NHS
South East London
Clinical Commissioning Group

Governing Body meeting
Questions received from the public with responses from the CCG

MEETING DATE: 16/07/2020

This first set of questions were received prior to the meeting taking place, with the response document then published on the CCG's website and also emailed to those who submitted the questions. Where a question was raised on behalf of a group, the person's name is listed below; where the person did so as an individual, then their name has not been published.

Question 1 **Ann Garrett, Richard Crook and Ashleigh Marsh (co-chairs, Save Our Local Hospitals and Services - Bromley, Bexley and Greenwich)**	Several hundred signatures have been collected on our petition to re-instate A&E at Queen Mary's hospital, Sidcup. People feel strongly this would relieve pressure on the A&E at the PRUH and Queen Elizabeth Hospital. Does the Governing Body think this is worth considering and will they discuss it at a future meeting?
Response	The decision to close the A&E department at Queen Mary's Hospital (QMH), which was made some time ago, was based on clinical evidence and patient safety. It has of course always been a key priority for the CCG to ensure that residents – in this case of Bexley - are able to access urgent care services in a timely and appropriate way. An urgent care centre was set up on the QMH site and assessments were made on the relative proximity of three emergency departments to the borough of Bexley. Travel studies were undertaken at the time, and it was agreed that this was the best course of action. Over the years, a great many other changes have taken place, and whilst there have been some significant developments in services for the local and surrounding populations at QMH, there are no longer the services on site required to support an A&E – for example acute medicine, acute surgery and paediatrics. It would not be possible, therefore, to consider opening up an A&E at QMH without changing significantly the configuration of many acute services in much of south east London.

	We could not at this time, nor in the foreseeable future, safely reopen an A&E service on the QMH site, and, because of this, we would not recommend such a discussion takes place. We would however, support the further development, more broadly, of health services on the QMH site, and this is part of many discussions that will be considered as new care pathways are developed.
Question 2 **From a member of the public in Southwark**	As we are yet to fully contain the coronavirus pandemic, what arrangements are in place to manage the ever growing list of cancelled specialists hospital appointments for patients with long term conditions who require regular/periodic specialist consultant review for their eyes, hearts, kidneys, legs, livers, lungs, etc., etc, etc., as they are not able to be seen face-to-face at present?
Response	Recognising that we are still in a category four major incident, many patients with existing conditions that need to be reviewed by their clinical team now have their regular check-ups by video call or phone. For some, however, regular face-to-face follow ups are taking place, but these may be at community rather than acute hospital sites. Where someone requires regular treatment that is life, limb or sight protecting, this continues to happen face-to-face, albeit in ways that protect all involved from Covid-19. Eye injections for those with macular degeneration and renal dialysis would be good examples of such services. In some cases, we are using capacity available through our colleagues in the independent sector to support check-ups to continue, for example surveillance endoscopy. What is very important, of course, is to note that each patient's circumstances are different – the benefit associated with a treatment approach for one person may well outweigh any risks, but this may or may not be the case for someone else needing the same treatment. This means that clinicians need to be flexible in their approach in providing continuing care for their patients.
Question 3 **Fraser Syme on behalf of SymeBros of Streatham Hill**	1) Given that the government has devolved the authority and responsibility for managing the Covid-19 pandemic away from central government to localities and has clearly stated that future lockdowns, if required due to either spikes/surges in the 'R' figure and/or in Coronavirus cases being identified, will be down to localities to effectively manage… What protocol(s) have the SELCCG implemented in relation to the following and when will these be published on their website: (a) What SELCCG 'R' figure threshold needs to be breached in order to trigger a localised lockdown?

	(b) How many new Coronavirus cases per 100,000 of population identified would trigger a localised lockdown? (c) How many new Coronavirus-related hospital admissions would trigger a localised lockdown? (d) In relation to (a), (b), & (c) above, how quickly will localised lockdowns be implemented? (e) In relation to not only those who have been 'shielding' but also all those deemed vulnerable through to extremely vulnerable and/or those with multiple comorbidities, how does SELCCG intend to keep this group (see Note below) appraised of ALL important Covid-19 developments (e.g. localised lockdowns etc) given that many will be in the older age range, potentially less tech savvy and may not possess any kit to accept digital communications? (Note: "According to a study of more than 17 million people in England published this [last] week in 'Nature', advanced age, and being male, Diabetes, severe asthma, obesity, chronic heart or liver disease, dementia, reduced kidney function and autoimmune diseases like rheumatoid arthritis, lupus or psoriasis — were also associated with a higher risk of death based on an analysis of the anonymized health records of 17,278,392 adults, slightly less than 11,000 of whom died with COVID-19.") 2) In relation to potential Covid-19 side effects: (a) How does SELCCG both consider and deal with the lethality of asymptomatic individuals in real terms especially given all the information being generated in relation to potential Coronavirus side effects e.g. brain etc even in those with just mild cases? Clearly the lethality of symptomatic individuals is easier to consider & deal with. Worryingly however, is the fact that doctors apparently may be missing signs of serious and potentially fatal brain disorders triggered by coronavirus, as they emerge in mildly affected or recovering patients, scientists have warned. (b) Although perhaps considered somewhat minor at present, how do the Adem (acute disseminated encephalomyelitis) cases in South East London compare with those recorded at UCL's Institute of Neurology - during what is being considered the first wave of Coronavirus - where Adem cases rose from one a month before the pandemic to two or three per week in April and May?
Response	<u>Question 1</u> Whilst the Government has devolved the management of local outbreaks in community settings, this responsibility has passed to local authorities and their public health teams, to work in partnership with Public Health England and the NHS. Each local authority across England has been asked to develop a local coronavirus (Covid-19) outbreak prevention and control plan that

sets out for the local community how outbreaks will be identified and managed, with support from NHS colleagues where required. These are all published on the respective local authority websites. For example, Lambeth council's plan, which was last updated on 30 June, can be found on its website. These plans will be updated by councils in line with changes in Government advice. The NHS, of course, will remain responsible – working with local public health teams and PHE – for managing any outbreaks that occur in sites such as hospitals – including ensuring those who are shielding currently, as well as people who are clinically vulnerable, are kept aware of any changes that occur.

The CCG is tracking all the key indicators for a potential outbreak, as well as reviewing any potential outbreaks in healthcare systems, on a daily basis. The Incident Gold command managed by the CCG has instituted a local early warning review system using data available from the previous day on:

- number of laboratory confirmed cases by borough
- total patients with Covid-19 admitted to south east London hospitals, by site
- total number of critical care beds occupied by Covid-19 patients, by site
- number of Covid-19 calls made to the NHS111 service

It is unlikely that one single indicator would trigger action, but if significant rises are seen in a couple of these indicators, this will trigger discussions with local boroughs and the South London Health Protection Team (which is part of Public Health England), along with wider discussion within the system. Surveillance using an amalgam of the data being collected, combined with outbreak monitoring in healthcare is essential. We stay in close contact with borough public health teams to ensure that we are all sighted on the data available.

Question 2

Covid-19 is an entirely new virus, with knowledge of the range of infection impacts growing daily as the body of research evidence expands. This work is being led by teams of clinical research staff working at a local, regional, national and international level, with evidence of research findings then being fed in to the guidance issued nationally by bodies such as Public Health England and NHS England/Improvement. This guidance is disseminated widely, especially with support from the Royal Colleges and related organisations. This guidance is also considered at clinical advisory groups, including the ones set up to cover London and south east London. Attendance at these groups is representative of the NHS organisations providing Covid-19 care, which means that national guidance can be shared widely – including to GP practices and especially around updates where important symptoms may not be being picked and for emerging conditions such as acute disseminated encephalomyelitis.

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Question 4 **Ian Fair on behalf of the Lewisham Pensioners Forum**	For the last SEL CCG meeting in [virtual] public on 21 May I asked questions about the impact on outpatient appointments,diagnostic tests and operations of the actions taken to deal with the Covid-19 pandemic. In the light of the CCG's response to these questions: 1. Can the CCG please report on the progress of the work to quantify and assess waiting list backlogs referred to in its answers to my questions? 2. Similarly can the CCG report on the progress of plans to restart elective/planned activity referred to in its response? In particular what activity has been restarted in SEL hospitals and other medical facilities? 3. Has the proposed communication plan aimed at clarifying for patients the next steps in their pathways been produced, and are the individual patients affected being told?
Response	Outpatient, diagnostic and elective (day case and inpatient) services have all been restarted in south east London's hospitals. The initial focus was on urgent patients from all specialties and those patients whose condition might deteriorate whilst they were waiting. Throughout the pandemic, treatment has continued for many patients where this was necessary to save their lives, limbs or sight - for example eye injections for those with macular degeneration and people requiring renal dialysis. A significant amount of work is now taking place to schedule patients for diagnostic procedures that have been delayed, especially endoscopy. This includes patients who normally have regular surveillance endoscopies. Additional sessions are taking place and the independent sector is also being utilised to increase the number of patients who can be seen. We are now focusing on routine, high volume specialties especially ophthalmology and orthopaedics. In these specialties there are inevitably now considerable backlogs and, although work has restarted, it is likely to be many months before waiting times are back to pre-COVID levels. Plans are being developed to improve the situation through the use of additional lists and capacity in the independent sector as well as sharing resources across SE London so there is not a big difference in waiting times between sites. Across south east London, the NHS is on track to have outpatient appointments back to 75% of pre-Covid-19 levels by early to mid-August, although the rate will vary slightly between different hospitals depending on local circumstances. A similar position is expected to be achieved for diagnostic imaging and endoscopy services, as well as for inpatient and day case services - although there is a slightly greater range for the latter as this is dictated by a number of different factors, including the capacity of operating theatres and related services. We would hope to be in a position to provide validated data by the

	next Governing Body meeting. In terms of waiting list management, different hospital teams will have a wide range of surgical and medical specialties that they will be seeking to restart, with an emphasis on focussing on those where the greatest risk may exist for patients in terms of clinical urgency and outcomes. Each hospital has also set up its own patient communication activities to support people coming in for appointments, procedures and treatments. This includes updated patient letters, information leaflets and online resources such as videos - for example this one from the Greenwich and Lewisham NHS Trust: https://www.youtube.com/watch?v=EiAYS_A3jvM&feature=youtu.be. The CCG is also supporting the national Help us Help you communications campaign, which is designed to provide people with reassurance and confidence that the required infection prevention and control measures are in place to support people getting the treatment and advice they need, be that from their pharmacist, GP or hospital clinical team.
Question 5 **Steve Lancashire, Southwark Keep Our NHS Public**	Has the CCG received its budget from NHS England/The London Recovery Board? How much is it and how are decisions going to be made about allocating funds for work undertaken by the CCG and also the Borough based Boards?
Response	Currently the NHS is operating under a temporary financial regime, which was put in place by NHS England and Improvement during the initial phase of the NHS' COVID-19 response with the aim of seeking to create as much short term funding certainty as possible in support of the pandemic response. Under this regime, NHS organisations are being funded for reasonable and necessary expenditure – including retrospective top up payments aiming to create financial breakeven positions for NHS organisations during the COVID-19 response. Under this arrangement, monthly adjustments to the CCG's allocation are made to match spend on COVID-19 and payments to the NHS trusts in south east London. These temporary arrangements will run until the end of August, with NHS England/Improvement will advise on arrangements thereafter for the remainder of 2020/21. For further information and detail, please refer to the month two CCG finance report in the papers for this Governing Body meeting.

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Question 6 **Susan Sidgwick, Lambeth Keep Our NHS Public**	In the event of continuing local outbreaks and/or future waves of the Coronavirus an effective system for finding, testing, contact tracing and support for isolation is crucial. There is widespread concern that the centralised NHS Test and Trace system, outsourced to commercial companies, that the Government has put into place fails to preform effectively in key areas such as case finding, proactive contact tracing, data sharing. Many believe that an effective system needs to be based on proven public health principles, embedded in local systems and able to engage proactively with local communities, mass testing to catch all carriers, respond rapidly and support isolation. The Outbreak Control and Prevention Strategies being developed by local authority public health systems are putting these principles into practice, but it is not clear what the overall strategy is and how local systems fit into the wider picture. **Questions**: 1. NHS Test and Trace, despite its weaknesses, is apparently being expanded. Is it the expectation that it will be carrying out the bulk of T&T for the general population in the future? Lambeth KONP doubts that it has the ability to do an adequate job. 2. In the event of a future wave (or indeed currently): - if NHS T&T is only testing those who come forward, how will asymptomatic cases be picked up? - local systems have the potential to test and trace proactively at scale, but would this entail the development of a system parallel to the national one, and if so, are they resourced to do this? 3. What are the respective roles and responsibilities of London Region, SELCCG, Borough/Place based Boards and local authorities in relation to dealing with (a) localised outbreaks (b) a significant second wave in the London Region? How do/will they relate to each other? What other bodies will play a significant role?
Response	<u>Question 1</u> Test and trace is an essential part of the programme to control the spread of Covid-19; there is evidence from elsewhere of its relevance to controlling the virus. Since the start of its implementation, Test and Trace has developed and improved; it will

need to continue to be in place across the country going forward. It is important to note as well that this is not the only route into testing. For months now the Department of Health and Social Care has offered access to testing facilities and the availability of this has expanded and now includes anyone with symptoms. People can self-refer for testing and additionally we have been testing NHS and social care staff locally through using NHS testing capacity; we expect that these arrangements will continue.

Question 2

By definition those people who are asymptomatic have few or no symptoms, meaning that they cannot be identified as easily. This is one of the main reasons why it is important for people to wear face masks in specified settings, such as public transport, and that we all practice social distancing.

Also, the test and trace system will pick up asymptomatic contacts of positive cases so an important element of the T&T is the co-operation of the public – firstly, that people with symptoms identify their contacts and secondly, that the contacts follow the recommendations (for example about self-isolation where needed).

With regular testing of certain staff groups and vulnerable people (for example in care homes), we will be able to identify people who may be infectious who are either asymptomatic or in the early stages of illness. The CCG is working with local organisations to define what this will look like, but national testing routes now allow testing of care home staff regularly, with hospitals also planning regular asymptomatic staff testing. They will also be testing before elective admissions (e.g. people who are asymptomatic but coming into hospital for other reasons) and are testing patients already before their discharge to care homes. This work, along with the other screening and social distancing measures in place, aims to support reducing the spread and impact of Covid-19

With regard to the second part of this question, local systems to manage some track and trace issues – especially for more complex incidents – have been developed through local public health teams. Although resources at a local level are limited to be able to do this, and there may be times when they are not required so a centralised system makes more effective use of the resources available. Trained people can be deployed where there is the need.

Question 3

Whilst the Government has devolved the management of local outbreaks in community settings, this responsibility has passed to local authorities and their public health teams, to work in partnership with Public Health England and the NHS. Each local authority across England has been asked to develop a local coronavirus (Covid-19) outbreak prevention and control plan that

	sets out for the local community how outbreaks will be identified and managed, with support from NHS colleagues where required. These are all published on the respective local authority websites. For example, Lambeth council's plan, which was last updated on 30 June, can be found on its website. These plans will be updated by councils in line with changes in Government advice. The NHS, of course, will remain responsible – working with local public health teams and PHE – for managing any outbreaks that occur in sites such as hospitals – including ensuring those who are shielding currently, as well as people who are clinically vulnerable, are kept aware of any changes that occur. The CCG is tracking all the key indicators for a potential outbreak, as well as reviewing any potential outbreaks in healthcare systems, on a daily basis. The Incident Gold command managed by the CCG has instituted a local early warning review system using data available from the previous day on: • number of laboratory confirmed cases by borough • total patients with Covid-19 admitted to south east London hospitals, by site • total number of critical care beds occupied by Covid-19 patients, by site • number of Covid-19 calls made to the NHS111 service It is unlikely that one single indicator would trigger action, but if significant rises are seen in a couple of these indicators, this will trigger discussions with local boroughs and the South London Health Protection Team (which is part of Public Health England), along with wider discussion within the system. Surveillance using an amalgam of the data being collected, combined with outbreak monitoring in healthcare is essential. We stay in close contact with borough public health teams to ensure that we are all sighted on the data available.
Question 7 **A member of the public from Greenwich**	1 Will the savings from the CCG merger be identified , audited and reallocated to front line services on a borough by borough basis ? 2 What are the views of board members on the level of independent lay patient membership on the Board and in draft proposals for the Engagement and Assurance Committee?
Response	Question 1 The management cost reduction required of all CCGs, which in the case of south east London was delivered through the merger, was a requirement set by NHS England/Improvement. The CCGs' running cost allocation was reduced by 20%, with the national commitment being that this was then invested in frontline services – thus this is not locally controlled re-investment. The CCG tried to ensure our approach both minimised impact on staff – e.g. creating a large amount of saving

(£1.8 million) from creating a single Governing Body – and that we can continue to invest locally as needed in what makes the most difference to patients and the public.

Question 2

Membership of the Governing Body and borough-based boards was tested extensively during our merger discussions. The Governing Body itself has good lay membership involvement, with each of the borough-based boards – which report into the Governing Body – have lay representation. In addition, borough-based board lay members are invited to attend Governing Body seminars and link in with their Governing Body lay colleagues through lay member fora.

With regard to the engagement and assurance committee, lay representation has yet to be confirmed – this work is being taken forward by a task and finish group that is being chaired by a Governing Body lay member and has strong public representation from our boroughs.