Unconfirmed Minutes of the Governing Body Meetings in Common Held in Public on Wednesday, 8th July 2020 at 2.15pm held by Microsoft Teams

Dr Sarah Raistrick	Chair – CRCCG
Ms Sharon Beamish	Chair – WNCCG
Mr Adrian Stokes	Interim Accountable Officer
Mr Chris Lonsdale	Interim Chief Finance Officer
Ms Jo Galloway	Chief Nurse and Deputy Accountable Officer
Dr Deepika Yadav	Rugby Locality Lead – CRCCG
Dr Imogen Staveley	Clinical Lead - WNCCG
Dr Godwin Igodo	Clinical Lead - WNCCG
Dr Arshad Khan	Clinical Lead - WNCCG
Dr Inayat Ullah	Clinical Lead - WNCCG
Dr Kiran Mandhyan	Clinical Lead - CRCCG
Ms Sue Turner	Practice Network Lead: North Warwickshire – WNCCG
Mr Chris Stainforth	Lay Member – Audit and Governance - CRCCG
Mr David Allcock	Lay Member – Audit and Governance - WNCCG
Mr Graham Nuttall	Lay Member - Primary Care – WNCCG/CRCCG
Ms Gemma Nistorica-David	Lay Member - Patient and Public Involvement – CRCCG/WNCCG
In Attendance:	
Mr Andrew Harkness	Chief Transformation Officer
Ms Jenni Northcote	Chief Strategy and Primary Care Officer
Ms Liz Gaulton	Director of Public Health - Coventry
Mrs Anita Wilson	Associate Director of Governance and Corporate Affairs
Mr Stan Orton	Public and Patient Group Representative
Mrs Rose Uwins	Senior Communications & Engagement Manager
Mrs Victoria Scholes	Governance and Corporate Affairs Officer (Minutes)
Apologies:	
Dr Shade Agboola	Director of Public Health, Warwickshire
Dr Pradeep Bahalkar	Clinical Lead - CRCCG

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1.	**Standing Items:**	
1.1	**Welcome and Apologies** Dr Raistrick welcomed Members of both NHS Coventry and Rugby CCG and NHS Warwickshire North CCG Governing Bodies and members of the public to the meetings in common which was held virtually by Microsoft Teams due to the COVID-19 pandemic.	
1.2	**Declarations of Interest:** Members were reminded of the need to declare their interest in any items requiring a decision and to remove themselves from such decision making. No declarations of interest were made.	

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1.3	**Minutes of the Last Meeting: 20th May 2020** Members **AGREED** the minutes as a true and accurate record of the meeting.	
1.4	**Matters Arising And Action Schedule:** Matters Arising**:** There were no matters arising. Action Schedule**:** Both items were noted as complete.	
1.5	**Joint CCG Chair's Report:** Ms Beamish presented the report, explaining that the items highlighted would be explored further in the other reports received. Ms Beamish welcomed Dr Bahalkar and Dr Mandhyan to the Governing Body in their clinical lead roles. Dr Raistrick thanked Dr Bryce for serving the Governing Body well and for his work in the implementation of Covid-19 Hot Hubs. Coventry and Rugby CCG and Warwickshire North CCG Governing Body Members **NOTED** the Joint Chair's report.	
1.6	**Accountable Officer's Report** Mr Stokes presented the report, highlighting the following: • **Our response to COVID-19:** It was possible that the level 4 emergency would continue for some time and managing this through an upcoming winter and potential Brexit scenarios means the CCGs may need to revise the approach to resourcing this. The financial challenges in relation to Covid-19 were becoming more complicated and discussions with the Treasury were ongoing. A workforce survey was undertaken for CCG staff in relation to Covid-19. The survey received positive responses with regards to morale, communication and working from home. • **BAME Risk Assessments:** This needed to remain a high priority and would be discussed further in the Equality and Diversity Report. • **Restoration:** The CCGs were expecting to receive a third letter from Sir Simon Stevens at the end of July regarding the recovery process. • **Merger:** The CCGs were still aiming to merge by 1st April 2021. Coventry and Rugby CCG and Warwickshire North CCG Governing Body Members **NOTED** the Accountable Officer's Report.	
2.0 2.1	**Strategy and Planning:** **Public Health Update** Ms Gaulton presented the report, which focused on Covid-19 and restarting the health and wellbeing agenda.	

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	Ms Gaulton confirmed that pillar 2 testing data had been published since the report was written. This could be accessed through https://staysafecsw.info/ The data was showing a lengthy tail end to an epidemic curve that was drawing to conclusion locally but there were higher cases in Warwickshire than anticipated. Ms Gaulton explained that the population was likely to be living with Covid-19 for the foreseeable future and services also needed to prepare for winter. Coventry City Council, Solihull Metropolitan Borough Council and Warwickshire County Council (CSW) had been selected as one of 11 national 'Beacons' to rapidly develop and test Local Outbreak Control Plans. Ms Gaulton directed Members to the population health model outlined on page 6 of the report. This provided examples of key areas of focus, including the impact on specific groups, such as BAME and long term conditions, such as diabetes. The Warwickshire County Council Recovery Principles and Objectives were outlined on page 7 of the report. Ms Gaulton confirmed that the Covid-19 Impact Assessment, which looked in more detail at the health impacts and opportunities, could be presented to a future Governing Body meeting Governing Body Members: • **NOTED** progress to date around Test and Trace and local Outbreak Control Plan; and • **NOTED** Coventry City Council and Warwickshire County Council approaches to reset and recovery from a local authority and public health perspective.	
2.2	**CCGs' Merger Programme Update** Mr Stokes reported that the single Accountable Officer (AO) role for the three CCGs was out to advert. Development sessions had been held with the Governing Bodies of the three CCGs to apprise members of key risks to the merger programme and the mitigations in place to address them. Work on the merger application process was due to continue at pace over the summer months. Governing Body Members **NOTED** the content of the report.	
2.3	**Restoration planning 2020/21** Mr Harkness presented the report which was an overview of the update provided to Finance and Performance Committee on the development and progress of the CCGs' Restoration Planning for 2020/21. A Restoration Group had been established to provide assurance to the CCG and the Governing Bodies on the approach. The information was being captured in three tiers: CCG (Corporate), Place and System. There were 4 priority areas: essential services, care home, test and trace, and mental health. The CCGs were aiming to ensure that work was happening at each level in those areas. Mr Harkness highlighted the importance of the communications and engagement process to ensure people are informed of changes and plans. The Governing Bodies: • **SCRUTINISED** the report and; • Were **ASSURED** of the contents of the report.	

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2.4	**Assurance Framework** Dr Raistrick explained that the Assurance Framework would be received next on the agenda. This was in line with the sub-committees of the Governing Body which had been received the Corporate Risk Register first on the agenda, so that the remaining reports could be viewed in the context of the risks. Mrs Wilson confirmed that the Assurance Framework would be moved to the beginning of future Governing Body meeting agendas. Mrs Wilson presented the quarter 1 position, explaining that the Assurance Framework had been revised in light of the approval of new objectives for 2020-21 and the Covid-19 pandemic. The front sheet highlighted the highest rated risks as: • AF1 – Urgent and Emergency Care • AF2 – Elective Care • AF3- COVID 19 • AF4 – Delivery of the financial plan Mrs Wilson confirmed that the risk owners were present at the meeting for any questions. In relation to the Covid-19 risk, Ms Beamish asked whether further planning was needed for the 6 high risk population groups. Mr Stokes confirmed that the Primary Care Expert Advisory Group (EAG) that reports into the Reset Coordination Group had already undertaken a lot of work and this will be ongoing. Dr Raistrick reported that it had been made clear that risk assessments were needed at an individual and environmental level for primary care staff. Two tools for undertaking this had been shared with Member Practices and plans were underway to consolidate the information that the practices receive to help build resilience and meet any capacity issues. In relation to CCG staff, Mrs Wilson confirmed that a deadline was in place for risk assessments to be completed for BAME and high risk staff. The CCG was due to publish data regarding this on the 23rd July. Dr Raistrick asked whether the likelihood of the Covid-19 risk would reduce as a result of the mitigating factors. Mr Stokes confirmed that the mitigations could moderate the impact but the likelihood was not likely to change without a vaccine. Dr Raistrick thought that the work undertaken on the Assurance Framework had ensured that it could be understood. She confirmed that any feedback could be directed to Mrs Wilson or to the risk owners. The Governing Body: • **RECEIVED** the Assurance Framework **NOTING** the updates and; • Were **ASSURED** that adequate actions were being taken by the Executives to mitigate the risks and that the assurances provided were satisfactory.	
3. 3.1	**Quality:** **Reports from Clinical Quality and Governance Committees in Common: 28th May 2020 and 25th June 2020** Ms Nistorica-David confirmed that the May and June meetings were the first that she had chaired. There were continuing themes in relation to the risk register and the Safeguarding Assurance report. The Committee would continue to pose questions to the representatives regarding the CCG's partnerships with social care. At the June meeting the Committee recommended their updated terms of reference for approval and adoption by the Governing Body meeting in Common. These would be presented to the next Governing Body meeting.	

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	Governing Body Members **NOTED** the reports.	
3.2	**<u>Quality Report</u>** Ms Galloway presented the report, highlighting the following quality issues on the CCG Quality Assurance Framework (QAF): • **Coventry and Warwickshire Partnership Trust (CWPT):** No new concerns had been added. There was one area of concern at level three which related to a Tissue Viability serious incident that resulted in patient harm. An action plan was in place and the CCGs would undertake a quality assurance visit. • **George Eliot Hospital NHS Trust (GEH):** No new concerns had been added. There was one area of concern at level three which related to a section 29A warning notice issued to the Trust. The CCG was monitoring the action plans. • **University Hospitals Coventry and Warwickshire NHS Trust (UHCW):** No new concerns had been added. There were no concerns at level three and four concerns at level two. • **Other Providers:** No new concerns had been added. There were two concerns at level three. One related to a Section 31 notice for Cygnet Healthcare Coventry. Cygnet had given formal written notification to commissioners of patients and would close on 12th July 2020. The CCG quality team was supporting the closure under the geographical host arrangements. The other level three concern related to a Section 31 notice for St Matthew's Healthcare Broomhill. All patients placed at the hospital by the CCGs and CWPT had been reviewed and no concerns were identified. All CCG GP practices registered with CQC continued to be rated as overall 'Good' or 'Outstanding'. The CCGs' Care Home Quality and Infection Prevention and Control teams had been working closely with and supporting Nursing and Residential Care Home providers with Covid-19 related issues. Ms Beamish highlighted the concern regarding Children and Young People in Crisis and asked about the change in service. Ms Galloway reported that this was initially a level three risk but had been reduced in March 2020. She explained that the new ways of working during Covid-19 have been positive as children had been supported at home rather than in hospital. A meeting was planned to reassess the level of risk. Ms Galloway added that the CCGs were working with CWPT and the Local Authority on new models of care and reducing backlogs for the Autism spectrum disorder (ASD) and Attention deficit hyperactivity disorder (ADHD) services. Ms Nistorica-David reported that concerns had been raised about support for children with additional needs and their families during lockdown. An update on this was expected at the next Clinical Quality and Governance Committee. Members of **BOTH** Governing Bodies **NOTED** the contents of the report.	
3.3	**<u>Learning Disabilities Mortality Review (LeDer) Annual Report 2019/20</u>** Ms Galloway presented the second LeDer Annual Report, explaining that this had been received by Governing Body prior to Committee due to timelines for reporting. The July thematic Clinical Quality and Governance Committee meeting would focus on learning disability and mortality review. The LeDeR programme was established to drive improvements in health and social care for people with learning disabilities, and to help reduce premature mortality and health inequalities	

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	in this population. There were 67 deaths notified to the programme from 1st April 2019 to 31st March 2020 across Coventry and Warwickshire; this compared to 47 in the same period 2018 – 2019. The disparity between the age of death for individuals with a learning disability compared to the life expectancy of the general population in Coventry and Warwickshire still remained at 20 years for males and 24 years for females. In relation to cause of death locally, carcinoma was the most frequent cause of death (21%), with pneumonia attributed as the cause of death for 19% of deaths reported; this compared to the cause of death reported in the last annual report. Genetic disorders were identified in 19% of deaths. A Coventry and Warwickshire system-wide 'Reducing Health Inequalities for People with Learning Disabilities Steering Group' was in place and the thematic Committee meeting was scheduled for July. Learning from the reviews most commonly related to: • Access to multidisciplinary services such as speech and language therapy (SALT), physiotherapy and dietetics; • Communication with and involvement of family/relatives in care and/or treatment decisions; • Training for staff supporting people with learning disabilities in all areas; • End-of-life care; • Annual GP reviews required with referrals to specialist services; • Age appropriate health screening. Ms Beamish asked whether GPs understood the issues in relation to the annual reviews. Dr Staveley explained that it had been made clear to all GPs that learning disability reviews should not stop in light of Covid-19 and that these could be done virtually. She thought that some GPs were postponing reviews until the risk of Covid-19 had reduced, rather than conducting these virtually. Dr Staveley reported that GPs in other parts of the country had been successfully undertaking virtual reviews and suggested that case studies could be provided. She thought that it was important for GPs to recognise that undertaking reviews that are good enough is better than no reviews. Ms Nistorica-David highlighted the importance of partnership working with the Local Authority with regards to undertaking reviews. Ms Galloway confirmed that annual reviews had been raised as an issue in both the first and second LeDer Annual Reports. The performance for Annual Health Checks is below where it should be and this was part of the focus of a recent escalation meeting with NHSE. Ms Galloway confirmed that there has been a lot of work focusing on annual health checks and she would provide an update on the actions in place to the thematic Clinical Quality and Governance Committee meeting in July. Governing Body Members **RECEIVED** the report for information and **NOTED** the content of the report.	**JG**
4.	**Finance and Performance:**	
4.1	**Reports from Finance and Performance Committees in Common: 4th June 2020** Mr Nuttall presented the reports. He highlighted that there had been an improvement in relation to risk management and aligning risks to finance and performance issues. The Committee had received an Estates Report at the June meeting in relation to the Heron House lease. Members were not assured by the report and a further report was therefore received at the July meeting. Governing Body Members **NOTED** the report.	

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4.2	**Finance Reports: Month 2** Mr Lonsdale presented the reports, highlighting the following in relation to both CCGs: • A temporary financial framework in response to Covid-19 had been put in the place to cover the period 1 April 2020 to 31 July 2020. • A revised framework was due out in the next few weeks. Based on briefings, the CCGs were not anticipating that the framework would change significantly over the next few months. • There had been a change to the way guidance was applied for finance nationally. • Reset was both a risk and opportunity with Referral to Treatment (RTT) pressure and a substantial number of pathway changes that could become permanent. QIPP and Transformational change had also been delayed as a system. • The process for finalising and agreeing monthly expenditure had yet to see confirmed results leading to uncertainty on the final position. • Capital was yet to be confirmed and carried a delivery risk to the CCGs. • The CCGs had a nationally mandated block payment system which was due to change next month. This could change the picture for month 5 and beyond and is a risk to the CCG position. Mr Lonsdale directed Members to the table within section 2.1 of CRCCG the report, which detailed the position for each service line. An additional £999k allocation was anticipated for month 2 to break even the CCG's position in line with national guidance. The over performance was partly related to Covid-19 and partly related to prescribing. Prescribing for both CCGs increased in March 2020. Based on month 1 data this had continued into April and would form part of the future forecast. The CRCCG over performance was not significant as the majority related to Covid-19 expenditure, however, the CCG had a £2.3m Acute underspend. Most of the Acute spend was mandated payments based on the block payment system, which masked over performance in other areas. This was not necessarily a problem in the short term but the CCGs needed to recognise the trend position over the long term. If the £2.3m Acute underspend was set aside, CRCCG was approximately £3.3m overspent. Mr Lonsdale directed Members to the table within section 2.1 of WNCCG the report. WNCCG had a £0.8m over performance, which offset a £0.6m under performance on Acute. In total for other areas there was a £1.4m over performance. NHSE/I had provided assurance that they would resolve Covid-19 finances and they would look in future months at reasonable over performance issues and offset. Mr Stainforth asked whether the uncertain financial position would mean that the CCGs could not take as many opportunities in relation to the restoration work. Mr Lonsdale explained that the original framework suggested that the CCGs would be supported if they took reasonable steps and this had not specifically changed but the risk was there. Capital was the main area where there was a level of concern. Mr Lonsdale confirmed that the CCGs were trying to understand the long term implications of decisions. Mr Stokes added that the availability of workforce was likely to be a limiting factor in the opportunities that could be taken. Ms Beamish highlighted that the main variants for WNCCG were prescribing, Primary Care Services and Primary Care Co-Commissioning, and asked how much variance was linked to Covid-19. Mr Lonsdale explained that prescribing was predominantly related to the month 12 position. There was an argument that prescribing levels had increased due to Covid-19, however, the CCGs were not able to offset the positon against Covid-19 as there was a national policy.	

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	In terms of delegated commissioning, Mr Lonsdale explained that a lot of the variance related to the General Medical Services (GMS) contract as the CCGs had not received an allocation and were expecting it to be topped up. The allocation had been topped up at month 3. Ms Beamish asked whether the Finance and Performance Committee had given a steer in terms of the risk appetite for deployment of expenditure on capital, given that the CCGs may break the statutory duty to live within resources. Mr Lonsdale explained the level of risk had been discussed with the Executive team, including Ms Northcote as the lead for GP IT, as a lot of the resource related to this. He explained his view that not doing GP IT would have a more costly effect. Ms Northcote confirmed that the capital in relation to GP IT had been scrutinised and the CCGs were clear on what was required for operational delivery and service continuity, particularly in the context of delivering more remote services. Ms Beamish asked whether the Finance and Performance Committee had confirmed that the CCGs could proceed at that level of risk. Mr Lonsdale advised he believed so and confirmed that he would review the minutes of the meeting and report back to Governing Body Members. Dr Raistrick asked whether the CCGs were confident on the processes in place with regards to prioritisation. Mr Lonsdale confirmed that an overall prioritisation framework should be in place. As part of the reset phase the CCGs would bring the prioritisations together and review them against the framework. This would also be undertaken across Coventry and Warwickshire and as part of the Place plans. Mr Harkness explained that it was understood across the system that organisations needed to work together to make changes within the confines of the financial envelope. CRCCG Members: • **NOTED** the position and retrospective adjustment; • **NOTED** that the adjustment was draft and subject to a regionally led assurance process; • **NOTED** the risks within the report and that the CCG is looking to take additional actions to mitigate where possible; and • **NOTED** the need for the CCG to proceed at risk on a level of Capital expenditure to reduce operational risk. WNCCG Members: • **NOTED** the position and retrospective adjustment; • **NOTED** that the adjustment was draft and subject to a regionally led assurance process; • **NOTED** the risks within the report and that the CCG is looking to take additional actions to mitigate where possible; and • **NOTED** the need for the CCG to proceed at risk on a level of Capital expenditure to reduce operational risk.	**CL**
4.3	**<u>Performance Report</u>** Mr Harkness presented the report, explaining that the information related to April 2020 unless otherwise specified. Focus was given to the priorities identified as key performance issues for both CCGs by NHSE/I, as well as the wider performance areas identified locally as issues Due to Covid-19 and the need to release capacity across the NHS, NHSE had paused the collection and publication of several key performance measures. The CCG was reviewing what other measures might be appropriate to report on during the pandemic. NHSE/I were also developing some measures but these were not yet available. Mr Harkness highlighted the following from the report: • A&E 4 hour waits performance Improved in May at UHCW to 93.3% and at GEH to 96.9%,	

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	above the 95% target level. There were no 12 hour trolley breaches. A&E and Urgent Treatment Centre (UTC) attendances are slowly rising towards pre-Covid-19 levels. • In April CRCCG and WNCCG Cancer 62 day wait performance fell significantly below the 85% target to 71.4% and 55.6% respectively. Cancer delivery had been severely impacted by Covid-19, mainly due to reductions in productivity from Personal Protective Equipment (PPE) restrictions. The independent sector was bought out nationally to help support NHS providers, and the BMI and Nuffield hospitals had been utilised, but again whilst the physical capacity was available, productivity had reduced because of gowning and degowning time between patients. • In April 63.5% of CRCCG patients and 63.4% of WNCCG patients had been waiting less than 18 weeks from their GP referral against a target of 92%. National decisions to defer non urgent treatment in March had caused a significant deterioration in RTT performance. • There were 34 CRCCG patients and 25 WNCCG patients who had waited more than 52 weeks at the end of April. Forecasts suggest that performance will worsen further in May and June. The system had been required to prepare restoration plans, indicating how they will get back to 100% of normal capacity by December 2020. • In relation to Transforming Care, inpatient admissions for NHSE Adults and NHSE Children and Young People were on trajectory in May. However CCG adult numbers were significantly over trajectory. • Out of area mental health placements continued to decline in line with the reduced demand for admissions associated with the early phase of the Covid-19 pandemic. Mr Stokes reported that some real time data on the number of patients waiting for treatment was available through the Recovery Coordination Group (RCG) and he thought it was important for that to be factored into the Performance report. While the CCGs were waiting for national reporting requirements to be confirmed, he thought it was important for the CCGs' own measures to be shared more widely. Dr Raistrick asked whether the CCGs had assurance from providers that patients and clinicians understood the reasons for over 52 week waits. Mr Harkness confirmed that the providers had clinically led prioritisation processes in place. He confirmed that he would seek further assurance and provide clarity in the next report. Ms Beamish highlighted the impact of Covid-19 on cancer delivery and suggested that the CCGs addressed this by focusing on the area that would have the most impact on patients. Ms Northcote explained that the CCGs' approach to this was slightly different than it had ever been before, as patients were making personal judgements about their own risk factors and their appetite for coming forward for care. The engagement with patients before coming in for procedures was very different and the CCGs had been thinking about how they support providers to keep in contact with patients if they first refuse treatment. Dr Raistrick agreed that patients should be encouraged to attend their GP practice if they have symptoms of cancer, but the CCGs also needed to ensure that the services were in place to provide the appropriate diagnosis and treatment. In relation to out of area mental health placements, Dr Raistrick highlighted that the improvements made should continue post Covid-19. The Governing Bodies: • **SCRUTINISED** and; • Were **ASSURED** of the contents of the report.	**AH**

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5.	**Assurance and Governance**	
5.1	**Report from Audit Committees in Common: 27th May 2020** Mr Lonsdale explained that the May Audit Committee approved the draft Annual Accounts and Annual Report due to the elongated process for year end. He confirmed that there were no material changes to the position and the month 12 position was as previously reported to Governing Body. Governing Body Members **NOTED** the report.	
5.2	**Equality and Diversity Report** Mrs Wilson presented the report which provided an update on the actions taken to ensure the safety and wellbeing of staff during the pandemic, with particular attention on BAME (Black and Minority Ethnic) staff, those with protected characteristics and those at greater risk. All BAME staff will have had an opportunity to have a discussion with their line manager and a risk assessment completed for them. The CCGs were due to publish the percentage of staff who had been risk assessed by 23rd July. The CCGs' Equality, Diversity and Inclusion Group was well established and well represented across staff groups. The group had been monitoring the NHS England/Improvement (NHSE/I) guidance and new research on the increased risk to vulnerable groups. The Workforce Race Equality Standard had been suspended due Covid-19 but the CCGs were now required to submit data by the end of August and were on track to do so. A report would be provided to the August Clinical Quality and Governance Committee meeting and an update to the September Governing Body meeting. A programme of reverse mentoring had been started, focusing on BAME and LGBT+ as protected characteristics. Mrs Wilson thanked everyone who was taking part. A Gender Pay Gap report for 2019/20 would be prepared and reported to the October Clinical Quality Governance Committee. The Governing Bodies: • **RECEIVED** the report and; • Were **ASSURED.**	
6.	**Primary Care**	
6.1	**Reports from Primary Care Commissioning Committee:** ***a) Coventry and Rugby CCG*** Mr Nuttall presented the report to Members and highlighted the work undertaken on the risk register. Coventry and Rugby CCG Governing Body Members: • **NOTED** the Coventry and Rugby CCG Primary Care Commissioning Committee Report. ***(b) Warwickshire North CCG*** Mr Nuttall presented the report to Members and highlighted the work undertaken on the risk register. Warwickshire North CCG Governing Body Members: • **NOTED** the Coventry and Rugby CCG Primary Care Commissioning Committee Report.	

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7. **7.1**	**<u>For Information</u>** **<u>Communications and Engagement Report</u>** Ms Northcote presented the report, explaining that the Communications and Engagement team had played a significant part in the response to Covid-19. The team had also continued to meet the statutory obligations for communications, engagement and involvement. Dr Raistrick thanked the team for their work. The Governing Bodies **NOTED** the report, which is provided for assurance and information.	
9.	**<u>Questions From Visitors</u>:** No questions were raised. Dr Raistrick highlighted that Dr Sarah Ajam was present and welcomed her to a new clinical leadership role in WNCCG.	
10.	**<u>Any Other Business</u>** None declared.	
11.	**<u>Date of the Next Meeting Held in Public</u>:** **Date:** 23rd September 2020 **Time:** 2:15pm to 5:00pm	

Signature: **(Chair CRCCG)** **Date:**

Signature: **(Chair WNCCG)** **Date:**

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