits to be maintained going forward. Two in particular are around smoking and healthy weight. While being aware of the inequalities involved in delivering this message, PH are using this time to encourage people to quit smoking given the

relationship between smoking, respiratory health and Covid19 and it will look to the CCG and the system to support this.

f) From a healthy weight perspective there was a lot of work from community colleagues encouraging activities during lockdown but some parts of our communities are less able and less willing to participate and so PH will be looking for opportunities to promote that message.

g) BKu commented that the public health budget has been cut this year as the city entered or was already in the pandemic and public-health messaging and the opportunity of having a budget to do that is critically important as well as developing programmes to address health problems as mentioned. Members should use the opportunity to make the point with NHSE and the Government.

h) From previous discussions, prior to the pandemic, members were aware that poverty impacted health outcomes over a lifetime. As steps are made towards recovery, the system needs to capitalise on opportunities and mitigate risks

i) BKu noted that as a nation there is a clap for key workers every Thursday yet there has not been time to mourn those who have died. The opportunity given here today to reflect during the minutes' silence at the beginning of the meeting was very much appreciated.

j) PFi queried why more females had died in Liverpool compared to the England average and whether this was connected to care home deaths?

k) MAs responded that Liverpool has had more people die regardless of gender compared to the England average. PH have been looking into the reasons behind this and they don't believe it's related to the quality of care delivered in NHS settings. It has been raised in the North-West excess deaths cell and work with the University of Liverpool so far indicates this is related to historical levels of deprivation and health inequalities.

l) PKi asked why the numbers for Liverpool and Merseyside were poor, either for the infection rate or for deaths, in the context of the previous Governing Body meeting where assurance was given about the NHS response. The death rate locally is significantly higher than the rest of the country. Were questions being asked at a national level about our response to the pandemic?

m) JLe responded that from working with the mortality group for the North West initially it did look like Liverpool was an outlier but it had been identified that the death rate per hundred thousand was highest in London and the West Midlands and then in the North-West. The local response had mitigated the impact. More analysis was starting to come through from the work taking place in the mortality cell.

n) MAs commented that members were not likely to know the full picture until all of the data became available. Questions will continue to be asked through the North-West mortality cell to properly understand it. MAs noted that everyone had worked really hard and nothing had been found to suggest that there had been critical failures in anything that had been done with initial observations indicating that the high death rate is mostly linked to deprivation and poor health.

o) JBl enquired about mortuary capacity and funeral delays asking if the situation had improved. Also, thinking ahead to flu season, what consideration was being given to how immunizing the vulnerable population and how it could happen with social distancing measures in place.

p) MAs responded that PH worked with the Local Resilience Forum which included an excess deaths cell looking at mortuary capacity and its ability to cope. It was clear that capacity had filled up quickly, however due to social distancing measures it was difficult to keep the funeral process moving as it normally would have done. Members acted quickly to move things forward working with faith partners across the city and this was no longer an issue. Further work was to be carried out around immunisation issues with regard to the vulnerable population both now and over the next few years, this work was to commence imminently. At this point it was not clear how it was going to work and it was under consideration.

q) DOh asked about the Public Health grant and the reduced PH budget stating that some of the local services had found the health trainers to be very useful. These were funded by PH and he enquired if these were one of the services which had to be reduced?

r) MAs responded that unfortunately the health trainers service had been decommissioned; they were currently on a notice period. As a result of historic poor funding for more than five years with public-health in Liverpool spending above its budget every year they were at the point where there were no reserves left to call upon and have had to make some very tough decisions. The intention was to work very closely with the CCG to integrate other similar services and develop different models of well-being support.

s) DOh reported that the health trainer service had been a key part of the response to Covid19 in helping with shielded patients and practices and primary care networks to support those patients at home. DOh asked if there was anything that could be utilised in the interim while the funding was reconfigured and were there any intentions to offer an alternative in the future.

t) MAs responded that unfortunately the point remained. This was down to budgets and there was no money to support any additional services at the moment.

u) CMo informed members that primary care networks were in discussion with health trainers about potentially integrating services with link workers who had been aligned to PCN footprints.

v) DOh made reference to the chancellors statement where he (the chancellor) stated that *anything we needed we could have* asking was this not true?

w) MAs responded that of the £3.2b that had been allocated, the 1st tranche of funding contained a health needs/deprivation factor but the second tranche did not. This meant that relatively, Liverpool received less money in the second tranche than it did in the first and the amount it received does not meet the costs of Covid19 to date.

x) BKu commented that as a city, Covid19 had cost £78m, with £38m received from government to date and no guarantee of anything further. As a city, collective approaches were needed to address the impact that poverty was having on every service around the city, including health.

y) STh stated that the focus on inequalities should be high in any recovery strategy. The health impact of Covid19 had fallen unequally, along with the impact of lockdown. 70% of people who responded to the Liverpool HealthWatch survey said Covid19 and lockdown had impacted on their mental health. Some respondents had pre-existing mental health issues which have been exacerbated;

some people are struggling with grief from deaths due to Covid19 and with the difficulty of grieving with social distancing and the extra impact on carers in the home there was likely to be a tidal wave of mental health issues the city would need to focus on coming out of lockdown.

z) Also in regard to inequalities, people have reported getting shielding letters in English when English is not always their first language. People had no idea what to do or where to go to seek help. People who have no Internet access were very isolated.

aa) Although not in attendance at the meeting MSm fed in comments stating how well care homes in Liverpool had responded in comparison to the North West and the rest of the country. Any changes made as the crisis progressed should be identified. Test track and trace will only work to contain the virus if diagnosed cases and their contacts are quarantined for up to 2 weeks. Is there a communications strategy to facilitate this and what enforcement methods if any are available?

bb) MAs commented that it was early days in the development of the programme with new guidance coming out regularly. The latest guidance issued stated that contacts of positive cases would be told to self-isolate for two weeks. There was likely to be a national campaign communicating the message around this which would be accompanied by a local message once there was clarity. The government had said the test track and trace program would be live from the 1st June. PH were working closely with national and regional colleagues to understand the implications of this and what it meant in terms of rolling the programme out and would share information once there was clarity. It was absolutely right to have testing in place, it is critical that our vulnerable population are protected. Contact tracing must work efficiently at a local level to identify the outbreaks and intervene to act accordingly.

cc) Although not in attendance at the meeting MSm fed in comments stating that he was glad to see the prioritisation regarding health improvement including smoking, weight, physical activity and drinking within safe limits.

dd) JBl asked about the reported high number of false negative tests and whether this was being taken into account in the strategy?

ee) MAs responded that testing in hospitals or clinical settings had been good. Self-administered tests appeared to be less accurate as these were undertaken by people with less experience. Interventions were around ensuring people knew how to administer the tests.

ff) JLe commented that there had always been concerns about the accuracy of the tests. There was no evidence it was related to technique. Initially the swabbing sites set up in Liverpool were self-swabbing facilities. When the data was compared, there was no difference in the outcome of the efficiency of the test whether it was self-administered or not. There was a question overall on the accuracy of the test. No figures were available although it was up to 30% false negative.

18.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Note the content of the report and seek support from partners to work together to deliver the priorities identified within the report. •			
• None identified			

B4 FINANCE REPORT

19. Mark Bakewell presented the Finance Report directing members to the slide which contained the following information:

Overall Financial Position

- As at the 31st March 2020 (Month 12), the CCG has achieved an out-turn position of £6.5m surplus for the financial year. A surplus was first forecast in the Month 11 financial report and primarily relates to the return of H&C Partnership resources, further slippage on investments and the impact of the revised approach with regards to partially completed spells as agreed at the audit committee.
- This surplus will enable an equivalent drawdown in both the 20/21 and 21/22 financial years on a 2:1 basis with £6.5m allowable drawdown agreed in the respective financial year. Given the current disruption to normal business due to COVID, NHSE have confirmed flexibility can be given to the phasing and timing of the drawdown.
- In-Year revenue resource limit allocations for 2019/20 total £963.3m with additional resources of £4.2m being made available in Month 12, including new allocations for Mersey Care NHS FT mental health pass-through funding £1.4m, C&M-H&CP lodgements £1.5m, 2019/20 UEC Transformation Funding £0.5m, COVID-19 funding £0.3m and other allocations totalling £0.5m.
- The year-end position incorporates a number of adverse operational programme expenditure pressures including key issues relating to high cost drugs and devices (£2.2m), continuing healthcare / health packages of care (£8.3m), premises recharges (£1.0m) and non-contract activity (£1.2m).
- These pressures are offset by the full utilisation of the £4.7m (0.5%) Contingency Reserve, delivery of the stated CRES position (£16.3m) and other favourable variances against Earmarked Reserves (including the utilisation of the Cost Pressure, Prior Year Benefits and slippage against Development & Other Reserves).
- The CCG has delivered £16.3m of efficiencies within the financial year which is £2.5m above the initial savings target.
- Costs of £276k incurred relating to the impact of COVID-19 have been fully funded via allocation from NHSE.

20. MBa then went on to outline the following:

a) The CCG completed all indicators of performance at green. Trends had remained consistent throughout the majority of the year and had required the identified cash releasing efficiency savings to deliver the position.

b) The draft accounts had been submitted in line with the revised April deadline. The result of the Covid19 pandemic has meant that the final date for submission of the accounts has been deferred to the end of June and work continues with external audit colleagues to facilitate that process as quickly as possible with no major issues to report at this stage.

c) RBa asked if the CCG had ended the year with a deficit would the deficit have been written off as Trust deficits have been written off.

d) MBa responded that this was not necessarily the case as presented in some instances, although it seems that Trust deficits have been written off in reality they have been realigned to a different type of debt and are still sitting on the balance sheet with an equivalent recurrent impact.

e) JBl queried whether the draw down amount was available for investment or did the CCG have to wait until later in the year to find out?
f) MBa reported that the CCG was still waiting for the full guidance for the 20/21 year to be published. The Covid19 pandemic had significantly altered the financial management arrangements for CCG's for the year and full year details had not yet been released. At the moment only the approach for months 1 to 4 was known, with the rest of the financial year remaining uncertain. Some of the surplus from last year was as a result of brokerage and other aspects and was repayable so was not necessarily all available for extra investment. The CCG were waiting for further information from the national teams, but needs to be recognised in the context of the 'command and control' environment and how this reflected on a local basis.
g) JBl asked if it was likely that some of the 'drawdown' funding would be spent on Covid19 expenses.
h) MBa replied that this was not the intention at the moment given the current financial framework and the claim process for COVID related expenditure, however for M1-4, there were no further resources available to CCG's without going through the 'claim' process. On the 15th June the CCG had submitted its first Covid19 claim and these were currently being assessed by the centre but the CCG were not aware of any issues at this stage. Should the centre come back and say they did not approve the claims then the CCG may be asked to deal with this locally but the information is incomplete at this point.
i) DOh mentioned that primary care networks had carried out a lot of work and had been told to apply for funding for the extra work they had done and the expense this has caused. Was it likely that they would be assessed retrospectively and possibility may not be funded?
j) MBa responded that the CCG had been working local providers to understand COVID expenditure but yes there was some level of risk. As time goes by it is believed that there will be an increase in the scrutiny of claims, particularly when moving out of the first quarter and that the financial regime may change. The CCG did not believe its claims would be rejected as it had a robust internal validation process and could supportits claims but it could not be guaranteed.
k) DOh asked if there was a risk that NHSE and Cheshire and Mersey system would remove some of the funding.
l) MBa stated that this was unknown at this point as guidance had only been given for the first four months.
m) SRo suggested that given this was a pandemic and was costing billions was it unreasonable to expect that the government will give any money to the system?
n) MBa stated that going into the early planning rounds it was known that the CCG didn't have enough budget to potentially cover its costs but that we needed to ensure that we were using available resources effectively. SRo commented that she had real concerns after seeing the effect of the 2008 financial crash but was sure the CCG would do whatever it could to support the local population.
o) Although not in attendance at the meeting MSm fed in comments stating that it was important to note that the acting as one contract had facilitated innovation in the hospital trusts and as the CCG moves forward it would be important to maintain this mechanism in order to allow provider trusts to embed new ways of working. For example, remote outpatient clinics and patient led supported

follow-ups.

p) MBa responded that one of the main purposes of the acting as one agreement was to achieve greater stability in the system to enable transformation to take place and some of this has been taken forward due to the current circumstances. The CCG was still hoping to move towards a cost based approach and this is partly reflected with the current regime and we need to make sure we keep the momentum up with regards to the positive aspects of current circumstances

q) FLe commented that despite living in incredibly uncertain times we could still be optimistic for how to do things differently.

21.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Notes the 2019/20 outturn financial position and next steps regarding the audit and submission of the accounts.;			
Further actions required: • Make Covid19 decision log available to GB members	F Lemmens	June 2020	On Agenda for GB July 2020

B5 PERFORMANCE REPORT

22. Sam James provided an overview of the Performance Report, informing members that:

a) There was a new format to the report with a different look and feel in its presentation. It summarised performance at a glance against national indicators and showed exception reports bringing together information around trends; underperformance; issues and actions; linking back to projects underway within the operational plan.

b) The data held at the time of publication referred to pre Covid19 with those areas highlighted as pressured in February becoming more pressured within the system. These areas included IAPT recovery; this was previously in a positive position achieving the 50% recovery target position. The CCG knew this was a fragile position and a lot of work had gone into the online offer which had been beneficial during Covid19. The position had deteriorated recently with the biggest issue being staffing capacity both in terms of turnover and also in releasing staff to undergo training to continue working.

c) There was absolute pressure in terms of bed capacity within mental health; the provider was looking to source or create new capacity across the system.

d) There had been a real shift towards online/virtual advice and support with the implementation of new advice or crisis lines along with bolstering the online support for young people.

e) Diagnostics in cancer was the main physical health issue with a reduction in February and an increase in March. Pressures remain in MRI; endoscopy and echocardiography. Pre Covid19 the capacity was bolstered but has since seen an increase in demand. There were 4% of patients waiting over 6 weeks for diagnostic tests and this has increased recently to 14% which has implications for achieving RTT and has implications for cancer patients too.

f) During the Covid19 pandemic the cancer alliance have largely been managing cancer related matters, setting up hot sites and aligning surgical centres by

tumour specialty with each trust dealing with specific tumour types and this work is continuing.

g) With regard to elective activity and RTT performance, in February there were zero 52 week breaches and this has slipped to 6 in March. Focus has shifted to clinical prioritisation and continued mutual aid. The waiting lists in place now are to be reviewed according to clinical priority rather than the 18 week standard. This work was being taken forward by medical and clinical teams within providers.
h) The biggest risks in terms of performance were around diagnostics; elective care in terms of waiting-list management; and also mental health. The priority was to treat the most urgent cases first.
i) FLe noted that members' comments regarding the format of the report were positive.
j) JBl suggested that the information may be difficult to interpret for several months now. During lockdown there had been a lack of demand on diagnostics. There may be a huge demand to follow.
k) FLe commented that things were going to get quite bad with challenges ahead. Clinicians would be involved in the prioritisation process thanks to JLe's persistence. Liverpool CCG has requested to be involved at all stages and FLe has been invited to join the medical directors clinical cell across Cheshire and Merseyside discussing work on clinical priorities and then looking at a local level. There would be conversations locally regarding how to work with primary and secondary care to achieve a collective effort.
l) JLe commented that local trusts had been experiencing a 25% reduction in patients accepting slots for surgery because they did not want to come into hospitals at this time. This meant capacity was being lost which added to the waiting list time at the other end. Members were asked to please encourage any waiting patients to take their slot as the CCG could not afford to lose the capacity. These patients were now on urgent lists and could potentially end up coming in for emergency surgery.
m) It was not known how many were not taking up appointments however LUFT were returning a significant number of breaches against their 62 day cancer referrals and this was due to patients not attending or cancelling appointments.
n) FOf stated that members could expect a big reduction in the dementia diagnosis rate which was recorded as decreasing by 249 from March to April on the register.
o) There had been a shift in NWAS from See and Treat to Hear and Treat which seemed like a culture change with FOf asking what was in place to ensure decision-making was safe?
p) SJa responded that NWAS were involved in the recovery conversation. Everything that had been put in place in response to Covid19 needed to remain in place and this message had been clear throughout. Recovery was about keeping the best of what was available and taking it forward. The CCG had started an evaluation looking at the new things put in place and how to keep them when moving forward. The assumption had been made that the mutual aid that had been in place would remain as all parties had benefited from this.

23.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Note the performance of the CCG in the delivery of key national performance indicators for the period highlighted and of the recovery actions taken to improve performance and quality. • Determine if the levels of assurance given are adequate in terms of mitigating actions, particularly where risks to the CCG's strategic objectives are highlighted.			
Further actions required: • Performance and recovery post Covid19 to be monitored on the risk register.	S James/S Hendry	June 2020	On Agenda for GB July 2020

B6 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

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

24. Stephen Hendry provided an update on the organisation's Governing Body Assurance Framework (GBAF), Corporate Risk Register, and Issues Log.

a) It had been a significant effort and a real challenge to keep the Corporate Risk Register (CRR) and the Governing Body Assurance Framework (GBAF) going while the Covid19 work had been underway and it was thanks to the Corporate Governance Team that it was able to continue.

b) One new risk had been added to the corporate risk register which related to COVID-19 and this was an internally focused risk in terms of business continuity and staffing levels. The comments made today so far have been noted and the register would be updated accordingly.

c) FLe commented that the narrative regarding CO 36 appears to refer to a different time mentioning winter pressures and so needed updating.

d) JBl enquired whether the situation regarding command and control caused a risk in the ability to deliver the One Liverpool plan.

e) FLe responded that the issue related to the GBAF and was something for discussion at a future Governing Body development session as it required an in-depth discussion when more guidance would be available.

f) SHe reported on the GBAF stating that when the GBAF for 2019-20 was closed the CCG was in a good position in terms of actions completed with the new structure and the new constitution, a lot of which had been delivered. With regard to 2020-21 it was more complex. The development session where members would have agreed the corporate objectives and the strategic risks had not taken place due to Covid19. There was a lot of uncertainty now due to being in a command and control situation. This needed to be discussed collectively and members were reminded that the GBAF was a work in progress. It was starting at a similar point to where it was the previous year and a lot of patience would be required to move things forward.

g) SHo commented that the Covid19 risks were constantly being reviewed as the situation changes. However, the executives could consider looking at what risks needed to be added to the register coming out of Covid19; there was the risk to the waiting list and the other things mentioned on the performance report; the impact on population health and a there was going to be a huge impact on mental health which should be considered for bringing to a future meeting.

h) DOh enquired about the committee structure asking if the structure in place needed to be captured to ensure all risks are mitigated for since the committee structure in place had temporarily been put on hold.
i) JLe stated that this was a good point. It would be reviewed as the Covid19 risks were reviewed. The CCG were not responsible for managing all of the risks due to the command and control structure in place and it needed to work through what the residual risks were to assess which risks it could legitimately manage until things went back to business as usual. The senior leadership team needed to work through this to give members the assurance that it was managing its responsibilities appropriately.
j) DOh observed that there seemed to be a lot of responsibility for the senior leadership team and decisions made were recorded in the decision logs which were going to be audited at some point possibly externally or through the audit committee. Was there a need to have a formal quorum or minute taking at that meeting?
k) JLe replied that the senior leadership team meetings were noted and the decisions were recorded and the decision log would be cited by the audit committee in line with the CCGs governance and SORD. Most of the decisions being made were within current delegated limits in line with current structures.
l) FLe commented that the new structures became operational from 1st April and members were working extremely hard and very long hours at that point and the instructions were to focus on Covid19. Now starting to come out of that period and looking at how to bring the committees back in order to support the senior leadership team who were carrying a huge amount of responsibility, as a governing body members could give more support to that as committees are put back in place.
m) PFi asked does CHC need to be added to the issues log.
n) JLu responded that this would be considered. Other CCGs had the same issue and it could be discussed at the Chief Nurse support call for a consistent response across the region.
o) Chi commented that the Liverpool Integrated Care Partnership Group was due to meet and one of the items for discussion was to review the impact of the pandemic and opportunities for One Liverpool. A reset of the One Liverpool plan was expected in 2020-21 to reflect the situation.
p) JBl queried how aligned was the Covid19 response to address health inequalities in terms of GBAF 03?
q) JLe replied that the response to Covid19 was a national response and it had highlighted the inequalities in deprived areas. The CCG would work with local authority colleagues to look at the impact of Covid19 and it could be addressed. The CCG did outline in the One Liverpool plan an aim to target those in most need. The increased deaths figures have highlighted the significant inequalities in communities across the UK.
r) Although not in attendance at the meeting MSm fed in comments stating that in GBAF 06 regarding gaps in assurance it talked about CCG improvement and assessment framework end of year rating not available until quarter 2, 2019-20 which seemed out of date.
s) Point 7 in GBAF 06 mentioned regular attendance of the AO at M&C. This needed to be checked as M&C did not resonate.

25.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Satisfy itself that current control measures and the progress of action plans provide reasonable / significant internal assurances of mitigation; • Notes the new risk (CO82) that has been added to the 2020/2021 Corporate Risk Register; • Notes the process used to develop the Governing Body Assurance Framework and Corporate Risk Register; and • Agrees the formal transfer of responsibility for the Issues Log to the Performance Committee.			
Further actions required:			
• Update CRR and GBAF in line with discussions in regard to typos and currency of information as listed above; (CO36 and GBAF 06)	S Hendry/J Davies	June 2020	On Agenda for GB July 2020
• Discuss situation of command and control regarding potential risks to One Liverpool Plan at future GB Development Session;	F Lemmens	June 2020	Added to future discussion items for GB Development Session
• Executives and SLT to consider risks to be added to CRR for consideration at future GB;	All	June 2020	On Agenda for GB July 2020
• Consider committee structure within Covid19 risks;	SLT	June 2020	On Agenda for GB July 2020
• Discuss adding CHC to issues log with Chief Nurses across region	J Lunt	June 2020	On Agenda for GB July 2020

B7 EMERGENCY PREPAREDNESS, RESILIENCE AND RECOVERY REPORT (EPRR).

26. Stephen Hendry delivered an update on the EPRR report stating that:

a) Significant assurance was noted for the work that had been undertaken throughout the year with regard to emergency planning resilience and response. At the end of the report information was included about the response to Covid19 with thanks to the digital team and Informatics Merseyside for enabling the system and allowing us to carry on working as we have done.

b) HDe asked would the CCG undertake a lessons learned review regarding its Covid19 response in EPRR terms. The response was a definite yes.

c) FOf enquired when the last pandemic exercise was carried out.

d) SHe responded that the last exercise was in 2016 which was the Cygnus exercise. The outcome and report were not published.

e) JLe informed members that the EPRR process was tested annually on localized incidences. National pandemic resilience testing was not carried out frequently and this may change.

f) Members thanked Stephen and the team for their hard work over the last month's while maintaining a cheery disposition. Members also appreciated the resilience planning that was done routinely.

g) Members were informed that the review of the Covid19 responses was also in

the internal audit plan for the year.

27.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Acknowledge the CCG's internal and multi-agency work to ensure compliance with The Civil Contingencies Act and NHS England requirements; • Note the substantial assurance rating for the CCG.			
Further actions required: • None identified			

B8 COMPLAINTS REPORT

28. Sallyanne Hunter updated members on the complaints report noting the following:
    a) MP enquiries were down from 61 to 21.
    b) FOI requests remained steady with 287 requests although the complexity of them had reduced and they had largely been turned around within 10 working days.
    c) Complaints had remained similar as had PALS contacts.
    d) There had been 2 ombudsman contacts and the team thanked members for their support in responding to requests.

29.

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

C FOR DECISION

30. No items.

D FOR NOTING

D1 CONSTITUTION

31. Stephen Hendry delivered a verbal update noting that the Constitution was live; it had been uploaded to the intranet in April. SHe thanked all involved for their contributions.

D2 CCG RESPONSE TO COVID-19

32. Sam James presented a report outlining the following:
    a) There was some information in the report that talked about the work that had been carried out regarding the governance checklist ensuring the CCG is in line with national guidance and making sure it is auditable later. At the beginning of Covid19 the CCG structured itself to respond to Covid19 and to maintain statutory responsibility; this has been the focus of the teams across the two

areas. The CCG made the decision to work remotely helping to keep its staff safe where they were able to work remotely. It carried out business impact assessments which helped to understand and capture what the business critical functions were and to ensure these continued. It is now reviewing these in terms of what were classed as amber and green and which activities it can start to think about bringing back on line in terms of recovery. The biggest changes were in contracts and finance as discussed. There was a business plan for 2020-21 which had to be suspended as the planning rounds were suspended. The projects the CCG intended to take forward have been put on hold while the CCG focused its attention on responding to the pandemic. The focus was now on lessons learnt and taking that forward and what new areas of work needed to be picked up. Staff have adapted to new ways of working and learnt to do new things in response. The CCG does not want to underestimate how this has been managed and responded to and it's thanks to the dedication and commitment of staff that it has been able to keep going as the incident unfolded.

b) MKu thanked to the digital team and Informatics Merseyside in facilitating getting everybody the equipment they needed and ensuring everybody could work to the best of their ability in such a speedy fashion.

c) Although not in attendance at the meeting MSm fed in comments stating that the CCG's proactive investment in infrastructure had been a huge benefit for the organisation and also for primary care. In addition the Tele health hub which had been going for some time with regional investment provided capacity to monitor up to 16,000 patients. Liverpool pays for monitoring of up to 6000 patients and will shortly have 4500 patients receiving telehealth monitoring via the hub. Pre Covid19 this figure was 1700 patients per day. The remaining capacity is being used by LUFT to support Covid19 patients post discharge and would be used to support community patients when the pathway goes online. The remaining 1500 capacity may also be used to support shielding patients if necessary. There was a remaining 10,000 capacity which would be offered to the out of the hospital cell across Cheshire and Merseyside.

d) Although not in attendance at the meeting MSm fed in comments formally noting his thanks to colleagues across primary care for their incredible response to the crisis, changing service delivery models and the rapid adoption of digital technology.

e) GGr asked was the Covid19 experience likely to change long-term working practices in the CCG?

f) JLe responded that the CCG had learnt a lot from the change in practice and it would take that learning forward. There would be a significant number of people enabled to continue working from home if they wished to do so. The experience of using online technology for meetings had changed working practices and that would be a future discussion item. Working from home was not for everyone as a recent staff survey had indicated. Some members of staff had space at home where they could sit in quiet and work undisturbed but this was not the case for everyone. There was a need to balance equity across the organisation and to work with staff to understand their needs while balancing the CCG requirements to explore if it could operate in that way. It was likely that the CCG would embed some of the learning as it moved forward.

g) RBa asked MAs if services paid for by local authorities would be maintained this

year as assurance had not been received yet although it had not been requested either. RBa also endorsed comments made regarding remote working saying it was fine in principle but there was a need to ensure it did not widen the inequalities gap, not everyone had access to technology and also being a person to person service some people didn't relate well to screens.

h) MAs responded that this was a conversation that needed to be discussed outside the meeting to ensure clarity of understanding.
i) FLe responded that it was clear that there were benefits and risks to the virtual world and both should be considered.
j) Although not in attendance at the meeting MSm fed in comments stating that the set up of hot hubs across the city had been variable. The response of the Liverpool Network Alliance (LNA) in coordinating work across the city had been exemplary. The LNA would benefit from high-level CCG support in order to address any recalcitrant practices in fully cooperating.
k) The pace of change had been quite remarkable and there was a period of time when it felt we were coming up against obstacles in setting up the hot tubs. It had been a fairly positive experience working with the LNA and the LMC. The CCG acknowledged the contribution from an LMC perspective. RBa had sent out daily bulletins to GP practices which had been hugely beneficial to the system and communications out to practices had been good.
l) HDe asked how the hot hubs fit with other structures.
m) FLe replied that NHSE sent instructions to GP practices at various points over the last eight weeks about the cohorting of patients with instructions to separate suspected or known Covid19 patients from non Covid19 patients. There were also patients with non Covid19 needs who still required face to face consultations so practices were asked to suggest ways to manage this either on their own or in collaboration with other practices. It was decided that a city wide model would be utilised to deliver safe services for patients suspected or known to have Covid19 so a move towards a system where a walk in centre could be used as a facility away from individual practices was delivered. This work was carried out in partnership with Merseycare. There were 2 hot hubs ready and working and others ready to go if required. Demand was not as high as anticipated so the others have been kept in place but not utilised until they may be needed. Practices had been able to manage demand successfully.
n) It was more difficult to coordinate the north of the city and this is believed to be due to there being a large number of smaller practices in this area. Also the estate was not as near conducive to that scale although all practices had plans in place which were being monitored to ensure they met the SOP requirements.
o) CRo enquired whether there were research and/or evaluation underway which may make the link between digital inequalities for the most disadvantaged communities and health inequalities?
p) JLe responded that the CCG was working with Liverpool University looking into Inequalities particularly around access. It would take some time to complete a good quality piece of work however the findings will be monitored and linked in where appropriate.
q) FLe thanked everyone involved in the very comprehensive report, noting that although the CCG had stepped up and responded hugely to the Covid19 situation business as usual had been maintained as much as possible. It may not always

have been quite as usual as it would have been under normal circumstances but it had continued to function as normally as it possibly could.

33.

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

E QUESTIONS FROM THE PUBLIC

34. One question was submitted by email the previous day. CHi agreed to discuss the question with Liverpool City Council as the question referred to care homes and social care and to test track and trace which Public Health would also be required to respond to. The response would be attached to the minutes in due course and the person who asked the question would receive a response by email which they said they were happy for. The response would be sent out in the next few days.

Action	Lead	Timescale	Status
Recommendations approved by the Board, namely: • Respond to the questions raised			
Further actions required: • Liaise with Local Authority and Public Health to respond to questions asked by public and share response with GB.	C Hill	ASAP	On Agenda for GB July 2020

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

35. The following items and committee minutes were noted:
    a) F1 - Update to the 2019/20 Audit, Risk and Scrutiny Committee Annual Report to the Governing Body;
    b) F2 - Finance, Procurement and Contracting Committee Feedback;
    c) F3 - Audit and Risk Committee feedback – 21/04/2020;
    d) F4 - HR & Remuneration Committee – 26/11/2019 & 21/01/2020;
    e) F5 - Quality, Safety and Outcome Committee – 04/02/2020;
    f) F6 - Committees in Common - 13/12/2019;
    g) F7 - Primary Care Commissioning Committee - 17/12/2019.
    Minutes for the Cheshire and Merseyside Health and Care Partnership System Management Board have been requested. Once these are received they will be provided to members.

G1 ANY OTHER BUSINESS

36. Although not in attendance at the meeting MSm fed in comments stating that the issue of data sharing and Control of Patient Information (COPI) regulations 2002 which allowed the processing of confidential patient information with a view to diagnosing communicable diseases, recognising trends in such diseases, and risks, controlling and preventing the spread, monitoring and management of said risks. The regulations allowed the setting aside of confidentiality for the purpose of processing confidential information in accordance with regulations for research purposes. The research must have been approved by the research authority and/or

the Secretary of State for Health.

37. COPI regulations did not allow a free for all with regard to the release of GP held patient confidential data and, for any release under COPI, an appropriate data sharing agreement must be in place, setting out the legal basis for sharing.
38. Data sharing was vital particularly during this period but it had to be done correctly to maintain public confidence. These comments were endorsed by RBa.
39. DOh enquired whether there was any difficulty in obtaining local level data on infectious disease control and notifiable diseases so that the information could be used to ensure a good local response.
40. MAs replied that PH did not have access to any of that data currently and it was trying hard to obtain it. There were different testing pillars and PH had access to the NHS pillar one information only. Work had taken place on IT systems to join the data up and there was talk from the government that there would be more local influence over testing at which point we would have access to that data.
41. JLe reported that the initial response for testing did not require private organisations to share the data, only to feedback to the individuals who had undergone testing. Concerns had been escalated regarding the lack of access to this data and also for individuals' data not to go back to GPs based on whether it was a positive or a negative result that was being addressed. This would be fed into GP records in the near future. It had come about initially in the rush to get a system up and running and was an oversight which had since been corrected. There was a responsibility under the notifiable diseases regulations which led to the rapid correction.
42. SRo asked if given the volume of deaths from the pandemic and the likelihood of requests, who could legally request patient information. Also psychiatric reports seemed to be shared inadvertently, was this allowed?
43. FLe responded that these were good questions but possibly beyond the scope of the meeting. They would be discussed offline with MSm and SRo.
44. No other items of business were discussed.

The meeting closed.