NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Minutes of the Governing Body Meeting in Public held on Tuesday 7 July 2020
By Microsoft Teams

Present:

Voting Members
Carol Anderson, Chief Nurse
Dr Mark Brookes, GP Member
Dr Jane Collyer, GP Member
David Finlay, CCG Lay Member
Dr Fiona Head, Acting Medical Director
Dr Gary Howsam, Clinical Chair
Julian Huppert, CCG Lay Member
Louis Kamfer, Chief Finance Officer
Stephen Mitcham, CCG Lay Member
Louise Mitchell, Director of Strategy & Planning
Dr Sripat Pai, GP Member
Nikki Pasek, CCG Lay Member
Dr Adnan Tariq, GP Member
Jan Thomas, Accountable Officer

In attendance
Sharon Fox, CCG Secretary
Jessica Bawden, Director of Primary Care
Gemma Keats, Corporate Governance Administrator
Tony Jewell, Consultant in Public Health (For Dr Liz Robin)
Jane Webster, Account Director
Jessica Randall-Carrick, Clinical Lead
Rob Murphy, North Alliance Programme Director
Laura Halstead, Head of Communications
Fe Toussaint, Communications Specialist
Alison Ives, Sustainability and Transformation Partnership
Danielle Harding, General Practice Nurse Consultant
Simon Barlow, Governance Support Manager
Vicki Peacey, Specialty Registrar in Public Health
Members of the Public

GB20/155 Welcome and Introductions

The Chair welcomed everyone to the meeting and introductions were made.

Agenda Item 1 – Patient Focus

GB20/156 Patient Reference Group Overview Report

Nikki Pasek, Chair of the Patient Reference Group advised the Governing Body that the Group had not held its usual monthly meetings due to the COVID-19 Pandemic. However, the Group had been kept up to date through regular e-mail briefings. A virtual conference had also recently been held which enabled the Group to raise and discuss any issues or concerns they had. It was noted that several questions had been raised around COVID-19 and the different treatments and arrangements in place and which had been answered by the

CCG's Chief Nurse. The use of video conferencing with patients in primary care and in particular how urgent medical issues were being adequately picked up was raised, Assurance and an explanation had been provided by the CCG's Clinical Chair, who had been in attendance. The current availability of services in secondary care was identified as a possible area of concern with patients not being clear around what was or was not available. The importance of communicating the right messages in a clear and timely fashion over coming weeks and months, to ensure patients were fully informed as and when services were back online was highlighted as a key area of work.

The Group also wished to formally pass on its thanks to the CCG and all its staff for their hard work over this period.

The Clinical Chair thanked Nikki Pasek for her update. The Governing Body **noted** the verbal update in relation to the Patient Reference Group.

Agenda Item 2 – General issues

GB20/157 Apologies for Absence

Apologies for absence were received from Sue Graham and Dr Liz Robin. Dr Tony Jewell was in attendance for Dr Liz Robin.

GB20/158 Declarations of Interest

There were no declarations of interest related to the Agenda.

GB20/159 Notification of Any Other Business

There was no notification of any other business.

GB20/160 Minutes of the Last Meeting

The minutes of the Governing Body Meeting in Public held on 23 June 2020 were agreed as an accurate record.

GB20/161 Accountable Officer's Report

The Governing Body received the Accountable Officer's Report. This paper linked to all of the CCG's current Corporate Objective's. The paper also linked to the following risks on the CCG Assurance Framework & Risk Register: CAF01, Impact on the delivery of health services as a result of the COVID-19 Pandemic and further risk of a second wave of COVID-19 Pandemic occurring in the CCG area post relaxation of national lockdown measures; CAF 07, Risk to not achieving key performance targets due to ongoing impact of COVID-19 Pandemic; CAF08, Risk to maintaining robust CCG Governance Arrangements; and CAF09, Failure to achieve the 2020/21 planned deficit and system control total agreed with NHS England / Improvement.

As previously reported, Jan Thomas advised the Governing Body that the CCG had been issued an allocation of £441.6m to fund months one to four expenditure including expenditure relating to COVID-19. NHS England / NHS Improvement (NHSE/I) had monthly block values for CCGs to pay to NHS provider and contracted directly with independent sector providers, so CCG

contracts and payments stopped. CCG's were required to contract with Non-NHS providers and a new rapid discharge process was established which meant there were no new NHS Continuing Healthcare (CHC) assessments and all discharged patients were to be funded by the NHS. As at month 2, the CCG was reporting an actual £7.2m deficit against its allocation with a forecast deficit of £13.2m. CCGs would be monitored against this allocation with the actual expenditure reviewed monthly by NHSE/I. A non-recurrent adjustment would be issued for all reasonable variances. It was noted that the CCG was presently seeking clarification from NHSE/I about what a reasonable variance was considered to be. The response to this was presently awaited. The importance of recording and maintaining accurate records of all COVID-19 related expenditure for future evidence and assurance was recognised.

Turning to performance, Jan Thomas said it was acknowledged that during the COVID-19 response, some performance measures had understandably deteriorated. Examples of this included Diagnostic Waits increasing with 26% of patients being treated in 6 weeks due to a 70% reduction in activity. Due to social distancing measures there would be limited opportunities to significantly change the waiting list position in the near future and as such it would be Important to maintain focus on the quality of services provided. In light of the COVID-19 measures which remained in place there was also apprehension around the practicalities and capacity with regards to stepping up services back to their pre-COVID levels, particularly in light of the anticipated additional demand. Carol Anderson, Chief Nurse commented that due consideration also needed to be given to the welfare of staff who understandably would be feeling tired as a direct result of the past three months activity.

Jan Thomas said the positive and innovative ways of working adopted by the Cambridgeshire and Peterborough system during the COVID-19 response period was recognised. It was noted the system was currently working on its Recovery and Restoration Plan, including how partners could work collaboratively to ensure they start to deliver against constitutional standards. As set out in the Integrated Performance Report (IPR) current focus was being given to the following areas:

- Cancer services: bring activity and performance back to pre – COVID-19 levels;
- Diagnostics: managing the waiting list and understanding the capacity gap;
- Restarting services: community and clinical priority services;
- Managing long waits (40 and 52 week);
- Assurance on clinical review and risk assessment process; and
- Utilisation of all available Independent Sector capacity.

Turning to Quality, Carol Anderson advised the Governing Body that the CCG was continuing to work closely with North West Anglia NHS Foundation (NWAFT) on a number of quality matters. Following the Care Quality Commission (CQC) inspection, the Trust had an action plan in place which set out all the 'must' and 'should do's' to be completed. Carol Anderson said she was supporting NWAFT's Chief Nurse and the new CQC Relationship Officer to ensure the action plan was completed in line with the trajectory. The CCG continued to have concerns around the Trust's Maternity Services as highlighted in the CQC Report. Concerns around respiratory care and in particular the difficulties in recruiting to vacant consultant posts was also highlighted. It was noted a deep dive of respiratory care at the Peterborough

site was to be initiated, with a view to identify a more recurrent solution to the issues.

The Governing Body discussed the draft Corporate Objectives as set out in the presented report. Stephen Mitchell, Lay Member expressed reservations about the achievability of the objectives as currently presented and questioned whether they were too aspirational. Jan Thomas, Accountable Officer advised the objectives had been purposefully developed to be less constrictive and more ambitious than in the past. They endeavoured to be more reflective of the new and more inclusive ways of working and thinking that had been adopted during the COVID-19 response and which were continuing to be developed. The approach being taken around diabetes services was highlighted as an example of this work. It was also emphasised the objectives had been drafted to cover a two year time-period, which the Governing Body welcomed as an important caveat. Dr Mark Brookes welcomed the inclusion of *Objective 2 – Level-up health and care provision to ensure our communities in areas of high deprivation and need get the resources needed to minimise inequalities.* Dr Fiona Head advised that this sought to more overtly demonstrate the shift away from the provision of services to the 'well-being and prevention' agenda'.

In relation to Objective 3, Focus time and resources on areas where people receive most of their health and care services, the community, the Clinical Chair said this should be identified as an important area which needed to reflect a shift in focus to managing Long Term Conditions at home and in the community. In relation to *Objective 4 – Facilitate organisations to join forces at 'place' and offer 'patient first' well-coordinated efficient services to those that need them,* Stephen Mitcham expressed the opinion that the wording of this objective be reviewed further as it was not sufficiently accessible or understandable to those outside of the organisation. He added that *Objective 5 – Deliver our statutory financial commitments as best as possible* – should consider the inclusion of the words '…as best as possible'. Does this provide a strong enough message around the CCG's duty to meet its statutory requirements?

Jan Thomas advised the Governing Body that work to develop realistic and tangible indicators to measure progress and outcomes of the objectives, once finalised, had still to be done. The Clinical Chair thanked the Governing Body for their comments. He said it was recognised further work to develop the CCG's draft corporate objectives was required at this stage and that this would be progressed in advance of their future presentation to Governing Body for approval on 8 September 2020.

The Governing Body **noted** the Accountable Officer's Report.

GB20/162 Care Homes Update

The Governing Body received a comprehensive update on Care Homes, covering the COVID-19 Pandemic. This paper linked to Corporate Objective 1, Ensure clear patient voice in everything we do; Corporate Objective 2, Deliver improvements that make best use of the public pound and save system 'cost'; Corporate Objective 3, Use data and information to prove everything; and Corporate Objective 4, Deliver the prioritised performance standards. The paper also linked to the following risk on the CCG Assurance Framework and

Risk Register: CAF05, Failure of Care Homes to be able to respond and manage resident care needs during the Pandemic and the Increasing expectation from NHSE/I on the responsibilities for care homes to sit with CCGs (currently rated 25 Red). Carol Anderson presented the paper, noting that many staff were providing support to care homes, not only from the CCG but from other settings such as hospices, Cambridge and Peterborough Foundation Trust and Primary Care. She said the CCG and the Local Authority came together early on, recognising a high number of deaths in care homes from COVID-19. This set the system in good stead to put in place an intensive support package before anything national came down. There was already a joined-up approach in place in terms of care homes pre-COVID-19, but these relationships had become much closer. Previous investment in the care home team saw one of the biggest achievements in terms of the roll out of Infection Prevention and Control training, where all Care Homes were trained in a 3 week period, including the donning and doffing of PPE.

Early in the COVID-19 pandemic, Carol Anderson advised the Governing Body that there was a need to commission support for care homes staff under emotional turmoil, due to the sad death of residents from the disease. Therefore, a bespoke emotional and wellbeing package was put in place and this continued to be rolled out. One of the other big issues to address was understanding Mental Capacity Act and Deprivation of Liberty safeguards and it was important this was in place with homes closed to visitors. Carol Anderson advised that there were a number of deaths in the beginning and a reasonable assumption was made that these deaths were a result of COVID-19, as testing was not in place at the time. Guidance had since been updated and swabbing increased which could therefore mean an increase in cases. Carol Anderson advised that there were still 3 outbreaks in homes but these had been identified by planned swabbing and were asymptomatic patients.

David Finlay asked about staffing. Carol Anderson advised that there had been investment in nurses, but the Local Authority was the lead commissioner for care homes. NHSE/I had clearly indicated that more assurance was expected through the health route and the CCG would undoubtedly have more oversight over the homes in future. There was work to be done to start to use multi-disciplinary team feedback mechanisms to get intelligence quickly. Carol Anderson advised that this would require more resource and work was being done to look at the governance around all of this.

Jan Thomas thanked Carol Anderson and her team for spotting this gap early on and for dealing with it in partnership. Jan Thomas said in terms of staffing there was a need to consider lots of services and many organisations had had to move staff around and it was tricky to move back to their ‘normal’ job. There were plans to ask for additional money to get the additional staff required. On behalf of the Governing Body, the Clinical Chair applauded the work done to facilitate the joint working across the care homes and the CCG, embracing the technology and the speed at which everything was done.

Tony Jewell added his congratulations for the hard work done and asked about the swabbing of staff and residents and whether there were any thoughts on how this would be completed regularly. Carol Anderson said this was a difficult area for care homes and the system had made it difficult. She advised the Governing Body of the two routes for swabbing, Pillar 1 with the Health Protection Team and Pillar 2, the national route. The new requirement was that

all care home staff and those affiliated into homes regularly would be swabbed weekly and residents every 28 days. This was via the Pillar 2 route. Carol Anderson advised that the CCG would be putting in a bid for additional money to pull together a peripatetic hit squad to undertake the swabbing. The manual administrative process prior to the swabs being posted was complicated and time consuming and the additional support was needed to do this. There was a need to look at how to involve primary care in this as it was anticipated this process would continue for the next 18-24 months. Staff members visiting care homes were also being recorded to ensure tracking of where people had been and this would be fed up to the Health Protection Board.

The Governing Body **noted** the update report.

GB20/163 CCG Assurance Framework & Risk Register

The Governing Body received the CCG Assurance Framework (CAF) and Risk Register. This paper linked to Corporate Objective 3, Use data and information to prove everything and Corporate Objective 6, Deliver the CCG Financial Plan. The Paper also linked to the following risk on the CCG Assurance Framework and Risk Register: CAF 08, Risk to maintaining robust CCG Governance Arrangements (currently rated as 8 Amber).

Sharon Fox presented the paper which was Version 1 for 2020/21 and had been discussed at the Integrated Performance and Assurance Committee. She reminded the Governing Body this was a live document and updated regularly. Sharon Fox said this was a very different CAF to a year ago. There were seven new risks included which linked to COVID-19 and had been grouped together. There was also regular review by the Chief Officer Team.

Julian Huppert thanked Sharon Fox for the update, commenting that this was much improved with focus on the red risks. He said he understood the risks around COVID-19 but asked why the only other increased risk was the risk to primary care business models and asked what the current assessment of this was and if it could be adjusted. He asked if this was a national problem. Jessica Bawden advised that one thing the Primary Care Commissioning Committee had been looking at was larger practices to operate safely with longer term contracts. There were parts of the patch that had to go out to procurement every 3 years and this was not stable for the system. This review had slowed down due to the COVID-19 pandemic. David Finlay commented on the identified risks, noting that there could be another wave of COVID-19 and dealing with a lot of uncertainty. He suggested running scenario planning exercises during this time of increased uncertainty.

The Clinical Chair thanked Sharon Fox for her paper. In line with the recommendations, he said the Governing Body had **discussed** the current CAF, highlighting any areas where further assurance was required on the actions in place to mitigate risks. The Governing Body **endorsed** Version 1.3 of the CAF for 2020/21.

GB20/164 Inequalities in Obesity and Diabetes

The Governing Body received a paper on Inequalities in Obesity and Diabetes. This paper linked to Corporate Objective 2, Deliver improvements that make best use of the public pound and save system ‘cost’; Corporate Objective 4,

Deliver the prioritised performance standards; and Corporate Objective 5, Deliver the 6 transformation programmes. The paper also linked to the following risks on the CCG Assurance Framework and Risk Register: CAF02, Risk that the disease itself, the COVID-19 response across all sectors and the impact of COVID-19 on non-COVID-19 diseases widens health inequalities (currently rated as 20 Red); CAF10, The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG commissions in acute care, community, integrated and mental health care(currently rated as 12 Amber); and CAF 11, The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG commissions in primary care (currently rated as 16 Red).

Dr Fiona Head introduced the paper advising that Rob Murphy, North Alliance Programme Director, Dr Jessica Randall-Carrick, local GP and Lead for obesity and Diabetes, and Laura Halstead, Head of Communications were in attendance to present. The paper summarised that the impact of health inequalities on obesity and diabetes had been highlighted through the COVID epidemic. The death rate in the areas of highest deprivation was significantly higher for COVID-19 due in part to obesity and diabetes. There was an existing health inequality for non-COVID-19 patients within the STP which also resulted in worse outcomes for some patients. The proposed programme outlined in the paper invests £1m in addressing this health inequality and would result in c£3m of savings to the system as well as mitigation of second wave COVID risk for the local population.

Dr Fiona Head and Dr Jessica Randall-Carrick agreed this was an important paper. Dr Jessica Randall-Carrick said when she was in Medical School the number one problem was all about stopping smoking. Since then obesity rates had doubled but smoking rates had fallen and now obesity is the number one issue. She said COVID-19 had revealed what a big problem it is with obese people twice as likely to die of COVID-19 compared to someone that is not obese. Obesity was the cause of many related issues such as high blood pressure and muscular aches and pains. The Governing Body heard about the need to tackle this head on to reduce the number of obese people and in turn reduce demand on health services. Dr Jessica Randall-Carrick advised that 64% of the population were overweight or obese. In 1974, half of adults smoked and this had reduced and the number one modifiable risk factor was now excess weight. Children were becoming obese by year 6 in school and obesity was linked to colorectal cancers in men and endometrial cancers in women. The proposals outlined in the paper would help support patients, identify problems and ensure services were there to support them when needed. It was important to note that the financial gains from this work were not primarily for the health system but social care too as well as contributing to the economy.

Rob Murphy advised the Governing Body that the proposal was to create a programme of work that allowed partners to work with the CCG to support delivery as there would be an impact on the wider population. There were some short term health related activities planned with communication and engagement support, together with a wide ranging campaign to lose 1m kilos. There was work to be done in children and adolescent services with help from providers in terms of all healthcare interactions across acute, primary and community care. There was a need for continuous reminders asking people if they had tested their weight, offering support to lose weight and get healthy.

There was a two week weight loss programme for those that needed to lose weight prior to an operation, which was timely in terms of improving outcomes of procedures. The work covered prevention in the community, where there was high prevalence of obese children with focussed work with schools and families.

The paper outlined in the proposal the costs, with the largest being £1.9m for the 'Very Low Calorie Diet' (VLCD) Ambition for Remission for diabetes. This was a maximum cost dependent on uptake of 1000 patients. Given the cost it was proposed to start with up to 100 patients at a cost of £190k. Due to the size of this as a standalone project it was proposed to bring a more detailed proposal back to Governing Body if the principle was agreed and an expansion to 1000 patients would then be proposed. This cost for the direct trial would likely span 2020/21 and 2021/22 due to uptake and trial duration. The Governing Body noted the total cost of delivery was estimated at £635k up to a maximum possible cost of £2.615m. Of the total costs of £2.615m, £2.44m was non recurrent funding spread over 2 financial years. This was set in the context that the CCG did not currently have confirmation of its funding allocation for 1 August to 31 March 2021. Therefore, it was proposed that the Governing Body approved funding of this work up to £1m with COT oversight of the spend with regular reporting back to Governing Body.

Laura Halstead commented on the communications and engagement to educate and motivate people to make a big change to their lifestyle. She shared slides on exercise, eating well, sleep and mindfulness. There were things already going on which were easy to work through and the CCG had been doing some soft marketing. There was an initiative called 'kick the kilos' which had quite a few challenges and risks associated, as focussing on weight could have the opposite effect. Another campaign just starting was BMI Can Do It. This represented different body shapes and used a number of different marketing mechanisms. Beneath this, the CCG would be utilising the power it had, working with community leaders, PR, social media etc. Laura Halstead assured the Governing Body that the Communications Team was motivated to get this done. The Clinical Chair thanked the Team for their input into this exciting work so far.

Julian Huppert commented that this was hugely exciting and there was something about what the CCG spends its time doing, and often was holding the ring on things and saying it did not have enough money. He said that rather than saying we did not have enough money it would be better to make it so we did not need so much money. He said it was good to see different teams working together. Julian Huppert referred to the Diabetes UK effort to ask people to sign up to do 1m steps in a month. He would encourage people to do this and said the focus on prevention and public health was exciting.

The Clinical Chair commented that there was a potential increase in Local Enhanced Service schemes and said GP members should declare an interest in this. however, he did not see this as a material issue. Tony Jewell fully supported this paper and the proposal, commenting on the good work already around smoking and the extreme interventions such as a ban on advertising in some places. He commented on the upstream interventions and the important link to children, families and schools on this. David Finlay asked if there was an online system / App to allow people to update their GP weekly with their progress. Dr Jessica Randall-Carrick said all GP practices were signed up to

Eclipse Vista which included a patient portal where they could do this which also automatically updated their record.

The Clinical Chair said he did not want all of this to be owned by health, it should be a movement to empower individuals to make changes to their lifestyle. He agreed with collecting data but not necessarily through GP practices. Dr Mark Brookes said he was supportive of this work and said it would be fantastic to have lost 1m kilos in a years' time. He added that the CCG should link with the voluntary and community sector too.

Dr Jane Collyer commented on weight loss interventions and supporting NHS staff to lose weight in terms of on-site lifestyle support. She said she would like to see employers making changes to get their employees moving by putting place measures to support people, such as standing desks for example. Nikki Pasek commented on smoking and that when she worked for Cambridgeshire County council, there were different organisations that worked together to find solutions to the problem. Laura Halstead advised that a big part of this work was about the different partners coming together. Louis Kamfer said he supported this programme of work which was an important focus. He advised that he had raised with the team that as we move forward there would be a significant amount of conversation on how to prioritise our resources, bearing in mind that this would come at the expense of something else. He added that there would be a certain level of uncertainty over the next five to twelve months.

Jan Thomas advised that she was accountable for working with Gillian Beasley, Cambridgeshire County Council and Peterborough City Council to respond as a system, to increase the chances and best prepare ourselves for the future. She said it was important not to think of this as just a diabetes programme or population health, it was important to know the system had done everything it could to tell people the facts, to enable them to protect themselves in the best way possible in terms of hand washing and social distancing but also ensuring people looked after themselves. Jan Thomas said it was easy to make this about diabetes but she said she felt an accountability to prepare people for a second wave and whilst she was cheerleading this work, it should not be forgotten that people needed to protect themselves as best they could.

Julian Huppert added to his earlier comments that the CCG had spent so much time in the past talking about not having enough money. He said if this programme did not move forward the CCG would always be in the situation where it had no money. He said if the CCG was going to spend a 100th of its budget on this, it did not strike him as unrealistic.

The Governing Body **acknowledged** the scale of the health inequality highlighted by COVID-19, due in part to obesity and diabetes and the existing health inequalities within Cambridgeshire and Peterborough that need to be addressed. The Governing Body **agreed** the interventions that make the obesity and diabetes initiative as set out in the report. The Governing Body **approved** the availability of up to £1m of funding to support the initiatives overseen by the Chief Officer Team and reported back to Governing Body. The Governing Body **agreed** that the mechanism and resource to support delivery would be through the Task and Finish Group.

GB20/165 Proposal to begin Public Consultation regarding the relocation of the Peterborough Urgent Treatment Centre (UTC) and Out of Hours (OOHs) services to the Peterborough City Hospital (PCH)

The Governing Body received a paper on the Proposal to begin Public Consultation regarding the relocation of the Peterborough Urgent Treatment Centre (UTC) and GP Out of Hours (OOHs) services to the Peterborough City Hospital (PCH). This paper linked to Corporate Objective 1, Ensure clear patient voice in everything we do, Corporate Objective 2, Deliver improvements that make best use of the public pound and save system 'cost', and Corporate Objective 4, Deliver the prioritised performance standards. The paper also linked to the following risks on the CCG Assurance Framework and Risk Register: CAF 01, Impact on the delivery of health services as a result of the COVID19 Outbreak and risk of a second wave of COVID-19 Pandemic occurring in the CCG area post relaxation of national lockdown measures (currently rated as 25 Red); and CAF 10, The possible serious impact of any failure in quality, safety, and patient experience in the services that the CCG commissions in acute care, community, integrated and mental health care (currently rated as 12 Amber). The paper provided the underpinning justification to begin an 8 week public consultation to garner the public's view on the co-location of the Peterborough UTC and GP OOHs services from the City Care Centre to the PCH site as part of a single site Emergency Department (ED) model. This would bring together three services A&E, NHS 111 and the UTC with UTC staff at PCH. The CCG was keen to get this in place before Winter if possible. There was a need to talk to the public about access, transport and inequalities. Meetings with Councillors at the Health Scrutiny Committee in Peterborough were scheduled and, this was the proposal to be discussed there. It was noted that the CCG would also speak to its Patient Reference Group (PRG) about this.

The Clinical Chair commented that urgent care and ensuring people were at the right place at the right time was so important. Jan Thomas suggested that the addition of working with the CCG PRG to shape the consultation was good and needed to be added to the report's recommendations. Jan Thomas said she was concerned about a second wave of COVID-19 and Winter with a tired workforce; therefore it was becoming more apparent that things needed to be less complicated for patients. A better patient experience was at the heart of this and the consultation needed to be robust. Dr Adnan Tariq reiterated the point that Jan Thomas made and said changes needed to be made and he could see the benefit to patients. He added that the consultation needed to get moving, ensuring a united approach. Dr Adnan Tariq commented on the Primary Care Network involvement and extended access. Jessica Bawden advised that the CCG would be looking at a much more virtual process for consultation and was working with others to also utilise their networks.

The Governing Body **formally approved** in principle the request to begin an 8-week public consultation on the proposal to relocate the Peterborough UTC and GP OOHs services to the Peterborough Hospital site, subject to Scrutiny support. The Governing Body **delegated** the final decision on proceeding with public consultation to the Chief Officer Team considering more detailed operational and financial information when completed. The Governing Body **noted** that work was taking place on the detailed case and programme which would be presented to a subsequent Governing Body meeting for approval. The Governing Body **noted** that there was a separate but related issue

regarding what services might move out of PCH into the City Care Centre, and handling of void costs. The Governing Body **agreed** to engage and work with the CCG PRG to help shape the Consultation.

GB20/166 Integrated Performance Report

The Governing Body received the Integrated Performance Report. Louis Kamfer presented the report, advising that for months one to four the CCG was told it would receive an allocation to cover the baseline spend plus COVID-19 expenditure. The CCG had submitted its spend to NHS England who had requested further information on some elements.

Louis Kamfer advised that the CCG was in the process of concluding the month three position. He said the CCG was seeing increased spend on prescribing and certain other areas and would therefore submit for a top up to forecast for month four. An exercise was being progressed across the STP to understand the current run rate and what the additional COVID-19 expenditure could look like. The CCG was awaiting guidance on funding for Months five to twelve. Recovery Plans had been submitted as an STP, asking for additional capacity and revenue which would be assessed. The STP was also going through a prioritisation exercise.

David Finlay commented that this was the first time he had seen the new Integrated Performance Report and said it was excellent and was much improved. He commented that the graphs and one page summaries were great with up to date data. He commended everyone that had worked on this and Louis Kamfer agreed to feedback to Sue Graham.

David Finlay referred to a recent Panorama programme, highlighting reductions in people coming for cancer referrals and treatment. He asked that the Governing Body noted that the CCG had been doing work to continue to get people through the door. The Chair advised that each GP practice had been taking all measures to ensure that people accessed services when they needed to. He added that acute trusts were also assuring people that it was safe to attend health services. The Chair said cancer services had been maintained and were available throughout the pandemic, although utilisation was down. Dr Fiona Head advised that there were charts that showed how referrals were ticking along and when this dropped and this was highlighted early on by cancer leads, and focussed advice was given to GPs. There were also focussed conversations with acute Trusts on prioritising, paired with local and national communications. This continued to be the message. Dr Fiona Head advised that the concern now was long term conditions such as heart disease and the impact of COVID-19. The Cancer pathway had been managed well particularly diagnostics. Jane Webster reiterated the proactive conversations with cancer leads, providers and other sectors to work in an integrated way to use all the capacity and space in the system. Pathways had remained open on a clinical priority basis to ensure people were getting the right treatment at the right time. Work was also underway with the Cancer Alliance and an update on a Deep Dive would come back in future.

The Clinical Chair thanked everyone for this discussion, hearing some key messages and he hoped the media in attendance would help to assure people services continued.

The Governing Body **noted** the Integrated Performance Report.

GB20/167 Integrated Performance & Assurance Committee Overview Report

The Governing Body received the Integrated Performance & Assurance Committee Overview Report. This paper linked to all of the CCG Corporate Objectives. The paper also linked to the following risks on the CCG Assurance Framework and Risk Register: CAF 08, Risk to maintaining robust CCG Governance Arrangements (currently rated as 8 Amber); CAF 09, Failure to achieve the 2020/21 planned deficit and system control total agreed with NHS England / Improvement (currently rated as 12 Amber); CAF 10, The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG commissions in acute care, community, integrated and mental health care (currently rated as 12 Amber); and CAF 11, The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG commissions in primary care (currently rated as 16 Red).

Dr Jane Collyer, Chair of the Committee presented the paper, highlighting that the Committee was suspended temporarily during COVID-19, however there were two virtual meetings in May and June 2020. She thanked David Finlay as the previous Chair of the Committee. Dr Jane Collyer drew the Governing Body's attention to two items in the report, on the Children and Young People's mental health deep dive which had had a difficult time through this period. There was an increase in the number of mental health concerns and the Committee received assurance that targets were being looked at and changes being made to deliver virtual consultations. The Committee had heard from the safeguarding team and was assured that safeguarding was very much at the forefront. An update on care homes was also received and it was important to note that the nursing team gave a thoughtful and heartfelt report on this. Dr Jane Collyer said it was important to thank colleagues at Arthur Rank and Sue Ryder Hospices for their involvement in end of life and bereavement support.

The Committee had received an update from the Clinical Policies Forum with an update on a number of policies. In particular, varicose veins, making it easier for patients to know when they were suitable for referral and a streamlined process. It was noted that the Committee discussed the Radiofrequency Policy, which was not approved due to lack of evidence in terms of benefits. This would be reviewed at the Clinical Policies Forum. The Committee had also discussed the CCG Assurance Framework and Risk Register.

The Clinical Chair reminded the Governing Body that this Committee was where the Integrated Performance Report was discussed in detail.

The Governing Body **endorsed** the work of the Committee, **noted** the contents of the Overview Report, and **noted** the approved minutes of the Committee meetings held on 25 February and 26 May 2020. The Governing Body **ratified** the following policies: IG Policy and Management Framework; and Risk Stratification Policy.

GB20/168 Primary Care Commissioning Committee Overview Report

The Governing Body received the Primary Care Commissioning Committee Overview Report. This paper linked to all of the CCG Corporate Objectives. The paper also linked to the following risks on the CCG Assurance Framework

and Risk Register: CAF01, Impact on the delivery of health services as a result of the COVID-19 Pandemic and further risk of a second wave of COVID-19 Pandemic occurring in the CCG area post relaxation of national lockdown measures (currently rated as 25 Red); CAF08, Risk to maintaining robust CCG Governance Arrangements (currently rated as 12 Amber); CAF11, The possible serious impact of any failure in quality, safety and patient experience in the services that the CCG commissions in primary care (currently rated as 16 Red); and CAF12, Risk that the business models for delivering primary care services become unsustainable (currently rated as 16 Red).

Nikki Pasek, Chair of the Committee presented the paper, advising that usually meetings were held in public, but given the recent circumstances, meetings in public were cancelled but the Committee had continued to meet in private. A summary of decisions made by the Committee during this time was appended to the paper for noting. Nikki Pasek advised that meetings of the Committee in public would resume from 14 July 2020 virtually via Microsoft Teams.

Dr Jane Collyer commented on the Roysia Practice and whether there was any clinical risk. Jessica Bawden advised that the Practice was working well with Royston Medical Centre and it was anticipated that a good solution will be agreed soon. She said a progress update might be available when the Committee next meets.

The Governing Body **endorsed** the work of the Primary Care Commissioning Committee. The Governing Body **noted** that the Primary Care Commissioning Committee would meet again in public using Microsoft Teams on 14 July 2020.

GB20/169 Audit Committee Overview Report

The Governing Body received the Audit Committee Overview Report. This report linked to Corporate Objective 3, Use data and information to prove everything. The paper also linked to the following risks on the CCG Assurance Framework and Risk Register: CAF8, Risk to maintaining robust CCG governance arrangements (currently rated as 8 Amber). David Finlay, Chair of the Committee presented the paper. The Governing Body noted the Head of Internal Audit Opinion and that the CCG should be encouraged by this.

The Chair reminded the Governing Body that the Annual Accounts and Annual Report approved by the Governing Body on 23 June 2020 were subsequently submitted to NHSE/I by the deadline of 25 June 2020. Louis Kamfer advised that work was in the final stages on the Annual Report prior to publication later this week.

The Governing Body **noted** the overview report of the Audit Committee held on 23 March 2020 and 23 June 2020 (Annual Accounts and Annual Report Meeting). The Governing Body **noted** the approved minutes of the meeting held on 21 January 2020.

GB20/170 Agenda Item 6 - Questions from the Public

There were no questions from the public.

Sharon Fox advised the Governing Body that the Governance Team was reviewing the Business Cycle for September meetings due to the August Bank

Holiday. It was likely the Governing Body in Public would change to Tuesday 8 September 2020.

GB20/171 Date of the next meeting

The Chair confirmed the date of the next meeting as Tuesday 1 September 2020 at 3.30pm. This would be held virtually.

Post meeting note: this meeting date was changed to Tuesday 8 September 2020 at 3.30pm.

Gemma Keats
Corporate Governance Administrator
7 July 2020