NHS
Liverpool
Clinical Commissioning Group

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Report to:	**Governing Body**
Meeting Date:	**9 November 2021**

MINUTES OF THE MEETING OF

GOVERNING BODY

Date:	Tuesday 14 September 2021	Time:	2.30pm
Venue:	MS Teams		

Name	Job Title (Division/ Organisation*) *if not Liverpool CCG
Present:	
Dr Fiona Lemmens (FLE)	Chair
Mark Bakewell (MBA)	Chief Finance & Contracting Officer
Dr Janet Bliss (JBL)	GP/Clinical Vice Chair
Dr Paula Finnerty (PFI)	GP Director
Dr Stephanie Gallard (SGA)	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
Jan Ledward (JLE)	Chief Officer
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
In Attendance:	
Dr Rob Barnett (RBA)	Liverpool Local Medical Committee
Hayley Barker (HBA)	Administrator, corporate Services, LCCG
Stephen Hendry (SHE)	Head of Corporate Services and Governance
Carole Hill (CHI)	Director of Strategy, Communications & Integration
Olivia Hlaing (OHL)	Contracts Team, LCCG
Dave Horsfield (DHO)	Director of Transformation Planning & Performance
Sallyanne Hunter (SHU)	Deputy Head of Corporate Services & Governance
Sarah Thwaites (STH)	Health Watch
Joanne Twist (JTW)	Director of Organisational and People Development
Amanda Williams (AWI)	Deputy Director of Quality Outcomes & Improvement
Debbie Richardson	Committee Secretary, Liverpool CCG
Apologies Received:	
Matt Ashton (MAS)	Public Health Liverpool
Helen Dearden (HDE)	Lay Member for Governance/Non-Clinical Vice Chair
Dr Shamim Rose (SRO)	GP Director

ISSUES CONSIDERED
2021

A1 WELCOME

1. FLE welcomed all those present noting that business would be conducted on the assumption that members had read all papers ahead of the meeting.
2. FLE reminded members that the Governing Body was meeting virtually, and an audio

recording of the meeting would be available on the Governing Body web page shortly after the meeting.

3. The meeting was also being broadcast live enabling members of the public to join online.
4. Members were reminded to keep microphones on mute unless they were speaking and to use the 'hands up' facility to obtain the Chairs attention when they wished to make a comment.

A2 APOLOGIES FOR ABSENCE

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

A3 DECLARATIONS OF INTEREST

6. There were no additional declarations reported for noting at the meeting other than those already listed on the LCCG register. MKH referred to the public health update which discussed integrated ways of working for sexual health; MKH was the sexual health lead for her network (IGPC) and had rolled out the integrated way of working since June and was informing colleagues of this. It was agreed there was no requirement for MKH to leave the meeting at any point related to this.

A4 MINUTES OF THE MEETINGS HELD ON 13 JULY 2021

7. The minutes of the meetings held on 13 July 2021 were accepted as an accurate record.

A5 ACTION LOG

8. The action log was discussed with the following points made:
   a) Items 1 and 2 were regarding the Public Health update and had come about from the Governing Body meeting in May. Item 1 was to *ascertain if cancer deaths had increased during the pandemic* and item 2 was to *clarify remit of insight team regarding mental health for the next year*. FLE agreed to follow these up with public health outside the meeting and prior to the next Governing Body meeting in the absence of a public health representative.
   b) Item 3 regarding Cheshire and Merseyside Joint Committee work plan. Suggest LMCs be included on joint committee memberships. FLE reported that this had been posed to the group of Cheshire and Merseyside CCG chairs and was the subject of an ongoing discussion, the decision would be made by the joint committee. Item ongoing.
   c) Item 4 regarding the Governing Body Assurance Framework (GBAF) and Corporate Risk Register (CRR) update. Completed, item closed.

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

A6 COMMITTEE REPORTS

9. SHO delivered the Audit and Risk Committee (ARC) Chairs report from the July committee meeting noting that the meeting would usually receive the external audit report however this was delayed due to the ongoing enhanced value for money work and would come to the September Audit and Risk Committee meeting. Two internal audit reviews had been completed with positive results and good progress continued with only four recommendations outstanding. The committee continued to provide

oversight and assurances to Governing Body.

10. CRO delivered the People and Community Voice Committee (PCVC) Chairs report from the August committee meeting reporting that there were no items to escalate. The committee had robust discussions which were highlighted in the report. Connectivity with community representatives and colleagues across different clinical fields continued to be a strong feature of connectivity within the committee with discussion focused on consultation around change. A representative from Clatterbridge attended the August meeting and the committee also looked at hyper acute stroke changes, and for this and future meetings focus would be on specific strategic risks. The committee had good attendance and continued to be a worthwhile committee to engage with.
11. FLE stated that an interesting amount of work had been carried out including consulting on major service change and transformation despite the overall feeling that CCGs were sidelined. It was good to see the amount of work still underway and the level of public engagement it was managing to achieve, noting the work of the exceptionally busy comms team with the considerable commitment to the vaccination programme and covid plans more generally asking for thanks to be passed on.
12. DOH commented that this was not only important work, but it was important that it was done at a local level and he hoped the scope would be there to continue as the transition progressed. CRO responded that Liverpool was a good role model for engagement with CCG colleagues working hard to support the discussion.
13. CMA delivered the Performance and Quality Committee (PQC) Chairs reports from the July and August committee meetings which demonstrated the considerable amount of work underway to ensure performance, quality and finance were being managed to meet the CCGs duties to achieve a smooth transition to the new organisation.
14. The reports and minutes demonstrated complex agendas. In July the committee received a verbal update on Continuing Healthcare (CHC), and confirmation of a contract support notice to Mersey Care Foundation Trust (MCFT). There was also an update on SEND for which there was the potential for re inspection in autumn. As partners were judged as a collective if one partner was failing then all were deemed to be failing. Considering this it had been agreed to be added to the committee risk register. There would be close monitoring and the committee would receive an update as appropriate. The Serious Incident (SI) policy was updated and approved by the committee.
15. The process for prioritisation and investment was discussed. The mental health investment paper was also discussed and approved. The process for prioritisation and investment was agreed at the August meeting. The financial report was received which updated the committee on the breakeven position, the allocation for H2 was pending. The performance report highlighted unprecedented demands across the system.
16. In August the committee received details regarding continuing healthcare and agreed that a monthly report would be provided to give assurance. The LeDeR annual report was also received and approved with key learning outlined in the paper. The Children in Care joint protocol was received and discussed in detail. Discussions took place regarding a proposed pilot scheme for enhanced access to primary care with the committee supporting the proposal once further work had been completed, the committee agreed that the Accountable Officer could approve the proposal when the further work had been carried out.
17. The bi monthly quality overview report was received outlining the quality issues and the risks across all CCG commissioned services. The performance report highlighted a declining position with increased demand and the overriding performance issues around the A&E 4 hour wait on the ambulance issues. The financial report continued to stay at break even position and information on H2 was still pending.

18. JBL referred to the mental health investment standards commenting that there were some elements of mental health provision considered key which did not fall under the mental health standard funding stream and while the risk in not funding these had been acknowledged they were a key risk and needed investment, specifically the areas were eating disorder services, autistic spectrum disorder, and attention deficit hyperactive disorder. Proposals had been submitted separately for funding and JBL asked did they progress through the prioritization process.
19. MBA responded that a lot of national external funding was targeted to the three service lines identified and the CCG had to get a balance considering all sources of funding. It was not fair to say that the CCG was not looking to invest in those areas, the CCG would look to use the national pots of money where appropriate and as it continued to progress its plans it did expect to continue to support improvements in those areas. DHO added that autism spectrum disorders and eating disorder services had progressed through the prioritisation paper. There were a lot of complex funding schemes and the intention was to continue to fund these services with the assumption that the income streams became available in the next financial period.
20. MBA reported that the CCG continued to maintain a balanced position financially with concerns there was a time lag remaining with some of the data. Prescribing and continuing healthcare were 6 to 8 weeks behind and work was being carried out to forecast appropriately. There was a concern that H2 was less than three weeks from commencement with no idea what the numbers would look like. A call the previous week announced H2 with no detail given. There was an expectation that increased efficiency would be required and it had been made clear that H1 and H2 would rollover and there was a need to address deficits. Work was underway trying to develop schemes recognising the challenge the system was under to ensure realistic reporting. Discussions were underway with NHS England to access the cumulative surplus and positive responses had been received so far.
21. FLE referred to SEND and a previous concern that the new structure meant assurance was obtained at a committee level asking was there anything that should be drawn to members attention. JLU responded that it had been added to the Governing Body committee work plan and an annual review was planned for later in the year which would give the opportunity to have a more formal informed update. It still posed a risk as it was managed as a partnership with slightly more balance towards the local authority and if one partner was judged then the partnership was judged. Monthly meetings continued with Ofsted and work was underway preparing for a potential inspection in autumn.
22. SHO noted that there was still a need to recruit a named GP for safeguarding asking did this add risk. JLU commented that it did not add risk however it was an important role and the CCG needed to consider other options. The challenge was not only that the CCG was without a named GP for safeguarding but also that the role would be needed in the future and may end up in a different part of the system migrating to a primary care network or local network alliance and there was a need to demonstrate a plan was underway.
23. GGR delivered the Primary Care Commissioning Committee (PCCC) Chairs report from the August committee meeting noting that there were no issues for escalation. Colleagues had approached NHS England again for representation and received no response, RBA had agreed to follow this up with NHS England. Updated versions of the risk register, work plan, and the terms of reference were presented, and a presentation was delivered regarding patient feedback. Key themes included access to GP services and problems with administration and registration. New risks added to the risk register included shortages of the flu vaccine. The financial report was as discussed in a break-even position.
24. DHO reported that subsequent to the papers being submitted a response had been received from NHS England to the effect that they would not attend regularly but

would attend if required.

25. STH reported that more comments had been fed back from discontented patients which reflected the demands on primary care with exhausted staff and fed-up patients. This was not just a reflection on Liverpool but was the national picture, it was a very fertile area of conversation with the public noticing the pressures primary care was under.
26. JLE stated that the CCG had been listening to what patients were telling them through its own complaints process and MPs had been raising concerns locally too over the last weeks. Regarding local issues there was desire to communicate publicly and explain about the increase in demand and the level of acuity not just in primary care but also in walk in centres and community services, hospitals, and mental health services. The rise in demand was across the board and any communication needed to be done effectively. The world wanted to get back to normal however the pandemic had not gone away, numbers had risen significantly particularly in Liverpool. The NHS was where people went to when they were sick and we should not be surprised at the demand, this year had been likened to working through a bad winter constantly and there was a need to share with the public what was being done about it reflecting what people want to see and communicating the challenges to the system.
27. STH supported this view commenting that she was happy to help. A statement was being prepared between Liverpool and Sefton Healthwatch and more could be added to this. Any Governing Body GPs who wished to support work on the communications were advised their input would be welcomed.
28. PKI presented the CEC report commenting that there was nothing to escalate to Governing Body. The main role of the committee was approval of clinical policies and to make this process timelier the committee had agreed to move much of the business online so policies could be approved more quickly.
29. FLE stated that she appreciated the difficulties of a committee born during a pandemic while ensuring clinical input.
30. It was noted that there had been no Remuneration and HR Committee meetings since the last Governing Body meeting hence no report.

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

B OFFICER UPDATES

B1 CHIEF OFFICER REPORT

31. JLE presented the Chief Officers Report noting that some areas mentioned in the report had already been discussed within the meeting and highlighting the following:
    a) The sad death of Dr Thomas of Sefton Park Medical Centre during August, recognizing the contribution Dr Thomas made to services in Liverpool previously commenting that this was a really sad loss.
    b) Colleagues were reminded that the Annual General Meeting (AGM) would take place the following week. The meeting would celebrate the successes of the previous year despite COVID-19.
    c) The vaccination programme continued to make great strides and progress and since writing the report it had been agreed that 12-year-olds and over could be vaccinated and more would follow on this. Colleagues were asked to encourage everyone who had not had the vaccine to come forward, people were on hand to provide reassurance of the safety of the vaccine.

d) A significant amount of guidance had been issued recently regarding the ICS, the main item being the HR framework which included a commitment to staff moving forward and the process regarding the appointment of the Chief Officer and Chair and board members prior to becoming a statutory body.
e) David Flory and Sheena Cumiskey had taken over interim posts of Chair and Chief Executive respectively however David could not continue in the role of Chair once the ICS became a statutory body. The announcement regarding a permanent appointment should come at the end of October.
f) The transition to a new organisation was being led by Dianne Johnson and there would be more detail for Governing Body members at future meetings. The CCG would be required to sign off and assure all systems and processes were appropriate and Governing Body would have oversight of this to ensure nothing had been missed.
g) The joint committee held its first meeting in public recently with two items for a decision, the agenda was likely to increase as CCGs started to wind down and the ICS built up.
h) The CQC inspection of LUHFT in July resulted in a section 31 notice regarding concerns of safe care and treatment. As a result of this an action plan had been developed to go to CQC for consideration and there would be a further meeting later this month to consider further actions. Steve Warburton Chief Executive had stepped down from his post and Sir David Dalton was announced as interim Chief Executive of the trust. Sir David had taken up post the previous week and was keen to revaluate and engage more broadly in the Liverpool system to make key improvements.
i) STH pointed out that papers published on the NHS Futures platform were not accessible to users without an NHS email address. FLE suggested they may be available on the NHS England web pages and for any particular papers that colleagues may wish to see but could not access then colleagues could contact the CCG to request a copy.
j) JLE referred to the minutes of the previous meeting where it was noted that the CCG had applied for Employers Defence Recognition Scheme Silver Award informing colleagues that this month the CCG had been notified that it had been successful in gaining the silver award. Members sent thanks to Richard Houghton for his work on this, it was a great achievement.
k) FLE returned to the LUHFT section of the report thanking the quality team for their involvement and the additional work that was being put in to monitor the situation. The CCG was looking at its own systems and processes to ensure it also learnt from this, engaging with the team at LUHFT recognising that the team was under pressure and adopting a critical friend approach for openness and transparency in conversations. A more detailed report would come to the next Governing Body meeting.
l) DOH discussed the movement towards the ICS commenting that the framework showed more governance arrangements could be moved to the ICS framework asking could the CCG be assured it didn't give away too much responsibility for members and the local population that the CCG represented with particular reference to the constitution of the ICS. JLE responded that the work underway as part of the One Liverpool Partnership Board was strengthening the relationship within Liverpool place and a conversation had taken place recently with the ICS about the scheme of delegation in relation to place and what the preferred option might be. Locally the CCG was in a good place to take on as much delegation as the ICS chose to give and the CCG wanted to take on as much as possible, it was confident it could work locally with a place perspective.
m) It was more difficult to be clear about the ICS perspective and it was hoped this would become clearer as we moved forward. The delays in appointing the chair and chief executive meant limited time for the transition of functions but the CCG

was supporting the process and working to ensure the transition was managed as smoothly as it could be.

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

B2 PUBLIC HEALTH UPDATE

32. In the absence of MAS, the Public Health Update report was delivered by FLE with the following comments raised:

a) There were several recommendations at end of the report and FLE drew members attention to the CCG identifying a lead to work with public health commissioning the sexual health services. This was in place and happening already. The CCG would be identifying someone to support the service.

b) The other proposals were around supporting the work of public health which the CCG was happy to do, all the proposals in the report were crucial to the health and well-being of the population. FLE commented that one of the positive outcomes of COVID-19 was how well the partners had worked together.

c) JLE commented that from a CCG perspective in response to the report the CCG would be seeking confirmation of public health input to the CCG. Since the pandemic there had not been an opportunity to carry out joint planning with public health and the CCG would like to know what public health's commitment was to fulfil that. FLE responded that if public health had attended it was likely that they would suggest most of the public health commitment had been to the vaccine programme whilstacknowledging that there was a need to do other work too.

d) It was agreed that any questions raised by members during the meeting would be compiled and FLE would meet with MAS before the next Governing Body meeting to address the issues raised. Any response received would be circulated to members.

e) PKI asked how suicide prevention was measured and what the indicators would be commenting that it would be useful to have that information. Furthermore, PKI asked if herd immunity was accepted as where we were and how we were going to live going forward as the government appeared to be acting in that way. If this was the case, then were these the levels of morbidity that we were going to have to accept in the long-term commenting that we would need to plan accordingly.

f) PFI reported that Professor Semple of SAGE and Alder Hey Children's Hospital (AHCH) had appeared on breakfast TV recently commenting that in future it would be local public health consultants that would be making decisions about wearing masks indoors. PFI mentioned the coordinated food effort that had taken place during COVID-19 and her role in food bank distribution when she was asked to provide certain items such as pot noodles, tinned potatoes, and tinned fruit raising concern over providing healthier food commenting that she would welcome proposals towards this.

g) DHO referred to the last recommendation regarding supporting the proposal for mental well-being resilience commenting that there was a need to make sure the scheme integrated into the wider mental health strategy. The CCG was willing to support the proposal however it must consider the bigger picture around mental health services.

h) RBA commented that he suspected government ministers assumed that having everyone vaccinated would help to get things back to normal however, although over 80% of people were vaccinated nationally, in Liverpool only 69% of the

population had had one vaccination and 63% had had two vaccinations. Looking at the winter plan nothing had been planned for except hospital admission, masks should be compulsory and isolation should be encouraged. In Liverpool the population must accept the fact that infection rates were going to continue to rise which would affect hospital admissions and would have a knock-on effect on waiting lists and primary care, the system was not in a good place.

i) JBL informed members that she had been invited to join the group looking at suicide prevention work. Numbers were thankfully quite small and it was difficult to show statistical changes. There had been an increase in Liverpool over the last 12 months and several areas had been identified where improvements could be made specifically in GP and coronial services. A patient may have had lots of contact with GPs but not always about mental health problems and very often GPs did not get feedback from coroners court and better more streamlined and timely communications may help practices to learn from sad cases.

j) DOH noted that the report talked about primary care network level hubs for women's services regarding sexual health services. This could imply that women would have 11 places to go when there were 86. Only six of ten primary care networks were ready to provide these services and they needed to be integrated with the rest of the healthcare provision. FLE commented that it did not preclude a practice from providing those services however many did not provide the service and this proposal may be a way to offer more than before. DHO stated that when the main contract was available he would clarify these elements. It was important to have equitable joined up access.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: • That Liverpool CCG Governing Body note the information contained in the report. • That the Liverpool Public Health Epidemiology team to continue to monitor the epidemiologic situation in a timely manner and alert the Liverpool system on any changes. • That Liverpool CCG Governing Body and Liverpool City Council work proactively to reduce inequalities in COVID-19 vaccination by delivering the COVID-19 vaccination inequalities plan. • That Liverpool CCG GB works with LCC to support the needs of our residents affected by the pandemic in Liverpool. Preventative and recovery measures need to be targeted to address the health needs of those who are disadvantaged by deprivation and by the direct and indirect impact of the pandemic.			
Further actions required: • Compile questions for PH and circulate responses when available.	F Lemmens	ASAP	Complete.

B3 GBAF, AND CORPORATE RISK REGISTER UPDATE

33. SHE provided an update on the organisation's Governing Body Assurance Framework (GBAF), and Corporate Risk Register (CRR) thanking members for their input to the GBAF and outlining the following:

a. Discussions during the meeting up to this point had been around items featured in the GBAF which was reassuring and the one that stood out was the H2 finance element.
b. There was a lot of external assurance for this update, the NHS England assurance letter had been received as had the value for money statement along with the ICS documentation which was being considered regarding where it would align to within the GBAF.
c. In the Corporate Risk Register the system capacity risk stood out, as previously mentioned within the system it felt like winter already with the demand on services.
d. Two risks were recommended for removal, CO77 which was a quality and safety risk relating to the financial and reputational risk due to the PUPOC cases not being processed in a timely manner. A discussion had taken place with the risk lead and this could move to business as usual. CO81 was regarding the stand-alone status of Liverpool Women's Hospital (LWH) and this was also recommended for removal as this risk had changed over time and in discussions with the risk lead it was established that existing quality surveillance mechanisms showed confidence that this could be managed at committee level.
e. The EU exit risk was now irrelevant however this had not changed in time for the meeting. It would be revisited to reflect the additional complexities on goods coming in and out of the country. The update would include the blood tube issues as it was important to have oversight now that this was a global shortage which impacted severely.
f. RBA referred to the blood tube issue commenting that the situation was likely to get worse before it got better. There was no assurance that the date of September 17th given by NHSE/I was based on anything. The issue had caused many problems particularly in performance measures not just patient health, this was an additional pressure that primary care had no option but to deal with.
g. FLE commented that it was not a realistic date to imagine the issue would be sorted by and it may be worth reminding some practices that did their own bloods if they had tubes due to go out of date that lab capacity was still available so it might be useful to use the tubes they had available.
h. FLE asked which risk register the continuing healthcare concerns were listed on. JLU responded that they were on the risk register of the Performance and Quality Committee.
i. SHO pointed out the need for the committee to note if it was happy to step the risks down. Members supported the stepping down of the two risks.
j. DOH commented that the format of the Governing Body Assurance Framework and Risk Register was good, thanking the Corporate Services Team for the work involved.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Governing Body is asked to: • Agree the 'close down' of the GBAF for the financial year 2020/21 and transfer of any relevant residual risks / mitigating actions to the 2021/2022 GBAF.			

• Satisfy itself that the 2020/21 GBAF has aligned appropriate risks, key controls, and assurances alongside each strategic objective. • Satisfy itself that the control measures and the progress of associated action plans provide reasonable / significant internal assurances of mitigation.			
Further actions required: • Update GBAF and CRR in line with discussions.	S Hendry	Nov 21	On Nov 21 GB agenda.

C FOR DECISION

34. No items.

D FOR NOTING

D1 GOVERNING BODY TERMS OF REFERENCE UPDATE

35. SHE presented the Governing Body Terms of Reference (TOR) for noting as good governance following on from the review and new constitution introduced in April 2020. The TOR had been updated and the updated version would be published on the CCG webpages once agreed.
36. JLE pointed out that lay member responsibilities had not been reflected mentioning the Freedom to Speak Up Guardian role as an example. JTW mentioned the Wellbeing guardian too.
37. SHO suggested section 5 regarding the frequency of meetings be updated to read 'may be' rather than 'should be'. Section 10 recommended a timetable for the sign off of the annual reports and accounts which was in fact delegated to Audit and Risk Committee and should be revised to state this. The agenda for private meetings needed to be revisited for consistency and alignment with the public meetings and would flow better within section 8.
38. JLE and FLE agreed to read the updated document for sign off prior to the next meeting in November.

Action	Lead	Timescale	Status
Recommendations approved by the committee, namely: The Committee is asked to: • Note the updated Terms of Reference.			
Further actions required: • Update document in line with discussions • Agree document for sign off	S Hendry J Ledward / F Lemmens	ASAP ASAP	On Nov 21 GB agenda. On Nov 21 GB agenda.

D1 GOVERNING BODY WORK PLAN

39. FLE presented the Governing Body work plan for noting.
40. The EPRR report was listed as due to be presented at the September meeting and had been moved to November as it was required to be presented to NHS England prior to coming to Governing Body. The report should be presented at the next meeting.

Action	Lead	Timescale	Status

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

E QUESTIONS FROM THE PUBLIC

41. FLE notified members that the one question was received from the public in advance of the meeting and would be responded to as soon as possible. The question was not submitted in time to be included in the meeting papers. Members would receive a copy of the question and the CCGs response.

F PAPERS TO NOTE/FOR INFORMATION – NOT FOR DISCUSSION

42. The following items and committee minutes were noted:
    a) Corporate Performance report – agreed at Performance and Quality Committee August 2021.
    b) Finance report – agreed at Performance and Quality Committee August 2021.
    c) Ratified minutes from the following committees:
        a. People and Community Voice Committee – 06/04/2021.
        b. Performance and Quality committee – 22/06/2021 and 27/07/2021.
        c. Primary Care Commissioning Committee - 29/06/2021.
43. It was agreed that papers from the Cheshire and Merseyside ICS partnership board and the Mersey CCGs Joint Committee would be included in packs going forward.

G ANY OTHER BUSINESS

G1 Summary of Business/Risk Review

44. FLE reviewed the meeting commenting that the meeting had been focused with good discussions. It was good to discuss the primary care pressures which were national, and the public health report had generated significant discussion which would be passed on to the public health team.

G2 ANY OTHER BUSINESS

45. Colleagues were again reminded that the AGM was taking place the following week and it would be valuable to be reminded of the positive work that had been taking place outside the pandemic work.
46. No other items of business were discussed. The meeting closed.
47. Date of next meeting Tuesday 9 November; 2.30pm.