NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 18th February 2020 at 10am
BOARDROOM, THE DEPARTMENT

Present:

Voting Members		
Cathy Maddaford	**CHAIR**, GB Lay Member / Registered Nurse	CMA
Jan Ledward	Chief Officer	JLe
Mark Bakewell	Chief Finance Officer	MB
Dr Janet Bliss	GP (Governing Body)	JB
Helen Dearden	Governing Body Lay Member for Governance	HD
Dr Paula Finnerty	GP (Governing Body)	PF
Samson James	Director of Planning and Performance	SJ
Dr Monica Khuraijam	GP (Governing Body)	MK
Dr Fiona Lemmens	GP (Governing Body Chair)	FL
Jane Lunt	Director of Quality, Outcomes & Improvement	JLu
Dr Stephen Sutcliffe	GP (Governing Body)	SS
In Attendance		
Scott Aldridge	Contracts Manager	SA
Dr Rob Barnett	LMC Secretary	RB
Laura Buckels	BI Team Primary Care Lead	LB
Kellie Connor	Contracts Manager	KC
Victoria Horton	Senior Finance Manager	VH
Dr Fiona Ogden-Forde	GP (Governing Body)	FOF
Sarah Thwaites	Health Watch	ST
Jacqui Waterhouse	Senior Programme Delivery Manager	JW
Debbie Richardson (DS)	**MINUTES**, Corporate Services	DR
Public		
No members of the public attended this meeting.		
Apologies		
Tom Knight	Head of Primary Care, NHS England	TK
Peter Johnstone	Head of Primary Care Delivery	PJ
Lynn Jones	Primary Care Quality Manager	LJ
Cheryl Mould	Programme Director, Provider Alliance	CMO

Part 1: Introduction & Apologies

CMA welcomed attendees and introductions were made. Apologies were noted as listed above.

1.1 Declarations of Interests

There were no new declarations of interest made relevant to the meeting's agenda. However, a conflict of interest was pointed out regarding item PCCC 05-20 – Primary Care Network Prescribing Cash Releasing Efficiency Savings (CRES) CRES Programme which potentially conflicted with the GP members and was being presented by a GP. Members agreed that FOF as presenter had more detail of the proposal than other members in attendance and there was no voting involved. Members agreed to proceed.

1.2 Minutes & Actions from Previous Meeting (17/12/2019)

The minutes of the previous meeting held on 17 December 2019 were agreed as a true and accurate record.

Action Log:

- Actions 1 and 2 had been allocated to TK who was not in attendance. SJ agreed to contact TK to clarify progress with the actions prior to the next meeting.
- The remaining action points were listed on the meeting agenda or not yet due.

1.3 Matters Arising

None raised.

Part 2: Updates

There were no updates to report on other than those within the meeting agenda which were discussed as separate agenda items later in the meeting.

Part 3: Governance

3.1 Primary Care Commissioning Risk Register, February 2020 (PCCC 01/20)

JW presented the risk register which had been updated and refreshed following the December meeting, and confirmed no new risks had been added to the register this month. Risk owners had been refreshed. Key updates were:

- 0.5 Primary Care Network (PCN) delivery - Jan; National specifications consultation had completed and final specifications released. Feb; Reporting evidence agreed, template in development
- 0.6 General Practice contract management frailty indicator - January 2020 - Performance Team had shared the national reporting requirements to iMerseyside Informatics Facilitators who had cascaded to practices who had asked for their support. Performance Team had shared best practice results from action plans with practices who had asked for support. The numbers of completed Electronic Frailty Index (EFI) assessments was increasing. February 2020 - 13 practices had asked for a quarterly Contract and Performance meeting to avoid drift away from trajectory.
- 0.7 PCN maturity - January; Liverpool Network Alliance of PCNs submitted a bid to NHS England (NHSE) with regards to a place based approach to delivery of the PCN development prospectus.

QUESTIONS & COMMENTS

RB expressed caution regarding GP practices signing up to the Directed Enhanced Service (DES) saying there was some disquiet over the contract and it was not easy to predict how many would be signed up in two months time.
CMA enquired whether RB thought the risk score should therefore be changed to which RB responded that this wasn't necessary, however members should consider what the risk should be in terms of what was happening nationally.
JLe stated that members were aware of the risks but there was national uncertainty which contributed to the volume of questions raised when exploring the risks. NHSE North West had some funding from the previous year which may be available for use.

CMA noted that the issues raised would be taken on board.

Part 4: Performance

4.1 GP Specification Performance Report (PCCC 02/20)
SA updated members on the status of the GP Specification Performance Report

- The targets were set on a two-year trajectory (i.e. to be achieved by end of March 2021) and monitored on a regular basis from July 2019.
- Indicator trajectories were monitored monthly and the risk of non-delivery raised with the practice, who were expected to put appropriate measures in place.
- Where a practice had not achieved against its trajectory for 2 consecutive months, the practice had been contacted to highlight the issue. If, after a further reporting period, the practice was still not meeting the trajectory, a formal letter would be sent to request an improvement plan.
- In order to deliver its responsibilities LCCGs Business Intelligence team devised and published the trajectories on the Aristotle portal and made available the data searches, so that at a practice level the practices could identify patient level achievement.
- At 13 November 2019, each practice was provided with the performance monitoring process and this was shared again in January 2020.
- In January 2020 each practice was contacted to highlight the number of KPIs that they were off trajectory for.
- Feedback from practices was that iMerseyside informatics facilitators had been supporting practices with any data quality issues for the GP Specification and Core Contract KPIs.
- The committee was being asked to note performance and accept assurance and also to consider stopping payments in October 2020 to those practices who were non-compliant.

<u>QUESTIONS & COMMENTS</u>

FL sought clarity on how far from reaching targets practices were; were they close to the target and likely to achieve with minor support or were they actually struggling and was this because of internal pressures or system issues or other reasons. SA confirmed that each practice had sight of the indicators, practices could interrogate the data to patient level so they knew who to target to meet particular KPIs.
SA informed members that feedback had been that there were some data quality issues with some practices requiring more support from iMerseyside than originally anticipated. A lot of practices were not far off meeting their trajectories and there had been shared working across practices via the PCNs.
RB enquired about whether the data was in real time or not, asking where it was up to and where it would be by the end of the year. A list of struggling practices would be helpful along with how far from the trajectory they were. SA replied that trajectories had been identified across the year with the data contained in the report being from January 2020. The data was used by NHSE to measure the LCCG outputs in terms of improvements to primary care so were important.
SJ stated that the report was an early indicator that some practices were below trajectory and would need a recovery plan if this continued. Capturing this data early meant support could be offered in terms of buddying up before a three months non-compliant recovery programme was required.
MB stated that the specification was intended to give practices an early warning with the process enabling an awareness of what the predicted model might look like. Early notification

of potential non-compliance should prevent more serious problems in the long term.
RB stated that data and codes being entered into templates erroneously needed to be acted upon quickly to avoid later problems and misrepresentation of data. SA agreed to follow this up as an action.
PF sought clarification that all practices were aware that support was available from informatics Merseyside with SA confirming that all practices had access to an information facilitator who had been proactive in acting as the link to the LCCG also.
CMA enquired about the start date for the three month period for failing to reach targets with SA responding that data was extracted monthly and built upon. All practices were written to on 13 November 2019 and told the process had commenced and recording commenced from that point.

ACTION:

SA to investigate instances of erroneous data being input to ascertain if this caused practices to become non-compliant.

4.2 Primary Care Contract, Performance & Quality (PCCC 03/20)
SA delivered an overview of the Primary Care Contracts, performance and quality report

- The report proposed a change to the process agreed in August 2019,
- The updated processes propose NHS LCCG approach to the contract, performance and quality management of Primary Care Medical Services in Liverpool
- LCCG had devised an escalation process to utilise contractual levers and processes in line with the management of other NHS contracts held by LCCG including acute, community, mental health, and independent trust contracts**.**
- This approach would also recognise the differences in Alternative Provider Medical Services (APMS), General Medical Services (GMS) and Personal Medical Services (PMS) contracts with legal requirements in relation to contract management.
- There were two elements to the current contract; the core element which was governed by a national framework and the GP Specification which could be tailored to local requirements.
- It was essential that LCCG had a consistent, transparent and robust approach for its management of Liverpool General Practices and that there was alignment of processes for the management of these elements across its 85 Primary Care Medical Practices.
- The LCCG had developed a contract monitoring dashboard which outlined the core contract requirements and showed providers compliance with the contract.
- The contract monitoring dashboard was applicable to all GMS / PMS and APMS providers.
- Failure to deliver any of the core contract requirements would constitute a breach of the core contract.
- Contract review meetings would ensure LCCG could demonstrate it had followed appropriate due process in investigating, communicating and implementing any actions where performance was a concern.
- Risks identified were:
    - Failure to effectively monitor the delivery of the core contract and associated contracts resulting in a practice not delivering their core contractual requirements.
    - The co-commissioning agreement required LCCG to have a robust contract monitoring process either face-to-face or virtual. Failure to implement these requirements would be in conflict with the agreement.
    - Annually Mersey Internal Audit Agency (MIAA) were responsible for assessing LCCGs co-commissioning arrangements. Contract and performance monitoring

was a key element of the assessment. Therefore, LCCG needed to demonstrate a robust process.
    - The Liverpool GP Specification clearly outlined a process for monitoring the GP Specification. The process listed included details of financial sanctions. Failure for LCCG to deliver its monitoring processes could impact on its ability to implement those sanctions.
    - If any practice was issued with a remedial or breach notice they were excluded from applying for any interim provider procurements that may occur throughout a 12 month period.
    - Three breach notices required LCCG to terminate the contract.
- The risks did not monitor the quality elements of primary care.
- Information was required monthly for contract purposes and a development process was underway to link the dashboard to enable this data extraction process.
- A new process needed to be identified for enhanced services.

QUESTIONS & COMMENTS

RB suggested members were cautious around what they agreed to regarding the contracts in particular with regard to access given the unknowns at that point. More formality was required when NHS Digital set up templates with EMIS which was likely to be completed by April 2021.
JLe stated that it was incumbent on members to raise awareness of the issue before it became a problem. FL asked how practices had been engaging and if they were prepared for the introduction of the system. SA responded that practices had been written to and the next stage was to invite them in to explain things as there were no longer practice manager or practice nurse meetings which would have been the method of communication previously. JLu stated that engagement had recently taken place with the local network alliance to share the message and a campaign was needed to get the right message out. Within the quality team each manager has been assigned to practices to meet with and talk through processes and discuss what was happening. This had taken time to get systems and processes aligned and planning was underway to socialise this.
SS commented that there appeared to be no opportunity for practices to raise concerns when under pressure prior to breaching the contract trajectories. JLu stated that this reflected the discussion at Quality Safety and Assurance Group (QSAG) which acknowledged the reactive state. Building relationships with practices would enable supportive working to mitigate issues and encourage better use of data.
RB asked for information regarding who within the organization (LCCG) was responsible for particular areas given the recent changes. JLe responded that roles had been filled and communication would follow detailing who would be responsible for what in which teams. A modified version would be provided by SA for RB to present to Local Medical Committee (LMC).
PF enquired about LCCG attending practice events with JLe responding that events needed to be considered from a commissioning perspective. It was important to encourage people to be involved with processes and two meetings were scheduled for March which would be used to promote primary care contracts.

ACTION:

SA to provide a modified version of the organisational structure to LMC.

4.3 PCCC Contracting and Finance Report (PCCC 04/20)

Primary Care Contracting Report
KC presented the key aspects of the CCG's Primary Care Contracting and Finance position for 2019/20 as at January 2020 (Month 10). Items highlighted by exception were:

Friends and Family Test (FFT) - It was a requirement that each month GP practices submitted their previous months FFT results onto Calculating Quality Report Service (CQRS) by the 12th working day of the following month. For the November 2019 return, 6 practices had failed to provide monthly FFT information to NHSE. Only 1 of the 6 practices was also highlighted as failing to submit FFT in November 2019. The 6 practices failing to submit in November 19 would receive formal notification from LCCG to obtain assurance the appropriate mechanisms were in place to meet the contractual requirements and ascertain the reasons for non-compliance.

Alcohol Consumption Scheme - The national reporting service CQRS was updated in November 2019. 44 practices were below 50% of new patients aged 16 and over having their alcohol consumption recorded. For those practices not on trajectory for the delivery of the core contract position, LCCG would ask for a contractual recovery plan.

Electronic Frailty Index (EFI) - The contractual requirement was that 100% of patients would have an EFI by 31st March 2020. The average LCCG performance in January 2020 for patients over 65 receiving an electronic frailty index was (46.01%), this was an overall improvement from the previous position in September 19 of (27.89%).

Partnership changes - Since the last Primary Care Commissioning Committee in December 2019, LCCG had processed the following Partnership changes: N82669 - a new partner was joining the practice; N82081 - a new partner joined the practice; N82110 - two partners would be leaving the practice; N82066 - a partner was leaving the practice, however a GP partner was joining the practice.

Practice Closures - Following the approval at PCCC in October 2019, Dr K Mangarai GMS (N82621) contract ended on 29th January 2020. A managed dispersal of the patients to the two co-located practices in Speke Health centre had taken place on 28th January 2020 and all patients were registered with their new practices on 29th January 2020. All of the practices concerned worked collectively and collaboratively with Liverpool CCG, iMerseyside and Medicine Management Team (MMT) to manage the process effectively, to minimise risk and disruption to patient care.

Medicines and Healthcare Products Regulatory Agency (MHRA) Central Alerting System (CAS) alert system - NHS England reported a total of 6 practices had not registered with the MHRA CAS Alert system as of 7th February 2020. A response was required within 14 days to demonstrate full compliance. One of the practices signed up immediately after being contacted by Liverpool LCCG on 7.2.20 and a further contract meeting was taking place on 12th February 2020 with the GP lead for the remaining 5 practices. If relevant the appropriate contract levers would be applied following the evaluation of the meeting on the 12th February 2020.

GP contract agreement: 2020/21-2023/24 - NHS England and NHS Improvement and the British Medical Association (BMA) had agreed the 2020/21 GP contract deal. This agreement updated and enhanced the existing five-year GP contract deal. NHSE was planning a series of roadshows to support colleagues in understanding the changes along with the publication of further guidance. Key changes included major enhancements to the Additional Roles Reimbursement Scheme to help secure 26,000 additional staff; measures to aid GP training recruitment and retention to help deliver 6,000 extra doctors working in primary care; a renewed focus on improving access including a new GP Access Improvement Programme; further improvements to Quality Oversight Framework (QOF) including significant reforms to the asthma, Chronic Obstructive Pulmonary Disease (COPD) and heart failure QOF domains and a new indicator on non-diabetic hyperglycaemia, worth 18 points; an overhaul of vaccination and immunisation payments to improve vaccination coverage; maternity medical services would become an essential service, with a universal 6-8 week post-natal check introduced for new

mothers; the Structured Medication Review and Medicines Optimisation, Enhanced Health in Care Homes and Supporting Early Cancer Diagnosis service specifications had been significantly improved in the light of consultation responses. They would be introduced in 2020/21. Also incentives under the new Investment and Impact Fund would be introduced in 2020/21. The Fund rewarded PCNs for delivering objectives set out in the NHS Long Term Plan and GP contract agreement. It would operate in a similar way to QOF. Eight indicators were included in 2020/21, relating to seasonal flu vaccination, health checks for people with a learning disability, social prescribing referrals, and prescribing.

Primary Care Finance Report

VH presented the key aspects of the CCG's Primary Care Contracting and Finance position for 2019/20 as at January 2020 (Month 10). Challenges remained around the prescribing budget positon although the overall deficit was reducing. The forecast outturn for prescribing was £87,205 as at 31st January 2020. This represented a forecast surplus of £6,000 against the 2019/20 budget of £87,211. The LCCG was anticipating achievement of a balanced budget over the 2019/20 financial year for GP practice dispensed drugs as the majority of expenditure occurs over the winter months.

The 2019/20 CRES target for Prescribing Initiatives of £2.7m is expected to be achieved in full and deliver planned savings by the end of the financial year.

TOTAL PRIMARY CARE	Annual Budget £000'S	Year to Date			Forecast	
		Budget £000'S	Actual £000'S	Variance £000'S	Outturn £000'S	Variance £000'S
PRC DELEGATED CO-COMMISSIONING	78,259	64,934	64,668	(267)	77,882	(377)
LOCAL ENHANCED SERVICES	11,003	9,141	9,336	195	11,231	229
PRESCRIBING	87,211	72,758	72,570	(188)	87,205	(6)
Total	**176,473**	**146,833**	**146,574**	**(260)**	**176,318**	**(154)**

The PCCC was asked to note the performance of the LCCG in delivery of Primary Care Medical commissioned services; the actions on control measures and the LCCG approach to gain assurance; the forecast financial position for 2019/20 as at January 2020 (Month 10) including key issues that had been factored into reporting assumptions; and the update to the GP contract agreement: 2020/21 – 2023/24.

QUESTIONS & COMMENTS

VH reported that the variance was largely due to prescribing with forecast price increases being lower than anticipated. December spending would increase so figures were likely to be in line with anticipated forecasts.

The two PMS practices that had not signed up to GMS contracts had been consulted. The reluctance to change was due to personal choice. The assurance differential had been equalized. One practice had a very small difference which became evident when delivery specifications were compared. The other practice requested additional resources to deliver the assurance however, the practice was initially funded over its requirements which had decreased over time so it was now in the same position as GMS practices.

RB informed members that LMC was planning to host roadshows with a negotiating team which would detail the proposed changes. JLe stated that it would be helpful if RB shared details of the roadshow when they became available.

Members stated that some practices did not know how locum payments were reimbursed and practices needed to be told this. SA responded that locum claims were submitted to the generic primary care account and processed. Reimbursement of CQC expenses was sometimes

delayed with around 12 practices still to submit claims.
FL commented that the frailty index measured a practices' ability to input a code, not the data behind the code. If a patient was severely frail this was not being measured along with the impact on health and care needs. Furthermore, there is not a code for a category of 'not frail'. SA reported that this could be added to the index.
JLe reported that the provider alliance identified frailty as an area to be improved with SJ stating that the GP Spec was getting smarter and clarity was needed around the new elements to what the GP Spec involved and this was the opportunity to work on this.
HD queried where the age was set at 65 and over for recording frailty and when told this was in line with national guidance she suggested this should be based on frailty of need. HD also asked what was different about how practices were contacted now as it seemed more effective. SJ stated that this had come about as part of the whole team being on message and involved. Communication had always taken place and now more information was given around next steps and the consequences of not engaging.
ST enquired as to how members speak to patients about their frailty and what patients next steps would be. SS suggested not mentioning that patients were frail but suggest other measures in their routine care.
MB stated that while the LCCG was happy to help and wished to remain supportive, it (the LCCG) was a finite resource. The practice community had each signed contracts listing the performance measures they needed to take responsibility for within their roles and a clear line of responsibility was required to manage outcomes. JLe agreed with this point suggesting members could facilitate the use of PCNs to support outcomes. The LCCG needed to communicate how it operated, explaining its business model going forward.
RB stated that he understood the message but reminded members to consider the past and how the LCCG had evolved to get to the point it was at. A balance was to be struck which maintained relationships.
SS stated that as a membership organization the relationship would be different. FL responded that she was comfortable with the approach being taken and members needed to be distanced to an extent. The relationship was different now as historically members were supported but not held to account. Now members were being held to account they were also providers and needed to understand the difference between the two roles.

OUTCOME

The PCCC noted the performance of the LCCG in the delivery of Primary Care Medical commissioned services; the actions on control measures and the LCCG approach to gain assurance; the forecast financial position for 2019/20 as at January 2020 (Month 10) including key issues that have been factored into reporting assumptions; and the update to the GP contract agreement: 2020/21 – 2023/24.

ACTION:

Agreed that SA would add a 'Not Frail' option to EFI and include report on data behind stats i.e. health and care needs for frail patients.

Part 5: Strategy & Commissioning

5.1 Primary Care Network Prescribing CRES Programme (PCCC 05/20)

FOF delivered the proposal stating that the LCCG had previously offered prescribing incentive schemes and whilst these initially generated savings, uptake and delivery varied between practices, furthermore engagement usually dropped in subsequent years and any gains were not always sustained.

A PCN focussed programme mirrored the direction of travel for general practice and, as the payments must be used to for network infrastructure and development; there was a strong incentive for the PCN leadership to encourage and support all practices to implement the projects.
The Prescribing team had identified projects with the potential for substantial savings. The Medicines Optimisation Committee would work with PCNs, supported by the Liverpool Network Alliance, to agree a three-year programme, with two or three projects being introduced each quarter. This partnership approach would support ownership of the programme by the networks and ensure that the degree of savings expected was realistic.
Each project would then run for 12 months, although the bulk of the work needed to be carried out in the first three months to maximise the impact and avoid projects stacking up.
Over time the programme would include projects that the LCCG could not deliver at scale without GP engagement:

- National expectations – for example, the reduction in prescribing of products with low clinical value had reached a plateau and needed to be revitalised;
- Large scale non-clinical switches – specialists had agreed in principle a product switch of drugs for e.g. ulcerative colitis, that could be implemented relatively quickly and deliver substantial savings but patients may need reassurance from their GP;
- Large scale clinical switches – the diabetes specialists had indicated support for a switch of a preferred treatment for type 2 diabetes. This project offered an opportunity to review patients' blood results and potentially change to more appropriate treatment;
- Challenging changes – some high cost / low volume products had limited evidence of effectiveness but patients were resistant to change. GPs had indicated that, with appropriate support, and the city acting as one, de-prescribing was possible

A gain share model encouraged PCNs to maximise the cost reduction and subsequent income, without risk to the CCG. The gain share needed to be sufficient to be an incentive to PCNs to deliver a substantial cost reduction, and would be offered at 50% of the achieved saving. Networks would only be able to use gain share monies to support the infrastructure and future work of the Networks and PCNs may be required to account for how gain share funds were spent.
Although savings would be generated by individual practices, calculation of savings and rewards would be at PCN level. The baseline costs would be set as the spend from the previous 12 months available data. Savings would be calculated from the cost for the 12 months following the start of the project. The rolling programme would deliver a regular income stream for PCNs, but also encouraged practices to implement changes during the first three months, to even out the workload. This maximised the savings for the LCCG and the gain for the network.
Payment of gain share would be made in three tranches. As each project was worked up, the likely level of achievement and savings would be agreed with networks and the Local Needs Assessment (LNA). The first payment would be made at the start of the project and would be 25% of the Networks' estimated share of savings. The second payment would be made at the end of the 12 months project, once ePACT data was received, and would be 50% of the actual gain share plus / minus any under or overpayment from the start of the project. PCNs would be expected to maintain the savings delivered by the programme. The final 25% of the gain share would be retained by the LCCG and only paid to the network if costs had not risen by 10% or more at a point 12 months after the end of the project.
Delivery of the savings was the responsibility of the PCNs and this work would not be undertaken by the MMT. However, the MMT and the CCG's prescribing team would support the networks by providing advice, designing EMIS searches, and sourcing tools such as PrescQIPP audit templates, guidance and advice, and patient leaflets.

QUESTIONS & COMMENTS

PF ensured that the proposal had been discussed with LNA previously and enquired about the

capacity of the PCNs to deliver the strategy. The majority of the work involved would be at practice level.
RB expressed concern saying the proposal relied on support from local pharmacists and often there were issues regarding what pharmacists said. The workload appeared intense which gave rise to potential errors. The proposal would need to be carried out city wide for each drug given that patients move city wide with GPs incentivised to prescribe differently. Consideration was to be given regarding how to publicise the initiative, people needed to know what was happening and why. Also consider whether people would revert to the original drug in year two or three. In response MB stated that the proposal offered an opportunity to make savings at a time when it was becoming increasingly hard to do so. It was helpful to hear comments and the LCCG was looking to explore different ways of working and embedding different behaviours. LNA supported the proposal in principle, there was a need to look holistically with PCNs and pharmacists et al at overall expenditure. It's a difficult conversation to have but necessary. The principle was supported to move forward. The savings may give the opportunity to offer more effective care.
HD reported that the discussion at FPCC suggested practices should already be doing this. JLe commented that it would be useful to compare with other CCGs in similar size cities or locally. Members were reminded that the proposal would reduce the amount of savings over time so it was not a regular income stream. The proposal would also address inequalities and members should consider how this would be perceived in terms of the message that was delivered. Secondary care would also be involved.
CMA noted that a lot of issues had been raised and the committee was happy to support the introduction of the proposal in principle.
FL asked for the proposal to be brought back to the committee with responses to the comments mentioned and explicit detail about the money saved stating that some switches would be easier to achieve than others.

ACTION:

Peter Johnson to report to next meeting with updated proposal in light of conversation.

6. Any Other Business

There were no further items to discuss.

DATE AND TIME OF NEXT MEETING:

Informal:
Tuesday 17th March 2020, 10am to 12pm Boardroom, the Department

Formal:
Tuesday 21st April 2020, 10am to 12pm Boardroom, the Department