NHS
Liverpool
Clinical Commissioning Group

Status of these minutes *(check one box)*:	
Draft for Approval:	☐
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Report to:	**Governing Body**
Meeting Date:	**10 November 2020**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 8 September 2020	Time:	2.30pm
Venue:	Skype Conference Call		

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

3. Members of the public were able to submit questions to be raised at the meeting for discussion and a response would be emailed to them in due course.
4. Both the question and the response would be circulated to all members and included in the minutes of the meeting.
5. Members were also asked to raise questions by email in advance of the meeting and any questions raised would be discussed as the meeting progressed.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

7. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register.

A4 MINUTES OF THE MEETINGS HELD ON 23 JUNE & 14 JULY 2020

8. The minutes of the meeting held on 23 June 2020 were accepted as an accurate record with typos and amendments forwarded outside the meeting.
9. The minutes of the meeting held on 14 July 2020 were accepted as an accurate record with typos and amendments forwarded outside the meeting.

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

A5 ACTION LOG

10. The action log was discussed with the following points made:
    a) Item 1 regarding the Community Investment programme was within the CCGs business as usual and no longer pending further action.
    b) Item 2 was complete with meetings scheduled.
    c) Item 3, JLE confirmed that the point referred to Liverpool not C&M, action closed.
    d) Item 4, JLU reported that 2 patients were Covid positive patients and the 3rd was not investigated nor followed up. Action closed.
    e) Item 5 was completed.
    f) Item 6 was not a priority and the conversation was ongoing with regard to health checks; this item would come to the next meeting where progress would be reported.
    g) Item 7, the risk register had been updated and this was not a significant risk. Action closed.
    h) DH had investigated the potential to use Alder Hey Hospital (AHH) facilities for adults for item 8. This could not be taken any further due to safeguarding issues. Action closed.
    i) Item 9 was closed with the development session scheduled to take place on 18th September.
    j) Items 10 and 11 were completed, as were items 13 and 14. Actions closed.
    k) Item 12 had commenced and an update would come to the next meeting.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the Governing Body Action Log			

Further actions required: • Update the action log in line with discussions	D Richardson	ASAP	Completed

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

11. Jan Ledward presented the Chief Officers Report outlining the following:
    a) Much of the content of the report was discussed at the AGM which had been delivered prior to the Governing Body meeting.
    b) The submission for planning report was on the agenda later. It was noted that page 5 was a blank page and was not missing information.
    c) Work was underway to manage staff concerns regarding returning to work and this would be discussed later on the agenda as would financial allocations.
    d) The statement in response to the proposed North Mersey merger of CCGs and the response to the Chairs letter from NHSE. The latter was only recently received and the CCG had not had time to consider the questions it raised at this point. A letter would be drafted in response in due course.
    e) STH expressed concern regarding the potential wider footprint of the NHSE suggested merger which would make it considerably more difficult to have meaningful conversations with patients. Also timescales, it was difficult to manage the process in the timescale with the smaller footprint and this would be made much more difficult with a wider footprint.
    f) JLE responded that there was a lack of clarity about the process with the CCG asking many of the same questions members were asking. One of the reasons not to support considering the wider footprint being that it felt too remote from the local population. The CCG felt strongly that it wanted to develop a footprint in Liverpool, Sefton and Knowsley to still be relatively local to the population. Things may become clearer when more information was provided by Cheshire and Mersey Partnership (CMP) and also NHSE.
    g) MSM commented that CMP was not a system but was geography; there was no flow of patients between Cheshire and Merseyside and vice versa. It would produce logistical issues in terms of finishing terms of office for Governing Body (GB) members given the timeframe mentioned. If the footprint was not North Mersey but was Cheshire and Merseyside then the dialogue would be about place. Would the place be Liverpool or North Mersey? Liverpool was different to North Mersey while being important in the North Mersey footprint.
    h) FLE stated that there was a larger conversation to be had.
    i) GGR asked what the CCG had been told to do. What direction did NHSE suggest and what would they (the CCG) be flexible to?
    j) JLE responded that the message so far had been that a North Mersey merger was agreeable. Staff from NHSE had been involved with the steering group. There had been no indication regarding how the change of direction had come about and these questions would be asked when replying to NHSE in response to the letter.
    k) PBR spoke for Liverpool City Council (LCC) saying it was not a council decision although they (the council) were key stakeholders. There were wider political issues.
    l) CCGs were initially created to resolve two perceived problems; giving primary care a practical guiding hand in directing resources; and to ensure there was local accountability as things did not always sit within the local authority boundary but for consistency. The proposal would appear to return to strategic health authority boundaries and has been done without any patient liaison, no consultation with GPs and had no coherence to the Cheshire and Mersey boundaries with Macclesfield going to Greater Manchester, West Cheshire to Chester, Southport bore no resemblance to Macclesfield in health terms and the proposal felt odd with no democratic underpinning.
    m) It was very disappointing to see as a model to work towards. The North Mersey proposal reflected favorably on patient flows with the importance of specialist providers in the Liverpool footprint showing local knowledge, experience and direct lines of accountability.
    n) PBR stated that the CCG and LCC working relationship had always worked, even when decisions were made by either side that were not welcomed, questions were always answered and concerns responded to and it would not be good to lose that.

o) The merger would be discussed on the next council agenda and it was unfortunate that this was being imposed on the CCG and it was not welcomed.
p) FLE thanked PBR for the support and his response.
q) DOH commented that STP and NHS England were both increasingly provider organisations with no remit for population or wider health, or medical input.
r) FLE stated that speaking with Chairs of other organisations the common concerns were around population health, governance and accountability also which was encouraging.
s) HDE asked how the CCG saw its role as reinforcing the COVID message with regard to the population. Also to what extent was patient confidence returning?
t) JLE reported that the CCG would continue to support colleagues in Public Health, sharing the message to remain vigilant and maintain distancing. Public confidence was not at the level it was prior to Covid19 although levels at A&E were almost back to what they were at the same time the previous year. Work was underway looking at how to address waiting rooms and there was a national move to promote the 111 first service given the difficulty of holding walk in and drop in sessions. Public confidence was felt to be returning slowly with patients being encouraged to use appointments or make contact with the practice when they couldn't make the appointment so the time could be used by another patient.

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

B2 CHIEF NURSES REPORT

12. Jane Lunt presented the Chief Nurses Report drawing attention to the following issues:
a) Trust updates were outlined within the report. In general the Phlebotomy service required a full remodel; capacity had increased dramatically in recent weeks and work was underway to address the issues.
b) There was additional demand for mental health services at Mersey Care Foundation Trust (MCFT) which was as a consequence of Covid and was reflected nationally. There was an update on SEND within the report; this was a key risk area and work was underway to deliver an improvement plan.
c) There was interest from a quality perspective in how Trusts were prioritizing waiting lists and a need to understand how effective clinical prioritisation was. An audit process was planned over the next two quarters which would aim to understand this and would report back via the committee process.
d) The Statutory Children in Care Service was undertaking a service review with Alder Hey Children's Hospital (AHCH) as there had been period when the improvement plan had not achieved all it had been required to achieve; there would be a full service redesign. Work was also underway to step the Continuing Healthcare framework back up in the next few months, and to review patients that had been discharged during the first wave of the pandemic (March – August 2020).
e) The SEND update highlighted issues around annual health checks with the next board meeting scheduled for the following week. August was spent reviewing the partnership board with a view to reinvigorating it to focus on the outstanding actions from the inspection 18 months ago which was due to be followed up early in 2021.
f) CMA made reference to children in care and the issue of limited and often unsuitable provision as raised by safeguarding leads within NHSE/I, asking who was responsible for ensuring provision was available.
g) JLU responded that this was not clear. From a health perspective it was the responsibility of the commissioner for mental health support however the problem was that sometimes behavioral manifestations often were just that with no underlying mental health illness. Individuals who presented with difficult and challenging behavior might in the past have been placed in secure children's homes with support such as psychologists and GPs to support their needs. Over time these homes had been decommissioned by local

authorities and not replaced so young people who present this way had no pathways. There was very little support available from the local authority commissioning route and a three to four week waiting time so this had to be managed locally in some way. This was a small complex group of young people whose outcomes were compromised with the lack of an appropriate pathway. This had been raised with NHSE/I and the local authority. The local authority were very supportive towards this group of young people.

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

B3 PUBLIC HEALTH UPDATE

13. Matt Ashton presented the Public Health Update report stating the following:

a) The response to the recent outbreak in Princes Park was pleasing however this was largely due to it being a defined community and this was not being seen across other areas where there were outbreaks.

b) The report mentioned that the health and social care recovery group were updating plans for winter and flu and the behavior change campaigns that had recently launched and the mental health steering group.

c) There was a large escalation in the number of positive Covid19 cases from around 14 cases per week in July to 200 cases per week at that point. Testing had decreased with the availability of testing being very challenged. There were no links to care homes at that point however the spread was across the whole of the city. Some wards had more cases than others and it appeared to be due to people mixing more through leisure activities, gyms, the nighttime economy etc.

d) Testing capacity was challenged nationally with capacity being directed to those areas that were listed as areas of concern which Liverpool was not at that point. There were also issues around laboratory processing capacity and this was not unique to Liverpool. Work was underway to identify ways to increase testing capacity within the city although nothing had yet been identified.

e) Admissions to hospital were low as were death rates with hospital admissions increasing both locally and nationally. 60% of cases were in under 40 year olds and it appeared that the consequences of catching the virus were less severe than they were in the first wave. However the risk was that the more virus infections there were within the community the easier it could transfer to those with higher risk status who were more vulnerable in the community which would increase hospital admissions and deaths. This was the pattern seen to be happening across Europe and America.

f) Because the infection rate was so widespread this time the response was difficult. More testing and stronger communications about personal responsibilities were being delivered. There was a need for more businesses to be Covid safe and if they weren't people should not use them and this was the message being put out. Business were being helped to be Covid safe; there were many good businesses with some less good which were followed up through the environmental licensing team..

g) Some restaurants may be Covid safe during the afternoon however as more alcohol was consumed over the day and into the evening, distancing measures were harder to maintain with customers. These venues could be closed down under the coronavirus act, however the lack of compliance must be demonstrated with the burden of proof for this falling to the local authority and there was a comprehensive legal process to follow.

h) Around 80% of positive cases from the national test and trace system were followed up successfully which leaves 20% not followed up successfully. Around 56% of contacts were followed up successfully at national level and plans were being tightened to reach more contacts. There was a significant amount of work being done at local level for this with the Cheshire and Mersey hub responding to contacts locally.

i) There was an issue around inconsistent guidance and inconsistent messages and certain demographics didn't always hear the message.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Building on lessons learned and best practice from the Princes Park outbreak, works with public health and other LCC and NHS partners to ensure a rapid response to any future outbreaks in the city. • Works with LCC health and social care recovery group to develop plans for preparing for a challenging winter, through a whole system approach. • Supports the promotion of all public health related communication across the city. • Participates in the development and implementation of the mental health strategy for the city of Liverpool.			
Further actions required: • None identified			

B4 FINANCE REPORT

14. Mark Bakewell presented the Finance Report outlining the following:

a) The report contained the financial performance update within the 2020/21 financial year and was based upon the revised financial framework for months 1-4 as determined by NHSE England. The position reflected the impact of revised in-year allocations, payment guidance to NHS / non-NHS providers and elements of COVID related expenditure up to Month 4 (July).

b) The main aspects of the CCG's financial reporting position in relation to the position were included on the executive summary.
- 'True-Up' funding of £7.5m received to date had delivered a break-even financial position as at Month 03.
- As at M04 reported position, the CCG was reporting a £4.79m overspend for the month against revised allocations as set by NHSE, but on the basis of the above the CCG was anticipating receipt of top up resources which would result in a break even position for the month.
- The £4.79m consisted of £2.78m of Covid related expenditure and £2.0m of other costs largely in respect of prescribing related to the budget setting / allocation methodology adopted by NHSE in implementing the revised financial framework.

c) It had been confirmed in recent planning letters that there would be an extension of the arrangement for months 5 & 6, however no further guidance had been received as yet regarding arrangements for m7-12 but there was an expectation that revised financial management arrangements approach would continue in some form and potentially to include allocation of resources at system level and potentially organisation level control totals.

d) Further information was included in pages 72-82 of the report.

e) The Governing body was asked to note the contents of the finance report.

f) MSM sought clarity regarding the statement that 'Primary Care contracts would be back to usual from 1st August' and was informed that this was related to messages received regarding the certainty of contracts and AQP activity.

g) MSM also noted the reference to the Performance Committee contained within the report which MBA explained had previously been presented at the Performance Committee and updated for the Governing Body meeting.

h) DOH asked if guidance had been received yet for the end of the next month and was told that this had not been delivered at that point. The finance team were working on the basis of months 5 and 6 and would replicate the claim for months 1 to 4 for Covid funding.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • The existing temporary finance regime that covers the period April to July 2020. • The level of anticipated 'true-up' funding expected to be received from NHS England during August 2020, that we deliver a break-even position for the reporting period. • That the CCG continues to work with NHS England and partners on resource drawdown requirements of the remainder of the 2020/21 financial year. • The update on the financial framework beyond Month 04.			
Further actions required: • None identified			

B5 PERFORMANCE REPORT

15. HDU provided an overview of the Performance Report, informing members that:
    a) The faster diagnosis standard had been achieved for the second month consecutively; and the 18 week waiting list was the lowest it had been for some time although this was due to reduced demand and reduced capacity.
    b) Performance had improved with mutual aid in place across providers with MRI and CT at Clatterbridge and echocardiograms and CT at Liverpool Heart and Chest Hospital (LHCH) and MRI and CT at Spire.
    c) Cancer decision to treat performance had improved and there remained challenges in the 62 day wait as there were pre Covid.
    d) Areas for improvement included endoscopy and the 18 week wait target.
    e) Theatre utilization was increasing and sessions were opened in the new Aintree elective care centre from August to bring capacity to pre Covid levels. Virtual clinics were being offered with attendances in the range of 50-70%. Providers had targets to aim for and were all implementing the attend anywhere system.
    f) IAPTs remained a real challenge with referrals increasing. Also, the 52 week wait was a concern and was likely to increase.
    g) There were considerable challenges around learning disability and physical health checks and dementia diagnosis rates. A paper would go to Primary Care Commissioning Committee about repurposing the GP Specification spend towards Covid recovery and the proposal would be to cover these areas of significant challenge.
    h) DOH commented that one of the reasons for being successful in some areas was due to the reduced number of referrals accepted by some Trusts. The system had data on patients referred and the number of bookings; it would be helpful to find out if there was a gap here. If the number of referrals versus the number of bookings was decreasing then if would be clear the gap was closing.
    i) FLE commented that rejected referrals should be reported to Dr Barnett and this would be picked up in the Primary and Secondary Care Interface Group.
    j) HDU responded that the CCG was aware of the need to get underneath the data to see how demand was changing and it was a watching brief to monitor how performance was being affected.
    k) HDE asked about the performance of NWAS and was informed that NWAS had returned to pre Covid levels of activity and was being monitored for winter and urgent care challenges as well as patient confidence.
    l) DOH asked if the number in use had reduced and was told that this would have to be examined to understand if this was the case or not.
    m) HDE noted that the report stated that NWAS staffing had dropped to the equivalent of 50 crews with staff holidays and sickness. This was a concern for planning and foresight,

leaders needed to consider this.

n) GGR commented that previous levels were not relevant as services did not have the same demands.

o) JLU proposed that the concerns raised be explored further with actions fed through to NWAS as applicable via the Cheshire and Mersey Quality group. A report would be brought back to the next meeting.

p) CMA enquired about the increase in ill health and falls in over 65s which was significant when compared with the national average asking if there were any assumptions behind why this was.

q) HDU reported that the national data did not include the winter period which the local data did. This accounted for the increase.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the performance of the CCG in the delivery of key national performance indicators for the period highlighted and of the recovery actions taken to improve performance and quality. • Determine if the levels of assurance given are adequate in terms of mitigating actions, particularly where risks to the CCG's strategic objectives are highlighted.			
Further actions required: • Raise NWAS capacity issue concerns via C&M Quality Group	J Lunt	Nov 2020	On Nov 2020 GB Agenda.

B6 GBAF, CORPORATE RISK REGISTER AND ISSUES LOG UPDATE

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

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

a) There was a narrative within the GBAF report explaining that the delay in developing the GBAF was due to Covid and the redirection of resources. A single item Governing Body development Session was scheduled for September to progress the GBAF. MIAA were satisfied with progress to date notwithstanding the Covid delays and the objectives for the next 6 months were to be agreed.

b) There were 4 additions to the CRR as an impact of Covid which included phlebotomy capacity; increased demand for mental health services; EU exit risk; and D2A guidance.

c) The issue log has been stood down with Performance and Quality Committee having responsibility for managing issues at this level. Further work needed to be done regarding escalation processes.

d) MSM made reference to the phlebotomy capacity issue stating that when this was discussed at Primary Care Commissioning Committee (PCCC) it was in the spirit of mutual aid to ease the burden on primary care. However it was presented with the expectation of delivering 3000 appointments weekly and the risk rating had been reduced. MSM was not happy to reduce the risk rating until it had demonstrated it was meeting its target.

e) DHO informed members that since the papers were circulated phlebotomy had seen a significant recovery with capacity outreaching demand. The paper did not reflect the conversation and would be revisited for the next meeting.

f) GGR commented that at PCCC it was mentioned that consultations were resulting in 3 events and how was this being managed to ensure it was not triplicating with people coming into surgery unnecessarily.

g) FLE responded that GPs were providing more access than ever to compensate for the virtual consultation and a significant proportion of patients were satisfied with the remote

consultation and there was an opportunity for face to face consultation when required. It was not a new concept and could be very efficient.

h) MSM echoed this stating that a range of approaches were available to ensure all populations were covered. It could be much more efficient to have a telephone call with a patient, they were responded to in a more timely manner. This issue was not for commissioners, it was up to providers to manage services efficiently, dealing with patients. The role of commissioner was as a system leader, advocating for safety.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Satisfy itself that current control measures and the progress of action plans provide reasonable / significant internal assurances of mitigation; • Note the three new additions to the Corporate Risk Register for September 2020 and; • Note that the process to develop the Governing Body Assurance Framework for 2020/21 has been 'paused' until October 2020.			
Further actions required: • Revisit phlebotomy proposal reflecting on risk register rating and revise as appropriate.	D Horsfield / S Hendry	Nov 2020	On Nov 2020 GB Agenda.

B7 BETTER CARE FUND 2020-21.

17. MBA deferred this item to the next meeting. Conversations continued with council colleagues and guidance was due in October.

B8 PLANNING UPDATE

18. MBA delivered the planning update noting the following:

a) The report provided an update to the Governing Body regarding the CCG's requirements in response to the phase 3 planning letter as issued by NHS England at the end of July.

b) The report contained information relating to the different activity / finance and narrative submissions that would continue to be developed up to the final submission by the Health & Care Partnership on 21 September 2020.

c) The partnership were coordinating the system response, with Clinical Commissioning Groups and NHS provider trusts being asked to submit activity plans and a place based narrative through to them for collation.

d) There was a significant amount of work going on to review initial returns and to triangulate between both commissioner and providers and also with regards to the expectations of the phase 3 letter and delivery trajectories given the inevitable COVID constraints on available capacity.

e) Recent exchanges would suggest particular challenges on trajectories on elective recovery, diagnostics and 52 week waits.

f) Further detailed information was included within the report and supporting appendices and further updates would be provided in due course.

g) The Committee was asked to: Note the planning trajectories and place based narrative that had been submitted in draft and to confirm support for the approach as described and given timelines for subsequent submissions, approve that senior management team led by the chief officer continue to develop and submit plans in line with phase 3 requirements.

h) JLE commented that it was difficult to articulate what was being asked of the system in layman's terms so the public understood it. The place based strategy did not reflect what

was shown and doesn't help to reduce inequalities.

i) HDE asked how the CCG was ensuring it did not just focus on activities and it continued to maintain quality. JLU responded that there were challenges around working within the CMP and quality may not be manifest within the plan. The CCG was working on the impact of Covid to the assurance system in both the short and longer term; looking at the quality of commissioned services, meeting in alternate months to pick up issues as they emerged and feeding these back to a North Mersey quality surveillance group which hadn't quite connected as it needed to at that point. There was a disconnect with hospital cell commissioners.

j) FLE stated that the timescales were not feasible to respond to the system while maintaining governance. Members agreed that they were happy for MBA to progress this.

k) JLE commented that the CCG was in receipt of some of this rather than making the decision and NHSE would decide the final outcome.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the (draft) planning trajectories and place based narrative that have been submitted in readiness for the second submission			
Further actions required: • None identified			

B9 CITY PLAN FOR LIVERPOOL

19. JLE delivered the City Plan update noting the following:

a) The City Plan was in effect a summary of the One Liverpool Plan for economic growth in the city. It had been presented to government asking for investment into the city.

b) Government support was needed to turn the city around. This was a local strategic partnership plan, owned by all aspects of the city. The organisations of the city had got together to agree the ask for improving the city and its potential. The plan would be accepted by all strategic partners across the city that each had a role in developing the aims in the plan.

c) FLE commented that it was well received.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Notes the crucial role that the CCG and the local health and care system will play in realising the ambitious objectives in the City Plan; • Endorses the City Plan for Liverpool, recognising the CCG as a key member of the Liverpool Strategic Partnership			
Further actions required: • None identified.			

C FOR DECISION

C1 RISK MANAGEMENT AND ASSURANCE STRATEGY

20. SHE presented the Risk Management and Assurance Strategy noting the following:

a) The strategy replaced the previous version which was due to be replaced in March but had been delayed due to Covid19.

b) The strategy had been discussed at a recent Audit and Risk Committee and colleagues were satisfied that it covered the next months. It reflected the revised management and committee structure.
c) Further development was needed within the organisation for risk appetite and approval was being sought to launch the strategy as a live document.
d) Members approved the strategy.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • Note the contents of the report; • Approve / ratify the updated Risk Management and Assurance Strategy for dissemination as a live policy / strategy document.			
Further actions required: • None identified			

D FOR NOTING

21. No Items.

E QUESTIONS FROM THE PUBLIC

22. No questions were received from the public in advance of the meeting.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

23. The following items and committee minutes were noted:
a) Audit and Risk Committee feedback 7 July 2020;
b) Remuneration & HR Committee feedback 16 June 2020
c) People and Community Voice Committee feedback 18 August 2020
d) Performance and Quality Committee feedback 25 August 2020
e) Ratified minutes from the following committees:
    a. Audit and Risk Committee 21/04/20 & 23/06/20
    b. People and Community Voice Committee 13/03/20
    c. Performance and Quality Committee 10/03/20
    d. Primary Care Commissioning Committee 26/05/20
f) Minutes from Cheshire and Merseyside Health and Care Partnership System Management Board - 29 Jan 2020; & 26 Feb 2020.

G1 ANY OTHER BUSINESS

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