NHS
South East London
Clinical Commissioning Group

CCG Governing Body meeting in Public

Minutes of the meeting on 19 November 2020

Videoconference/ Streaming via MS Teams

Present:

Name	**Title & Organisation**
Dr Jonty Heaversedge (chair)	Chair SEL CCG
Dr Dianne Aitken	Lambeth GP Lead, SEL CCG
Dr Clive Anggiansah	Bexley GP Lead, SEL CCG
Dr Angela Bhan	Bromley Borough Director SEL CCG
Andrew Bland	CCG Accountable Officer and SEL ICS Lead
Mary Currie	Registered Nurse Member
Dr Rob Davidson	Southwark GP Lead, SEL CCG
Dr Sid Deshmukh	Bexley GP Lead, SEL CCG
Joy Ellery	Lay Member, Public & Patient Involvement
Andrew Eyres	Strategic Director, Integrated Health & Care Lambeth
Neil Kennett-Brown	Greenwich Borough Director SEL CCG
Shelagh Kirkland	Lay Member, Governance & Audit
Dr Nancy Kuchemann	Southwark GP lead, SEL CCG
Prof Simon Mackenzie	Secondary Care Doctor member
Dr Adrian McLachlan	Lambeth GP Lead, SEL CCG
Usman Niazi	Chief Finance Officer, SEL CCG
Dr Ruchira Paranjape	Bromley GP lead, SEL CCG
Dr Andrew Parson	Bromley GP lead, SEL CCG
Peter Ramrayka	Lay Member, Primary Care & Commissioning
Stuart Rowbotham	Bexley Borough Director SEL CCG
Dr Sabah Salman	Greenwich GP Lead, SEL CCG
Martin Wilkinson	Lewisham Borough Director, SEL CCG

In Attendance

Sonia Colwill	Director of Quality
Dr Nada Lemic	Public Health representative
Julian May (minutes)	Head of Governance SEL CCG
Theresa Osborne	Director of Commissioning System Reform, SEL CCG
Dr Simon Parton	LMC representative
Folake Segun	Healthwatch representative
Christina Windle	Chief Operating Officer, SEL CCG

1.	**Welcome and apologies**
1.1	Dr Jonty Heaversedge welcomed all to the south east London CCG governing body.
1.2	Apologies were received from Dr Jacky McLeod, Kate Moriarty-Baker, Dr Krishna Subbarayan, Dr Faruk Majid and Michael Boyce
2.	**Opening business**

2.1	No conflicts of interest were identified in relation to items on the agenda.
2.2	The governing body **ACCEPTED** the minutes of the meeting on 17 September 2020 as an accurate record.
2.3	The action log was updated.
2.4	There were no matters arising.
3.	**Public Questions** **(please note questions are provided verbatim)**
3.1	**QUESTION: NHSE has made an announcement about long covid clinics. What is the CCG, that includes three such well-known teaching hospitals with research institutes, doing about it? As someone with long covid I can't get any direct answers.** RESPONSE: Dr Jonty Heaversedge responded that there was increasing understanding of the effects of Covid-19 and longer term complications associated with the virus and time spend in intensive care. There was an impact on many organs in the body and long term rehabilitation needs. The National Institute for Health and Care Excellence had published a definition of long Covid, and a multidisciplinary group was looking at ways to respond to those needs under the leadership of Dr Irem Patel who worked at Kings College Hospital. This included developing hospital clinics in addition to routine post-acute follow-up provided by hospital trusts for those who had recently been discharged after being treated for Covid. The CCG was rapidly trying to establish support in primary care, building on work already undertaken in Bromley.
3.2	**QUESTION: What boroughs in SEL are involved in local contact tracing? Are decisions around this a matter for the local authority, SEL ICS or London region?** RESPONSE: Dr Nada Lemic reported that all six boroughs in south east London had expressed an interest in local contact tracing and five had started already, with the sixth starting next week.
4	**Showcase: Big health week**
4.1	The governing body heard an update from William Davies on the Learning Disability Big health week from hosted virtually from 2-6 December following the success of a previous year's event in Greenwich. The event had been hosted by the CCG but delivered by 24 organisations and service providers working together to provide 35 sessions of health information, advocacy, advice, and activities including dance, cooking, fireworks and a big quiz. An average of 22 people attended and had shared excellent feedback through surveys, social media and video interviews. The week had attracted a diverse and representative audience and had generated energy at a difficult time when this was needed and had promoted physical health checks and cancer awareness to the community. Learning from the event would be incorporated in future events.
4.2	Neil Kennett-Brown highlighted the success of the event, praising the work of the team and William Davies, Ian Ross and Yvonne Davies, for providing an event for

	the community which they could participate so fully. It had been a joyful series of events during a difficult time and had promoted vital messaging on physical health checks. The event had grown from Lewisham and Greenwich to all 6 boroughs, and it was hoped to expand this even further with the use of digital.
4.3	Dr Dianne Aitken welcomed the presentation and congratulated the team on the event, noting that there would likely to be demand to share the lessons learned so that this success could be shared.
5.	**David Bradley - Chief Executive South London and Maudsley NHS Foundation Trust**
5.1	The governing body heard a presentation from David Bradley on South London and Maudsley NHS Foundation Trust (SLAM) hearing how the trust had developed from the world's first psychiatric hospital to providing the widest range of mental health services in the UK with over 50 national services, 20 of which were for children.
5.2	Addressing current challenges the trust had reduced the number of people sent to out of area placements to zero, and continued to work to reduce length of stay and waiting times. The summer had seen a 40% increase in referrals to community services, but there had been a 45% reduction in people accessing IAPT services, which a big communications campaign was hoping to address particularly to meet some of the challenges created by lockdowns.
5.3	During the pandemic the trust had worked to support the system by providing bed capacity for step down and creating clinical assessment units and additional crisis support to reduce pressures on emergency departments.
5.4	With the support of the trust's charity and private donations, the trust had ambitious plans to invest in improving estates, with the Pears Maudsley centre hoping to bring together in a single site clinical services and researchers from the Institute of Psychiatry, Psychology & Neuroscience, with the aim of halving the time needed to bring research into clinical practice.
5.5	The trust had worked with local authorities, other trusts and voluntary organisations and communities to discuss how to improve prevention of mental ill health. The South London Partnership working with other mental health trusts in London was putting clinicians at the centre of designing new services and care models with £400m delegated from specialist commissioning budgets by NHS England. Among the achievements was to reduce from 70miles to 7miles the distance children needed to travel to be admitted, a 36% reduction in patients sent out of area and an assessment of complex care patients allowing over 70 to be transferred to less restrictive conditions.
5.6	Strategic priorities included working with partners to become the best mental health organisation globally by investing in estates, community services and particularly addressing reducing disparities faced by people from black and minority communities and an emerging strategy was being developed.
5.7	Dr Jonty Heaversedge reflected that the governing body had discussed the benefits of using digital technology but also some of the disadvantages and asked what the trust had found in this area. David Bradley noted that Covid had

	transformed the ways of working, although it was recognised that some were disadvantaged by a digital approach. The trust had therefore discussed how to deliver services online, but also had developed guidance for clinicians and staff to identify when people need to be seen face to face. There were many opportunities for service delivery in this area, and many found it helpful to find support online for minor mental health problem, in addition the data collected could help transform services and inform a review of estates needs.
5.8	Joy Ellery asked how patients and the public had been engaged about the Clinical assessment units opened during Covid and if they had had an impact on emergency departments. David Bradley noted that a review of the different models was being undertaken following mixed experience and pilot work was being supported by the ICS in south east London. It would be important to clearly message what such units were intended for, and develop generally a better solution to long waits in A&E for people with mental health problems.
5.9	Dr Di Aitken asked about progress with the 'Patient and Carers Race Equality Framework' (PCREF) project. David Bradley noted the project had the potential to transform experiences for people, and the trust was one of the national pilots. Although the pilot was in its early stages, there had been discussions across the organisation about how to change practice for the better.
5.10	Stuart Rowbotham commented that the work of the south London Partnership had emphasised the importance of partnership approaches centred on the place where people lived, and factors such as housing, community, and safety, to improve mental health. David Bradley agreed employment, housing and friendship are big determinants of good mental health and there was a need to do more work at localities and at PCN level with flexible solutions for each place.
5.11	Andrew Eyres asked about how the trust could ensure services were accessible, and delivered in a way appropriate to the communities they served by a workforce whose diversity reflected those receiving care. David Bradley responded that as part of addressing this it was important for the trust to work more closely with others who were better placed to provide culturally appropriate services, such as community and faith groups.
5.12	Dr Adrian McLachlan noted the work on delegated specialist commissioning and asked if there were any lessons to be learned as the ICS developed. David Bradley commented that a key benefit had been that the three mental health trusts worked as a partnership, and instead of trusts competing for savings delivered, were able to use a population health view across the places served by the trusts to reinvest savings where there was a particular need.
6.	**COVID-19 update** **Current response status**
6.1	Dr Angela Bhan updated provided an update on the response of SEL CCG. Following an increase in rates England had moved to a tier system and later to a full lockdown. South East London had lower rates than other areas of London going in to the lockdown although this had changed in the recent weeks. All parts of the NHS are open Elective care open, and media work and a video campaign to support this with the public.

6.2	The response was being managed with Gold Silver and Bronze rotas providing incident support over 7 days, regular system leader's calls with all acute, mental health and community health trusts, and work streams on areas such as care homes, and urgent care pathways. Some of the regular governance had been stood down to facilitate this.
6.3	A successful response would depend on good testing, good tracking system to trace people in contact with positive cases, and a robust Covid-19 vaccination programme. This was in the context of the NHS facing usual winter pressures, and the need for flu vaccination. Additionally preparations for EU Exit would need to be made and checks were being made with suppliers to ensure they had the appropriate arrangements in place for the transition.
6.4	Christina Windle noted that in addition to more robust pillar 2 testing for the public, there were robust arrangements for testing symptomatic health and care staff, as well as new technologies available for asymptomatic testing, including recently lateral flow. Those working in tests would be able to administer a test twice weekly to be followed up with laboratory testing in positive cases. This was a step forward in providing capacity and it may be possible to expand into some areas of the community.
6.5	Angela Bhan noted that priority cohorts for Covid 19 vaccination had been identified including care home residents and staff, those over 80 and health and social care workers. The top ten priority groups would amount to over one million people and vaccinations would be provided through vaccination centres, through primary care, and also a roving model for those unable to leave their homes. Work to identify sites, recruit and train the additional staff and work with IT was on-going, as well as efforts to put in place IT solutions to track delivery and communications for the public through a variety of channels. There was positive news of the efficacy of vaccines, and two vaccines called Talent and Courageous were likely to be delivered in London. The Courageous vaccine would require storage at below minus 75°C and home individual housebound patients would be vaccinated with the Talent vaccine when available. A programme structure with a board chaired by Dr Andrew Parson had been set up to oversee the work.
6.6	Dr Nada Lemic outlined the latest epidemiology noting that figures had increased particularly the 7 day average, and increases were being seen in the 60+ age group. Although there had been more testing, this did not explain the whole increase and suggested there was sustained community transmission.
6.7	Each SEL borough had a health protection committee, supported by a weekly incident management team with the six directors of public health, public health England consultants and representatives from the CCG. All partners worked in collaboration including sharing intelligence such as joint epidemiology reports to track outbreaks and high risk groups. Testing and contract tracing was also underway and all six boroughs have started enhanced local contract tracing which build on national test and trace. There had been an increase in the success of track and trace, although in some cases people were reluctant to isolate because of the effect on them of stopping work.
6.8	Mass asymptomatic testing was being rolled out and although still a new programme, could potentially be used for targeted testing in specific sites where there were outbreaks, or sets of workers such as teachers and domiciliary care

	workers.
6.9	Sarah Cottingham gave an overview of progress on recovery. Work continued to understand the public health burden and inequalities, and identify actions and interventions to address them over the longer term. There had been positive progress on restarting services safely, and many services were back to pre-covid levels of activity despite increasing demand, and the need to implement infection and prevention control requirements. The system was building on ways of working which had been necessary during the pandemic such as digital and remote access, 111 first and same day emergency care. Funding had now been agreed across the partnership over the remainder of the year. The work already done gave a strong foundation of measures and relationships, and the recovery plan had been interlinked with readiness for winter and the second wave of Covid.
6.10	Challenges included the annual demand and capacity challenges over winter, during a second wave of Covid. Good communications were needed to give patients confidence they could access services safely, and enable the system to continue to address demand that had built up over the first wave. Finance and funding was challenging for the NHS but also for local authorities and the NHS.
6.11	As a system there was work on discharge and length of stay to understand demand but also improved ability to collectively forecast expected demand both in and out of hospital. Delayed transfers of care were not being formally reported nationally but being tracked locally along with length of stay and bed occupancy. In relation to delays there trend was not deteriorating and generally discharges were keeping pace with admissions. However there was remaining work particularly at weekends and where sites had existing challenges to capacity and high levels of bed occupancy with high. This was being addressed by local urgent and emergency care boards and discharge hubs and flow centres for sites to support early planning and expedite discharge where patients were medically fit.
6.12	Dr Jonty Heaversedge asked about the significant drop off of referrals during the first wave, and noted the work to avoid a reduction in elective work. There were concerns about people diagnosed with cancer. SC responded referrals for the two week wait suspected cancer pathway were back to pre-Covid levels with some variation across different types of cancers. There was some concern in relation to lung cancer where the referral rate was 60% of the pre-Covid level, and the symptoms had some cross-over with those of Covid-19.
6.13	Dr Ruchira Patel added that patients stayed away during the first wave, and it was pleasing that the work in primary care to keep the focus on diagnosis and adapting referral pathways had helped. There was a challenge in relation to screening services which had come back on line, with some reluctance in patients coming forward for screening.
6.14	Folake Segun asked about the communications around the myths surrounding the vaccine and the communities that may get them. Dr Angela Bhan stated that it may be necessary to look at other ways of communicating with people, building on what was learned from the promotion of flu vaccine, where videos of community leaders had been shared to encourage people to come forward for vaccinations. People would also need to be assured that centres for vaccination were safe and had good infection prevention control measures. There was a role for Q&A and myth busting approaches as well as more personalised approaches

	based on local data where possible. Communications teams were also planning work to align with national communications.
7.	**Equalities update**
7.1	Christina Windle noted the governing body had discussed improving equalities at several meetings, and had agreed the need to meet all the statutory obligations and requirements from national guidance on the issue but also go beyond this to ensure that the CCG was making a demonstrable difference. The Equalities committee had agreed a plan to bring around 40 objectives together, assign senior executive leads. The plan was intended over a number of years but the ambition was to deliver most in the first year.
7.2	The focus in borough recovery plans had been to address the inequalities brought to light as a result of Covid, as well as ensuring population health management was effective and consistent across the ICS. A lot of work had been done to map ways of engaging the seldom heard population to ensure their voices were hear as well as sharing best practice across the ICS.
7.3	An EDI network with representation across the organisations to enable mutual support, learning and best practice hoped to meet early December. Within the CCG staff had been supported not only by addressing race equality issues, but support for health and wellbeing for staff to mitigate the challenges to throughout COVID.
7.4	The CCG had set up a staff network and over 60 people had put themselves forward. In addition to the Beyond BAME group, three further groups had been mobilised to work on protected characteristics and had all met once. All four groups had been clear that they were open to those from within these protected groups but also allies. Actions identified in relation to race equality had been outlined and developed by well attended race equality forums, but lessons learned from these actions would be used to inform the approach to other equality issues.
7.5	JH welcomed the report which had addressed the governing body's request for intense focus leading to action and progress on this issue, and noted the work going on in individual boroughs.
8.	**Accountable Officer's Report**
8.1	Andrew Bland referred members to the accountable officer's report and expressed his thanks for the way plans on Covid vaccination, increased testing and a number of other demands had been carried out by executives and their teams with enthusiasm and to a high standard. He also drew attention to the mention of ICS governance in the report, and noted that Senior Responsible officers had been identified to provide a co-ordinating function across the ICS partners for estates Jim Lusby at Lewisham and Greenwich trust. Julie Screaton from Guys and St Thomas' NHS foundation trust Workforce. Bev Bryant for CIO for both Guys and St Thomas' NHS foundation trust and Kings
8.2	He pointed out that high attendance at staff sessions on race equality relative showed a good engagement on the work that Christina Windle had been leading, and thanked Christina for her work as she would be leaving temporarily for

	maternity leave.
8.3	The governing body **NOTED** the accountable officer's report
9	**Report of the CCG Prime committees**
9.1	Christina Windle noted that no decisions had been referred to the governing body but the report reflected the large amount of work that had been done. Noting that some of the committees had been stood down to support the work on Covid, the report in January may look different and there may be more decisions for the governing body to take.
9.2	The governing body **NOTED** the report of the CCG prime committees
10	**Board Assurance Framework (BAF)**
10.1	Christina Windle explained that the board assurance framework was reviewed in the Integrated Governance and Performance committee. Noting that the correct risk score for risk two was 12. Two new risks had been added Risk 26 about the achievement of flu targets, and risk 15 the delivery of the learning disabilities and autism programme. Risk 12 had been closed following the completion of the nursing and quality directorate restructure.
10.2	The governing body **NOTED** and **APPROVED** the board assurance framework
11	**Quality update**
11.1	Sonia Colwill referred members to the presentation on quality, drawing particular attention to the safeguarding reports for all six CCGs, both for adults and children. These would be published as soon as possible on the website, and would be reviewed by safeguarding colleagues to identify themes and actions to take across the boroughs.
11.2	The Learning Disability Mortality review programme had monitored a spike in the number of deaths during the first wave of Covid, and this linked in with the annual health checks which had been discussed earlier in the meeting.
11.3	Neil Kennett-Brown noted that a the update on the big health week, as well as the focus on equalities, noting that that in some cases those with learning disabilities died of conditions that may not have been identified and proactively managed. The Learning Disability Mortality review programme looked at the reasons and learning from these deaths, and one of the key measures in response was the annual health checks for people with learning disabilities. These were detailed conversations with GPs and had been promoted at the big health week, and guidance and checklists from south east London were being considered as best practice nationally.
11.4	The governing body **NOTED** the quality and nursing report

12	**Finance report month 6**
12.1	Usman Niazi outlined that at month 6 there was an overspend of £12.18m. This consisted of £8.99m of Covid-19 expenditure, with a £3.18m overspend on other non-Covid budgets. Non-covid overspend remained consistent, however Covid spend was higher than earlier in the year, mainly related to the hospital discharge programme put in place to create capacity within the acute sector for its response to the pandemic. A table in the pack set out the causes of the overspend. The CCG had operated for the first months of the year within the temporary financial arrangements established as a result of the Covid pandemic. These had been extended to cover months 5 to 6. The CCG had been able to report a breakeven position based on top up funding received throughout the year from NHS England and Improvement.
12.2	The governing body **NOTED** the month 6 report.
13	**2020/21 CCG budgets - month 7 to month 12 update**
13.1	Usman Niazi noted that additional guidance had been received by CCGs for finances in months 7 to 12 which the finance team had been working on to understand the implications and set effective budgets for the CCG. The CCG would receive the £1.522 billion core allocation to fund business as usual. However in in addition the CCG would also receive £16.3 million in growth funding, the majority of which would be used to ensure the CCG met its commitment to invest in mental health. A top-up allocation of £191.1 million would be passed straight through to providers. A further £115 million of Covid-19 funding would be available to meet the non-recurrent costs of the response to the pandemic.
13.2	The core allocations had been used to continue commitments to programmes such as the better care fund, and ensured corporate budgets aligned with the structures agreed in the change progress. It had also been thought prudent to significantly reduce assumptions on the savings that the CCG would be able to make. The allocations had been set out, but members should note that Covid expenditure would be in addition and the hospital discharge programme would be funded retrospectively.
13.3	Shelagh Kirkland noted that the QIPP requirement for months seven to twelve had been considerably reduced, although understating this would have an impact on the next financial year. She also noted that the risk from GP at hand and the incorrect allocation from the first six months had been corrected in the running cost allocation for months 7 to 12. Usman Niazi confirmed that discrepancies relating to the running cost allocations, GP at hand and the better care fund because of the way the allocations were made had now been corrected. Regarding QIPP the CCG had been realistic about what was possible, while recognising this would have an impact in the next financial year. However a lot of work had been done across a number of teams before Covid on QIPP plans, many of which would still be relevant after quarter four.
14	**Public Forum** **(please note questions are provided verbatim)**
14.1	**QUESTION: Why do Lambeth BBB have a hour Q & A verbally with supplementaries, when SEL CCG and Greenwich BBB find this not**

	possible? RESPONSE: Dr Jonty Heaversedge noted there was space at the beginning and end of the meeting, as well as work to fully answer questions submitted in advance. He recognised that the format had limitations however noted the broad range of questions and answers that had been asked and answered. Christina Windle noted that the live version allowed large numbers of people to join.
14.2	**QUESTION:** Re. the upcoming C-19 vaccination programme: mention was made of re-deploying and recruiting to the workforce. Do you know if appropriate people who are on the volunteer NHS Bring Back Staff database might be contacted and, if not, how might people volunteer for consideration, please? RESPONSE: Dr Angela Bhan noted that use was also being made of returning NHS staff in particular nurses. If people wanted to consider helping with the programme, they were welcome to contact the CCG.
14.3	**QUESTION: Can the Board confirm that 2 patients from each borough has been appointed to the Engagement Assurance Committee. If so have their names and biographies been published? If not when will this happen? How will they be acccessible and accountable to local people through the borough based boards and PPGs?** RESPONSE: Joy Ellery noted that a written response had been provided detailing the effort put in on the committee. A lot of input had been provided from members of the public across all boroughs, culminating in an interview process selecting two members of the public from each borough, and planning to have an introductory meeting towards the end of the year.
14.4	**QUESTION: Pathology -As this £2.25 bn contract requires a safe transition/transfer for 6 months in 3 boroughs. Why was this regarded as a procurement process not including service change. This meant the CCG stated that no engagement was needed. This not my reading of the Statutory Guidance (which I have in front of me). Please explain and cite your reasoning. Is this argument, avoiding engagement likely to be the new normal.** RESPONSE: Neil Kennett-Brown noted that the CCG had agreed to be part of the procurement process in 2017, however there was no service change involved. GP's would fill out a form for the tests, and receive the results of them in the same way. The only thing changing would be the lab where the results were processed, and so although the service provider was changing, there was no service change and therefore it a formal consultation had not been appropriate. However there would be engagement and updates provided via public meetings, and a transition programme had been established to ensure the transition was a smooth one.
14.5	**QUESTION: The Annual Learning Disability Mortality Review Programme Report, appears to indicate an increase in the deaths of people with learning disabilities; is this correct, what lessons are being learned; can we get an update at a future meeting.** RESPONSE: Sonia Colwill confirmed that there had been an increase in deaths of people with learning disabilities as a result of various illnesses that had affected

	them. An annual report would be provided on the website shortly and updates at future governing body meetings.
14.6	**QUESTION: What authority was approved for the appointment of officers to the non-statutory ICS** RESPONSE: Andrew Bland noted that national guidance required each ICS to have a non-executive chair, which was ultimately appointed by NHS England in consultation with ICS partners in south east London. However the Senior Responsible Officers (SROs) referred to in the accountable officers report were officers of their employing institutions within south east London, who had agreed to undertake an additional important co-ordinating role across a number of organisations in south east London.
14.7	**QUESTION: At the Southwark CCG, I was repeatedly assured that it had not approved contracts with GP at Hand! What am I hearing from the CFO about GP at Hand?** RESPONSE: Andrew Bland confirmed that Southwark CCG did not approve GP at hand contracts. However the CFO was obliged to report anything with implications for the CCGs budgets, even where decisions had not been taken by the CCG, for example national tariff decisions, and so had reported the effect of GP at hand even though the CCG had not made a decision in relation to this.
14.8	**QUESTION: Annual Assurance Framework-section 9. states the CCG is finalising the final CCG engagement strategy for November Board approval. Will it be tabled today and if not, when?** RESPONSE: Joy Ellery noted that the CCG had been working on an approach to engagement before Covid-19, considering all the ways the CCG could engage with the public. It had been thought important to take this strategy through the Engagement Assurance Committee, for which there had been a large number of high quality applicants, an induction meeting in 2020 and a formal meeting early next year. The strategy would therefore not be ready in November but could be expected early in the coming year.
14.9	**QUESTION: What is the CCG, Trusts and ICS doing to counter fake news and false allegations about the safety of the developing vaccines or 'political' reasons for Government's use of vaccines.** RESPONSE: Dr Angela Bhan recognised the importance of the point and the need to work with local partners to ensure communications were joined up. There was a need to be clear about what was known, and what was not known about the vaccines, as well as tailoring communications for specific communities and groups.
15	**Any other business** There was no other business
17	**Date of the next meeting in Public: 21 January 2021**