NHS
South East London
Clinical Commissioning Group

CCG Governing Body meeting in Public

Minutes of the meeting on 17 September 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 Faruk Majid	Lewisham GP Lead, SEL CCG
Dr Adrian McLachlan	Lambeth GP Lead, SEL CCG
Dr Jacky McLeod	Lewisham 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
Dr Sabah Salman	Greenwich GP Lead, SEL CCG
Dr Krishna Subbarayan	Greenwich GP Lead, SEL CCG
Martin Wilkinson	Lewisham Borough Director, SEL CCG
Stuart Rowbotham	Bexley Borough Director SEL CCG

In Attendance

Simon Beard	AD of Corporate Services, SEL CCG (producing)
Dr Nada Lemic	Public Health representative
Julian May	Head of Governance SEL CCG (minutes)
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 third meeting of the SEL CCG governing body.

1.2	Apologies were received from Sarah Cottingham
2.	**Opening business**
2.1	Dr Faruk Majid requested duplicate entries to be corrected in the register of interests. No conflicts of interest were identified in relation to items on the agenda. **Action: JM to correct duplicate entries in the register of interest.**
2.2	The governing body **ACCEPTED** the minutes of the meeting on 16 July 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: I have just asked my new GP practice in Woolwich (the largest) about when I could get a flu jab as I have asthma. I was told that they don't yet have any flu supplies and they don't at the moment know when they will arrive. They had been on order for at least a month, but now in the middle of September no vaccines for adults including the elderly and extremely vulnerable. They do have children's vaccines. The same staff member told me that the CCG was the one responsible for the vaccines order.** **Can you please explain why the largest GP service in Woolwich has not yet had delivery of flu vaccines. When are they going to arrive and what is the CCG going to do to ensure that it is as soon as possible. Why has this occurred, especially during a coronavirus pandemic when protection from other respiratory viruses during the winter is key to ensuring our NHS copes.** **Can you also confirm how widespread this problem is, how many GP practices are also in the same position within Woolwich, Greenwich and the wider geographic area of the CCG.** **I'd like to note that I know other GP surgeries in other parts of the country have already started their flu vaccination programmes so their supplies have not been hindered.** RESPONSE: Dr Angela Bhan re-iterated the importance of the flu vaccination for as many people as possible who were as eligible. All practices had ordered Flu vaccine but this was being delivered in a phased way ahead of the formal start of the programme in October. A lead for flu was in place in each borough to assist practices. No delivery issues had been reported, and the practice would be able to advise on the dates when they would receive supplies of the vaccine
3.2	**Can you please tell me why there is no public consultation for moving of eye services out of the Princess Royal University Hospital to Queen Marys Hospital Sidcup and to another potential site of Orpington Hospital which will mean fragmenting the service.** **This move will affect so many people who are Bromley residents and patients. There was also a Are you also a petition signed by 6,000 people opposing this move in the summer, but no action appears to have been taken.** **The Orpington site is poorly located (with respect to so public transport**

	links for patients and accessibility of the building (steep steps). I believe there is an obligation for the NHS to consultation the public and this seems to not be happening. RESPONSE: Dr Angela Bhan noted that COVID-19 had meant that some services had been adapted temporarily at short notice. The West Kent eye centre had been on the first floor in the Princess Royal University Hospital (PRUH), surrounded by wards used for caring for Covid-19 positive patients. It had become clear that changes were necessary to protect staff and maintain services. The eye centre itself is now based at the Orpington hospital, with clinics continuing at the PRUH. Discussions were underway with Kings College Hospital NHS FT colleagues on how best to the deliver the service going forward, however no further changes are planned currently; the CCG will fulfil its obligations to engage with patients on any substantive service change.
3.3	**QUESTION: I am extremely worried about the irresponsibility of some private care providers.** **The care provider for my partner who is vulnerable with advanced Parkinson's condition doesn't issue masks and gloves for its visiting carers to his flat. When I emailed them about this they told me that masks are only issued for carers who visit clients with the Covid virus and to contact social services about my concerns. I don't feel it is appropriate for me to do this, and I feel if I do so, it might jeopardise the care for my partner, as I would be classed as a trouble maker. I wonder if you could advise me and also provide detailed information about the monitoring of the quality of private care services, especially during the present serious Covid situation.** RESPONSE: Kate Moriarty-Baker confirmed that all home care providers must follow national guidance on the use of PPE for home visits, including gloves, masks and aprons for direct care as well, along with other infection prevention and control precautions. The Care Quality Commission is responsible for monitoring providers, with the local authority and CCG having processes in place to monitor the quality of care provided. Those with concerns should raise them, in the first instance with the care provider. If concerns remain, then these can then be raised with the commissioner of the service or directly with the CQC.
3.4	**QUESTION: SEL Pathology Item 13 , Enclosure 9 p147ff We ask you to respect your public undertaking in response to previous questions from the Save Lewisham Hospital Campaign that decisions on pathology direct access service would be discussed and taken at borough based boards. It is very disappointing to see this commitment broken and a decision tabled to take away direct access for GPs and community services in Lewisham, Greenwich and Bexley to Lewisham and Greenwich NHS Trust for financial year 2021-2022 - a service that clinically has been working well to our knowledge. We were given an undertaking on more than one occasion at both Lewisham CCG public meetings and at Lewisham Healthier Communities Select Committee that the commissioning of direct access for Lewisham would be decided at the BBB. Reflecting devolved aspect of commissioning. LGT income of £12m out of the £29.4m in 2018/19 is over 40%of LGT's pathology income. Has the SEL made a risk assessment of the impact on the SEL health system, including the risk of destabilising the LGY Pathology service? Losing of contract for 2021/22 would mean loss of staff and service capacity and undermine the ability to demonstrate value for money for future years, 2022/23 onwards. Will you do this and leave the direct access to LGT until completed?**

	RESPONSE: Andrew Bland confirmed that there was agreement prior to the merger of the six CCGs in south east London about which decisions would be delegated to boroughs and which would not. Pathology is a decision reserved for the Governing Body as it covers all of south east London, which is why it had been brought here for agreement. The proposal had also been discussed at the commissioning strategy committee, which like the governing body, had representation from all boroughs. There will be no changes to how GPs or their patients accessed or experience the service. Although it was neither possible nor appropriate to speak on behalf of the board of the Lewisham and Greenwich NHS Trust (LGT), the CCG understood that LGT had been aware of the risk that these services, which were within the scope of the ICS London Pathology Network procurement, may no longer be commissioned from the trust.
4	**PRESENTATIONS The Acute Provider Collaborative in south east London – Professor Clive Kay**
4.1	Professor Clive Kay gave a presentation in his role as member of the newly formed acute provider collaborative in south east London. • Good partnership working had taken place in south east London, and the collaborative was an attempt to formalise this into a robust system. • Not a single patient was sent out of south east London for their care, possible through mutual aid and working together as a system. The importance of continuing to work together on the recovery had led to the start of the APC in April. • Chief executives of Guys and St Thomas' NHS Foundation Trust, Lewisham and Greenwich NHS Trust and King's College Hospital NHS Foundation Trust met in person fortnightly. The executive was supported by a clinical strategy and operations group with other groups planned to standardise approaches in the future, and an advisory committee in common across the trusts had held its first meeting. The APC was represented as a core part of the Integrated Care System leadership group. • The intention for the APC was to co-ordinate all activities across the acute trusts in a true collaborative, however currently the priority was elective restart as well as diagnostics and critical care for non-Covid patients. • Urology was a particular example of good working, with a well-established network, and joint consultants in place, chaired by the CEO of LGT. The network had agreed principles such as equity of access and avoiding long waits which were seen as applying across south east London, so that it would not be acceptable that one trust should have long waits while there was more capacity elsewhere. Endoscopy followed the same principle of individual trusts working collaboratively rather than in competition to provide equity of service across the south east London area. • Challenges included identifying workforce, with many of the workforce accustomed to working entirely within a single trust. Patients would need to be willing to travel to other parts of south east London. There was also a need to achieve an equal standard of care across south east London trusts, and minimise any unwarranted variation. In addition there was a need to provide separate pathways for patients with COVID and those without. • Next steps included standardising approaches 'horizontally' across the trusts, with clinical directors appointed south east London. There was also an opportunity to work vertically with all healthcare providers on a system-wide basis to join up care. This was a long term process rather than a short term fix, with the goal of acute providers sharing a single voice, standardising

	processes and even sharing waiting lists and working to reduce health inequalities highlighted by the pandemic.
4.2	Dr Jonty Heaversedge noted that the acute trusts were very large organisations and could be described as anchor institutions and asked what the role of the APC would be in relation to local communities. Prof Clive Kay agreed that the trusts were anchor institutions and so should be significant influencers in the populations we serve. Commenting on his own Trust, King's College Hospital NHS Foundation Trust, he reflected that more work could be done to go out influencing health in the community.
4.3	Dr Simon Parton noted that engagement across providers at inception of the design process would be beneficial, and suggested early engagement with primary care. Professor Clive Kay reflected on the speed at which the collaborative had set up much more quickly than in other areas in view of the pandemic, but recognised the need to engage with all elements of the ICS, looking at other models from elsewhere such as joint primary and secondary care leads.
4.4	Neil Kennett-Brown asked about the role of King's Health Partners (KHP) to support the APC and how this could strengthen the role of Lewisham and Greenwich NHS trust. Professor Clive Kay noted that discussions were ongoing, but the value of KHP becoming more inclusive had been recognised.
4.5	Folake Segun asked if, as the trusts were improving the visibility of waiting lists with each other, this would be shared with patients and how this would contribute to patient choice. Professor Clive Kay noted there is a need to be communicating more widely with patients, to outline that we now have very long waiting lists, and need to let patients know if it might be appropriate for them to have procedures at another site, whilst preserving patient choice.
4.6	Dr Jonty Heaversedge added that it was the responsibility of the whole system to develop communications in the way highlighted, with previous engagement showing that patients were often willing to compromise on choice in order to access care rapidly and safely.
4.7	Dr Nancy Kuchemann commented that Southwark had identified variation in catheter care and identified an opportunity for schemes such as programmes of rotation for nurses to share skills across primary and secondary care. She asked how similar transformational work could be supported across south east London by the APC. Professor Clive Kay emphasised his commitment to integrated working and reflected that in his work on a previous wave 2 ICS in Harrogate and West Yorkshire, subsidiarity had been a driving principle. The south east London APC would need to ensure the acute services were working effectively independently, but also to realise that the only way to provide better care with limited resources was to work in an integrated way. For this it was necessary to standardise care across the system and describe clearly how this care was joined up.
4.8	Dr Jonty Heaversedge thanked Professor Kay for his presentation, and also on behalf of the whole governing body thanked all the staff at King's College Hospital

	NHS Foundation Trust who, together with wider frontline staff across south east London had worked incredibly hard during the pandemic and were continuing to work to restart services.
5.	**PRESENTATIONS Showcase: Childhood vaccinations**
5.1	The governing body heard a video prepared by a GP practice in south east London encouraging patients to bring their children for childhood vaccinations.
5.2	Dr Angela Bhan noted that during the period of the pandemic the uptake of childhood vaccination has fallen, and although these levels had returned to normal there were historically areas of inequality in relation to vaccination. The CCG was therefore working to not only return to normal but to improve, focusing on supporting good systems of call and re-call in GP practices, while ensuring good infection control. There had also been work in boroughs with other teams such as the schools' immunisation team who by providing areas where people could be vaccinated safely over the summer, had been able to catch up with the expectations of the programme.
6.	**COVID-19 update** **Current response status**
6.1	Christina Windle noted the increase in COVID cases generally, but while each death was of course a concern, the additional deaths were proportionately much slower in this phase of COVID. The NHS was continuing to monitor these closely, sharing intelligence with public health and local councils, as well as discussing regularly with local providers. Preparations for increasing cases were important, and an after action review had been conducted to gather learning from management of the previous wave.
6.2	Annabel Appleby explained the overall recovery plan objectives had been set out - addressing the public health burden, addressing inequalities, a safe return to service delivery, capitalising on new ways of working and working within the resources available. Borough recovery plans had focused on understanding the impact of COVID-19, local plans and enabling infrastructure; they provided a local context which was the foundation of the south east London plan. The final plans would also take into account phase 3 planning guidance which set out delivery objectives related to the recovery of activity and restarting services paused during the pandemic. Phase 4 requirements were expected for 20/21 and the planning process for 2021-22 was set out in the papers.
6.3	Nada Lemic shared cumulative cases, rates per 100k and seven day case rate. She noted that data had very recently changed, and many of the indicators had changed for the worse, particularly in Lambeth and Southwark, meaning they were areas of national concern. A lot of surveillance was being carried out, and it seemed that while incidence was going up positivity rates remained relatively stable. Capacity in public health was an issue so joint working was important. South east London directors of public health now meet regularly with Public Health England and meetings included the Chief Nurse and Chief Operating Officer of the CCG. There was also joint working with Public Health England on contact tracing and more work on individual settings and schools.
6.4	Joy Ellery asked if the time taken to get results from COVID testing had improved.

	Christina Windle noted that a substantial change had not been seen to the 48 hour time for testing results. Biggest challenge was around getting tests through pillar 2, as capacity had been diverted because of hotspots and outbreaks. Because of capacity, any support from within south east London would likely only be possible for health and care staff rather than the public.
6.5	Dr Jonty Heaversedge asked about preparedness for the flu season. Angela Bhan confirmed that south east London had developed a strong network for flu planning. Regular communication with practices with advice and information ahead of a national campaign had been delivered. Supplies of vaccine were being monitored, and advice provided about ordering sufficient stocks. All lead providers had submitted flu plans for audit and were asked to ensure their staff were vaccinated. People 50-64 years of age would also be vaccinated later in the season, and there was work to ensure care home residents were vaccinated. The CCG was looking at the potential for mass vaccination centres as well as areas of less testing.
6.6	Mary Currie asked how healthcare staff were being supported to access tests in south east London through routes such as occupational health. Christina Windle noted that there was no formal process through occupational health to access pillar 2 testing in this area, however the first priority is to ensure additional provision for health and care staff, so had been talking directly with local labs.
7.	**Equalities update**
7.1	Dr Faruk Majid reminded people the governing body has taken particularly seriously the issue of black people's health, particularly in relation to the unequal impact of COVID-19. There had also been a commitment to address disparity in representation of different members of the population within health services. Welcoming the benefits of closer working and standardisation of care, he highlighted the importance of good communication with patients, and the use of the ICS to examine assumptions made around certain groups in regard to medicines or risk. Basic issues such as access to services was also important and it should be possible to explore ways of providing people the information they needed, rather than someone having to take a whole day off to see a GP for 10 minutes. A great deal of work was being done and there was an opportunity for more.
7.2	Christina Windle updated on work underway: additional governance forums had been added to ensure the equality agenda was being rapidly progressed. The CCG had been working with the director of inequalities and population health for the ICS to look at what best practice could be shared and what work should be joint across the system. Work with staff on race equalities had resulted in a commitment to ten areas of action. These had been reviewed and augmented by experts in NELCSU in relation to Workforce Race Equality Standard (WRES), to develop a WRES action plan and this was currently being engaged on with staff. Work was also being developed to support improvement in other areas of equality with a successful staff network under which it was proposed to start sub-groups for particular topics such as LGBTQ and Women and maternity issues.
7.3	The governing body **NOTED** progress and **ENDORSED** the direction of travel.

7.4	The governing body **SUPPORTED** chairs action to approve the WRES plan submission
8.	**Accountable Officer's Report**
8.1	Andrew Bland referred members to the accountable officer's report noting the critical importance of flu vaccination in view of the increased challenge this year, and work on the phase 3 planning response and recovery that the governing body had discussed.
8.2	The governing body **NOTED** the accountable officer's report
9	**Report of the CCG Prime committees**
9.1	Dr Jonty Heaversedge noted the large amount of work which was summarised in the report and thanked governing body members for their contributions to these committees.
9.2	Christina Windle outlined decisions required including minor changes to the schedule of matters delegated to officers recommended by the Integrated Governance and Performance committee, Remuneration committee recommendations which would be approved at private part two of the Governing Body, and the SLP Complex care business case, which had been recommended by the Commissioning Strategy Committee for approval following clarifications to explain the joint working with local authority and engagement planned.
9.3	The governing body **APPROVED** the schedule of matters delegated to officers.
9.4	The governing body **APPROVED** the SLP complex care business case.
10	**Board Assurance Framework (BAF)**
10.1	Christina Windle explained that the board assurance framework was reviewed in the Integrated Governance and Performance committee. There had been discussion on the rating of the equality risk, and agreement that it is an appropriate score based on mitigations being put in place. There had also been an agreement to do some deep dives and discuss in more detail some of the risks.
10.2	The governing body **NOTED** and **APPROVED** the board assurance framework
11	**Quality update**
11.1	Kate Moriarty-Baker outlined the work of the Quality and Safety sub-committee She noted that suicides were an area of concern during the pandemic and the committee received a report which suggested these had not increased. The independent medicines and medical devices safety review (the Cumberledge review) had also been examined by the sub-committee, and noted actions and processes in place in response. The quality and nursing directorate was working with Healthwatch to ensure patient voice was listened to as part of the work to improve quality and patient safety.
11.2	The report listed 93 Serious incidents (SIs) taking place in July and August

	including one 'never event' at Guys and St Thomas's NHS Foundation Trust. No particular themes to the SI's had been identified, but it was noted that in some a number of errors related to administrative errors, and support had been suggested in this area.
11.3	A review and staff consultation for the quality and nursing directorate had now been completed, intended to provide integrated working, a common approach, greater capacity and increased leadership to meet statutory responsibilities as well as supporting boroughs. The management response was being finalised.
11.4	Dr Jonty Heaversedge shared discussions about ensuring the safety of patients on waiting lists in south east London, noting an assessment process already in place and a detailed clinical review of patients waiting for long periods was proposed. Kate Moriarty-Baker confirmed that the Quality team were aligned with the commissioning directorate and so were able to work closely on these issues.
11.5	Mary Currie praised the ongoing work of the quality team which had been carried out at the same time as a staff consultation.
12	**Public Engagement principles**
12.1	Rosemary Watts presented engagement principles developed with local people and governing body members particularly Joy Ellery and Folake Segun. Important principles included clarifying the purpose, engaging with people early, recognising equality diversity and inclusion, and engagement and outreach to work with hard to reach groups. Digital engagement should work across various platforms and not incur cost to users. Non-digital engagement would need to consider issues such as ensuring printed material was up to date. The principles had also aligned well with those published by national voices and local people should be thanked for their time and contribution.
12.2	Neil Kennett-Brown reflected on a recent Greenwich Healthwatch event on black lives matter and BAME communities, where there had been a request for the CCG to go out to the community rather than the community coming to the CCG. Rosemary Watts noted that the issue arose in discussion frequently on the task and finish group. It was important to reaching out to community groups and leaders, and this approach had been followed to inform upcoming flu work as well as local events.
12.3	Dr Jonty Heaversedge welcomed the work stating the importance of the CCG working at a very local level with local communities.
12.4	Peter Ramrayka reflected that the principles and the equalities paper that we received today, demonstrated the strong commitment the CCG had to these important areas of collaboration, thanked those involved and supported the principles.
12.5	The governing body **APPROVED** the public engagement principles
13	**SEL Integrated Care System Pathology Programme**
13.1	Usman Niazi highlighted points from the paper for members: • The programme was not new; the ICS STP had set up a pathology network in 2017 responding to national requirements, which included

	direct access pathology as part of its scope and included representatives of all providers all six CCGs. • Final approval was always dependant on value for money, and the paper set out that the new network provision would not produce any additional costs and would save money. It is important to note however that the proposed option also scored the highest in terms of quality. • This change would not involve any service change for patients. GPs will continue to collect samples from the same premises, the only change would be to where these tests would be processed. • The decision would only be for 2021-22, even though the wider procurement is a longer arrangement, the commitment being made is only for the following year. • The paper set out some of the non-financial and financial benefits of the change. In all scenarios considered the CCG would make a financial saving. • The work had been done in partnership with NHS partners as part of the pathology network.
13.2	Dr Krishna Subbarayan asked if the calculations of financial savings were sufficiently robust so that taxpayer's money saved could be spent on other essential services. Usman Niazi noted that the modelled savings had been conservative so there was good confidence that it could be achieved.
13.3	Dr Clive Anggiansah highlighted the importance of ensuring GP's, district nursing teams, and anticoagulation teams had continued access to the service as part of the transition. Usman Niazi noted following an approval a transition programme would be set up to make sure there was continuity of services.
13.4	Joy Ellery asked for more detail on the quality benefits. Usman Niazi noted that the CCG had been part of the programme board, which had scored the proposed supplier highest on a number of service model and clinical criteria, and this had been reviewed with clinical representation.
13.5	The governing body **APPROVED** the commissioning of all direct access activity for 2021/22 from the Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH) Pathology partnership following the conclusion of the south east London Integrated Care System Pathology Procurement.
14	**Finance and planning report**
14.1	Usman Niazi presented the Finance report for month 4 for period to end of July 2020 in which the CCG had a year to date overspend of £11.57m but had reported breakeven position because of retrospective top-up funding available for COVID-19 related costs which had now been received. The majority of COVID-19 expenditure related to the costs of the discharge from hospital programme. In other areas, the prescribing position had been challenged since the beginning of the year because of increasing volume and unit costs, and continuing health care was being reviewed with the quality and nursing directorate to ensure control of costs.
14.2	The governing body **NOTED** the report and the CCGs month 4 financial position.

15	**Public Forum**
15.1	**QUESTION: Has any thought been given regarding those patients who would have to travel to the APC units, particularly those who may be in pain, elderly, disabled etc? Also need to consider currently the vulnerable during Covid on public transport. Any thought perhaps to help more with transport? Could perhaps treatment be at an APC and follow ups more locally?** RESPONSE: Dr Jonty Heaversedge noted that although Prof Clive Kay was talking about the proposals that could potentially mean some people travelling to different areas of south east London to keep them safe from Covid-19 when undergoing hospital treatment, these were still being discussed. Engagement undertaken with people from across London showed that they were willing to compromise on patient choice; they were equally clear that the CCG should put in place mitigations for vulnerable people in such circumstances. Experience in joint working so far had resulted in improved outcomes, and it had been possible to arrange follow ups more locally and put in place transport for the actual surgery.
15.2	**QUESTION: In the last year I have had telephone triaging from hospitals which worked very well, although the follow up conversations on test results need attention. As we move forward are there any plans to increase the telephone or video triage/consultations?** RESPONSE: Dr Jonty Heaversedge stated that telephone and video triage would continue to be available throughout the pandemic, as it was important to use these tools to reduce risk from Covid-19 to both patients and practice staff. The purpose of triage processes was to identify if people would benefit from a face-to-face consultation for those that needed it.
15.3	**QUESTION Communication is vital. As a patient with complicated medical history having used the services at all the APCs, I find that the PC systems used do not talk to each other which means the consultants do not have full medical information to hand. To aid this I carry an A4 sheet detailing all the information asked for or to help. To enable the APC to work together the systems used need urgent work (possibly by replacing pc which would be a cost)|.** RESPONSE: Dr Jonty Heaversedge agreed that sharing information was one of the most important challenges and it was vital to develop an understanding of what has been happening to people in different parts of the system. One of the key enablers for closer working would be to support teams from different specialities and organisations to work together with the same information. Work to build on, and bring together such approaches – for example the local care record in place already in some boroughs – was underway.
15.4	**QUESTION: The engagement principles are excellent, and demonstrate the commitment of all those involved in producing them. While we should ensure that people the CCG engages with at general meetings are representative of all people and communities being served, what they have to say should be well recorded and capable of dis-aggregation by the protected and other characteristics. This is not without its challenges, but without this dis-aggregation, it will not be possible to fully tailor CCG responses to specific needs and circumstances.** RESPONSE: Joy Ellery set out the work of the engagement task and finish groups had undertaken in carrying out around the monitoring of demographic

	information, but not thus far done for questions raised with the Governing Body as some like to ask anonymously. She welcomed further detailed feedback on how engagement could be improved.
15.5	**QUESTION Given the clear evidence on COVID in March and April, should the six CCGs have considered postponing restructuring to allow for all available resources to be allocated to the pandemic? In terms of engagement why was Greenwich left with no patient reference group unlike other boroughs?** RESPONSE: Christina Windle explained that by March 2020, considerable work had been undertaken already on the merger process. It would have been more destabilising, therefore, for the CCG to have halted the process rather than continue taking it forward. The CCG had recognised, however, the need to devote resources to the pandemic, redeploying some staff to support NHS frontline partners directly and also focusing on work streams within the CCG to address the impact of the pandemic.
15.6	**Questions received for which there was not enough time for a full response during the meeting are listed below, together with the CCGs response** **QUESTION: In terms of horizontal standardisation of services across SEL can patients assume that services will be levelled up to the best example of provision rather than meeting the lowest common denominator? E.g Can patients expect not to travel further for existing services?** RESPONSE: In making any changes to services, two issues are always at the heart of any decision – improvements in quality and impacts on inequalities. The latter, which includes where some people may have to travel further for their care, is a very important factor that requires very specific attention and public engagement to inform decision-making, as required. **QUESTION: I miss verbal questions and secondary questions. My emphasis would be on LOCAL whether its layers to deal with engagement and engagement assurance at the local level or the central role of an expanded Public Health in track and trace.** RESPONSE: Thank you for your question and we do hope that at some point in the future we will be able to return to holding meetings that support face-to-face conversations, but it is also important to note that virtual meetings also widen out access to those who may not be able to travel to such events. Additionally all meetings are meetings in public not public meetings and the approach to questions (with questions submitted and then answered in appropriate sections) is the same. On the issue of public and patient engagement, this will continue to be delivered locally as well as at a south east London level, with central oversight provided by the CCG's new engagement assurance committee to ensure consistency of approach across south east London. With regard to public health, this is a service provided by local authorities – which includes delivering requirements set nationally by Public Health England. Here in south east London, public health teams do work together to address common issues. Our Governing Body does have a public health representative and public health directors have been represented heavily in the systems put in place to deal with the current Covid-19 pandemic for example to ensure that the health and care systems in south east London provide a co-ordinated response.

	QUESTION: What public engagement has been undertaken around the pathology procurement? RESPONSE: This is a procurement process not a service change – clinicians and patients will see no changes in how the service is delivered and where. Assuming that a new contract is confirmed by our colleagues at Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust, they will develop a mobilisation project that will involve engagement with GPs and their staff in particular in the roll out of the new service during 2021/22.
16	**Any other business** There was no other business
17	**Date of the next meeting in Public: 19 November 2020**

NB: All questions shown in bold are quoted verbatim from the questions raised to the CCG